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THE

# Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF BRITISH AND FOREIGN MEDICAL SCIENCE, CRITICISM, AND NEWS.

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SUBSCRIPTION, \$3 PER ANNUM.

All Communications, Letters and Exchanges must be addressed to the Corresponding Editor.

TORONTO. APRIL, 1878.

## Selections: Medicine.

### TREATMENT OF ASTHMA BY IODIDE OF POTASSIUM AND IODIDE OF ETHYL.

M. Germain Sée, the learned Professor of Medicine in the *Faculté de Médecine* who lately introduced medication by the salicylates with so much *éclat* and success, has recently been making new discoveries in the domain of therapeutics. The object of his experiments this time (asthma) has been about as inveterate and intractable an enemy to human health and comfort as was the rheumatic subject of his former studies which the salicylates have done so much to mitigate, and it only remains to hope that experience at large will verify his last discovery as fully as its predecessor. We subjoin an account of his experience taken from *L'Union Médicale*. "After the trials made, with varying success, both by French and foreign physicians, of the employment of iodide of potassium in asthma, M. Sée, in 1859, conceived the idea of trying upon his own account this form of medication for the relief of so cruel and rebellious a disease. He had collected a number (24) of observations of patients whom he had been able to follow, some for a year at least, others during two, three, and four years. This number comprised 4 children, 6 adolescents, 10 adults, and 4 aged. In all these cases, except one, he obtained most remarkable results, totally regardless of the variety of asthma with which they were affected. At the end of some hours after the administration of the remedy he was able to observe a notable diminution of the symptoms

of dyspnoea and oppression. The severer attacks were generally arrested at the end of 24 or 48 hours, and by persisting in the employment of the remedy the disease itself was definitively removed. By giving the medicine some hours before the usual attack he had been able to prevent the paroxysm; and by giving it during the paroxysm he had succeeded in notably diminishing its intensity. M. Sée begins by administering the iodide of potassium in doses of  $22\frac{1}{2}$  grains, sometimes alone, sometimes with the addition of half to one grain of extract of opium. When the oppression is considerable he administers 15 to 30 grains of chloral at night to promote sleep. The doses of iodide of potassium are gradually increased from  $22\frac{1}{2}$  grains to 30, and even 45 grains per day, taken at meal times so as not to disturb the stomach. M. Sée has observed that symptoms of iodism, when they have occurred, have been produced as readily if not more readily by small than by large doses of the remedy, so much so that, following the example of M. Gosselin, it has happened to him more than once to arrest the first symptoms of iodism by doubling the dose of the preparation of iodine. The primary action of the iodide of potassium is to notably increase the secretions of the respiratory mucous membrane, and thus to liquefy the bronchial mucosities, the dryness of which renders the paroxysms of dyspnoea so painful for the patients, and thus causes to disappear the dry and sibilant *rales* of the early stage, to diminish the difficulty of respiration, and render it freer and easier at the end of some hours by permitting the atmospheric air to penetrate completely to the pulmonary

vesicles. The orthopnoea gives place to normal respiration, and under the influence of the remedy the recent emphysema disappears as well as the exaggerated resonance of the chest. Whatever be the variety of the asthma, whether nervous or catarrhal, the effect produced is just the same, a fact which justifies the supposition that the iodide of potassium exerts a direct influence upon the nervous system. In order to maintain the happy effects of the remedy it is necessary to continue it uninterruptedly for months, and even years, under penalty of seeing the attacks return.

M. Sée has also been induced to try, in the paroxysms of asthma, another preparation, the iodide of ethyl, discovered by Gay-Lussac in 1825, and first studied from a therapeutic point of view by Dr. Huette, a collaborator of M. Claude Bernard, who, in 1850, established its principal physiological effects. M. Sée has observed the same results as M. Huette from the employment of this remedy, which is composed of ether and of iodine. When 5, 6, or 10 drops are given to a patient in a paroxysm of asthma the symptoms of dyspnoea are seen to be at once allayed, and the paroxysm to disappear. The patients declare that they experience a perfect calm, and themselves demand new doses of a remedy which has so rapidly afforded them such extraordinary relief. Thus, says M. Sée, in concluding his communication, therapeusis possesses in the iodide of potash an excellent remedy wherewith to combat asthma and all forms of dyspnoea by warding off or diminishing their attacks, to ameliorate and even cure the disease when its employment is long continued; it possesses, besides, in the iodide of ethyl a means of arresting at their inception those very painful paroxysms of dyspnoea and oppression whereby the disease is characterized.

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NITRATE OF AMMONIA AS A SUBSTITUTE FOR ICE.—As a substitute for ice in reducing the body heat, Dr. Rochelt (*La Salute*) recommends nitrate of ammonia. He employs one part in five of distilled water. Placed in a bladder and applied locally this will in a very short period cause a reduction of one or two degrees. —*Allg. Med. Cent.-Zeit*, No. 1, 1878.

## ON SUDDEN DEATH AFTER SEVERE BURNS.

At the recent Medical Congress at Munich, Professor Ponfick, of Göttingen, described some experiments he had performed with the view to discover the cause of sudden death after extensive burns. Scalding water was applied to dogs, and the results were classified with reference to the extent of the injured surface and the intensity of the heat applied. In all cases in which the burn was severe, important changes in the blood could be shown to take place a few minutes after the injury; the red corpuscles underwent disintegration, and were broken up into an infinite number of minute coloured particles. After a time, varying with their original quantity, these particles disappeared, but not without having set up serious disturbances in several organs remote from each other. The kidneys appeared to bear the brunt of the mischief; they excreted a large proportion of the hæmoglobulin which had been to some extent set free and was circulating in the blood. Their action in this respect, however, at least in severe cases, was accompanied by very severe parenchymatous inflammation, which was shown by the appearance in the urine of peculiar coloured casts by infarction of the uriferous tubules, fatty degeneration of the epithelium, etc. Another portion of these fragments remained within the organism; it disappeared in the splenic pulp and the medulla of the bones, being taken up by the contractile cells, to undergo, in all probability, a gradual resolution. The reception of the particles by the cavernous tissue of these parts caused the organs to appear greatly enlarged, even to the naked eye, and to exhibit increased redness and succulence on section. Taking into consideration all the symptoms connected with burns, Professor Ponfick is inclined to believe that the fatal issue in many of the severe cases and the serious symptoms in others which recover are to be explained by the fact that the red corpuscles undergo extensive and sudden disintegration. He leaves as undecided the question as to how far acute uræmic poison may contribute toward the fatal issue. If this theory be true, transfusion would appear to be indicated as a rational therapeutic measure; and Dr. Ponfick recommends that in all urgent cases recourse should be had to this operation.—*Louisville Med. News*.

DIFFERENTIAL DIAGNOSIS OF MULTILOCULAR CEREBROSPINAL AFFECTIONS.

M. CHARCOT.

In the subjoined Table we have written in *italic letters* the symptoms to which greatest importance should be attached.

