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# Ontario Medical Journal.

SENT TO EVERY MEMBER OF THE PROFESSION IN ONTARIO, BRITISH COLUMBIA,  
AND NORTH-WEST TERRITORY.

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All Communications should be addressed to the Editor, 147 Cowan Avenue, Toronto.

VOL. III.]

TORONTO, MARCH, 1895.

[No. 8.

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations. Physicians who do not receive their Journal regularly, or who at any time change their address, will please notify the editor to that effect.*

## Editorials.

### THE ACT TO AMEND THE ONTARIO MEDICAL ACT.

During the last election for the Legislative Assembly, a very important class of the community in Ontario, representing the farming element, made a fairly successful attempt to get representation of their own in the House, irrespective of the two old parties. The movement is an old one brought up in a new form, and promises to be of some use, both to that particular part of the community and to the public at large.

The members elected are men of good standing, and presumably of good understanding, being supposed to be the strongest in the riding for which they were elected. Whether they are the strongest, or, indeed, whether they are strong, they have still to show, as their actions so far, both in the line of voting on measures on which they built their platform, and on measures promulgated among themselves as new Acts or the repeal of Acts, are a source of wonder to ordinary thinking men.

Politics are far from our line, but one bill,

brought forward by Mr. Haycock, with the Patron support, is most decidedly our business, namely, "The Act to amend the Ontario Medical Act." It was our intention to give an expression of opinion on this bill to the medical public before the second reading, but, unfortunately, through unforeseen circumstances, we are publishing too late. An apology is hardly necessary for the delay, but if anyone wishes it we are quite willing to give it.

The gist of the bill was ridiculous in the extreme, both from the standpoint of benefit to the profession and benefit to the general public. All the good clauses in the Act were to be repealed, and many others, almost iniquitous ones, to be added, giving scope to any kind of quacks, fakirs and midwives. We are satisfied that if it had become law the Patrons would surely have been the first ones to ask for a repeal of their own legislation after a trial of one year, as their constituents would certainly have been that part of the people most open to the workings of the class they were allowing into the profession.

The questions dealt with showed their real value when every member of the House, except the Patrons themselves and one other, voted against them *in toto*. There was no thought to

go through clause by clause as is usually done in any Act worth debating over. The remarks of Sir Oliver Mowat, Mr. Whitney and many others of both the Reformers and Conservatives must have shown the Patrons the feelings of the general public. Truly Mr. Haycock needed a good experienced nervous specialist after the shock to his—back-bone, we had almost said, if we thought he had any.

Ever since the opening day a certain couple of tabooed medical (?) men have been going round the city boasting of what they could do and were going to do when this Act passed. These were the same men who inspired—in fact, wrote—the article in the *Farmers' Sun* attacking the Medical Council. Taking into consideration the public characters of both medically, and one of them in the Police Court, we are surprised that such a sensible body of men as the Patrons should have had anything to do with them.

The position of the profession and the Council as their representatives is assured, and they could not have a better example of the good opinion that the general representatives of the people have of them.

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#### THE TREATMENT OF INFLUENZA.

In the *Presse médicale* for February 6th there is an interesting article on the clinical forms of this disease and their treatment, by Dr. A. F. Plicque. The whole article will well repay the reader's perusal, but our space will not admit of our dealing with more than the therapeutical part of it. In the common forms of the disease, without special complications, hygiene, with rest in bed, says M. Plicque, should be the foundation of all treatment. Hot drinks also may be employed. Milk is one of the best, and has the advantage of being an active diuretic. Coffee is also useful in prostration and headache. Antipyrine, in daily amounts of from thirty to sixty grains, gives good results in headache, although it sometimes increases the cough and the bronchial irritation. Tincture of aconite root, from ten to thirty drops a day in divided doses, may be given when there are fever, general malaise, and laryngo-tracheo-bronchial catarrh, but it occasionally increases the nervous agitation. Quinine still remains, perhaps,

says the author, the agent that more thoroughly reaches the disease, although it sometimes aggravates the feeling of weight in the head; this, however, is less marked with quinine hydrobromide and with the valerianate than with the sulphate. A gentle purgative is always useful during the first two or three days in cases of gastric derangement. If the thoracic symptoms are intense, manna or castor oil is preferable as a purgative.

In the common forms of the disease the most important advice to give the patient is perhaps that which deals with the antiseptic treatment of the nose, the mouth and the pharynx. Gargling with a solution of boric acid, or with a 1 per cent. solution of chloral, intranasal applications of vaseline and boric acid, and great care in cleansing the mouth, are pretty sure to prevent certain complications, such as angina, abscesses, otitis, perhaps even broncho-pneumonia, and will certainly be of great service.

The thoracic symptoms of grippe are extremely variable, and the most painful symptom, which was particularly observed during the last epidemic, is a convulsive cough which often gives rise to vomiting. The following prescription, which was recommended by Monin in cases of whooping-cough, has given rather good results: Tincture of belladonna, tincture of aconite and tincture of drosera, each thirty grains, tincture of myrrh, 150 grains. From twenty to thirty drops a day are to be taken in divided doses.

The congestion of the underlying structures often resembles that of typhoid fever, and, as in typhoid fever, it is combated by the lateral recumbent posture and the sitting posture. It is often indispensable to make the patient lie down for several hours a day on a couch. Daily dry cupping, or, if necessary, wet cupping, in robust persons, should be practised. Blisters are usually more harmful than useful. Tonics, coffee, cognac, and Todd's potion should be employed.

In cases of respiratory catarrh with abundant expectoration, an emetic is often used for children and adults. Preparations of kermes and antimony may be carefully used. Forty-five grains of ammonium hydrochloride a day, given in six doses, is preferable to the former. In cases of nervous symptoms of an ataxic type, with agitation and delirium, potassium bromide is the best calmative:

it has no harmful, depressing influence if it is administered in small doses. From thirty to sixty grains a day may be given. Chloral is more efficacious in insomnia, but it sometimes increases the cough, which, however, is not so marked if a syrup of chloral containing a bromide is used. In addition to these medicines, cool compresses on the forehead and cooling lotions are indicated, and in obstinate forms heroic measures, such as a cold or hot bath.

Adynamia is, in the nervous form, more frequent than ataxia. Here hygienic means, such as pure air, stimulating frictions over the entire body, inhalations of oxygen, coffee, champagne and alcohol should be employed. Adynamia is sometimes so marked that LeGendre, says M. Plicque, advises strychnine. Kola is also very efficacious in the nervous depression that manifests itself in certain forms of the disease. It may be given as a wine, as a tincture, in powders, or granulated. The latter form seems to contain the largest quantity of the active principles. If the tincture is used, it may be associated with equal parts of tincture of coca.

In the cardiac form, aside from external means, subcutaneous injections of caffeine and of ether may be resorted to. Injections of 150 grains of sterilized olive oil and thirty grains of camphor are also productive of good results, given from once to three times a day. To the ordinary remedies for the adynamic symptoms tincture of digitalis may be added, and from twenty to thirty drops a day may be given in divided doses.

The gastro intestinal form should be treated in the beginning with emetics in young persons and with saline purgatives in old persons. Frequent washing of the mouth with an alkaline water will diminish the sensation of puffiness and anorexia. For profuse diarrhoea intestinal antiseptics, such as salol, bismuth salicylate and naphthol, should be employed rather than opium, the action of which is always doubtful in infectious diseases.

In convalescence, often long and painful, hygienic treatment is especially indicated, and arsenic, cinchona, coca, kola, and sometimes iron are particularly indicated. In cases of neurasthenia and of persistent weakness, it should be ascertained if the phosphaturic albuminuria described by M. Albert Robin is present.—*New York Med. Jour.*

## A DEARTH OF OBSTETRICIANS.

It is a decided anomaly as well as a paradox that almost all obstetricians are either general practitioners of medicine or gynecologists; at least these are the names they seem anxious to be called by. If a man has surgical knowledge, or is ambitious in that direction, and has, in addition, a well-deserved reputation for obstetric experience, he submits to his reputation but calls himself a gynecologist. Another, if he be willing to acknowledge no special training or capacity in practical surgery—and few indeed there are of these—will pose as a general practitioner and rely on consultation for operative assistance. But none of them will call themselves that which they are in fact—specialists in a science which their large experience, hard work and accepted writings prove they know most about. Why this is so we are at a loss to explain; and moreover we do not like it. It smacks somewhat of a hypostatic union of doctor and undertaker. For, as we have had occasion more than once to point out, obstetrics is a science of such far-reaching effect in relation to other branches of medicine that, if a man puts his best efforts into this, he must be prolific indeed if he have time or energy for the mastery and practice of any other; while so great and dependent is the relation between gynecology and this science that, when the latter has reached a position of usefulness commensurate with its aim and scope, the gynecological *specialist* must break his tools and seek another trade. Therefore, as we suggested in our reference to the combined personality of doctor and undertaker, an obstetrician who practises as a gynecologist would seem to *sow* in the one specialty and to *reap* in the other. To gynecology does obstetrics owe, in great measure, its marked advancement in the past twenty years. To a gynecologist does it owe the axiom: "When the child's head fails to recede after pain, apply the forceps." Owing to the general adoption of this advice not only have many lives, both of mother and child, been saved, but vesico-vaginal fistula, once the commonest sequela of labor, is now almost a *rara avis* in gynecological hospitals. To a gynecologist is also due much of the successful treatment in the prophylaxis of abortion and in its arrest when threatened. This specialty, indeed, has been as a mirror of truth to

the obstetrician, and the latter has not failed to profit by what he has seen therein. It would not be surprising, then, if he studied gynecology for the better understanding of his own specialty; but this does not seem to be the reason why. For, however well equipped he may be in his special knowledge, he does not claim to be an obstetrician practising in the light of gynecology; rather is he a gynecologist who practises obstetrics as a side-branch. Does not this present the spectacle of "the horse riding inside the cart"?

An obstetrician should undoubtedly know gynecology. If he would advance he must study his own science by reflected light; but he should not practise both specialties. Where he gains in one, he will lose in the other; for it is a clever man who is a complete master of *one* trade. Indeed, we are inclined to think that, in adopting the practice of gynecology, an obstetrician rather interferes with his usefulness as a practical obstetrician. He is apt to become prejudiced by his new training. A gynecologist is accustomed to repair the *results* of obstetrical mistakes; he goes to Nature's assistance after she has completed her immediate efforts at repair and is quiescent—when she is "stalled," as it were, and is waiting for assistance. And if he attempts with equal assurance, as he is apt to do, to apply these same methods when Nature is in an active, intolerant mood, as in childbed, he will often find his confidence misplaced.

Finally, we believe in specialties strictly adhered to. Their existence is at the same time a confession of the paucity and inaccuracy of our knowledge and the best remedy for these. In the present state of medical science, specialties are the necessary stimulus and the quickest method by which to approach scientific exactitude. In the medical millennium, there will be no specialists nor need of any; our successors of that time may rely on their title of general practitioners. But the millennium for us is a long way off, and we shall, therefore, hail the day when our many distinguished and deservedly eminent obstetricians will be proud of this title and content to be known as *specialists in obstetrics*. Then will this noble science receive a new impetus and advance with giant strides, until the time arrives when gynecology will have fulfilled its end and will receive

its euthanasia.—*Editorial, American Gynecological and Surgical Journal.*

## British Columbia.

*Under control of the Medical Council of the Province of British Columbia.*

DR. MCGUIGAN, Associate Editor for British Columbia.

### STATUS OF MEDICAL MEN.

It is about time that the medical profession set about seriously to assert its rights and to resist the tyranny which time out of mind has been assailing it.

Many articles have been written in medical journals and in books showing how our profession is imposed upon, but still the work goes on. It seems to be generally agreed on all sides that the medical profession is a fair field for plunder; and the most that can be got out of it for the least money, so much the better. It is not that there is anything mean or small about the disciples of Esculapius in their dealings with their fellow-creatures, for a more altruistic body of men it would be hard to find. If such exists anywhere they will have to be sought in some other planet, for certainly they are not to be discovered on the earth. In that bright sphere of the West called the evening star, which bears the name of the goddess of Love, there may be creatures who in their self-sacrificing affection for their species may rival the extraordinary beings we are now speaking of belonging to this world, but as we have never heard of them, the palm must still be retained by the human bipeds known as the followers of Galen.

From the nature of his calling the medical man is liable to be summoned at any hour of the day or night. To state this is only to repeat a common-place remark. But it is in the readiness with which the physician responds to appeals to his assistance that he shows himself to be the real friend of suffering humanity, and one would think that the gratitude of society would be spontaneously extended to him. On the contrary it tries to do him up on every possible occasion, and if he makes a mistake or is guilty of the slightest moral lapse, nothing too severe can be done or said against him.

The physician is one of those unfortunate men

who often have to work for nothing and pay their own expenses, and when they are paid it is often grudgingly and after periods of time which place the accounts almost beyond the statute of limitations when collection is impossible. Even in legislation, which is the highest function of society, the doctor is discriminated against. In cases which come under the administration of justice, where the skilled knowledge of the medical specialist is called into requisition, he is dealt with in a parsimonious, niggardly way not at all in keeping with the importance of the momentous questions he is called upon to decide.

In determining whether a certain suspicious death has been produced by criminal means or not, the agency of a medical man of first-class qualifications is frequently required. The work required to be done under these circumstances is always most particular, frequently laborious, and often positively disgusting and nauseating. It is work, too, on which the safety of society depends, for upon the evidence of the medical man it rests whether the sleuth-hounds of the law shall be let loose and a criminal be pursued to his doom, or on the contrary, that no further steps are necessary and that justice is satisfied.

Let us see what is his reward. In Ontario, the premier province of the confederation, the fee for a *post-mortem* and evidence is ten dollars; in British Columbia and Quebec, which with Ontario are certainly the most intelligent portions of the Dominion, if we may judge from the fees paid, the amount is also ten dollars. In Nova Scotia it seems that five dollars is considered sufficient recompense for the amount of knowledge imparted by a medical man to a coroner and his jury after making a *post-mortem* examination, but we notice that the blue-nose legislature gives him five cents a mile for travelling expenses. This latter item speaks well for the abstemiousness of the average medical practitioner of Nova Scotia, for certainly five cents a mile allows him very little room for the indulgence of any expensive fancies unless everything else is on the cheap scale on which his services are reckoned. Even this very insignificant pittance seems to be grudged him, for he is to be allowed nothing at all unless he is called by the direction of the majority of the jury, and a certificate from the coroner that such an examina-

tion was required. In Prince Edward Island the same remarks are applicable as in the case of Nova Scotia, with the exception of the certificate of the coroner and the majority of the jury, which do not seem to be necessary. In New Brunswick fees are a little better than in the two last provinces mentioned, for eight dollars is the sum set down for a *post-mortem* and attendance there. It is remarked in the work from which we are quoting, "Boys on Coroners," that in Manitoba witnesses at coroners' inquests are seldom paid. If a medical witness is paid at all he is allowed four dollars a day. Comment on the foregoing is unnecessary. In the various charges, too, laid under the Act for the adulteration of food, medical practitioners with special knowledge are often summoned to give expert evidence in what may be called quasi-criminal cases, and it would appear from what transpired in the police court in Vancouver not long ago that a physician who can give expert evidence may be summoned and be compelled to testify without any recompense at all.

The following from a Vancouver newspaper, the *World* of Feb. 27th, speaks for itself. It was a case of alleged adulteration of milk, and after many witnesses of various kinds had been called in without eliciting very much definite information, Dr. Thomas, who has devoted himself for years to chemical analyses and is considered a good authority on the subject, was summoned to give his evidence. "He said that he knew nothing of the facts of the case and did not care to give expert testimony unless his fee were guaranteed.

"The magistrate said that he had no power.

"Mr. Russell for the defence said that he would give no undertaking on behalf of the defence.

"Mr. Hamersley asked if in a quasi-criminal case a witness could demand his fee.

"Dr. Thomas said he did not see why he should give gratis what had cost him time and money to acquire.

"The magistrate said he would look into the matter and requested the doctor to give his evidence."

We must cordially endorse Dr. Thomas' stand in the above matter and we feel certain that he will be backed up by the medical profession everywhere in the Dominion. It is a simple outrage

that such things should be and that medical men should have to work with the sweat of their brows without thanks and without pay as in this particular case and others like it to protect the general health of the public. It is almost unthinkable, and yet it is a fact. It is a subject worth pondering over once more, and haply in time the medical profession may be successful in devising some means of escaping from this ignominious position.

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### Original Communications.

#### PROSTITUTION IN THE PROFESSION.\*

BY DR. JAMES SAMSON.

This little paper, I have to assure you, will be wonderfully barren of all that literary decoration which has always added so much to the delightful interest we have experienced in listening to the many papers that have from time to time been presented to the Society. It shall, instead, be simply a few plain, cold-blooded observations in reference to a malignant pustule that has, during the present generation, planted itself on the body of the profession with very much of the same results that always have and always will follow the history of malignancy everywhere.

The medical profession has for a long time enjoyed the dignity of standing in the very forefront of respectability among the educational organizations of the world, and it has, we all believe, I trust, honestly deserved this recognition: first, from the high standard of its attainments; second, from the tremendous interests involved in its pursuits, and, lastly, from the fidelity and honorable energy with which its disciples have, in all modern days, dedicated their best energies to the duties of their chosen avocation. And all of this dignity has been but an accumulation of the individual worth of the members of the profession. That this condition of affairs shall always continue, is a "consummation devoutly to be wished for," both for ourselves and in the interests of those whose very destinies are so largely in our hands.

So literally is this true, that no wiser injunction could be impressed on him who passes through the portals of admission to the profession than to remember that his dignity and self-respect will win him half the power and usefulness he shall ever possess, and that the great public to whom he goes will ever respect him most who most respects himself. And so I believe that he who peddles his profession prostitutes it, and pays for his crime the inevitable price that prostitution has always paid—both in his own personal humiliation and in the degradation that his debauchery brings on the craft to which he belongs.

It was no honorable motive that first inspired the damnable heresy of co-operative medicine, nor has anyone ever claimed that it was even a humane impulse that fathered this ill-begotten innovation. Almost every so-called benevolent organization known among the sons of men in our day had a bastard birth, and under the hypocritical guise of Christian charity, was chartered and founded to fill some man's pockets or the measure of his ambition. And as all men in their average daily conduct seem so prone to value their money more than their lives, the audacious scheme was concocted of offering them the bonus of gratuitous medical attendance as a special inducement among all the others. And so the profession that has always done and always will do, to the very verge of eternity, more for charity's sake than all others, was asked to add a halo of respectability to this scheme of modern philanthropy, to accept all men as paupers, to care for them in sickness and distress at the ordinary rate paid by all other corporations for all other paupers, a rate which, by the way, has always been considerably less than the average horse-breeder would gladly pay a veterinary surgeon for the care of as many average horses. And so doctors in hundreds and thousands, with a strange fascination for that which promises money on the spot, have taken the thirty pieces of silver, and made themselves part and parcel of the scheme. Some enlisted because poverty suggested the crime: some because of the promise of a possible inroad into homes to which they might otherwise for a long time remain strangers, and perhaps never reach, unless artifice was employed as an accession

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\* Read at the February meeting of the Windsor Physicians' and Surgeons' Association.

to brains; some from an easy-going thoughtlessness as to the true inwardness and inevitable tendency of the ill-shapen scheme, and some from that wasted love of charity that so strangely seems to grow faster in some doctors as they themselves grow hungrier. Charity, forsooth!—a charity unique, in that it curses both him that gives and him that receives.

And so it goes on, and the man who possesses houses, and lands, and stocks in the bank, and a mortgage on the physician's home, can command his services and claim his professional bondage for a year for the same money he would pay a dog-healer for the inspection of a hound with the mange. And the hireling going from door to door gathering mites from the rich and the poor, no greater often than the umbrella-mender gets, and with more feeling of contempt for himself than his fellow-practitioners have for him, slowly and quietly ousts the old family physician out of the home, and little by little makes of him an enemy. Or he sees the sick man recover and himself dismissed with as little ceremony as a beggar, and the day after sees another carriage at the door and another doctor caring for the family, and his own humiliation increased. Or he finds that the man who pays like a pauper commands like a king, and wants as much attention paid to a carbuncle as would be given to a garrison poisoned with cholera. And he comes and he comes, again and again, and goes into the house half sneaking, and comes out of it cursing the contract that gave him a pittance to put himself under obligations and be a slave to an unreasonable hog. And then he himself is sick of it all, and knows as he lives that there is no enjoyment or satisfaction and but little present or prospective profit in it, and that he and all his fellows around him know that there never was one righteous reason why he should have enlisted in the work, and in his sober moments now nothing this side of heaven but a native-born, constitutional meanness, that should have kept him out of the profession forever, can prevent him feeling assured, beyond all doubt, that the entire system is a crime against the dignity and harmony and prosperity of the profession. And with the patient really sick, and growing sicker every hour, the prospect of a con-

sultation with the family physician, and all that such a consultation implies and always will imply so long as man is human, there are moments then that no schedule of lodge fees ever yet fully provided for. And with the man in his grave, the recollections of the expression on the face of his wife as he first entered that home on his mission of woe come to him with a vividness that threaten to make them permanent; and as there looms up before him a picture of the place that same woman may occupy in his affairs during the next ten years, he will feel that there is an item of suspense also not provided for by either the constitution or by-laws of the great high and mighty muck-a-muck who laid the foundation for this wonderful bulwark of philanthropy. And when the grass is green again in the church-yard, and the widow and the heirs and administrators of the deceased have closed out their whole edition of their versions of the cause of death, and the annual meeting of the lodge has come around again, and a "put up" vote has put another physician in charge, it is then that he (the doctor I have been writing of) goes to his home in the dark, and goes away out behind the barn to swear that Scugog Lodge No. 784 will see his face no more forever, and to swear it alone, where no man may hear, and go away wondering whether the doctor's motives were manly or mercenary when he first stood at the door of Scugog 784, praying so earnestly for admission to all its rites and ceremonies.

And, finally, I need not linger long in referring to the moral of it all. That man is now, and ever was, and ever will be the best member of any profession who himself most highly esteems his membership. The physician who has learned to place a low estimate on the value of his services, will learn sooner or later that no one else's estimate is higher than his own. His charity should be charity pure and simple and undefiled, and all else should be business and business only. Those will be his most steadfast and abiding friends whom he has won by the most dignified, most manly and most skilful display of his real worth and his own individual pride in his profession. And his personal standing among his fellows will some day appear to him as they really are—matters of intense importance.

## AXILE ADJUSTMENT—A NEW AND RATIONAL METHOD OF DELIVERING THE PLACENTA.\*

BY WM. R. NICHOLS, M.D., BADEN, ONT.

The paper I have ventured to bring before your notice to-day, under the heading of "A New and Rational Method of Delivering the Placenta," needs an apology for its title, since it is new only, in the sense that no reference to its principles can be found in any literature at hand, but it is not presumed that many of you, who are experts and veterans in the obstetric art, have failed to practise long before the writer some of the procedures appertaining to the method. On the contrary, it is believed that, as your experience has become riper and your management more dexterous, you have departed from the teaching of the schools and books and have arrived at a practice in accord with principles I now attempt to establish.

If these principles be intrinsically true and universally applicable, then the methods in vogue must be incidentally successful, and, as such, irrational, irrespective of the measure of success they apparently give, and the discussion of these principles, which this paper is sure to evoke, cannot fail to be of interest and profit: for they vitally concern that stage of labor which is admitted by all to be the most important, and the most fraught with dangers and accidents to the lying-in-woman.

The manner of delivering the placenta has been described as being accomplished by one of four methods, viz.:

The natural method, wherein Nature herself is competent, as she is generally, with the child;

The method of traction on the cord now fairly obsolete;

The method of expression, as enunciated and taught by Crede, but which had been practised long before his time, by the Dublin school, and taught even in our own backwoods province by the late Dr. Workman, when Professor of Obstetrics in King's College, Toronto;

And lastly, the method of manual extraction, the last resort in failure of the former methods.

As the method of Crede has superseded the

former methods, and is accepted without question as the method *par excellence* it is to it we wish to pay our respects, and to do it the deference of quoting its technique in full and of commenting thereon. "Firm pressure is to be made upon the uterus downwards and backwards in the axis of the pelvic ferrein when a contraction is felt to begin." At the outset it is admitted that much success has attended this manipulation, but the same may be said of any particular procedure, in any condition wherein nature co-operates—in other words, where success is incidental to the method and not intrinsic or essential. The limits to which this "ferrein pressure" and these forcible efforts may be pushed appear to be, on the one hand, the amount of violence the woman can tolerate, and on the other the manual strength of her intellectual attendant. I speak of what I have seen, and, it may be, of what I have practised. I can never forget the amount of violence offered to a uterus and abdomen (not to speak of tender endothelium) at my first case of labor in a lying-in hospital. The vivid remembrance of that occasion must bear the onus of inflicting this paper upon you. Cases that cannot be thus delivered are denominated "retained placenta," and such retention is taught to be due to either hour-glass contraction or organic growth to the uterine walls. As I have been unable to satisfy myself of having met more than two, if even so many, cases of true organic growth of the placenta to the uterus, and not even one instance of hour-glass contraction in over half a thousand accouchements, I am obliged to consider the retention to be due, in the great majority of cases, to other factors. That cases of retention are fairly frequent, we are led to believe from the histories of patients whose statements that the afterbirth was grown fast, is by no means uncommon.

Meeting occasionally with cases of natural delivery wherein nature is competent, without any assistance from art, and, at other times, with cases of "retained placenta" under conditions apparently as favorable, I felt myself mystified when attempting to furnish an explanation for the difference, and when I was obliged to submit my patient to the risk of manual extraction for a placenta showing no trace of organic growth to the uterine walls, or any other condition accounting for such

\* A paper read before the Waterloo Medical Association, at Berlin, December 7th, 1894, and by it sent for publication.

retention, I was far from feeling comfortable and satisfied.

If a careful palpation of uteri at this stage of labor be made, it will be found that they possess marked variations in form. Some are markedly irregular and bossed, whilst others are fairly uniform. These variations, so far as I am aware, have met with no interpretation: they are significant, however. Reflecting that the structures superimposing the placenta, viz., the abdominal and uterine walls, are uniform in thickness, I was forced to the conclusion that the variations are due to the position of the contained placenta, but in just what shape the placenta was I could for a long time form no proper idea. An observation that I had previously made, long before I could attach to it either diagnostic import or indication for treatment, has a bearing upon this point. It was to the effect that, when blindly manipulating the uterus *a la Crede*, I was on a number of occasions almost startled by a sudden slipping or jerking within my hand, accompanied by a transformation of its contents, which was manifest to the patient as well, though not painfully, and delivery generally occurred soon after without further solicitation. By degrees it began to dawn upon me that this slipping and transformation was a turning or version of the placenta upon its axis, similar in manner to the version of the fetus at times. Further attention to these points showed that a certain rough relationship existed between the form (as felt through the abdominal walls) and the ease with which delivery was accomplished. When the uterus was fairly uniform, free from bossing and elongated rather, nature was frequently competent, or but little difficulty was experienced by artificial methods. When the uterus was markedly bossed, irregular, and broadened rather, more placental dystocia was present, or retained placenta were obtained.

As before stated, I regarded these variations in shape to be due to the position of the contained placenta; in other words, to the relation of the placental axis to that of the uterus.

In order to have an intelligent conception of the placenta, it is necessary to examine one that has been delivered. It will be found to be possessed of an elliptical rather than a circular form; but it is not by virtue of this that we can speak of its

having an axis, though doubtless this may occasionally be so. There will be revealed also, deep sulci or furrows on its uterine surface, which surface, before the birth of the child, presents a convexity corresponding to the concavity of a segment of the uterus, against which it is in opposition. The sudden diminution consequent upon the expulsion of the child but completes a process of folding the placenta upon itself, already initiated by its previous convexity and sulci. It is with this folded placenta we have to do. Folded it may be seen when emerging from the ostium vaginal, folded it may be felt when passing through the os uteri, and folded it lies within the cavity of the uterus. It matters not whether it is folded equally or unequally, the practical consideration being that a more definite axis has thereby been given it, which passes, roughly speaking, through the points of reduplication of its edges, these points corresponding to the poles of the fetus. Simply its relative length has been increased. We will now define the axis of the uterus to be in that diameter which passes from the centre of the os to the centre of the fundus.