*Multilocular Cerebro-Spinal Affections.*

	TABETIC SERIES.	MULTILOC. SCLEROSIS.	DISSEMIN'D SYPHILOSIS.	GENERAL PARALYSIS.
CEPHALIC SYMPTOMS.	Epileptiform Apoplectic Attacks.	<i>Epileptiform Apoplectic Attacks</i>	Epileptiform Attacks..	Epileptiform Apoplectic Attacks.
	.....	.....	Par. Hemiplegic Epil'y	.....
	Vertigo .....	<i>Vertigo</i> .....	<i>Vertigo</i> .....	<i>Vertigo</i> .
	<i>Diplopia, Strabismus</i> .....	<i>Diplopia</i> .....	<i>Amblyopia, Optic Neu-</i>	Diplopia.
	.....	<i>Nystagmus</i> .....	<i>ritis</i> .....	Amblyopia.
	<i>Amaurosis</i> .....	Amblyopia, White Atrophy .....	<i>Diplopia</i> .....	<i>Inequality of Pupils.</i>
	<i>Inequality of Pupils</i> .....	.....	.....	.....
	<i>Facial Anæsthesia</i> .....	.....	<i>Headache, Fixed Pain</i>	Headache.
	<i>Deafness</i> .....	.....	.....	.....
	<i>Meniere's Vertigo</i> .....	.....	.....	.....
Laryngismus .....	<i>Embarrassment of Speech</i> .....	.....	<i>Embarrassment of Speech.</i>	
Embarrassment of Speech .....	<i>Difficult Deglutition</i> .....	.....	.....	
.....	Pneumogastric Palsy .....	Total Facial Palsy .....	.....	
VISCERAL SYMPTOMS.	<i>Gastric Crises</i> .....	<i>Gastric Crises</i> .....	Non-nervous Crises .....	.....
	<i>Nephritic Crises</i> .....	.....	.....	.....
	<i>Vesical Crises</i> .....	.....	.....	.....
	<i>Paresis of Bladder</i> .....	.....	.....	Paresis of Bladder.
	<i>Cystitis</i> .....	.....	.....	.....
SPINAL SYMPTOMS.	<i>Girdlepain</i> .....	Lightning Pains .....	<i>Pseudoneural Pains</i> ..	<i>Lightning Pains.</i>
	Hyperæsthesia, Anæsthesia .....	<i>Plaques</i> .....	<i>Spinal Hemianæsthes.</i>	<i>Tingling.</i>
	<i>Incoordinated Movement</i> .....	Incoordination .....	.....	<i>Incoordination.</i>
	Contractures and Trepidations .....	<i>Special Trembling</i> .....	<i>Spasmodic Paraplegia</i>	<i>Paresis. Trepidation.</i>
	.....	Spasmodic Paraplegia .....	<i>under form of Hemiparaplegia</i> .....	<i>Special Trembling of Hand.</i>
TROPIC SYMPTOMS.	Eschars .....	Eschars .....	.....	Eschars.
	Arthropathies .....	Arthropathies .....	.....	.....
	Fractures .....	.....	.....	.....
	Muscular Atrophy .....	Muscular Atrophy .....	.....	Muscular Atrophy.

We should be guided chiefly by the symptoms which are, so to speak, characteristic. Thus, if we observe, in a patient, ataxy with nystagmus we must think of multilocular sclerosis and not of locomotor ataxy (tabetic series), because nystagmus is a valuable symptom of multilocular sclerosis. In the same way spasmodic paraplegia (recognized by the continual trembling movements which are produced when a single blow is struck upon the soles of the feet) is much more characteristic of syphilosis than of multilocular sclerosis, especially if accompanied by *fixed pain*, which always indicates a phenomenon of compression. Ex.: paraplegia consecutive to Pott's disease.—*Gaz. des Hôp.*

## THE HYPODERMIC INJECTION OF DIALYZED IRON IN CHLOROSIS.

\* \* \* \* \*

The girl has improved vastly under treatment. She is getting plenty of rest and good food, but she had them both in abundance before she came to us. Her rapid improvement is altogether due, I think, to a new remedy which I am employing in a very novel manner. I refer to the rapid introduction of iron into the girl's system by means of the hypodermic needle. Why has this not been practicable before the present day? Because it has been well-nigh impossible to obtain a non-irritative form of iron for hypodermic use. The tartrate of iron, although one of the mildest forms, is entirely too liable to cause irritation and abscesses. Lately a new preparation of iron, the dialyzed iron, appeared in the market, which, it is claimed, is neutral and non-irritating. It struck me at once that this was just the thing to be used in my proposed hypodermic injection. I have been using this dialyzed iron hypodermically in this case for the past few days, and it has come fully up to its reputation. There have been none of the usual after-effects of iron, such as costiveness and disordered digestion. All these are done away with. I have been giving daily hypodermic injections of fifteen minims of pure dialyzed iron. The iron was diluted at first, but, experiencing no unpleasant after-effects, the assistant has, for the past day or so, been using the dialyzed iron undiluted. For the last four days the girl has had a daily injection of fifteen minims. The scars marking the spots where the needle has been introduced show no sign whatsoever of inflammatory action. To-day the patient shall have an injection of twenty, to-morrow of twenty-five, and on the next day of thirty minims of the pure, undiluted iron. I think we are going to gain in therapeutics by this case. I certainly expect to find a very rapid change for the better in the girl's condition in the course of the next five or six days. I will bring her before you again and report progress on Saturday next. Between now and then I will see that her blood is carefully examined under the microscope by an expert.

[The girl was again brought before the class

two weeks afterwards (February 23). She showed the most wonderful improvement. Dr. Da Costa said, "You will remember that when I last brought this case before you the blood-murmurs were distinct, and that there had been no menstrual flow for the space of three months. The daily injection of thirty drops of the dialyzed iron under the skin of the girl's arm has not caused the least irritation. Her digestion is admirable, and, what is most wonderful of all, she has menstruated during the past week. Her strength is so much better that she wants to go right home. You see how the colour is coming back to her lips, gums, and tongue. Another evidence of her very marked improvement is the 'venous hum' which was so loud and marked two weeks ago, is comparatively distant and faint this morning. I am convinced of the most positive and marked improvement in the case. The temperature is normal and steady. She feels well, her appetite is good, her bowels regular, and her headache all gone.

"I consider the case as practically cured.

"Do I think that we should have had such a rapid cure, and one so unattended with constipation and indigestion, if we had given the iron internally? I think not. You see, therefore, how excellent a method that by hypodermic injection is when the stomach will not retain the iron. Where the stomach will retain slight quantities of iron, we might give a little of the drug by the mouth, and the bulk of it hypodermically.

"Knowing how the iron thus introduced has acted here, we might with advantage employ this treatment in cases of pernicious anæmia. I say we ought to retry the use of iron in pernicious anæmia,—try its use hypodermically. The only reason, perhaps, that it has thus far failed to do good in that disease has been because of the great digestive disturbances attending its use."—*Dr. DaCosta, in Philadelphia Med. Times.*

OBITUARY.—Dr. James Blundell died last month at the advanced age of 87. Fifty years ago he lectured on Midwifery at Guy's Hospital. The Count de Kergardec, discoverer of fetal auscultation, died lately in Paris at an advanced age.

## PLEURISY OF THE APEX.

BY I. BURNEY YEO, M.D., F.R.C.P.

\* \* \* \* \*

In the preceding, and in several other cases of which I have taken notes, there undoubtedly existed a pleuritis of one or other apex, without any consolidation of the lung. I do not wish it to be understood that I think this a common affection. On the contrary, I believe it to be a somewhat rare one; but I am persuaded it is a condition which would be more frequently recognized than it is, were it not for the prevalence of a very faulty manner of examining the chest. I allude to the custom of examining only the upper and anterior part of the chest. Many appear to think that they have sufficiently explored the lungs when they have carefully examined the subclavicular regions, and listened, through the clothes, to both bases. You will certainly not discover a pleuritis of the apex by such a mode of examination, since the friction-sounds, in such cases are almost invariably limited to the posterior aspect, viz., to the supraspinous fossa or to the upper third of the dorso-scapular region. It is in these situations that you must seek for the physical signs of this affection, and it is usually unilateral. The characteristic symptom in these cases is the cough: in a person in apparently good health (generally a young woman), with no marked fever, with no, or with slight emaciation, with no dyspnoea, with no mucous or crepitant *râles* anywhere to be heard, with no expectoration, you have a persistent, harsh, dry, shallow, incomplete cough; generally jarring and shaking the patient a good deal, so as to produce often painful fatigue of the expiratory muscles and much injection of the face. What is especially noteworthy about the cough is its shallow, incomplete character. It is suddenly cut short without effecting its object, if, as is generally the case, the object of a cough be expectoration. I have never seen a case of this kind in a male, a circumstance which may possibly be accounted for by the fact that the male sex never wear low dresses. It occasionally accompanies or is the cause of asthmatic paroxysms, and, when this is the case, the treatment of the asthma must be com-

bined with the special treatment necessary for the pleuritis; and that special treatment is continued and repeated counter-irritation, either in the form of a flying blister—a small blister, about the size of half-a-crown, moved about from one spot to another over the supraspinous fossa and the upper third of the dorso-scapular region—or in the form of the strong linimentum iodi. I think I have also seen benefit derived, in some of these cases, from small doses of iodide of potassium. But the ordinary remedies for the relief of cough are not of much avail, but they should not be withheld, as they may moderate the violence of the paroxysms, and so relieve the jarring of the chest somewhat. It is a disease which is very prone to recur.