If, now, within the cavity of the uterus the placental axis as previously defined corresponds to the axis of the uterus as above given, we will have, as determined by abdominal palpation, a fairly uniform, somewhat globular and elongated form. This form, I have already remarked, obtains wherein nature is frequently competent, and wherein the least dystocia occurs. The reason is obvious. If, on the contrary, the axes do not correspond, we have more or less irregularity and bossing as the placental axis deviates from or approaches that of the uterus, the greatest deviation resulting in a "placental crossbirth," a condition much more frequently met with than foetal crossbirth, owing to the antecedent disparity in size of container and contents to the original site of implantation and the subsequent contractions of the uterus. In the condition referred to as placental crossbirth the poles of the placenta do not present at the os and fundus, but at two opposite points midway between these. A relatively broad surface is thus in opposition with the os, too broad and too large for it to enter that opening, and any contractions occurring (which operate below the lower pole as well as above it) tend to imprison rather than to expel

the placenta, until such times as a correspondence of axes has by whatever means occurred. In this we have the explanation for the cases of so-called retained placenta, so common without trace of organic connection. This correspondence of axes is occasionally brought about by successive contractions indefinitely prolonged; but it is evidently the duty of the physician not to wait for the efforts of a partially exhausted organ, lest further efforts induce complete exhaustion and precipitate inertia and hæmorrhage. When the axes correspond or have been adjusted, a pole presents at the os, which uterine contractions now cause it to enter and readily dilate by bringing into play the mechanical principles of the wedge—the blow or power being represented by the contractions, the wedge by the sloping pole of the placenta, and the resistance by the moderately contracted os.

My limited experience in this undeveloped field leads me to believe that it is possible in the vast majority of cases to diagnose the condition of placental crossbirth, and in cases of less axial obliquity to determine whether the upper pole is anterior or posterior, or right or left with the lower pole in a corresponding opposite position. Nor is the acquiring of this degree of refinement in palpation to be considered a feat of any comment, when slightly enlarged appendices and tubes are daily diagnosed and accurately mapped out in abdomens having nothing of the flaccidity that is present in the third stage of labor. Who of you will affirm it to be impossible to locate within the abdominal cavity a body having the dimensions of a folded placenta? I know, gentlemen, you have met with no difficulty in palpating the floating kidney, and I believe that when you have given this subject your serious attention you will diagnose the position of the placenta much more rapidly than I can even speak of it. The projections or bosses correspond to and are caused by the poles of the placenta, which the hand, rapidly swept over the fundus uteri, deeply behind it and over its lateral and front walls, readily detects. There is also a resistance at the poles entirely different from that at other points, and, the poles located, the position is determined. Some of you may object to this, and say, if it be such a simple affair to diagnose the correlations of the placenta, why is it we do not apply the same method to determining the position

of the child, instead of resorting to vaginal examination? Whoever of you has had a *foetal* cross-birth, and has taken the trouble and care to examine the abdomen, will have been struck by the unusual form—so unusual that inspection surmised the condition before palpation confirmed it. We are the slaves of habit, and are so accustomed to rely upon the vaginal examination, that we have thrown over and lost sight of the really valuable evidence derivable from external methods of examination. The fact is that in one of the largest German obstetric clinics no other method of examination than external is permitted in labor.

The slipping and transformation that I have spoken of, as occurring when blindly manipulating the uterus, and which I have interpreted as a version of the placenta on its axis, gave me hopes that it would be possible to perform version when so desired, and so obviate recourse to the dangers of manual extraction in case of dystocia or retention. Now that we have an intelligent conception of the placenta (contained or retained), and can, in the vast majority of cases, approximately determine its axis, its version or adjustment of axis presents but little difficulty.

Before attempting this, it is desirable to refer to the terms we shall use, viz., placental crossbirth, placental obliquity, placental version; the latter being accomplished by three methods, viz., external, internal and combined or bipolar.

As external placental version is the method upon which reliance is placed, we will speak of it fully, and state that it is much more readily performed than *foetal* version, though much in a similar manner. We presume the hand has followed down the uterus after the expulsion of the child, has maintained its contraction, and, most of all, has determined the position of the placenta. Now, when the uterus announces, by instituting a pain or contraction, that its physiological rest is over, which has given time for blood coagulation to seal the mouths of the uterine sinuses, a period of from ten to twenty minutes after delivery of the child, we wait for the interval, or, at any rate, when complete contraction is absent. In antero-posterior obliquity, we proceed by grasping the upper hemisphere of the uterus, in either hand, more conveniently pressing the fingers well down upon the posterior wall, whilst the thumb searches down-

wards over the anterior surface. When the upper pole is anterior the thumb pulls upwards and backwards on this projection, whilst the fingers press downwards and forwards on the lower pole, but without any pressure, whatsoever, in the direction indicated by Cr  d  . Should a contraction occur, it will be found expedient to desist, and wait for another interval. Suddenly the slipping, the transformation is felt, and version has been accomplished. The pole, the point of reflection, the analogue of the wedge, enters the os, which the finger may now make out, with some difficulty, covered, as it may be, with membranes containing clot or fluid. When the upper pole is posterior, the manipulations are reversed. In obliquity, where the upper pole is lateral—right or left—the version appears to be more readily brought about by the two hands applied on each side over a pole, making proper pressure, which may also be accomplished by one hand. The combined or bipolar method of version appears to be indicated only on the rarest occasions, when the external has failed. Whilst corrective pressure is made over the fundus uteri (as already referred to in the external method) by one hand externally, the other makes moderate traction upon the cord. This appears to be a perfectly justifiable and harmless procedure, notwithstanding authoritative opinions to the contrary—and an interval, also, is the proper time for its exhibition. When turning is felt to have occurred, we must immediately desist. A battledoor implantation of the cord on the lower pole, when posterior or lateral, suggests its propriety and success; but, if on the upper pole, when anterior especially, it would have the tendency to diverge the axis and increase the dystocia, a condition actually brought about in practice at times. Internal version is simply manual extraction, so seldom to be used as only to require mentioning in a classification of methods, as a last serious resort, when former methods have failed, organic growth exists, or h  morrhage necessitates.

Now that the axes or poles have been adjusted, uterine contractions, reinforced at times by slight assistance, are sufficient to produce expulsion, if all the other factors are favorable—but it is essential that we ascertain this. In the non-gravid state the uterine axis does not normally correspond with the axis of the vagina, but subtends it at an

angle. In the gravid state this antiversion, if I may term it, is frequently exaggerated by the weight of the child, acting on lax abdominal parietes, and also by the downward pressure of the diaphragm, during the last powerful pains, when the child is emerging. The relatively large size of the foetal head, or breech, has the effect of obliterating this angle, and rendering for the time being the parturient canal straight. But the placenta, unable from its size to effect this, has its point of opposition on the sacrum, a solid body, which opposes its progress, instead of into the lumen of the vagina, its destination. It is evidently to our advantage to adjust these axes as well, by lifting the fundus uteri, and deeply depressing it into the abdomen. We will now expect, and are generally not disappointed, in finding the next or succeeding pain effect delivery, aided only occasionally by the slightest amount of pressure upon the upper hemisphere of the uterus, which is to be applied, not in an interval, as was the version, but during a pain. The pressure, even at this favorable stage, is not to be made according to Cr  de's dictum, "downwards and backwards in the axis of the pelvic brim," as it would move placenta and uterus *en masse*, without liberating the former. The pressure should be of a compressive nature, as it is by virtue of the result out of this compound force that the placenta is propelled, whilst the womb remains behind in the grasp of the hand.

The sudden diminution in size of the womb, as united by the hand, announces that the placenta is expelled, which may be found in the vagina, protruding therefrom, or lying in the bed, with membranes born or unborn. Instead of proceeding to deliver these at once, we wait for uterine relaxation. As the factor of the relation of the placenta to other bodies, is over, and a soft, almost fluid body, as the membrane, being practically without an axis, we might consider we had practically nothing more to do than to twist them into a rope. Of much greater consequence is it to maintain the fundus uteri well down into the abdomen, so as to render the canal as straight as possible, for the os has closed down to the size of a silver half-dollar, and intra uterum, the membranes are spread out over its lower surface, after the manner of a fan. Considerable adhesion exists between these moist surfaces, which requires some little force to separ-

ate, and this force is applied at a disadvantage when acting at an angle. Simply hooking the fingers under the membranes is sufficient in the majority of cases, if uterine adjustment be maintained; but twisting them into a rope is a valuable device for preventing tearing.

We are now in a position to understand the incidental success of the Creden method, since (a) such fluid manipulations, from themselves, occasionally produce version, (b) uterine contractions; from internal stimulation, produce version, (c) uterine contractions, from external stimulation, directly or indirectly through the hypogastric sympathetic plexus, produce version. Retentions are common, which cannot be accounted for, on the grounds of hour-glass contraction or organic connection.

This is, I believe, the rational method of delivering the placenta, and I hold that forcible expression, as it is now largely practised, should have no place in the methods of the modern physician, since the obstacles, which these forcible efforts are put forth to surmount, are more surely, more readily and more painlessly removed by axile adjustment.

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### Correspondence.

*The Editors do not hold themselves in any way responsible for the views expressed by correspondents.*

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#### MEDICAL PROSECUTIONS.

*To the Editor of ONTARIO MEDICAL JOURNAL.*

The following cases were disposed of for breaches of the Ontario Medical Act :

David Cline, Belmont, fined \$25 and costs.

William McDonald, Tilsonburg, case dismissed.

August Meyers, Tara, fined \$25 and costs.

Prof. J. H. Wesley, Petrolia, two cases; fined \$25 in each case.

Mrs. Hershley, St. Thomas, *re Viavi*.

Indian doctor, Lakeside, has gone to Stratford.

In regard to Professor Wesley, he has fought his cases for the last three years, and has cost the Council a large sum of money. His method is, if he is fined, to appeal the case; if the decision goes against him, he keeps it up by a further appeal; if the appeal is against him, we have to pay the costs, as he is gone somewhere else. Last

year I had him fined \$100 in Glencoe. He appealed the case to London. The appeal was dismissed, but no warrant was issued. Since then he has been operating around Petrolia, and last week I had him fined on two charges. He could not put up the costs, so now he is in Sarnia jail serving sixty days. As soon as that is served he will be arrested and taken to London jail to serve sixty days more. The police in London have the warrant to that effect.

In the case of August Meyers, who was prosecuted by my assistant, E. Briggs, High Constable of the County of Bruce, the Walkerton *Leader* speaks for itself.

I am working on several Discipline Committee cases, which I intend to bring before the Council.

THOS. WASSON, *Detective*.

March 25th, 1895.

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#### OUR BERLIN LETTER.

*To the Editor of ONTARIO MEDICAL JOURNAL.*

DEAR SIR,—To visit Berlin without giving some attention to the new treatment for diphtheria, is to play Hamlet with Hamlet left out. Through the courtesy of Dr. Kossue, assistant of Prof. Koch and physician in charge of the institute for infectious diseases, the privileges of the institution were extended to me, and after examining the patients from time to time, together with an investigation of the reports, I have seen sufficient to convince me that in the *heil serum* method of treatment a great advance has been made in the therapeutics of this dreadful scourge.

It might be of interest, at least to some of your readers, to briefly state the principle upon which this treatment is based, with the method of preparation of the serum. It is a well-known fact that when poisons are slowly introduced into the system, a certain toleration becomes established, so that in the course of time an amount of the poison that at first would have proved fatal, may be taken with impunity. The explanation is, that under such conditions the system manufactures a substance known as *antitoxine*, which counteracts the poison and thus protects itself from much of the injurious effects that otherwise would have followed the absorption of the large amount of poison. This may be the explanation of the ability of the

*morphine habitué* and the arsenic eater to ingest such enormous amounts of these poisons without fatal effects, and the same may be said with regard to the snake poison. However, Behring has shown that this law obtains with reference to that poison which is the result of the diphtheritic bacillus, known as diphtheritic toxine or ptomaine, and that the recovery from ptomaine poisoning depends upon the ability of the system to manufacture antitoxine by means of which the poison is destroyed. But this happy result does not invariably occur. The tissues, frequently, are unable to manufacture the antitoxine sufficiently rapid to antidote the deluge of ptomaines, and serious, if not fatal, results follow. The injection of the prepared antitoxine into the tissues of the patient supplies at once the material necessary to counteract the original poison, and thus anticipates the efforts of Nature by supplying a "horse-power" antidote without necessitating an overdraft upon the vitality of the patient.

Preparation of the serum: A piece of the diphtheritic exudate is submitted to the usual culture process until a pure culture of the Klebs-Löffler bacillus is obtained. This is developed upon a sterile nutrient bouillon in a warm room or in an incubator for a few weeks, until a sufficient development is obtained. The culture contains both bacilli and their products (toxine), which must be separated so that no bacilli enter the animal (preferably the horse on account of his size), in whose blood the antitoxine is to be developed. This separation is produced by different methods. Behring kills the bacilli by introducing one-half of 1 per cent. carbolic acid; Aaronson, by introducing a similar amount of grekrisol; and Pasteur, by passing fluid through an unglazed porcelain filter, through which the bacilli cannot pass. The toxine is then ready for use. About one-half cub. cent. of this fluid (toxine), sufficient to make the horse show considerable rise of temperature and *malaise*, is injected into the cellular tissue of the neck. After a few days, when temperature has become normal and the animal has recovered, a larger dose, from one to two cub. cent., is injected. This also causes illness, but possibly less marked than that caused by the first injection. This process is continued with increasing doses of the toxine until the

examination of the horse's blood shows the antitoxine present in sufficient quantity for withdrawal. The estimation of the amount of antitoxine in the animal's blood is made by withdrawal from time to time of a small amount, and mixing it with an amount of toxine of known strength, say, ten times the amount that would be required to kill a guinea-pig in ten days. This mixture is then injected beneath the skin of the guinea-pig, and the results watched. If the animal shows no abnormal symptoms, we know that the antitoxine exists in the blood in considerable quantity; if, however, the guinea-pig becomes ill and dies at the end of a few days or a week, "we know that the antitoxine is present in the specimen of blood in but small amount, and the injection of the toxine into the horse must be continued until the test shows that the blood contains the antitoxine in required amount." When this point is reached, the neck of the horse, over the jugular, is shaved and sterilized, a small incision is made with a lancet and a trocar introduced into the vein. (Meanwhile the horse has his attention diligently concentrated upon a bucket of carrots.) Attached to the trocar is a rubber tube, and to the rubber a glass tube. When the blood begins to flow the glass tube is thrust through the paper cover of a sterilized jar, which is sealed as soon as filled. Six litres are extracted from each horse. On account of the lowered blood pressure through the wound, no elaborate dressing is required. The blood is kept in a warm room for twelve hours to facilitate coagulation, and is then removed to a cool room for twenty-four hours. The serum is then syphoned off and is ready for use. In order to preserve it, Behring adds one-half of 1 per cent. of carbolic acid. Pasteur introduces a small amount of camphor. The dose of this serum for a child one year old, is ten cub. cent.; and for an adult, twenty cub. cent. The third day after the horse has been bled, a large dose of toxine is injected, on the fifth day a larger dose, and this is repeated until the amount of antitoxine in the blood is sufficient to justify a second bleeding, which generally follows in the course of thirty days.