I have noted cases of this kind now for some years, and, as I have never seen attention called to them, I have thought it might be useful to direct the attention of this Association to the subject; believing that, as they become better known, we shall hear less of "hysterical" and "stomach" coughs, and that, "pleurisy of the apex" will be recognized as a distinct form of pleuritis, with a characteristic clinical aspect.

## THE PROGNOSIS IN CEREBRAL HEMORRHAGES.

—The following aphorisms are laid down by Dr. Lapponi in the *Rivista Clinica de Bologna*. A cerebral apoplexy whose coma continues for over twenty-four hours must be considered as a hopeless case; this rule, generally correct, has, however, some exceptions. In many apoplexies, accompanied by coma, we observe at longer or shorter intervals before the return of consciousness, several attempts at yawning; if these movements, however, follow close upon each other the prognosis must be decidedly lethal. Apoplexy, associated with paralysis of the buccinators, is very grave, as the seat of the hemorrhage is so close to the medulla oblongata; the presence of labio-glosso-pharyngeal paralysis renders the case still more hopeless. Vomiting coming on thirty to forty minutes after the "stroke" leads us to predict an absolutely fatal termination, and depends, as shown by Lussana (*Manuale de fisiologia*), upon implication of the vagus. Life is threatened by the occurrence of pharyngeal paralysis (vagus) and by polyuria (medulla oblongata), as well as by a marked diminution of the body temperature; if this depression be followed by an elevation of temperature death is certain.—*Clinic.*

## RECTAL ULCERATION RESULTING FROM THE CARELESS ADMINISTRATION OF CLYSTERS.

We not unfrequently find in the rectum an ulcer, first mentioned by v. Recklinghausen, whose configuration and locality readily distinguish it from all other known forms of intestinal ulceration. Small, usually round, but frequently conical from below and within, upwards and outwards, with little or no inflammatory deposition about its borders, it is always situated on the anterior walls of the rectum; generally about two inches above the anus, but never less than one or more than three inches. Frequently the mucous membrane only is ulcerated, but the destruction of tissues sometimes extends through the entire rectal wall and in a few cases pelvic cellulitis and abscess result. Fatal peritonitis has on several occasions followed the rupture of such an abscess, and cases have been even observed in which a so-called puerperal peritonitis has been simply the extension of this rectal ulceration.

The form and locality of the ulcer leave no doubt of its traumatic nature, and it seems quite clear that the careless administration of clysters is the immediate cause. In many cases the origin of the difficulty can be traced directly to the time of such injections. It is just at this spot that the mucous folds of the intestine, the prostate, the uterus, or during labour, the descending head of the fœtus, presents an obstacle to the introduction of the syringe by pressing backwards the anterior rectal wall. Should the syringe be now forced forward—the patient being, as usual, in the horizontal posture—the nozzle may easily wound or even penetrate the mucous membrane. If the fluids be now injected, the sub-mucous or peri-rectal tissues become infiltrated and the further consequences are clear.

In a paper on this subject, Prof. Kæster, of Cologne, (*Correspondenz-Blatt d. ärztl. Vereine von Rheinland*) calls attention to the circumstance that Ribes' investigations, as well as the opinions of all surgical authorities, unite in locating the orifices of internal rectal fistulæ at the very same point at which these clysmatic ulcers appear; these fistulous openings are never on the posterior wall and are never more than three inches above the anus. From these facts, as well as the actual history of many of the cases, he argues that a large proportion of fistulæ originate in injuries received during the administration of clysters.—*Chronic.*

## SUGGESTIONS FOR THE TREATMENT OF SLEEPLESSNESS.

The following suggestions are taken from an article by Dr. W. A. Hollis, in the *Practitioner*.—One of the most efficient means of inducing natural sleep is by the application of mustard poultices to the abdomen. In cases where sleeplessness arises from natural worry, abdominal flatus, or other annoyances, this remedy is invaluable. Schüler states that large sinapisms applied in this way produce first dilatation and subsequently contraction of the vessels of the pia-mater in trephined animals. They may thus act as do pediluvia and warm compresses to the abdomen, by diminishing the amount of blood in the brain. The same writer says that cold abdominal compresses and the cold-pack produce at first dilatation of these vessels, and subsequently bring about an energetic contraction of the cerebral vessels, which lasts for some hours.

Where the insomnia depends upon brain exhaustion, I have found that the administration of a tumbler full of hot claret and water, to which has been added sugar and nutmeg, is of great value. Both the syrup and the spice, in this instance, are hypnotics, according to Preyer and Cullen. The mixture must be taken just before bedtime. In slight cases of wakefulness (as we all know) the reiteration of certain words sounds mentally, at the same time drawing a slow and deep inspiration between each word, is occasionally sufficient to produce sleep.

When sleeplessness is associated with acid dyspepsia, the alkalies and alkaline earths, especially the carbonate of magnesia and bicarbonate of soda, are very useful. In cases where the indigestion is owing to a sluggish peristalsis of the stomach and upper intestines, a full dose of Gregory's powder, or ten grains of the compound rhubarb pill, will remove the disagreeable epigastric sensation and induce sleep.

The posture of the sleeper is of some importance. Many persons can sleep in their arm-chairs by the fireside, who court the fickle god of sleep in vain when lying upon their beds, some few hours later. The posture of the dozer and the surroundings of such a fireside nap sufficiently account for his somnolence on

physiological grounds. When sleeplessness results from an over-worked brain and consequent paresis of the vaso-motor nerves, the stimulus of electricity has been resorted to. Althaus recommends this treatment. Two large pads are used with a Weiss' constant battery of from ten to fifteen cells. One pad is placed over the nape of the neck, the other, which can be conveniently made of an old reflector, and covered with chamois leather, is placed over the stomach. The anode is applied to the back, the cathode to the stomach, for about half an hour at a time.

In the wakefulness arising from defective cardiac power, on the other hand, it frequently happens that digitalis, by strengthening the force of the heart's beats, drives the blood into the capillary system more vigorously, and relieves the congestion of the central organs and the anæmia of the extremities. By thus equalizing the circulation, we diminish the necessity that previously existed for an increased flow of blood through the cerebral vessels, and so we promote sleep.

By many therapeutists the bromides of potassium, sodium, ammonium, and camphor are supposed to possess hypnotic properties, but my own experience with these drugs is not confirmatory of such conclusions. These salts undoubtedly act as sedatives on the nervous system, and as such may occasionally induce sleep, but they cannot, I think, be ranked as true "sleep producers."

#### —♦♦♦—

#### DAINGEROUS COLOURS IN WALL PAPERS.—

Mr. L. Siebold, in a lecture on this subject, stated that out of sixty or seventy papers of various colours, blue, red, brown, pink, etc., analyzed by him, ten only were harmless, the rest containing arsenic. There is a popular impression that green papers only are to be feared; but the result of Mr. Siebold's examination should have the effect of rendering householders and heads of families suspicious of some of the most innocent-looking colours. It is reasonable to assume that to the presence of deleterious ingredients contained in certain wall papers may be ascribed many little illnesses of children, where no apparent cause exists for the same, and which sometimes puzzle the medical attendant.

## Surgery.

### PHLEBITIS.

In publishing the following epitome of a lecture on Phlebitis delivered by Mr. W. S. Savory, F.R.S., at St. Bartholomew's Hospital and published in the *British Medical Journal* for 2nd and 9th February, we can only regret that want of space prevents our transcribing the lecture *in extenso*, for it is admirably illustrated throughout by details of most interesting and instructive cases.

*Pathology.*—The old distinction between adhesive and suppurative phlebitis is now no longer held. Adhesive phlebitis is no longer recognised, because it is now known that the inflamed vein is rendered solid, its channel is blocked up, not by the effusion of plastic lymph from its wall, but by a coagulation of the blood which it contains. There is thrombosis. Suppurative phlebitis, in the old sense, is now no longer recognised, because we know that the fluid substance found in some cases in the interior of the vessel is not pus, in the proper acceptation of the term, but blood clot, which has softened and become fluid from degeneration: puriform, but not purulent. \* \* \* Then in phlebitis there is inflammation of the coats of the vein; and this is associated with the coagulation of the blood in the canal: thrombosis. The inflammation of the walls of the vein may lead to thickening from lymph, or to suppuration more or less extensive between the coats, which may, and perhaps usually does, extend into the surrounding cellular tissue. \* \* \* \* \*

*Etiology.*—First among the causes of phlebitis may be mentioned thrombosis, \* \* \* \* and I should say it was one of the principal. (Phlebitis may sometimes, though very rarely, occur without thrombosis; much more frequently the two conditions occur together. We may believe that phlebitis is sometimes a cause of thrombosis, but thrombosis may occur without phlebitis. It is sometimes, or rather frequently the apparent cause of phlebitis; but it sometimes exists for long periods without evidence, either during life or after death, of inflammation.) If then thrombosis is to be

reckoned among the causes, we ought next to inquire into the conditions under which thrombosis is likely to occur. \* \* \* We all know how the blood slowly coagulates in the great vessels after death, and that this change in some cases precedes death. It occurs during the act of dying, more especially perhaps when this process is prolonged or marked by extreme exhaustion, or when it forms the closing scene of long-continued and exhausting disease. And with reference to the question whether a clot has been formed before or after death, the subject is not a very profitable one, and from its very nature cannot admit of a definite answer. The process of dying is oftentimes very gradual. Molecular death is not synchronous with systematic death; and the coagulation of the blood which is the visible sign of its dying, is in the body oftentimes a very ill-defined change. It is more satisfactory to enquire the age of blood-clots; whether these are quite recent, or bear evidence of change subsequent to their formation, in their degree of contraction, their dryness, density, and corrugation; in their colour and construction, whether laminated, or in minute structure fibrous; or—and this is usually most marked in the centre—showing signs of degeneration; or adhering to the living membrane of the vessel which is more or less affected or destroyed. Only one word further with regard to their colour. These clots are generally described as becoming paler with age. But this holds good in one respect only. When clots have formed in the living vessels, and have at first the colour of the blood, undoubtedly, as time goes on, they gradually grow paler. The hematine is absorbed, they come to consist of fibrine only, and this at length assumes a pale yellow or buff tint, and so it may remain. But we all know very well that, after death, clots are frequently found in the cavities of the heart and larger vessels, which are so soft and uniform that we have no doubt they have been rapidly and recently formed—little or no doubt that they have been formed after death—and which are nevertheless very much paler; in fact, almost white. Of course the immediate explanation of this is obvious enough. It results from the mode of their formation, and the difference is

due to the relation which the fibrine holds to the cells during its production. But, again, "The great veins are very liable to become obstructed by clots forming in them when the patient is greatly debilitated, and when the circulation is enfeebled, by inflammatory affections, by discharging abscesses, difficult labours and other causes." (Prof. Humphry.) \* \* \* But sometimes simple thrombosis appears to be determined by causes which are more purely local. Thus pressure on veins, producing obstruction of the circulation, may lead to the formation of clots. \* \* \* So also, and with far more probability, will injury, such as laceration of the walls, or the presence of adjoining mischief. Thus inflammation or its products may coagulate the blood. But in the last case, the thrombosis is usually associated with and forms part of phlebitis; and to the causes of phlebitis I now return. Phlebitis, then, may result from wounds of various kinds, and other injuries of veins. \* \* \* Phlebitis may complicate gangrene, ulceration, erysipelas and other affections. \* \* \* In this class may be reckoned that form of phlebitis which sometimes occurs after delivery: puerperal phlebitis. Then there are causes of a phlebitis, which is more common in men than in women, that may be termed idiopathic. The rheumatic diathesis was formerly supposed to be a predisposing cause; but now perhaps for rheumatism we should substitute gout. \* \* \* You all know what Sir James Paget has written on this subject—gouty phlebitis—and I shall not venture to add any touches to his picture. Then phlebitis often exists in the course of blood poisoning in its various forms. \* \* \* Phlebitis is not common in childhood.

*Symptomatology.*—The phenomena of phlebitis—its symptoms—are comparatively simple, and for the most part sufficiently clear. The disease often starts with pain—or, perhaps, more accurately speaking, aching—and acute tenderness in the course of the affected vein, which in the majority of instances, I think, at the outset presents to the touch evidence of being plugged. At other times, beyond perhaps an aching of the leg, or other part, the only local evidence of the mischief is œdema.

But this is usually, I think, very significant. The œdema of this affection is firmer, and apparently more generally diffused throughout the limb, than when it is due to simple obstruction or failure of the circulation. The affected limb, or part of it, is enlarged and thickened, but often with comparatively little alteration of shape, the skin pale and tender, and, when the part is grasped, the texture feels uniform and solid. One misses the characteristic pitting, upon moderate pressure, of ordinary œdema. The whole condition of the limb seems one rather of the state in which it is often left after an attack of phlegmonous erysipelas. And it seems to me important to distinguish between these two classes of cases: those which commence with local pain and tenderness, and those that are marked only by œdema; for, in the former case, the superficial veins only are at fault; in the latter, the deeper veins. \* \* \* I have often been surprised in noting with how little constitutional disturbance this affection, even when severe and extensive, is accompanied. Nothing may be observed beyond a trifling and transient rise of temperature, and often even this is absent. There are exceptions, of course, and sometimes grave ones; but, as a rule, in these cases the patients neither show the signs nor complain of illness, and oftentimes one of our chief difficulties is to ensure rest. Of course, as in the rheumatic or gouty form of the affection there may be special indication of constitutional mischief. \* \* \* \* \*

*Prognosis*—The great majority of these cases terminate in recovery, and the recovery is usually at length complete. All evidence of any clot or plug in the vein is gradually lost, the vessel becomes natural to sight and touch, and all signs of any obstruction to the circulation through it disappear. What becomes of the thrombus? It is said to be absorbed. Where, and by what means? That we hardly know. What change does it undergo previous to disappearance? If much time elapse, it shrinks and contracts, and probably degenerates after the fashion to be noted presently. Often, however, the vein remains permanently thickened. \* \* \* In the most of these cases there is probably only a partial restoration of the current through it. A corrugation

and apparent thickening of the vein wall, due to contraction of a clot attached within, must not be confounded with the condensation and rigidity of the vein wall, which is due to inflammation. In the former case the vessel can be restored to its natural state by injection. (Callender—System of Surgery) \* \* \* \* \* We may thus have in the veins clots of all degrees of duration and obstruction. So too in the effect produced upon the limb. There may be no perceptible œdema throughout, or the whole limb may be converted into a huge, unshapely appendage. When the œdema is considerable, or, indeed oftentimes even when comparatively slight—as we should expect from its solidity—it only very slowly disappears. \* \* \* Nay, sometimes the limb never after recovers its natural size or shape, for the tissues remain permanently infiltrated and hard. A varicose state of the surrounding veins is not often seen, in consequence of thrombosis. They are far more frequently dilated, tortuous and overgrown, from obstruction due to other causes, as from the pressure of a tumour. This may be because the larger veins are hardly ever permanently obstructed by thrombosis. There is the widest range in the extent to which the veins may be plugged. The whole mischief may be within an inch, or it may extend throughout large tracts of the venous system, spreading in all directions from the vessel first affected, but especially towards the heart. \* \* \* The clot once formed may change in another way. It may undergo degeneration becoming liquefied and broken down generally first in the centre. \* \* \* And what is the consequence of this diffusion of liquefied clot into the blood? When blood clot breaks down, and its fragments or *débris* mingle with the blood, that infraction of distant vessels results there can be no doubt. And it can be easily understood how this embolism will vary in its character and effects. If the detached fragment be large and coherent, a large artery, such as one of the chief branches of the pulmonary, may be plugged, and instant death may be, and has often been, thus produced. If the clot has been so softened as to become puriform before its diffusion, then results capillary embolism in the lungs or elsewhere; and not immediate death, but

severe disturbance, provoking very grave consecutive mischief, but still, at first local; and leading to changes in the parts affected—to inflammation and suppuration and perhaps gangrene—to which different observers have applied different terms. But with all this, not necessarily, or even commonly, I think, pyæmia. \* \* \* \* \* I can well remember, years ago, when the doctrine of Virchow was dominant, with what anxiety these cases of phlebitis and thrombosis were watched; how from hour to hour pyæmia, with all its terrible phenomena, was expected to supervene. But now this is, for the most part, changed. We watch anxiously for signs of embolism, and we do all we can, by enforcing rigid rest, to guard against its occurrence; but we do not anticipate pyæmia. Still, although even the occurrence of embolism in any of its forms is exceptional, I would earnestly advise you always to act as if it were imminent in every case. Fortunately for his peace of mind, the patient does not see this Sword of Damocles, but you must never forget that it hangs over him.