At the time of my last visit there were six children, between the ages of three and five years, in the institution. Of these, two had had invasion of the larynx by the membrane, necessitating

tracheotomy, but were convalescing satisfactorily, and in neither case had the kidneys been affected. The treatment in one of these cases had been begun on the fourth, and that of the other on the fifth day. Two other cases, sisters, presented suppuration of the sub-maxillary glands, necessitating incision and drainage. The temperature continued high, owing to the mixed infection, but the membrane had disappeared from the throat, with the exception of one small patch on right tonsil. One showed slight albuminuria; treatment begun on third and fourth days. A fifth case, treatment begun on third day—satisfactorily convalescing—presented a scarlatina rash. A sixth case, treatment begun on fifth day, presented feeble pulse, persistent albuminuria and infiltration of base of lungs, symptoms which point towards a fatal result.

In order that the patients obtain the full benefit of the serum, the treatment must be begun during the first days of the disease before the system becomes infected with the ptomaines of the streptococcus, or those of other than the diphtheria bacillus, as the *heil-serum* only antidotes the products of the one bacillus. According to the report published by Dr. Kossue, not one case has terminated fatally in which the treatment had been begun during the first three days of disease. Doubtful cases receive the same injections of serum as those that present well-marked symptoms. If the exudation remains uninfluenced by the treatment, we are safe in pronouncing it other than diphtheria.

The following reports I have obtained from a fellow-student who has paid a great amount of attention to this subject:

1. Girl, aged five years, brought to the hospital on 25th, at 2 p.m. She had been apparently well up to within twenty-four hours of her entrance, so that the case may be regarded as one of the first day. At the time of her entrance both tonsils were covered with diphtheritic membrane, temperature 103.8° at 10 p.m. Eight hours after her entrance an injection of the serum was given. The temperature continued to rise till midnight, when it was 104.6°. It then dropped by crisis so that by 4 a.m. of the 26th it was 103°; by noon 100.4°; by midnight 99°. I saw the child about 11 a.m. on the 27th, and looked into

her throat. She had then a temperature 99.4°, and was feeling perfectly well, although both tonsils were largely covered with membrane. To day, the 28th, I again saw her, that is, three days after her admission to the hospital and on the fourth day of the disease. There was a necrotic-looking patch not larger than a split pea still left on one tonsil; aside from that, no membrane was to be seen.

2. Three children were brought to the hospital from one family. Only one child had diphtheria; the other two were brought because they had been exposed to the disease. One of these two had a somewhat rapid pulse, but aside from that showed no signs of being unwell. Because of the rapid pulse the child received an injection of the *heil-serum*, as did the one with the well marked disease. The third child was apparently perfectly well, and as a kind of control experiment, was left untreated. The next morning the one which previously showed the rapid pulse was in a perfectly normal condition, while the one which had been well and received no treatment, had developed into a typical case of diphtheria.

There have been no cases of kidney complication attributed to the injection of the serum, as have been reported from Vienna and other parts. In one case albumen was present upon the entrance of the child to the hospital, but examinations subsequent to receiving the treatment showed the urine completely free from albumen, and the experience in the Berlin institution gives no cause for suspecting that the serum has any prejudicial effects upon the kidneys.

ERNEST HALL.

Berlin, Feb. 21st, 1895.

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### Book Notices.

*Diseases of the Ear.* A Text book for Practitioners and Students of Medicine. By EDWARD BRADFORD DENCH, Ph.B., M.D., Professor of Diseases of the Ear in the Bellevue Hospital Medical College; Aural Surgeon, New York Eye and Ear Infirmary; Fellow of the American Otiological Society, of the New York Academy of Medicine, etc. New York: D. Appleton & Co. Canadian Agent: Geo. Morang, Toronto.

This is a work of very great value, both to the general practitioner and to the special surgeon.

It has been the author's aim to adapt it to the needs of both, and he has entirely succeeded. Section I. of the book is taken up with a chapter each on the Anatomy and Physiology of the Ear, a third on the Physical, and a fourth on the Functional Examination. These chapters are exceedingly interesting and valuable, especially to the general practitioner. Section II. contains twenty-two chapters on Diseases of the Conducting Apparatus, viz, the auricle, the external auditory meatus, the middle ear and the mastoid process. Then follows a section on the Surgery of these parts. Section IV. treats in ten chapters on Diseases of the Perceptive Mechanism. The last section, in nine chapters, deals with Complicating Aural Affections, e.g., aural affections dependent upon chronic visceral conditions, and disturbances of audition dependent upon functional nervous diseases. Treatment is given a most important place throughout the work, and the effects of particular drugs on the sensitive auditory organs are fully given. The need of a thorough functional examination is emphasized, and the results of recent investigations are clearly placed at the disposal of the reader, and throughout the work it is plain that the author has written from a personal experience. In the text there are 152 illustrations, with eight colored plates of exceptional merit. It is a work that the general practitioner especially cannot well afford to do without. The work of the publishers is, as usual, of the very best.

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## AN EPITOME

OF

## CURRENT MEDICAL LITERATURE.

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### MEDICINE.

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**Chronic Polyarticular Rheumatism.**—Folli (*Il Policlinico*) discusses the pathology of this affection (rheumatoid arthritis) in respect to the nervous theory. He reports in full three cases with the minute morbid anatomy. In two the clinical manifestations were quite typical, the hands presenting the characteristic deformity. The wrist, elbow and shoulder-joints were also affected, but in decreasing degrees. Here lesions

were found in the anterior horns, atrophic in the first case, but degenerative as well as atrophic in the second. The lesion became less marked in passing down towards the periphery through anterior nerve roots, nerves and muscles. In the third case the disease was most marked in the shoulder-joints, gradually diminishing downwards, so that the hands were but slightly affected. Here the morbid changes were but faintly marked in the nervous system, whereas the muscles and articulations were profoundly altered. The more minute lesions in the first two cases consisted in a diminution of the number of cells in the anterior horns, with a disappearance of their processes and increased deposit of pigment. There was a rarefaction of the neuroglia, more marked towards the inner parts and at the junction of the two horns. Where the neuroglia was most attenuated the alteration in the cells was greatest. The nerve roots and nerves were also atrophied. The author thinks that the lesions in the cord were in all probability primary because the changes were so pronounced there, and because disease in the cord can cause arthropathies. He gives details of a fourth case of this disease, death taking place from tuberculosis. Here cavities were present in the grey matter, and they corresponded to places where in the other cases the neuroglia was most thinned and the cells most atrophied. The author does not believe that the lesions could be attributed to disease of the limbs. He likens the lesions found in Cases 1 and 2 to the Duchenne-Aran type of progressive muscular atrophy. All cases of arthritis deformans cannot be thus explained. In Case 3 the lesions in the spinal cord were too slight to attach importance to.—*Medical News.*

**The Abuse of Astringents in Diarrhoeal Diseases of Children.**—In his work on "Diseases of Children," Smith says "that the vegetable astringents are now seldom used in the treatment of diarrhoeal diseases of children; that even the mineral astringents, acetate of lead and nitrate of silver, have gone out of use, and that bismuth and the alkalies have taken their place in the treatment of these diseases. If this statement were true—if the vegetable and mineral astringents had gone out of use in this class of cases, this paper would not have been written; but if one can judge from

current medical literature and conversation with fellow-practitioners, such is not the case. If we consider for a moment the causation of infantile diarrhoeas, on the one hand, and physiological action of the vegetable and mineral astringents on the other, we cannot come to any other conclusion than that in the vast majority of cases they do harm instead of good when administered in these affections. First, then, in the light of modern investigation, what is the cause of diarrhoeas in children? I think that we are justified in stating that all diarrheal disturbances of any gravity, whether caused by improper food, exposure to cold, bad air or water, or other agencies, are due directly to certain pathogenic microbes, either introduced from without or resident in the alimentary canal. The biology of bacteria is still in its infancy, but that some non-pathogenic bacteria may, under certain circumstances not well understood, become pathogenic, is believed by some who have investigated this subject both in its bacteriological and clinical aspects. Indigestible food and other agencies may cause considerable intestinal flux from simple irritation of the intestinal mucous membrane, but no serious or inflammatory diarrhoea can occur except through the agency of germs. If it be true that the cause of these diarrhoeas is microbial in its nature, it is plain that so far as these organisms are concerned, astringents can neither destroy them nor neutralize the products of their activity—products the absorption of which produce the general symptoms. In the stomach the vegetable astringents combine with albuminoids and pepsin, rendering the latter inert, they are only partly carried off by the intestines in the form of gallic and pyrogallic acids, so that they could not act by precipitating and rendering insoluble ptomaines or toxalbumins as might tannic acid if brought into contact with them. When the pathological condition is located in the large intestine or rectum, tannin injections would be of service because of their local action. Given by the stomach the vegetable astringents must be used in large doses to be effective in controlling a diarrheal discharge, and when so given would be very likely to irritate an already irritable stomach, precipitate pepsin, diminish secretion, and do much harm. If they succeed in checking the intestinal flux, this result is not desirable until the cause is, as far as

may be, removed, when it will cease without their use. It is only in cases with profuse watery discharge threatening speedy collapse from too great loss of fluid that their use would be justifiable, and even in these cases opium usually relieves the condition much more speedily and effectively. The objections to the use of vegetable astringents do not apply with equal force to the mineral astringents, but they too, if given in considerable quantity, precipitate pepsin, irritate the stomach, and can readily be dispensed with, except perhaps in certain chronic ulcerative conditions of the intestinal mucous membrane. If astringents are not to be used in the treatment of diarrheal diseases of children the question may be asked, What is the proper treatment? This question will be answered in brief outline only.

1. *Eliminative and Corrective.*—If undigested or decomposed food, vitiated secretion or bacterial products are in the alimentary canal, as is usual when the case is first seen, a purgative, preferably calomel and soda, should be given, even if the diarrhoea is profuse. Besides clearing the alimentary canal, calomel arouses the secretions and acts as an antiseptic. The contents of the intestines are usually highly acid, hence the utility of the alkalis. There would be as much sense in putting an antiseptic dressing on a wound covered with stinking pus without first cleansing it, as to check a foul, bad smelling diarrhoea without first cleansing out and disinfecting the alimentary canal.

2. *Sedative.*—To soothe the irritated mucous membrane and nervous system opium may be given if necessary, and its effects carefully watched. Opium also checks excessive discharge if given in full doses. Irrigation of the large intestine when the disease is located here is both eliminative and sedative, and can also be made antiseptic. Of course, remedies to relieve nausea and vomiting are to be employed.

3. *Antiseptics.*—Any medicine not destructive to the organism, which will destroy germs or neutralize their products answers this purpose. They should be given conjointly with the other remedies and form the basis of the treatment around which cluster other measures as indicated by the condition of the case. Nothing can take their place and their early and continued use is indicated in all cases. Salol and sodium salicylate are my favorites.

4. *Supportive.* No food should be given during the stage of excessive gastric irritability or until the digestive powers are equal to the task of properly disposing of it. A pre-digested food may be necessary for a time; afterwards the food should be such as is easily digested. Stimulants are to be used as needed.

If these general principles, briefly and inadequately set forth, are faithfully and intelligently carried out, we will seldom, if ever, need either the vegetable or mineral astringents in the treatment of infantile diarrhoeas. —H. C. SHUTTLE in *Archives of Pediatrics*.

#### The Dose of the Diphtheria Antitoxine.

—Roux states that his practice has been to give 20 c.c. (over 5 drachms) of serum to each little patient on admission, and the same quantity, or half the same quantity, according to the severity of the case, twenty-four hours afterward; and if the pulse and temperature still remain high, the same dose is again given. He adds that the smallest quantity he has used has been over 5 drachms, and the largest quantity about 4 ounces, in one exceptional case he gave as much as between 6 and 7 ounces. Practitioners should remember these facts, and that Roux's series of cases is by far the largest and most important hitherto published.—*Med. Rec.*