Pyæmia, then, as a consequence of phlebitis, is so exceptional that we hardly think of it as among the dangers to which our patient is exposed. The possible or probable occurrence of embolism is a source of far more immediate anxiety, but even this accident is comparatively rare. The majority of cases of thrombosis and phlebitis escape without it. The consequences of this affection are usually from first to last local—that is to say, limited to the vein or veins affected, and to the limb in which it occurs. Any direct evidence of disintegration of the clot within the vein is, for the most part, wanting. As a rule, all we are able to trace is the very gradual disappearance of the signs of thrombosis. The vessel, which at first is tender, distended, and solid, gradually becomes less sensitive to the touch, then reduced in size, but withal firmer and more cord-like; then, week by week, this solid passive cord becomes less and less distinct. The cases are very exceptional in which it remains completely and permanently plugged. No doubt, far more frequently the whole of the clot at length disappears; but, perhaps, in the majority of cases, a portion of the clot remains, either as a thin or thick layer lining the interior,

or in the form of fragments shrunken to one side and adherent to the walls. For all practical purposes, then, recovery is complete; and, therefore, in these cases, the prognosis, as a rule, is favourable. I have, however, already mentioned that, where there has been any considerable œdema of the limb, this condition is very apt to linger, and the leg may thus remain cumbersome and troublesome for very many months; and I have already mentioned, too, that, in the gouty form of the affection, there is an especial liability to relapse, and consequently oftentimes much disappointment in the progress of the cure.

Almost the whole of the treatment of phlebitis is described in one word—rest; rest in the horizontal posture, or with the limb affected somewhat raised. When the liability to this affection is great, the most trivial causes seem to determine the formation or extension of clot. It is often started by extra exercise—an unusually long walk or slight overexertion. Even very moderate pressure on a vein, as from one leg resting on the other, will sometimes start it. And, after it has begun, the chances are that the mischief will spread to some extent, do what you will. But absolute rest is the best safeguard. For it is not only of chief efficacy in controlling the extension of the disease, but no other means are known which can be reckoned of any material value in lessening the chance of any of those accidents which wait upon phlebitis. Drugs may be employed when there are any special indications for them. When, for example, there is any evidence of gout or rheumatism, much good may come of physic, or when there are signs of other forms of constitutional disturbance, such as pyrexia. In all circumstances, measures of general hygiene should be carefully attended to. The patient should lie at rest in air as pure as possible; and, in view of the tediousness of these cases, it is often well to have him soon carried to some place where this condition can be best fulfilled. We know how phlebitis is apt to complicate the convalescence of fevers, and cases can be mentioned in which thrombosis or an attack of phlebitis has followed exposure to emanations from foul drains, in such a way as to suggest that some poison mingling with the blood, instead of continuing

to disturb the whole mass, has coagulated a portion of it, and has thus been separated from the rest.

Neither can very much be done in thrombosis or phlebitis by local measures. The application of leeches in the course of the vessel has gone out of fashion. The relief they give is but temporary, and sometimes the irritation of their bites will prove mischievous. When the pain is very severe, it can be controlled by the local or general use of opium or morphia, or of something else. Otherwise, I think the most grateful application is, in the early period, a very strong lotion of acetate of lead; one part of the liquor plumbi to seven or eleven or nineteen of water. But, perhaps, the application of cloths wetted in simple water is nearly as good. Bandages at first are not advisable. They heat the limb, and otherwise increase the discomfort. But, when all signs of active mischief have subsided, when little or no tenderness remains, and the oedema is the chief trouble left, then bandages properly applied are undoubtedly very useful. Still later on, shampooing and baths of various kinds may be tried; but these should only be thought of when all risk of disturbing clots has long passed by. The baths of Aix les Bains, or Wiedbad, or the mud-baths of Marienbad may be suggested, and evidence is not wanting of brilliant cures effected by their means.

But, given a case of phlebitis, and it is not difficult to describe in general terms the prospect. At the best, it is likely to last long and prove tedious. It is not without risk to life; but a fatal issue, even from its several causes conjointly, is comparatively rare; and as time goes on, these risks diminish. But, if the patient would reduce these several risks to their lowest value, and otherwise accept conditions most favourable to his recovery, he must make up his mind to lie still for a long time.

A German paper gives a test for watered milk which is simplicity itself. A well-polished knitting-needle is dipped into a deep vessel of milk and immediately withdrawn in an upright position. If the sample is pure, some of the fluid will hang to the needle; but if water has been added to the milk, even in small proportions, the fluid will not adhere to the needle.

## TREATMENT OF CANCERS AND ADENOMATA OF THE BREAST BY COMPRESSION.

At the Session of the French Academy of Sciences of the 4th of February, Dr. E. Bouchut advocated the treatment of tumours of the mammary gland by compression by means of vulcanised caoutchouc and cotton batting. He related the particulars of a case in which a satisfactory result followed this treatment. The patient was thirty-nine years of age and had noticed the tumour six months previous to the time when she came to M. Bouchut. She had consulted three eminent physicians all of whom advised her to submit to an operation. This she was unwilling to do, and readily consented to the advice of M. Bouchut to wear a cuirasse of caoutchouc over a very thick compress of cotton batting. The breasts were not very large, the skin not involved, and freely moveable over the tumour, which was about the size of a small hen's-egg. There were three small moveable glands to be felt in the axilla, each about the size of a small nut. A rather thick band of caoutchouc from sixteen to twenty centimetres broad and long enough to almost surround the chest, with shoulder straps to prevent its slipping down and fastening behind either by lacing or a double row of buttons, was very tightly applied over four thicknesses of cotton batting sprinkled with lycopodium, the latter being used to prevent itching. This was left on a week, at the end of which time and at like intervals during the year it was removed and reapplied over fresh layers of cotton batting. At the end of two months, the tumour had ceased to be painful and had commenced to shrink and flatten. No respiratory difficulty resulted and sleep was undisturbed. At the end of six months the tumour had diminished half and the glands in the axilla equally compressed were much smaller. At the end of a year the tumour had almost disappeared, and the axillary glands were reduced to a rudimentary state. After fourteen months' compression the tumour had entirely disappeared and the axillary glands were the size of a small pea. Both breasts were equally atrophied, flattened and almost absorbed, so that the ribs could be readily counted in the mammary region.—*Gazette des Hôpitaux.*

## CLINICAL LECTURES ON FRACTURES

BY FRANK H. HAMILTON, M.D.

I shall have to speak of certain peculiarities which characterize fractures of the shaft of the femur in children, and which make them different from the same kind of fracture in the adult.

In the first place, then, such a fracture in the child is always transverse, while in the adult, you will remember, it is always oblique, and not infrequently to an extremely marked degree. Secondly, it is not only transverse, but it is of a denticulated character. It affords a good example of what is known as the "green-stick fracture," a name derived from the resemblance of the ends of the fragments to the denticulated surfaces of a freshly-broken stick, such as I show you here. This denticulated character, however, is not so marked in fractures of the femur as in some others, those of the clavicle and radius, for instance; and the several degrees of green-stick fracture, I may say, would be very well represented by fractures of the clavicle, radius, and femur respectively. While in fracture of the clavicle in the infant the bone is rarely broken off entirely, this is commonly the case in fracture of the thigh. In this respect it resembles that in the adult, the fragments sometimes slipping quite past each other. Three degrees of green-stick fracture have been described:

In the first the bone is bent, but resumes its original shape. This was very fully illustrated in a series of experiments upon the bones of animals, which I published a number of years ago.

In the second the bone is bent and remains in this condition.

In the third the bone is not only bent, but broken off, and the fragments remain separated.

So much for the pathology of the accident.

These are the only indications present:

First. To prevent bending.

Second. To prevent shortening.

Not infrequently the second indication does not exist at all, there being no danger of shortening, on account of the transverse character of the fracture and the easy adjustment of the fragments. In any given case the essential

question to ask is, How shall we prevent bending? and this has always been the stumbling-block of surgeons.

As in almost all other fractures, of course, some sort of splint has been resorted to, but the trouble here with splints and the bandages necessary to keep them in position is, that they make pressure upon an exceedingly delicate skin, and that underneath this tender skin is a very large amount of adipose tissue, which yields very readily to any compressing force. As a consequence, the circulation is greatly interfered with, and long before the end desired (the union of the fragments of bone) is accomplished this interference becomes so serious that the most disastrous results are liable to follow.

Another reason why sloughing is apt to occur is, that the urine soils the dressing when the child is too young to understand the situation, and this, of course, causes excoriation. Hence we find that almost all cases of sloughing occur in children, adults not labouring under the same disadvantages. There are other reasons, also, why it is so difficult to treat fractures of the femur satisfactorily in children, and the following summary includes them as well as the reasons just mentioned:

1. The delicacy of the skin.
2. The abundance of fat.
3. Excoriation from urine saturating the dressing.
4. The fact that the limb is so short (its long and its short axes being almost of the same length) rendering it very difficult to get any purchase for splints.
5. The restlessness of children, who are continually tossing and tumbling about, and so are almost certain to disarrange any form of dressing that may be employed.

Since these difficulties are so numerous and serious, then, how have surgeons been accustomed to overcome them? I can give you very little information on this subject, for you may search surgical literature almost in vain for it. The books do not say much about it, for their authors have found it no doubt a very disagreeable subject; and most of them make no distinction between fracture of the femur in the child and in the adult. Some authorities have treated their little patients by laying the

limb over an inclined plane; but this method is of no use whatever. The child invariably slips down out of position, and the fragments consequently become displaced. If you attempt to remedy this by elevating the hips, you are apt to drive the limb up, and so displace the fragments, and you may consider yourself extremely lucky if you should happen to keep the child in some one position for twenty-four or forty-eight hours just at the critical time when union is on the point of taking place. Fractures usually unite rapidly in children, and it may be that in some such brief period as this sufficient union between the fragments may be secured to withstand the strain to which they will be subjected in the future by the constant movements of your restless patient.

Again, plaster of paris has been used more recently; but anybody who has employed it once will be scarcely likely to try it a second time. I am very sure that it must be a bad plan, and a little reflection will convince you why this should be the case. The plaster must necessarily get wet with urine in young children, and as certainly as it does it will cause excoriation. But even if this could in any way be prevented it would be exceedingly apt to cause excoriation, and even sloughing, as it not infrequently does in the adult. If there is danger of sloughing in the latter, this danger is infinitely increased in the case of the child, on account of the necessity of applying the bandage more tightly in children.

I have, then, only added to and improved upon some of the plans adopted by others. The essential feature of the treatment is a long double splint, but I will describe the whole apparatus in detail. In the first place, after the adjustment of the fragments, the fractured thigh is dressed with four coaptation splints, precisely as in the adult, and to render the demonstration less tedious they have already been applied in the case of the child who represents the patient for us to-day. Next a long splint, very carefully padded, is placed on the outside of the limb (extension having first been made), and this is secured by rollers. As it is a troublesome matter to keep the limb straight, and this is so essential an object, the splint must be made long enough to reach to the axilla, and

the upper portion of it should be made fast by additional rollers passing around the chest. This is designed to keep the axis of the thigh and leg (including the fragments, of course) in a line with that of the body; and the indication will be fulfilled in this manner, provided there is no overlapping of the fragments or tendency to shortening. If this is the case, it will be necessary to make extension by means of the weight and pulley, as in the adult (though a traction-force of only two or three pounds is required), and counter-extension by means of a perineal band, only moderately tight, secured to the long external splint. The weight of the body cannot be relied upon for the latter purpose in children, as in adults, and the perineal band answers every purpose perfectly well. This extension and counter-extension are required in perhaps one case out of four. Another very important feature of the apparatus is a second long splint, which is secured to the sound limb and also passed up to the axilla, and the object of this is simply to keep the child quiet, for otherwise it would be constantly tossing about, to the imminent jeopardy of the straightness of the fractured thigh. Great care should be taken to have the knee firmly secured especially, for if it is not the patient will be sure to work the limb loose. Finally, the dressing is completed by making the lower ends of both the long splints fast in a wooden cross-piece. It will be found in practice that children submit with quite good grace to the inevitable, and they are usually perfectly contented after the apparel has been on them for two or three hours. When the bed has become soiled by urine or faeces, the child and the whole apparatus can be lifted on to another one with the greatest facility, and thus the bed can be changed as often as is necessary.—*Philadelphia Med. Times.*

ROYAL COLLEGE OF PHYSICIANS OF LONDON.  
—At the ordinary meeting of the College on January 30th, exemption from re-examination in Chemistry and Materia Medica was recommended by the Council in the case of candidates for the licence of the College who had previously passed in those subjects at an University in the United Kingdom, in India, or in a British colony where the degree or a licence to practise was granted.

## THE LOCAL USE OF SOLUTION OF QUININE IN CHRONIC IRRITATION OF THE BLADDER.

BY T. W. NUNN,

SURGEON TO THE MIDDLESEX HOSPITAL.

Some few years since (summer of 1872) I commenced, in the wards of Middlesex Hospital, the local employment of quinine as an antiseptic after operation, in a case of necrosis of the tibia. For the removal of the sequestrum in this case it was necessary to clip away new bone to the extent of some inches from the anterior aspect of the shaft of the tibia. Of course, after the sequestrum, corresponding in length to the bone cut away, was lifted out, a long trough was left, in which the pus accumulated, and became fetid.

My then dresser, Mr. G. Karop, suggested quinine as a bactericide under these circumstances, in answer to my appeal to be furnished with such an agent. I appealed to Mr. Karop, as he had just returned from the Vienna school, and was, moreover, especially qualified, by his histological and microscopical labours, to respond to my request.

The result from the local exhibition of the quinine was most satisfactory. We used a solution of the disulphate of quinine, one grain to the ounce of water, the smallest quantity only of sulphuric acid that would suffice to complete the solution of the alkaloid being added. I have since made frequent use of the solution of quinine as a local application. It appears to me to be especially efficacious, either alone or combined with the bichloride of mercury or the chloride of zinc, in certain forms of soft chancre.

The most striking result, however, is obtained by injecting the solution of quinine into the bladder in those cases where the urine is loaded with pus, and is *intensely offensive*; the bladder being irritable, the desire to urinate recurring every hour, or more often, for example, where the bladder only imperfectly empties itself, or when the continual use of the catheter is called for in enlarged prostrate, or in atony of the organ. Within the past few days I have been informed by a patient who has habitually had recourse to the catheter, the urine voided being

alkaline and highly offensive, that the injection of the quinine solution has been followed by such an abatement of the sensitiveness of the neck of the bladder that the desire to micturate comes on now only after the lapse of six or seven hours, in place of after the lapse of every hour or hour and a half.