**Lactophenin and its Action in Acute Arthritis Rheumatica.**—Ever since Buss introduced sodium salicylate into the Pharmacopœia, about twenty years ago, as a remedy of almost specific action in acute articular rheumatism, it has maintained its rank undisputed, despite the fact that cases continue to occur frequently enough in which its action proves futile or is necessarily suspended, owing to the noxious collateral effects which supervened. Recently a remedy has made its appearance which promises to achieve for itself a lasting place in our modern *materna medica*, if we may judge from the warm endorsement which it has received from a number of medical authorities, and we have accordingly been prompted to ascertain by experiment whether in this agent we have not an eventual substitute for sodium salicylate. Lactophenin is simply a lactic acid derivative of the phenetidin, and is dis-

tinguished from phenacetin only by the fact that, in place of the acetic acid, bound to ammonia, we have here a lactic acid radicle. It is a white, crystalline powder, of slightly bitter, but not unpleasant, taste, soluble in three hundred and thirty parts of water. Schmiedeberg, who first tested the remedy on animals, reports as follows: Like the other antipyretics of the antipyrin and phenacetin group, lactophenin effects prompt depression of temperature, especially when the latter has been artificially elevated. At the same time it produces a much greater degree than phenacetin; for example, a condition of hypnosis and a striking diminution of sensibility to painful impressions, respiration and circulation remain unmodified. With the aid of lactophenin, sensibility and voluntary mobility may be completely suspended in rabbits, and reflex excitability almost completely suppressed, without notable depression of respiration and cardiac function. The condition thus produced is accordingly similar to the narcosis of urethan. Even when, during the persistence of this state, the convulsions peculiar to the entire group of these antipyretics supervene, complete recovery follows within a few hours. Despite its slight solubility, lactophenin is well absorbed by the stomach, so that the maximum effect is obtained in a short time after the administration of the proper dose. Lactophenin has been employed therapeutically by Landowski, of Paris; Jaksch, of Prague, and Jaquet, of Basle. Reports have been made by Dr. Scheben, a practitioner in Oestrich; Dr. Gissler, of Pforzheim; and Dr. Sternberg, of the Fourth Medical Department of Dr. Scholz, in Vienna. These experiments have shown the new remedy to be (1) an antipyretic in doses of .6 gramme; (2) an hypnotic in doses of 1 gramme; (3) an anti-nerve. In order to make manifest the advantages which distinguish lactophenin from the remedies which resemble it in its antipyretic and hypnotic action, we need only mention the fact that antipyrin (and to a greater degree antifebrin) has to be employed with the greatest caution, in view of past experience with the unpleasant side action on the heart. Frequently the remedies derived from the group of anilides produce cyanosis, vomiting, and exanthema. In conditions of collapse, therefore, antipyrin and antifebrin are universally contraindi-

cated. Furthermore, the literature of sulphonal includes several cases of death. We must also not forget that in using sodium salicylate we encounter such very unpleasant symptoms as dyspnoea, giddiness, buzzing of the ears, and even delirium and hallucinations. Lactophenin was administered by Jaksch in daily doses of 1 to 6 grammes, and in one thousand individual experiments (by Jaquet in forty-two cases) without producing unpleasant collateral effects; neither dizziness nor discomfort was ever perceived. In two cases reported by Jaquet and in one case by Jaksch, vomiting ensued, and one of these patients suffered a chill after the second dose. In the sequel, however, the medicament was well borne. Jaksch declares that when administered to typhus patients a sensation of hunger resulted. In certain individuals a sensation of pressure and heat in the region of the stomach was felt, but this disappeared on further use of the medicament, save in one case. Another symptom which occasionally supervenes, and which may alarm the patients as well as their attendants, is cyanosis. The latter, however, is not accompanied by any other symptoms proceeding from the respiratory or circulatory organs, and usually disappears after a short time, even when the medication is prolonged. It may be the result of the action of lactophenin on the blood itself,—that is, on its hæmoglobin. This inference harmonizes with the statements of the authors, who declare that they never perceived any debilitating action on the heart. However, in the two cases of a rhythmic pulse reported by Jaksch it was dubious whether that symptom should be ascribed to the action of lactophenin. It would, likewise, not do to charge to the new remedy the symptoms of oppression which Dr. Scheben observed twice in a case of fatty heart. We ourselves have never observed irregularity of the pulse. With respect to the dosage and administration of lactophenin, it is best to administer it in capsules, or by simply mixing with water, in doses of .5 to 1 gramme, which may be increased, in accordance with the antipyretic or sedative action desired, to 6 grammes *pro die*. About an hour after administering .5 gramme a subjective sensation of heat is experienced, and that is succeeded by a more or less violent diaphoresis. Usually the pulse becomes

slower and fuller; respiration is not modified. But the chief advantage of lactophenin, according to Jaquet, is its admirable hypnotic effect. In individual cases and in one to two hours after absorption of 1 gramme of lactophenin, a sleep of several hours' duration supervenes. In most cases excited patients are soothed and, if they do not fall asleep, their subjective condition is much improved. In cases of croupous pneumonia the patients declare distinctly that they feel less pain and can breathe more freely. In four cases of phthisis, Jaquet observed mitigation of the cough; but the calmative action of the remedy was most strikingly illustrated in several cases of erysipelas with delirium. Dr. Sternberg has had a similar experience in tuberculosis, with atrophy of the brain, involving violent delirium. Jaksch makes a yet warmer plea for lactophenin, on the ground of its favorable action on the nervous system in eighteen cases of typhoid. He says: "Lactophenin exerts an uncommon sedative influence on the patient. Delirium vanishes, the sensorium becomes free and the patients without exception rejoice in a subjective well-being which I have thus far observed in no other method of treating typhoid." With respect to its effect on the temperature, we must unite with Jaksch and Jaquet in recommending lactophenin as an agreeable and reliable antipyretic, possessing an advantage in the fact that the depressions of temperature ensue gradually after the administration of a suitable dose, and the temperature remains depressed for hours. The elevation of temperature which then follows is not accompanied with chills, even when descent and ascent follow in close succession. Collapse was never observed. The remedy seems to have no action on the secretions. Diuresis remains normal, with the increased transpiration we have mentioned above. The excretion proceeds through the urine, which reveals a paramidophenol reaction. The diseases in which lactophenin has thus far been tried are as follows: Typhus abdominalis, pneumonia, influenza, erysipelas, acute febrile tuberculosis, scarlatina, sepsis, influenzal neuralgias, chronic arthritis rheumatica, and acute arthritic rheumatism. Good results were reached in twenty-eight cases, whose histories we cannot give at length for lack of space. We therefore content ourselves with



by osmosis and by excretion, and, by the principle of osmosis, more morphine will be excreted if it is decomposed as soon as it passes into the stomach. Reasoning on this principle, we would expect that repeated small doses of potassium permanganate by the stomach would be of use in cases where the morphine has been absorbed into the system. This is rendered more probable by the fact that morphine, as a rule, is a slow-acting poison. — *Canadian Practitioner.*

**Vagus Pneumonia.** — Meunier discusses (*Arch. Gén. de Méd.*) the clinical aspects and pathology of vagus pneumonia. In cases of aneurysm of the aorta, the frequency of pulmonary lesions due to pressure on the vagus was noted by Habershon and others. In the cases reported by Hanot the lesions were twice tuberculous and once an ordinary pneumonia, the disease in the vagus being very distinct. Suppurative broncho-pneumonia has been described in this relation. In a case of alcoholic paralysis, Déjerine found pulmonary lesions and disease of the vagus. Section of a vagus in operation has been known to be followed by pneumonia. The author gives the details of a case of Hanot's in which the pressure on the vagus was due to mediastinal glands enlarged by secondary malignant growth. Here there was pleuro-pneumonia with necrosis and suppuration. Possibly lesions of the pneumogastric centres may account for pulmonary changes in some cases. At the present time a neuro-infective theory must be added to the others advanced to account for vagus pneumonia. In an early stage the morbid lesions found are emphysema, increased bronchial secretion, congestion, ecchymoses. Later they are of an inflammatory order. Broncho-pneumonia is most often met with. There may be a gangrenous or suppurative pneumonia, a form rare in animals. The division of the pneumogastric diminishes the resistance of the lung tissue to micro organisms, and the individuals may become the subject of broncho-pneumonia, ordinary pneumonia, tuberculosis. One lesion is so constant and striking that it has been termed vagus pneumonia. In human pathology section of the vagus, compression from any cause, a toxic neuritis, a neuroma, or even a functional affection may act as causes for the pulmonary lesions, but no single

cause will by itself account for them.—*British Medical Journal.*

**The New Epidemic of Influenza.**—There was a very marked increase last week in the fatality of influenza in London. The deaths directly attributed to this disease, which had been 16, 13, and 24 in the three preceding weeks, further rose to 111 during the week ending Saturday last, February 23rd. In addition to these deaths primarily attributed to influenza, there were others in which influenza was certified to have occurred in the course of other diseases. As in the case of previous epidemics, the mortality among elderly persons from the disease shows a marked excess, 50, or about 45 per cent., of the 111 deaths being of persons aged upwards of 60 years. These 50 deaths from influenza among elderly persons were equal to an annual rate of 9.3 per 1,000 persons estimated to be living at that age-period, while the remaining 61 deaths which occurred among persons under 60 years of age were equal to only 0.8 per 1,000 persons living at that age-period. In other words, among equal numbers living influenza was last week nearly twelve times as fatal among those who had reached the age of 60 years as among younger persons. Although the disease is becoming more or less generally prevalent throughout the metropolis, it is proportionally much more fatal in West London, especially in Kensington, Fulham, and St. George Hanover Square, South London appears to be more free from the epidemic than any other part of the metropolis, although influenza appears to be fatally prevalent in Brixton and Battersea. The deaths referred to diseases of the respiratory organs in London last week were as many as 1,119 and were more than double the average; they included 787 from bronchitis and 256 from pneumonia. It is certain that many of the deaths primarily attributed to these diseases were indirectly due to influenza. As in the first onset of this group of outbreaks, namely, in 1889, the disease has appeared to spread with great rapidity over large areas. We hear of it in Berlin, where for some years back it has not appeared with such severity as it has lately shown; in Munich, 30,000 people are reported to be affected; from Russia reports arrive; and from many districts in England, we receive information

of the spread of the disease. Our Edinburgh correspondent says: Influenza has now attained to the dimensions of an epidemic in Edinburgh. Every doctor is overwhelmed with work; some are themselves down with the plague. The death roll for the past three weeks will perhaps best indicate the state of affairs. In the week ending February 9th there were 100 deaths, of which 54 were due to chest disease, and of this total of 100 there were 32 of persons over 60 years of age. In the week ending February 16th there were 132 deaths, 83 due to chest disease, and 63 of persons over 60 years of age. Last week 188 deaths—115 due to chest disease and 54 of persons over 60 years of age: that is, the deaths from chest disease for these weeks stand at 54, 83, and 115 respectively. The death-rates were 19, 25, and 36 per 1,000. The type of influenza does not appear to be so grave as in former years, save in the debilitated; nor is the duration of the attack as a rule so long. As before, there are sad cases of pneumonia supervening, because some persist in "fighting against" the malady. There would appear to be a larger number of cases where albuminuria is a complication, and in some cases hæmaturia. Our Dublin correspondent writes: There are indications of a reappearance of influenza in Dublin. The cases are not numerous, and, so far, the symptoms have been mild. As might be expected, there has been a great increase in deaths from diseases of the respiratory organs, last week's number (82) being 26 above the average of the past ten years. There were 60 deaths from bronchitis and 17 from pneumonia. From New York, also, reports arrive of the rapid spread of the malady. It would appear from the accounts which have come to hand that during this outbreak the disease has shown a great tendency to affect more especially the respiratory organs, differing in that respect from the epidemic of 1889, which fell with especial force upon the nervous system, and conforming more nearly to the type of disease which prevailed in the spring of 1891, and in the winter of 1891-92. Dr. Thorne Thorne, speaking of the investigations of Dr. Klein, says that while in the blood only one of the cases examined showed the bacilli believed to be the cause of the disease, "it was otherwise with the bronchial sputum" of the cases which had

passed through the febrile stages. This in each instance contained bacilli as described by Pfeiffer and Kitasato, which in a recent case were so numerous as to amount almost to a pure cultivation. We may picture influenza to ourselves as an infectious febrile disease, the primary seat of which is in the mucous membrane of the respiratory tract, where it may sometimes be so severe as to cause rapid death from pneumonia, sometimes so slight as to be almost overlooked, while the toxins which it produces are absorbed, and lead to great depression and enfeeblement of the system, and predispose to the occurrence of pneumonia, broncho-pneumonia, and bronchitis as secondary infections. *British Medical Journal.*

**Antipyrin as an Antiseptic and Hæmodynamic.**—Roswell Park, of Buffalo, has found a 4 per cent. solution of antipyrin useful as a hæmodynamic in checking general oozing from a bleeding surface, and also by experiments claims for it antiseptic properties which compare favorably with most of the anilin and coal tar derivatives. By experiments on animals he has shown that it can be used with safety on the peritoneum, and he now employs it in general surgery. As a styptic it has the advantage of constricting the small vessels without causing any external clot, which may break down. In cases of epistaxis he has found it useful when sprayed into the nose. In this form of a spray to the nose he has found it useful in certain cases of inflammatory occlusion, and also for ordinary headaches, coryza, etc.—*American Medical News.*

**Treatment of Diphtheria.**—L. G. Papkoff (*Uratich*), of the Odessa City Hospital draws attention to the method of treatment suggested by N. S. Ignatovsky. It consists chiefly in painting diphtherial areas with a mixture of kerosene (5j), turpentine oil (5j), peppermint oil (5ij), the application being repeated every two hours, or even every hour or half hour. As adjuvants there are employed gargles of a 4 per cent. solution of boracic acid mixed with a few drops of mint tincture, sometimes steam inhalations of the same mixture, hot compresses to the neck, etc. The best results are obtained in catarrhal forms of faucial diphtheria, the percentage of recoveries amounting to

98. The deposits gradually disappear in five or six days, leaving no trace, and the general course of the disease remains mild. The method also proves "fairly successful" in gangrenous forms, though recovery takes place much more slowly. In septic forms the paintings are efficacious only in earlier cases—that is when the treatment is commenced before the appearance of prostration and constitutional symptoms due to absorption of the virus. In advanced septic cases, as well as in croupous forms, the treatment fails to arrest the morbid process. —*British Medical Journal*.