The following is the method of using the quinine as a bladder injection:—Dissolve twenty grains of disulphate of quinine in twenty-five ounces of water by the aid of a few drops of dilute sulphuric acid or a teaspoonful of *common brown vinegar*. Of this solution inject into the bladder two or three ounces, and let it remain.

REMOVAL OF FOREIGN BODIES FROM THE AUDITORY CANAL.—Among the various means suggested for the removal of foreign bodies from the ear, I see no mention, either in the JOURNAL or in text-books on the subject, of a simple and harmless plan which I have used lately with success. Some months ago, a boy aged 12 was brought to me with a round smooth white pebble in the auditory canal. It could be plainly seen, and had been there for two days, during which time, I was told, repeated efforts had been made to remove it; but their only result was to cause pain, congestion, and swelling of the mucous membrane, which firmly grasped the foreign body, and prevented the possibility of passing any instrument beyond it. I syringed the ear for some time without any good result; and, as his friends were very anxious to have other means tried, I did not like to send him home unrelieved. Having at hand a bottle of the cement known as coaguine, which seems to be a solution of isinglass in acetic acid, I prepared a piece of soft pine-wood, about as thick as a No. 8 catheter, by hollowing the end so as to cause it to fit accurately on the convexity of the pebble. Having now melted my cement by placing the bottle in hot water, and having dried the foreign body with cotton-wool, I covered the hollow end of the piece of wood with the cement, and applied it to the pebble. After waiting for ten or twelve minutes for the cement to set, I made gentle but steady traction, and had the satisfaction of withdrawing the stone firmly cemented on the end of the wood. This plan will obviously be more suitable for round smooth bodies which fill the canal than for small angular ones; but the former are the ones most difficult to remove by any other procedure.—GEO. GRAY, M. D., Castlewellan, Co. Down.

## Midwifery.

### THE VOMITING OF PREGNANCY AND ITS TREATMENT.

BY M. O. JONES, M.D., OF CHICAGO.

WITH NOTES OF A CASE.

BY J. MARION SIMS, M.D.

Believing that the vomiting of pregnancy is a reflex phenomenon, is it not strange that nearly all our efforts to relieve it have been mainly directed to the stomach, the helpless sufferer from the fault of another organ? Why not direct our curative or corrective measures directly to the source of mischief? Impressed with the correctness of this idea, I decided to put it in practice in the first case that might come under my care.

It has been now six years since my first opportunity of testing this idea, and within that time I have treated five cases, and in each case a very gratifying result ensued. I thought by exciting an irritation or superficial inflammation of the os and cervix uteri, the reflex nervous phenomena would be concentrated at the point of irritation, and thereby relieve the stomach.

To the first patient I applied the solid nitrate of silver to the os uteri only. The benefit was very noticeable within twenty-four hours. Being somewhat apprehensive, I applied the caustic rather sparingly, and in a few days applied it again, obtaining still greater relief. I used it a third time, but suspect the third application was really unnecessary. The patient remained free from sickness or vomiting to the end of gestation. To the second case the caustic was applied twice only. Improvement followed the first, and complete relief the second, application. The third patient required but one application; it was used more freely than in the preceding cases, and applied to the os and a portion of the cervix uteri. The fourth patient needed but one application, and this was one of the most harassing and persistent cases of vomiting that ever came under my care. The stomach rejected everything taken into it, and the patient grew feeble and became so emaciated that she was scarcely able to leave her bed. The caustic in this case was very freely applied to the os and vaginal cervix. The relief ob-

tained was beyond my expectation, for it was almost immediate. She vomited only twice or thrice in the thirty-six hours following, and no more after that time. She was able to retain food; assimilation was good, and she gained rapidly in health, strength, and flesh. The fifth case was one in which the vomiting was not so frequent, but quite as persistent. In this case, in addition to the vomiting, the abdomen was quite tender—as I supposed from the violent retching. The caustic in this case was applied twice before entire relief was obtained.

In all these cases, before resorting to the caustic, I had faithfully tried, and for some time, remedies which are usually resorted to in such cases, without any benefit whatever in the fourth and fifth cases and only temporary improvement in the others. These were all cases of first pregnancy, except the second one. In the first and second there was slight erosion of the mucous lining around the os; in the others none whatever, all three being perfectly healthy in appearance.

#### NOTES OF A CASE BY DR. MARION SIMS.

Madame de C—, aged twenty-two, married at sixteen, tall, 175lbs. in weight. Has one child four and a half years old. During her pregnancy she suffered from nausea for two months or more. Did not nurse the child, and conceived again a year after its birth. Nausea began with conception and ended with a miscarriage in two months at Arcachon in 1874. In 1875 conceived again, nausea followed immediately and again ended in a miscarriage at the end of the second month in Havre. In 1876 she again miscarried, in New York, at the end of the second month, from prostration induced by the nausea. First saw her October 24th, 1877; gave me a history of her miscarriages, and feared she was again pregnant, the nausea having returned during last ten days. Ordered bismuth to be taken by day, and bromide of sodium at night. There being no improvement on the 29th I ordered oxalate of cerium. Four days later sent for me; had been in bed ever since my last visit; was much prostrated from nausea and starvation. She imagined herself worse on alternate days, so I

ordered quinine. This produced vomiting and purging and aggravated her condition. Then gave her bromides without effect, and determined to try local treatment. There was right lateral ante flexion, os tincæ granular and covered with a glutinous leucorrhæal secretion. A case for Graily Hewitt's pessary treatment, or Copeman's plan of forcible dilatation of os and cervix. Thought of trying Dr. Jones's plan. Cleared away the discharge and applied a solution of nitrate of silver (5 ij to ʒj) freely over the whole surface of the cervix till it was well whitened, and stopped all other medication. On the next day Madame de C—— was sitting up in bed, a marked improvement having taken place. She had had a good night's rest, and had taken a liberal breakfast: a show of blood followed the application of nitrate of silver. At the end of five or six days, there was slight nausea, and the neck of the womb was penciled with pure carbolic acid. On the next day she said she was perfectly well. On November 19th she reported that she had occasional nausea and she stated that she had never felt so well before during the first two months of any of her pregnancies.—*Lancet*.

**HYPODERMIC INJECTIONS OF ETHER FOR THE CONVULSIONS OF A TEETHING INFANT.**—In *La Tribune Médicale* for January 6th, 1878, is a paper by Dr. Gellé on this subject. After referring to this mode of administering medicines of various kinds, he details the following case:

An infant, aged seven and a half months, who was just cutting the lower incisor teeth, began suffering with frequent and obstinate vomiting, diarrhoea, and subsequently convulsions. During the intervals when the child was not convulsed, it was comatose, and hence it was impossible to administer remedies by the mouth, even if the vomiting had permitted it. There was high fever, and pressure on the abdomen evidently caused pain. The face was pale, and wore an expression of suffering. The pulse was quick and respiration labored. There was evidently a subacute "catarrhal state." The convulsions were caused by the general trouble of the organism. There was also a slight pneumonia which was just developing. The chief indication was

first to arrest the vomiting and convulsions; in the second place, to reduce the temperature by bringing on free perspiration; and finally, to lessen, as far as possible, the pulmonary trouble.

Ten drops of sulphuric ether were injected slowly in each thigh of the little patient, who seemed to feel the prick of the needles, though it paid but little attention to it.

The convulsions did not appear again after the injection,—at least the only two which occurred (ten hours after) were so slight as scarcely to deserve the name. The vomiting ceased entirely and the little patient fell asleep.