**General Paralysis.**—The old proverb—It is the pace that kills—finds nowhere a more striking illustration than in this disease which, under the hurry, anxiety, and excitement of modern life, is becoming more and more common. For some unexplained reason the affection is more common in this country than in many others, and is, comparatively speaking, infrequent in Scotland. This has been explained by northern patriots as another illustration of the harmlessness of whiskey as compared with beer, a fallacious argument, for the onset of general paralysis may have been preceded by no excesses, and, given other factors, may occur in total abstainers. But while much with regard to the etiology remains obscure, one factor is almost always to be traced, namely, hard work under conditions of excitement and responsibility. Among the educated classes it is men, and occasionally women, in the prime of life, whose careers are arrested at the point when success is almost within their grasp. Among skilled artisans, too, it is often the industrious, earnest man who is singled out—the man who is always anxious about the quality of his work, and will work all night, if allowed, to finish his task. And there are many, though not so large a number as is usually imagined, in whom previous excess appears to have caused the onset of symptoms; but in many cases this conclusion is due to a confusion between cause and effect, since in most cases of general paralysis a certain amount of moral perversion is symptomatic of the early stage of the disease. The disease is practically confined to the first half of adult life, and those who have stood the strain until they are fifty need have little fear of being attacked by this terrible complaint. The name of

the disease gives little guidance to the symptoms met with, and many different clinical groups are classed under the same head. One feature, unhappily, is common to them all—the progressive character of the paralysis and the absence of any hope of recovery, medicine being powerless at present to do more than delay the inevitable result. In all forms, also, when the disease is once established, there is gradual, steady failure of the physical and mental powers of the patient, until finally the paralysis becomes complete, and death closes the scene. There is probably no disease of such gravity in which the onset is more insidious. On looking back, when the physical weakness, etc., have become marked, and the disease has declared itself, symptoms are remembered lasting for years past, which by themselves seem trivial, and are looked upon as mere accentuation of personal peculiarities, but which, taken together, have the gravest significance. "Restless, unwonted activity, mental and physical, is of frequent occurrence; a feeling of superabundant energy, for which there appears no adequate relief; often undue irritability, which will not brook control or contradiction; an unreasonable demand upon the time and indulgence of others; waywardness, fickleness, or outbursts of furious passion upon trivial prettexts in those who had previously been more self-controlled and amiable; a growing change in the disposition and character, usually signalized by perversion of some one or more of the moral sentiments, a fact of primary import from the medico-legal point of view." Such is the description of the symptoms found grouped in most early cases, given some years ago by one of the greatest living authorities.\* The occurrence of some of these symptoms separately is common in healthy persons, but when several of them occur together, and persist, a close watch should be kept for any more definite signs. These usually occur from the physical side. There is no longer the power of executing finely co-ordinated movements, "the right hand has lost its cunning," tremulousness of the facial muscles of expression becomes prominent, and a similar tremulousness affects the muscles of articulation, so that the speech can scarcely be distinguished from the thick slurring speech of intoxication, for which it is frequently mistaken. The subsequent course of

\* Bevan Lewis, "A Text-book of Mental Disease."

the disease varies remarkably in different cases. In many there is mental excitement, with the development of delusions of grandeur, followed ultimately by dementia, and the description of this classical form is too well known to require further comment. But in a considerable number of cases met with in practice, this phase of mental exaltation and of delusions is absent, and the only mental change is the perturbation already described as belonging to the initial stage, and the gradual uneventful failure of the mental powers which is an invariable symptom of the disorder. Neurologists frequently see such cases, both in hospital and private practice, and their number appears to be rapidly increasing. In this type of case, the course of the disease appears to be somewhat less rapid, but the fatal termination is rarely delayed beyond four or six years from the time when the disease manifested itself. In its nature as a degenerative structural disease, general paralysis comes into the same pathological group as locomotor ataxy, etc., and although there are few diseases which have been as carefully studied by a host of painstaking and able observers, and although the morbid changes have been more thoroughly worked out than in almost any other disease, it is still a reproach to medical science that power to prevent or cure these conditions is not at present within our grasp.—*British Medical Journal*.

#### SURGERY.

**Brain Surgery.**—Nasse (*Berl. klin. Woch.*) relates two interesting cases of perforating wounds of the skull. Case 1.—A man, aged 43, was admitted twelve days after a heavy chisel had fallen upon his head. He was apathetic, and complained of headache. He was aphasic, and the lower branches of the right facial were paralyzed. The fundus oculi was healthy. Later, motor weakness appeared in the right side. On trephining, a small perforation was found in the dura mater through which softened brain tissue escaped. The dura mater was incised, and the contents of an abscess in the brain substance evacuated. Improvement began at once. The aphasia completely passed off in three weeks, and the lower branches of the facial improved later.

The progress in the right extremities was slow, a difference in the strength of the two sides still persisting. This was an example of a subacute, subcortical traumatic abscess near the motor-speech centre. Its position exactly explained the symptoms. Case 2.—A boy, aged 6, received an injury to the skull from a piece of falling wood containing a nail. On the next day he was somnolent, and vomited. On the third day there was disturbance of speech as well as clonic spasm in the cheek, extending later to the arm. On admission there were symptoms of a focal lesion. On trephining, the inner table was found splintered, some of the splinters having been driven into the brain substance. These were removed. There was a focus of softening, but no abscess. The recovery was complete. Nine days later an osteoplastic operation was performed by which the defect in the skull was closed.—*British Medical Journal*.

#### The Primary Lesion in Tabes Dorsalis.

—Nageotte (*Bull. de la Soc. Anat.*) remarks that, according to one view, the degeneration in the posterior columns is secondary to a lesion in the posterior nerve roots. Redlich and Obersteiner have instanced disease of the pia mater as a cause of the degeneration in the nerve roots. This posterior meningitis, however, is variable. The author has sought for a lesion farther towards the periphery. He has investigated four cases: (1) general paralysis, (2) and (3) recent tabes dorsalis complicating general paralysis, and (4) pure tabes of twenty-five years' standing. In Cases 2 and 3 there was a triangular band of sclerosis in the centre of the posterior columns. Lissauer's zones were involved and the posterior roots markedly degenerate. In Case 1 there was no trace of a lesion in the lumbar region, but the sacral roots were diseased, and there was an early sclerosis in the dorsal cord. The author found in these three cases of locomotor ataxy of different ages a mesoneuritis between the ganglion and the entry of the roots into the arachnoid sac. The lesion had begun as a round-celled infiltration, which tended to develop into fibrous tissue. The focus of transverse neuritis acts either by compression or by irritation upon the nerve fibrils traversing it. This perineuritis, intense about the posterior roots, was

also found about the anterior roots, but here the nerve fibrils had escaped. The walls of the arteries were intact, but those of the veins infiltrated with round cells. The cords of general paralytics with commencing tabes are best adapted for examination, for here the lesions are early. In Case 4 the same lesions were present, but in a much more advanced degree. Here there was even a cavity in the posterior nerve root. Within the arachnoid the proliferation of the interstitial tissue ceases, but the nerve fibrils are degenerate, showing the lesion not to be primarily parenchymatous. The anterior roots appear much more resistant than the posterior. The author maintains that this perineuritic lesion is of the same order as the lesion of vascular encephalitis (Raymond) found in general paralysis, and there is no histological reason for not admitting that it is of a syphilitic nature.—*British Medical Journal*.

**The Treatment of Appendicitis.**—Concerning the medical treatment little need be said. Locally, cold alone is appropriate in the beginning, and if slow in development, heat may be of utility in hastening the process. This was exhibited in the second case, seen four days after its inception and operated on on the tenth day. Internally, opium is by far the most appropriate in all cases where it agrees, and no fears of "masking the symptoms," as some surgeons put it, should be entertained. This drug gives physiological rest; and, more than that, it controls the inflammatory process, actually diminishing the calibre of the arterioles of the mesentery and peritoneum better than any other drug yet used. If the colon be filled with fecal matter, a mild saline, just sufficient to remove this cause of embarrassment, is appropriate, and for the purpose no prescription is superior to the one used in the writer's cases, namely, fifteen grains of sulphat of magnesium in half an ounce of peppermint water every hour until the desired result is obtained. This mixture is well borne by the stomach, and is efficient after a few doses. The diminution of the abdominal contents from the emptying of the gut of fecal matter and of gas was most marked in the cases where it had been used, and at the time of the operation the freedom from interference of inflated intestines much facilitated the operation. If general peri-

tonitis develop, possibly the saline treatment alone is more scientific; but this is not settled. In such an event the author has never seen a case which recovered from either medical or surgical treatment, however skilfully it may have been applied. Salol is of great value, as in so many intestinal diseases, by its efficiency in controlling fermentative processes in the intestinal canal. The diet should be entirely restricted to fluids; and, so long as vomiting continues, nothing but barley-water or oatmeal water or ice water should be permitted. With the amelioration of the primary symptoms, diluted milk, with a tablespoonful of lime water to each glass, may be allowed. These cases teach that an early diagnosis, the timely association of a surgeon in the management of the case, and the harmonious working together of the physician and surgeon will save many valuable lives that otherwise might be lost to the world. — HILFRON, in the *Medical Record*.

**Reproduction of the Uterine Mucosa after Curetting.** Bossi (*Gaz. degli Osp. dal*) gives the results of his experiments and clinical observations on this subject. In 1884 Duvelius examined and reported on the uteri of two cases in which hysterectomy had been performed two and four months after curetting, and in each case the mucosa was completely reproduced. Bossi endeavored to find approximately the minimum time that the uterine mucosa takes to reproduce itself so as to be physiologically active after curetting. By direct examination of the uterus in three cases where hysterectomy had been performed twenty five, twenty seven, and fifteen days respectively after a previous curetting, he was able to affirm that in each case the mucosa was completely reproduced, so that from these three cases he arrives at fifteen days as a minimum limit. In seven other cases he fixed upon the first menstrual period after curetting as a sign indicating that the uterine mucosa was physiologically active: in these cases he found that normal menstruation occurred twenty, nineteen, eighteen, twenty-one, twenty-two, and seventeen (two cases) days respectively after curetting. Reckoning the first fecundation followed by full term pregnancy as a more certain sign that the mucous membrane has been healthily reproduced, Bossi found that in seven cases

fecundation occurred twenty-five, twenty-eight, twenty-seven (two cases), twenty-six, and twenty-nine days after curetting. Experiments on dogs gave a considerably longer period for repair, this was probably due to the greater severity of the operative *technique* on animals. Notwithstanding the evidence of these figures, Bossi would still recommend a period of at least sixty days' sexual rest after curetting. — *British Medical Journal*.

**Intestinal Anastomosis by Murphy's Button.**—Wiggin (reprint from the *New York Medical Journal*), in his comments on a complicated case of intestinal obstruction, points out that Murphy's button should be used by surgeons with a proper understanding of its dangers, which are held to be numerous. In the author's opinion, it is somewhat unsurgical. It has been proved by experience that the button may be retained in the intestine, act there as a foreign body, and necessitate a secondary laparotomy for its removal. Murphy's method renders the patient dependent on the craft of the cutter rather than upon the skill of the surgeon, the spring of the button being made at times too strong, and at other times too weak. It is not always possible for the surgeon to lay his hand on a button of the proper size. A case has been reported in which perforation followed the use of a button a little too large for the portion of intestine united. There is a danger in the weight of the button which may act as an anchor to hold the bowel in a flexed position, and so cause obstruction. There is also a danger of the lumen of the button becoming plugged with hard fecal matter, thereby causing fatal obstruction. The holes placed at the ends of the buttons for the purpose of drainage may cause perforation, if care be not taken in pressing the segments together. On the other hand, the statistics collected by Wiggin are much in favor of Murphy's method. In eighty-four cases of intestinal anastomoses, of gastro-enterostomy and of operations on the gall-bladder, the mortality was 14 per cent., which compares favorably with the mortality of intestinal anastomoses by other methods, which, according to von Baracz, is 24.5 per cent.—In a consideration of Wiggin's objections which is published in this reprint, Murphy states that of the numerous cases in which his method has been prac-

tised, not a single instance has been reported to him of obstruction due to retention of the button, and he has heard of only two in which the button had been retained. In the case on which Wiggin bases this special objection, the button, it is held, might have been removed by an operation which no surgeon would consider of grave importance. In answer to the objection that in practising Murphy's method the surgeon depends mainly on the craft of the cutter, it is pointed out that he depends also on the silk manufacturer for the silk he uses, and as he tests his silk, he should test also his button. Murphy has sent models to all manufacturers who have requested them, and asserts that he would gladly inspect, and does inspect, all buttons sent to him. The fact that defective buttons have been manufactured cannot, he believes, be brought forward as a valid argument against the utility of his method.—*British Medical Journal*.

**So-called "Choked Disc."** Flschmig (*Wien. klin. Woch.*) reviews the various theories as to the origin of "choked disc"—for example, Graefe's pressure theory, the Schmidt-Manztransport theory, the Perinaud-Ulrich suggestion of œdema, and the Leber-Deutschmann germ theory. Choked disc is merely a clinical term for cases of optic neuritis where the summit difference of the disc equals at least two or three dioptries. He examined the optic nerves of fifty-five cases of intracranial disease—that is, twenty-one cerebral tumors, twenty-eight inflammatory cerebral affections, especially syphilitic, six cases of increased intracranial pressure (from hæmorrhage or œdema). Evidence of inflammation was found in every case. The increased volume of the disc is chiefly due to inflammatory changes, œdema, diffuse hyperæmia, hæmorrhage, effusion, thickening of nerve fibres, etc. In older cases where atrophy is going on, the new connective tissue accounts for what swelling there may be; also a certain extrusion of disc substance out of the sclero-choroidal canal. Perineuritis is frequently found. An anapulliform extension of the intervaginal space is only met with in half the cases. In no single case in which the disc was inflamed was the optic nerve free from signs of inflammation. It is important to make sections in different parts of the optic nerve. Against all

mechanical theories as to the origin of choked disc is the fact that damming up of fluid in the inter vaginal space has no effect on the circulation in the disc; in typical choked disc this damming may be absent; œdema of the optic nerve trunk is often absent; evidence of compression of the central vessels of the optic nerve is regularly wanting; again, in typical cases of increased pressure from cerebral tumor there may be no trace of œdema of the disc, but plenty of evidence of inflammation. The inflammation of the optic nerve may arise (Leber-Deutschmann) from the presence of phlogogenic substances in the cerebro-spinal fluid or lymph. But are these substances generally to be found? Perhaps the associated meningitis may have something to do with the neuritis. In the author's twenty-one cases evidence of more or less intense meningitis was found thirteen times. Increased intracranial pressure is not an essential condition in the production of intra-ocular optic neuritis; moreover, the lymph stream is centrifugal in direction. The only point determining the presence or absence of choked disc in optic neuritis seems to be the behavior of the lamina cribrosa. In choked disc it is almost always pressed forward, becoming convex, and no doubt has considerable influence in producing the ophthalmoscopic and anatomical picture of choked disc, but is probably not the real cause, which yet remains to be discovered. Whatever this may turn out to be, Elschnig thinks it cannot be mechanical.—*British Medical Journal*.

**Appendicitis.**—Murphy holds that every case of appendicitis, promising or unpromising, should be treated by surgical operation at the earliest possible moment. This surgeon has operated in 194 cases, with a mortality of 9.6 per cent. He would not delay operating in a case that might be progressing favorably, and, on the other hand, would not shirk the risk of operating on the most dangerous cases. The following outline is given of the various conditions found in operating for appendicitis: (1) When the abdominal wall is infiltrated and the abscess is opened without opening the unaffected portion of the peritoneum, there may be (a) a small circumscribed abscess with the appendix forming part of the wall; (b) a small abscess with a track leading to a

deep-seated, larger abscess; (c) a large abscess filling the iliac fossa, containing fecal concretions or a gangrenous appendix floating in the pus, closed in by firm adhesions; (d) there may be multiple abscesses with no connecting sinuses—a rare condition; (e) there may be an abscess in the opposite side of the abdomen. In another class of cases, when the peritoneum is opened and no adhesions to the anterior abdominal wall are found, a circumscribed abscess may exist in the posterior wall of the abdomen, the appendix and pus being enclosed within adherent omentum and intestine. This is the most common condition found in the early stage. In such cases the field of operation should be thoroughly protected by careful packing with iodoform gauze. The adhesions should then be separated, the pus sponged out, and the appendix liberated from its adhesions, and be ligatured and removed. Whenever the peritoneal cavity is opened directly the appendix should be removed. In another class of cases the peritoneal cavity will be found to contain a large quantity of free pus with no limiting adhesions, and the bowel may be smooth and glossy. All these cases recover. On the other hand, the bowel may have a livid and blistered appearance and be much distended. The great majority of such patients die. In either of the cases mentioned the appendix is usually gangrenous and perforated. Extensive drainage should be employed in both instances, and irrigation must be avoided. In some cases there is a small quantity of pus around the appendix, with partial adhesions protecting the peritoneum. This condition may be caused by perforation of the appendix; by gangrene of the mucous membrane without perforation; by a simple non-perforating ulcer of the appendix; by accumulation and retention of muco-purulent fluid in the appendix, with only an abrasion of the mucous membrane of that organ. All the acute symptoms of appendicitis may be produced by tuberculous and typhoid ulcers of the appendix without perforation or infection of the peritoneum. In another class of cases the canal of the appendix is partially or completely obliterated, or sufficient stenosis of the canal is produced to cause retention of material at the distal end, and to give rise to recurrent attacks. In such instances removal of the appendix during

a quiet and intermediate stage is indicated. In the condition known as appendicitis stercoralis there is a large accumulation of feces surrounded by mucous or muco-purulent adhesion. The attacks of pain, which recur frequently, are severe and usually accompanied by high fever, and by vomiting and other symptoms of intestinal obstruction. The appendix in cases of this kind is very much enlarged at the distal end and small at the proximal end, and its mucous membranes thickened. The dilated portion of the canal contains a large quantity of hardened feces.—*Brit. Med. Jour.*

### The Treatment of Ear Disease by the General Practitioner.

— In the *Polyclinic*, Randall writes from his personal experience. He says that the exploration of the nose and Eustachian tubes calls generally for their cleansing, even when they seem little obstructed by collected secretions. This is usually best achieved with the atomizer, spraying an alkaline solution of the same specific gravity as the blood-serum. If denser than this it causes osmosis outward through the mucous membrane; if less dense, endosmosis, in each case with decided irritation. This can best be employed through the anterior nares, a "Magic No. 2 Atomizer," costing seventy five cents, serving as well as any other form, and the hand atomizer seems almost better than the more elaborate apparatus. If the tip of the nose be pressed upward by the bent thumb, while the fingers are spread upon the forehead, the tip of the atomizer will find quite a secure rest wholly external to the nose, where it can deliver its spray in any desired direction, while there is no soiling of the instrument nor risk of injury if patient or surgeon make an unguarded movement. The bottle of the atomizer should be held between the thumb and index, the other three fingers sufficing to compress the bulb and give a practically continuous spray. Two or three pressures will generally carry the fluid back to the pharynx, and the patient can be directed to lean forward and clear the throat by spitting, while the fluid drains from the nose. The handkerchief should be but slightly used, and only after such removal of all fluid which might be forced up the Eustachian tubes. At times the post-nasal syringe forms a better means of cleans-

ing, since the warmest fluid feels cool when sprayed; and, with a tractable patient, the measure is neither very difficult nor disagreeable. Either procedure should be followed by mopping of the vault of the pharynx to complete the cleansing, and generally to make an astringent medication of this most important tract. The visible lesions of the lower pharynx are generally secondary to the condition above, which especially concerns us in ear treatment. A slender cotton carrier, bent to a right angle twenty millimetres from the end, and armed with a pledget of cotton of appropriate size, should be dipped in the medicament (e.g., 2 per cent. glycerole of iodine), squeezed free of excess, and carried in as the patient makes a loud inspiration, to turn quickly up behind the velum and sweep the tube-mouths and vault clear. A tongue-depressor is generally worse than useless—in the way, rather than helpful, a great annoyance to the patient, and another instrument to demand cleansing, or to risk conveying contagion. A spray of albolene medicated with menthol camphor (2 to 5 per cent.) forms a good protective and mild stimulant to apply to the nares; and if inflammatory trouble is present, Randall finds dusting with calomel generally very efficient as a sedative, antiseptic alternative. With the nares cleansed, we are ready for the inflation which is generally needed for exploration or treatment, but had better first study minutely the condition to be seen in the auditory meatus. Here we may find purulent matter requiring removal if furuncle of the canal or suppuration in the tympanum be present, and the use of the syringe may afford not only the best cleansing, but by the heat of the water used (105° to 112° F.), be an excellent stimulant. The pain which is often present or elicited by manipulation yields as surely to heat thus applied as to any other means, and as this is affected by the tonic contraction of vessels and the absorption of exudate, its effect is curative as well as palliative. Drying should follow, and any clinging flakes of epidermis gently wiped away with the delicate cotton carrier armed with a wisp of absorbent cotton. If clean, the meatus should offer no impediment to the study of the drum head and the diagnosis of the affection and the institution of appropriate treatment. Inflation, if now practised, should show its effect by blowing out additional secretion from a suppurating

tympanum, manifesting, perhaps, a perforation previously ill seen; or it may distend the depressed drum-head in a catarrhal case, and give relief to deafness and tinnitus previously present. In an ear apparently normal, it should serve to show normal patency of the Eustachian tube—a condition better proved than assumed. For the inflation, the pear-shaped bag of Politzer is the appropriate instrument, connected by a few inches of rubber tubing with an olive nozzle. With this so held as to occlude one nostril and the other closed by pressure of the fingers, the bag is pressed as the patient swallows, says "huck," or blows out the cheeks, and the air prevented from escaping from the nares will generally force its way up to the ears. Slight pressure should be used at first, increased only if necessary. Completion of the cleansing as perfectly as possible in the suppurating cases, with the aid of peroxide of hydrogen on the cotton pledgets, and light dusting of the inflamed surfaces with impalpably powdered boric acid, completes the treatment of most of this type of cases: pneumatic massage of the drum-head in the catarrhal cases; inunction with the yellow oxide of mercury ointment in the furuncle or the eczema cases—surely this, with a few self-suggesting modifications, constitutes a routine of treatment that should be within the easy execution of every practitioner. Yet this is just what forms the bulk of the work of every aurist in his office as in his clinic, and the small remainder of cases is such as to tax his skill in diagnosis and treatment to the utmost. These last can hardly be dealt with by the non-specialist.—*Therapeutic Gazette*.

**Treatment by Erysipelas Serum.**—Emmerich (*Münch. Med. Woch.*) concludes his researches, along with Most, Scholl and Isuboi. He says that it is possible to treat successfully malignant growths, lupus, tuberculosis, syphilis, by the erysipelas serum. He gives some details of recorded cases, showing the beneficial action of erysipelas on malignant disease. Experiments are related to show the action of this serum on tuberculosis in animals; it hinders the development of the tuberculous process, as seen in the anterior chamber of the eye. His experiments would lead him to think that tuberculosis in man could be thus brought to a stand-still, or by long-continued

treatment even cured. The author, along with Popoff, has found no such results with the products of other microorganisms. Erysipelas has also marked healing effects on diphtheria, and illustrative cases are given. The author obtains his serum from sheep inoculated with the erysipelas streptococcus; it is filtered free from the microorganisms. Caution is needed in the use of the serum, to find out how much may be given without doing harm. Basing his arguments on experiment, and the results obtained by the action of erysipelas itself on certain diseases, the author advocates the treatment with this serum. *British Medical Journal*.

**Ichthyol in Fissures of the Anus.**—Van der Willigen warmly commends ichthyol in the treatment of fissures of the anus (*Journ. de Méd.; Monatshefte für Praktische Dermatol.*). The pure drug is introduced into the anus by a brush. The contraction of the sphincter forces this into all the folds of the mucous membranes. Little pain is excited. Treatment should be repeated daily. The patient is given liquid diet and occasionally castor oil. The first patient, who had previously been treated by every means short of operation, was cured in eight days, the other three in two or three weeks. One had already been subjected to operation without benefit. There was no recurrence.—*Therapeutic Gazette*.

**Gastro-Enterostomy with Senn's Bone Plates for Pyloric Stenosis.**—The choice between gastro-enterostomy by lateral anastomosis and the Heinecke-Mikulicz operation of pyloroplasty in cicatricial contraction of the pylorus is one that can only be satisfactorily made when the abdomen is opened. The plan of Loreta of digital division is not likely to be favorably considered when compared with the newer methods mentioned. In the case detailed below, gastro-enterostomy was preferred on account of the indurated condition of the pylorus. This was judged to be non-malignant at the time; but lest subsequently this estimate should prove to have been erroneous, the operation of gastro-enterostomy appeared the safer course to adopt. G. W., aged 43, had been a dyspeptic for twenty years, but he did not begin to

suffer acutely till twelve months before operation. Previously occasional bilious attacks, with vomiting and diarrhoea, had occurred. After an attack of sea-sickness, however, frequent gastric pain, relieved by vomiting, became a more constant feature during the next year. The site of the pain was some three or four inches from the pylorus, showing, as many other cases of gastric ulcer have done, that pain is a most fallacious guide to the situation of an ulcer. Doubtless this was the period of active ulceration, though no hæmatemesis occurred at any time to confirm this opinion. No palpable pyloric tumor could be made out. Increasing weakness and emaciation followed, and the signs of dilatation of the stomach developed rapidly. The organ, when distended, reached  $2\frac{1}{2}$  inches below the umbilicus. Everything in the way of gastric medicines and digestive aids had been employed by Dr. Austin, Dr. Eustace Smith, and other advisers with little effect, including one-tenth grain doses of bichromate of potassium. Washing out the stomach with the siphon tube gave most relief, though this lavage exhausted him much. Nevertheless, he steadily lost strength, flesh and color, and gave up his employment after losing three stones in weight. An operation was determined upon for his relief, upon the assumption that cicatrization of an ulcer was responsible for the dilatation. On opening the abdomen, gastro-enterostomy was selected in preference to pyloroplasty, on account of the hard cartilaginous feel of the pylorus, and Senn's decalcified bone plates were employed. As the visceral wounds were made very ample, the plate sutures were supplemented by a row of Lambert's sutures all round. The stomach was incised about  $2\frac{1}{2}$  inches from the greater curvature and about 7 inches from the pylorus. The jejunum was opened about 1 foot from the duodeno-jejunal junction. The intestine was doubled back upon itself, as suggested by Rockwitz, before applying it to the stomach in order to secure correspondence in the direction of the peristaltic waves in the two organs. The operation was aseptic rather than antiseptic, and the course afterwards was uneventful, neither pulse nor temperature being disturbed. Neither opium nor morphine was given. For three days absolutely nothing by the mouth was permitted. Four nutrient injections were admin-

istered each day of the formula recommended by Dr. Knut Hoegh.\* These injections were well borne, and gave more satisfaction than other forms of nutrient enema that had been used in other cases. On the third day, tea, wine and water and meat juices were allowed by the mouth. By the fifth day, soup, beef-tea and white foods were given, and on the eighth fish and fowl were added. Finally, on the twelfth day ordinary solid food was ordered. The patient rose on the fifteenth day, and on the seventeenth was exhibited to the members of the North of Ireland Branch of the British Medical Association. A fortnight later he reported himself as feeling well, having gained two pounds in weight, and proposed resuming his duties as an engineer to a railway.—THOMAS SINCLAIR, M.D., F.R.C.S. ENG., in *British Medical Journal*.

#### MIDWIFERY.

##### A Complicated Midwifery Presentation.

I was called to a case of midwifery recently, and found, on vaginal examination, a hand, a foot, the funis and the vertex presenting. The hand (which I made out to be the right, and which seemed larger than normal) was situated to the right of the symphysis pubis. Behind and at the upper part of the right side of the hollow of the sacrum was the foot, though on a higher level than the hand. Entwined around these was the funis, which had no pulsations; and a little farther up than the foot, in the left occipito-anterior position, was the vertex, partially engaged in the brim of the pelvis. The possibility of twin pregnancy suggested itself, but of this, however, I could not find any confirmation. This was the woman's fourth confinement, all her previous ones having taken place without any hitch. Her age was twenty-six. I could not get any exact history of how long the membranes had been ruptured. The pelvis was roomy. The pains were so strong and frequent that I could not get an opportunity of passing my hand past the presenting vertex. Failing this, and as labor was

\* *Annals of Surgery*, Part 18: 1 ounce of glucose boiled with 1 drachm of flour and 5 ounces of water; after this has cooled there is added  $\frac{1}{2}$  an ounce of claret and 2 eggs beaten up with  $\frac{1}{2}$  an ounce of water.

not progressing, I tried by pushing up the leg and the arm with the funis to engage the head in the brim, but without success. Traction on the foot and version were tried with similar want of success owing to the whole presentation being tightly jammed into the opening of the pelvis. These attempts occupied an hour. I then went for my principal, Dr. Anderton, and in a very short time returned with him, when we found that labor had made rapid progress, notwithstanding that the presentation was still as described above. The hand was outside the vulva, and the head was well engaged in the pelvis. The forceps were applied, and the delivery was completed in a couple of minutes. The child, which was dead, lay in the following position: The right arm was extended at full length above the head, and the right leg was flexed up along the body, reaching over the right shoulder; entangled around these was the funis. The child was full time and fully developed, and the mother stated she felt it move a couple of hours previous to sending for me. The largeness of the hand was due to œdema, the result, no doubt, of pressure, which also, acting on the cord, pro-

duced asphyxia.—R. HILL SHAW, M.B., in *British Medical Journal*.

**Some Practical Points in Obstetrical Work.**—Crow, in the *Virginia Medical Monthly*, gives the reasons which have led him to adopt the following routine as regards antiseptics in obstetrics. While it was not the result of scientific bacteriological investigation, but purely that of practical results obtained in the treatment of about eight hundred cases, it is, nevertheless, in accord with the results of our scientific investigators, namely: 1. If the patient tells him that she has no abnormal secretions from the vagina, then he advises a plain douche of hot soft water at the beginning of labor. 2. If she has an abnormal secretion, then he advises a douche of hot water, carbolized, once or twice a day prior to expected confinement. 3. If the secretions are profuse and irritating to the parts, then he advises a local treatment as a means of relief, in connection with the carbolized douche. 4. A 5 per cent. creolin solution he finds the best antiseptic lubricant for the hands of the accoucher at the time of confinement.

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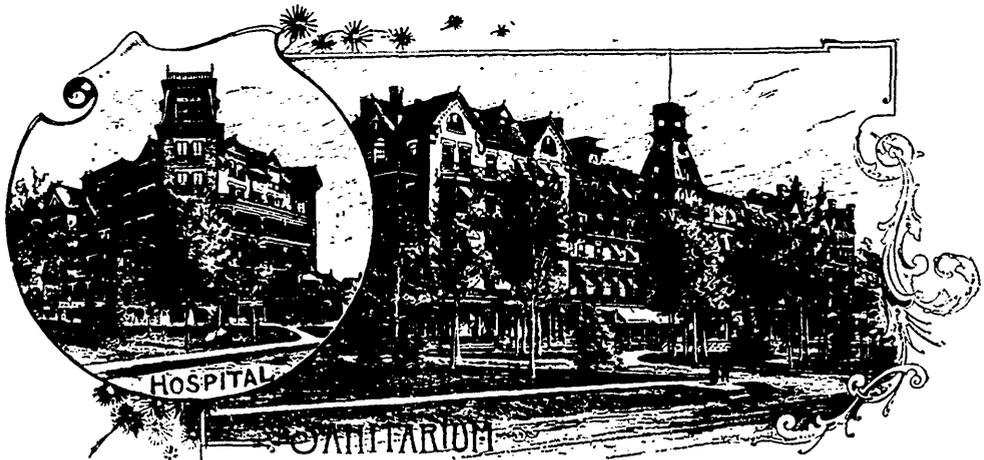
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5. He uses a dressing of boric acid on absorbent cotton over the vulva, changing it whenever the cotton becomes saturated, and then bathes the external parts with some warm antiseptic solution. 6. He never advises a vaginal douche for the first week or ten days after labor in normal cases with no rise of temperature. 7. He tries to impress upon the nurse the importance of thoroughly cleansing her hands before attending the patient. Even with this treatment, arrest of flow, rise of temperature, etc., sometimes occur, probably due to undue exposure of the patient and using water of too low a temperature in bathing, and lack of proper cleanliness on the part of the nurse, especially in families where the nurse in attendance has to be cook, washerwoman, housekeeper, and attend, perhaps, to the numerous wants of older children, etc. It must be remembered that nature does a great deal in throwing off the material for sepsis to take hold of; and too much interference with the mother in the way of douches and washes repeated too often during the first few days is harmful, for it breaks her rest and adds to the

already high tension on the nervous system, which is altogether unfavorable to the normal restoration of the functions. Therefore, let us do what is necessary to make the mother comfortable in a cleanly, scientific way, and then we will have done our whole duty and will get the best results.—*Therapeutic Gazette.*

**Two Cases of Asphyxia of the New-born Recalled to Life by the Rhythmical Tractions of the Tongue.**—In *La Tribune Médicale* for September 6, 1894, two cases of asphyxia of the new-born are reported, the first by Nordman, who extracted a child which did not respire, with pale skin and very feeble heart-beat. The mucus was quickly removed from the nose and mouth by the index finger. The tongue, being seized by a hæmostatic forceps, was drawn in the prescribed rhythmical fashion. After ten minutes' perseverance of this plan the child gave a single inspiration, but only continued to inspire so long as the tractions were continued; ten minutes later the child commenced to cry and continued to breathe,



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the heart beat stronger, and life was saved. The second case was reported by Dr. Bonnet. This child was born after a difficult labor, very much cyanosed and not breathing, apparently dead. Flagellations, frictions, insufflation of air by means of a laryngeal tube, and artificial respiration were tried alternately for almost half an hour without result. Recalling the system of Laborde, a hæmostat was applied to the tongue, and rhythmical tractions persevered in for about a minute, when a hiccough and a cry or two announced the commencement of normal respiration.—*Therapeutic Gazette.*

### Personals.

Dr. Dillon Brown has resigned his position as editor of the *Archives of Pediatrics*. His resignation will go into effect after the distribution of the April number.

Thomas Wasson, the detective employed by the Ontario Medical Council, has been elected President of the Provincial Constabulary Association.

This will aid him very materially in his investigations of the actions of fakirs and others of that ilk.

### Miscellaneous.

Announcement that Messrs. Duncan, Flockhart & Co., of Edinburgh, have established an agency in Canada for their Blaud Pill Capsules will be a welcome one to the profession. The fame of these capsules has long since reached us, and now that they are available here they will come into immediate and general use. They are made in one, two and three pill sizes—the three-pill capsule being little larger than a single Blaud Pill, while it is of three times the strength, perfectly soluble, and guaranteed never to oxidize or harden. "D. F. & Co. Capsules" hold the same place in the esteem of the profession the world over as does the chloroform of the same firm. Messrs. Duncan, Flockhart & Co. have made no mistake in locating in Canada, or in the representative they have secured. We direct attention to their advertisement on first page of present issue.

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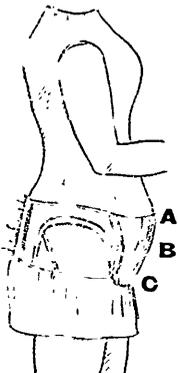
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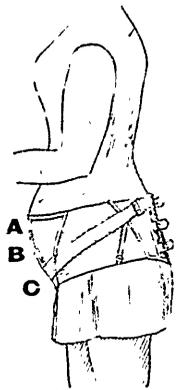
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Much is being said in England on the hygiene of railways. The subject should be vigorously agitated in this country. The influence of the medical profession, whose power is always recognized in social and sanitary questions, should be brought to bear on this matter of vital public interest. *Maryland Medical Journal.*

The poor often envy the wealthy, but do they always appreciate what those in better circumstances do for the poor? The heated weather is a trying time for all of every class, especially for those in the extremes of life. In large cities there are societies for the amelioration of the condition of those who by force of circumstances are compelled to stay in town. There are free excursions, there are homes provided where children and even the grown of not only the poor, but of those in even better condition, may spend two or more weeks in rest and recreation, and again there are the true philanthropists, like Straus of New York, and others, who provide pure milk and abundant ice for the poor at prices within the reach of all. Every city provides for the shiftless and unfortun-

ate alike, and each year facilities for the improvement of the condition of the poor grow, and the good done is seen if not appreciated.—*Maryland Medical Journal.*

TO BLOW OR WASH?—In these days of warfare against dirt, why don't we wash our noses? Surely they get quite as dirty as our teeth, which we brush so laboriously every day. The civilized nose is, in fact, one of the dirtiest organs of the body; for so long as civilization, which mostly means crowding, involves the breathing of dirty air, the nose which is the organ by which the air receives its first preliminary purification, must become loaded with all sorts of nastiness. The man with a cold, who is always sneezing and slobbering with his handkerchief, is not a pleasant companion; but, for all that, by dint of much "running," his nose at least is washed, and is cleaner within than that of the fine lady who has trained herself never to use the highly-decorated little bit of lace which she carries about and calls a handkerchief; for in that nose condense and accumulate the soot, the dust, and the microbes of our far from cleanly cities.—*Ex.*

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PROPHYLAXIS OF DIPHTHERIA. --In the *Am. Lancet* the following points are emphasized :

1. Bacteriological diagnosis.
2. Quarantine of quarters.
3. Isolation absolute, with one nurse.
4. Better disinfection, to be under the charge of the health officer.
5. The notifying of the pastors of churches and superintendents of Sunday Schools of the disease and its locality.
6. The establishment of the overflowing drinking cup in all the schools.—*Archives of Pediatrics.*

BICYCLING FOR WOMEN.—The much-discussed question as to whether bicycling is *per se* an exercise suited to women is, perhaps, now of minor importance, since it has become fashionable, and will, consequently be adopted by the gentler sex, without much regard as to its immediate or remote effects. Its popularity is, however, a very satisfactory proof as to its capacity as a giver of health and pleasure, since it is not conceivable that the bicycle could ever have won its way, as did the corset, for instance, as a fancied adjuvant to physical charms.

The late Dr. Wilham Goodell, wise in an unusually wide experience, gave the exercise his unqualified endorsement; and, from the almost entire absence of adverse criticism, it is apparent that the majority of gynecologists are of the same mind. The whole question is an exceedingly simple one, and has been summed up by Dickinson (*American Journal of Obstetrics*), who concludes a very clear and complete paper upon this subject as follows. "Under proper conditions of costume and posture, with care that the exercise be gradually increased and properly graded for the individual case, and where there is no acute inflammation to contraindicate it, bicycling will probably show itself capable of large results as an agent in curing pelvic disorders, since it is one of the few exercises which attract women. In view of woman's disabilities and the disadvantages under which she has suffered in attempts to obtain interesting and beneficial muscular exercise, it seems hardly too much to say that the promise from the bicycle is far-reaching. Through it and the habits it will engender we look for better dress, freer dress, shorter dress in bad weather; for better exercise, for out-of-door activ-

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ity, for steadier nerves, stronger muscles, painless periods, easy labors." *Therapeutic Gazette.*

WIND COLIC OF INFANTS.—Dr. G. C. M. Godfrey in the *Medical Record* suggests the following.

R Extract of zingiberis fluidi . . . . c.c. 6 ʒiiss.  
Tincturæ asafetidae. . . . . c.c. 12 ʒij.  
Aquæ menthæ piperitæ,  
Aquæ cinnamomi. . . . . aa c.c. 30 ʒj.  
Syrupus simplicis. . . . . q. s. ad. c.c. 120 ʒiv.

℞.

Sig. — ʒj (c.c. 4) t. i. d. in water before meals.

Of course, the practitioner will change the quantities and ingredients to suit each case; it is very hard for an infant to take.—*Col. and Clin. Rec.*

DEATHS UNDER ANÆSTHETICS.—From a report which has been placed at our disposal, we learn that the patient who died under an anæsthetic at the Middlesex Hospital on January 3rd was a very muscular man, but fat and of alcoholic habits. He had been admitted on the previous evening for the removal of suppurating glands in the

neck. The anæsthetic, which was freshly-prepared A.C.E. mixture, was administered on an ordinary flannel inhaler. The patient struggled most violently, and had to be restrained. After a little chloroform had been sprinkled on the inhaler, the struggling subsided. The A.C.E. mixture was then resumed. After about two minutes the muscular rigidity became less marked. A little later the breathing became shallow, and the pupils, which had been contracted, began to dilate. The anæsthetic was discontinued, but the face became paler, and the radial pulse could not be felt. Finally, respiration stopped, the face later becoming very cyanosed. The operation had not been commenced, and the anæsthetic had not been given more than five minutes. The head was immediately lowered, and artificial respiration started. Hypodermic injections of ether and enemata of brandy were given; hot applications were made to the chest and amyl nitrate held to the nostrils, but no signs of animation appeared. Artificial respiration was discontinued after an hour. At the *post-mortem* examination, the right ventricle was found to be very dilated, and there

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### TESTIMONIALS.

The late D. CAMPBELL, M.D., Edin., President, College of Physicians and Surgeons, of Toronto.

"I have used your 'Guaranteed Acetic Acid' in my own case, which is one of the forms of Asthma, and in several chronic forms of disease in my patients, and I feel justified in urging upon the medical profession an extended trial of its effects. I consider that it acts in some specific manner, as the results obtained are not only different, but much more permanent than those which follow mere counter irritants."

Extract from "The Physiological and Therapeutic Uses of our New Remedies." By JOHN BUCHANAN, M.D., Professor of Surgery, University, Philadelphia.

"New Cure.—'The Acid Cure' is attracting a great deal of attention at the present time in some parts of Europe. It has been introduced by Mr. F. Coutts in a very able Essay on the subject. He begins by stating that the brain and spinal cord are the centres of nerve power; that when an irritation or disease is manifest in any portion of the body, that an analogous condition of irritation is reflected to the cord by the nerves of sensation, so that in diseases of long standing there is a central irritation, or a lack of nerve power, and in order to reach all diseases it is necessary to strike at the original—the root of the nerve that supplies the organ diseased. . . . The Acid seems to stimulate a renewal of life in the part, then to neutralize the poison and overcome the morbid condition; in all diseases the Acid is potential, and as a prophylactic, never found to fail. As a preventive to disease, daily bathing the entire body with the Acid has been found to ward off the most pernicious fevers, infectious and contagious diseases, and is productive of a high grade of animal and mental life."

DR. J. T. COLLIER, Brooks, Maine, Oct. 26th, 1877, writes:—

"With regard to the 'Acetic Acid,' I have used it in my practice until I have become satisfied that it has a good effect, especially in Typhoid Fever and in cases of chronic complaints. I have no hesitancy in speaking in its favor."



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was marked fatty infiltration of its wall. The left ventricle was also dilated, and its wall had undergone some fibrosis. The lungs were emphysematous, and these organs, together with the kidneys, brain and spleen were markedly congested.

*British Medical Journal.*

FOR ECZEMA OF THE FACE. — Carefully remove all the crusts. Avoid water. Keep the following ointment constantly applied to the lesions by means of a soft linen mask :

R Ung. picis . . . . . ʒi.  
 Ung. diach . . . . . ʒij.  
 Ung. zinci ox . . . . . ʒij.  
 Mix. Sig. For external use.—*Ex.*

TO RELIEVE DYSURIA OF GONORRHOEA. — Blackham (quoted in *Canadian Practitioner*) .

R Sodii salicylate . . . . . ʒii.  
 Tr. belladonna . . . . . ʒij.  
 Tr. aurantii . . . . . ʒi.  
 Aq. dest . . . . . ad ʒvi.

Sig. : One tablespoonful every hour.—*Therapeutic Gazette.*

Dr. Robert H. Babcock, of Chicago, has been using Maltine with Coca Wine, and says he is convinced of its great service when it is desirable to check undue waste or to enable a patient for a time to endure unusual demands upon his strength. He recently prescribed it for a female patient with tubercular induration of one apex. The tendency was to fibroid transformation rather than caseation, but for some reason she had come to a standstill, and his efforts to improve her condition seemed futile. Her chief complaint was a feeling of weakness. After using Maltine with Coca Wine for a week, she reported herself as feeling better, and certainly appeared stronger and more cheerful. She continued the preparation for a month, and the decided improvement in her condition dates from that time. Malto-Yerbine is, in his opinion, a good stimulating expectorant, and in one case of broncho-pneumonia contributed much to the patient's recovery. He says it seems to be a good vehicle for the administration of other expectorants in the case of children, and it has been occasionally so employed by him.—*Maryland Medical Journal.*

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