A slight pneumonia of the apex of the right lung occurred, which was followed by an obstinate bronchitis; but after some time, the child's health was entirely re-established. No local trouble occurred at the points of injection.—

*Virginia Medical Monthly.*

**PHYSIOLOGICAL MEANS OF PREVENTING THE PRESENTATION OF THE SHOULDER.**—M. Pinard (*La Tribune Médicale*, Jan. 13th, 1878), after calling attention briefly to the danger, both to mother and child, in shoulder presentations, states, for some years past, he has been endeavouring to determine the cause of such faulty presentations, with a view of preventing them. He claims that the cause lies in the too great laxity of the abdominal walls; and in proof of this, he calls attention to the fact that shoulder presentations are seven times more frequent in multiparæ than in primiparæ. The cause does not reside in an original malformation of the uterus. If this be true, he continues, by giving to a woman, whose abdominal walls are too lax, a band to wear during the latter months of pregnancy, the abnormal presentation of the child will be prevented. He states that in more than twenty cases, when shoulder presentations were recognized before labour set in, the malpresentation has been rectified by the band, so as to cause the vertex to present. In only two cases where this means was resorted to, did it fail, and then version had to be practised. In conclusion, he says that in every case when the head is not in the pelvic excavation during the last month of pregnancy, every means should be adopted to bring it there.—*Vir. Med. Monthly*.

## Hospital Reports.

### HOPITAL DE LA PITIÉ.

BY M. VERNEUIL.

#### ON PURULENT ARTHRITIS CONSECUTIVE TO LYMPHANGITIS.

We have rather frequently observed that lymphangitis of the lower limb has been followed by very serious, articular troubles in the knee. There certainly is between these facts a relation of cause and effect which has not yet actually and clearly been made out. Billroth has observed that when there has been suppuration in the course of the lymphatics the articulations of the same limb have been seen to contain pus, but he has not sought the cause of this. I have observed, in a cachectic man, suffering from ulcerations on the feet, a lymphangitis followed by induration and abscess of the lymphatic tracts: I successively opened these various abscesses; one of them appeared to have opened into the kneejoint, and determined a purulent arthritis which was rapidly fatal. I have also seen, in consultation, a young girl of twelve years who was affected with lymphangitis consequent upon an excoriation of the great toe. The knee joint was also affected without there having been any abscesses in the lymphatic tract. A purulent arthritis with abscess and fistulæ was developed and proved fatal at the end of three months of suffering. At the *Hôpital Lariboisière*, I also saw a cachectic man affected with a contused wound of the foot which was followed by a vast slough; a lymphangitis declared itself, and there was also communication with the knee joint and death. It is worthy of remark that these communications were always made by abscesses on the *inner* side of the knee.

Here lastly, in this ward, bed No. 22, is lying a man, a railway employé, with varicose veins, who also presents the same phenomenon: hydarthrosis consecutive to a lymphangitis produced by an excoriation of the foot. An abscess threatens to form and open, not on the inner side but below the knee, on the surface of the triceps, which fact allays any apprehension of communication of pus with the knee. But there is hydarthrosis. At the elbow, hygroma often

occurs when there is lymphangitis of the arm. As for the knee, it is extremely desirable to watch very attentively abscesses which form on its inner aspect, and to open them very early.

In order to explain this relation we may invoke the disposition of the lymphatics which enter serous pouches in the subcutaneous connective tissue which may serve as channels of communication with the articulations. We may also suppose that there occurs in the lymphatics and articular serous membranes, a *centrifugal* lymphangitis, analogous, for example, to the erysipelas which, in operations upon the breast is propagated from that region towards the extremities of the fingers. Finally there is an obscure point here which is connected with the general study of the lymphatics, and which deserves to be observed and studied.—*Gaz. des Hôp.*

### CLINIC OF PROF. D'ACOSTA.

#### PENNSYLVANIA HOSPITAL.

#### CHRYSOPHANIC ACID IN CHRONIC PSORIASIS.

James B., æt. 27, a teamster, never had syphilis. Was in this Hospital from 24th of October last until November 14th. He had, when admitted, a chronic disease of the skin, which he said had lasted more than ten years. The eruption first appeared during warm weather upon his scalp, and gradually spread to his legs, arms, and body. It was scaly from the first, appearing originally in the form of a papule, and then spreading and scaling, the skin becoming thickened, fissured, and raised in its progress. It itched so badly as to prevent him from sleeping at night.

When I first saw him he had been using various remedies, including arsenic, internally and externally, the alkaline green soap, so much used by Hebra in Vienna, with but slight success. I determined at once to use chrysophanic acid, and the effect was most striking, as the following note made of his condition when he left the Hospital will show: "The skin was decidedly better, and shows nearly a normal surface. Treatment has been followed by very marked results. The skin upon his chest and arms has nearly recovered its normal colour, and the skin feels softer every-

where, and there is little tendency to scaling. Patient considers himself almost well."

He comes back this morning; although not so well as before he left, he is still conscious of great improvement, and returns to have the same treatment pursued.

The following will be the details of treatment. For the purpose of cleanliness he shall take a warm bath every morning, remaining in it fifteen minutes; the water to be made slightly alkaline by the addition of half an ounce of carbonate of potassium; and the following ointment—

Acid. Chrysophanic. . . . . ʒss.

Ung. Simp. . . . . ʒi.

To be rubbed in thoroughly at night.

#### DIABETES INSIPIDUS CURED BY ERGOT.

The next patient, Joseph H., æt. 21, was shown to you once before during the height of his malady. He had a family history of phthisis, his mother having died with pulmonary consumption, and his father of some acute disease following a cold. He had never received any injury to the head, and had never been sunstruck. Was uniformly healthy until May last. At that time he simply noticed that he was passing a good deal of urine. Since then, up to the time of his admission, he had fallen off rapidly in weight. He had also complained of irritability of the neck of the bladder, but nothing had been found to account for the irritation. On admission we found he was passing from eight to ten pints of urine daily, although at the same time he only drank five to six pints of fluids (including milk, tea, and soup). The urine was acid, of low specific gravity 1.005, contained no particle of sugar, and was entirely free from albumen. We therefore recognised it as a case of diabetes insipidus, or polyuria, as it is sometimes designated. This disease is extremely difficult to eradicate.

We began our treatment December 1st, and directed him to take the fluid extract of ergot in one drachm doses three times daily; subsequently increased to four doses; and for five days he took six drachms in the twenty-four hours. The effect was most marked. The

amount of urine rapidly and steadily fell to five pints, and then to three pints; but before he had got down to the normal quantity we reduced the ergot, and afterwards stopped it altogether and placed him on a little peppermint water, not so much, however, for its stomachic as for its mental effect. He has now had no ergot for two weeks, and I can give you the gratifying information that the effect has been permanent. Since his recovery he has undergone an operation for phimosis, and now the irritability at the neck of the bladder has entirely disappeared, and he leaves the Hospital perfectly well. We shall direct this patient to take half an ounce of cod-liver oil two or three times daily as a general nutrient.

#### CHRONIC PLEURISY. REMOVAL OF A LARGE EFFUSION BY JABORANDI IN LESS THAN THREE WEEKS.

John L. C., a weaver, æt. 23, was in good health until last summer, when he was exposed to wet at the seashore, and since has been subject to occasional pain in the left chest, and a slight cough, dyspnoea and mucous expectoration tinged with blood. He went into "Episcopal Hospital" five weeks before his admission here. At that time he had daily chills. His chest was then aspirated and five pints of clear serum drawn off. He improved after this and left the Hospital. His former symptoms, however, returned, including the chills, and he came to our ward five weeks after he had been aspirated. I found effusion in left chest, displacing the heart to the right and causing much suffering. I was unwilling to aspirate again, because in chronic pleurisy after aspiration the fluid is apt to return, and after several aspirations the fluid may become purulent. I therefore gave him a drachm of the fluid extract of jaborandi four times daily. The effect was as follows: chills passed away, temperature was reduced from 101° to normal, the pulse and respirations are almost normal. As regards physical signs dullness has disappeared except at lowest part of left chest. I can everywhere hear the respiratory murmur, although it is feeble at lowest part. The effusion has therefore almost disappeared. I think the

relief obtained is permanent; for if you can remove a fluid by medical treatment it is generally not likely to return. During the treatment the patient was sweating profusely, and I may say that the larger quantity of this effusion passed away by the skin. (It should be added that the case progressed to a perfect cure, and the patient was discharged January 19th, 1878.)

#### ARSENIC IN ECZEMA CAPITIS.

From *Dr. E. F. Walker's Clinical Reports of Demill Dispensary.*

John M., *æt.* 7 months. Face and hands covered as by one scab. Mother said he was taking a pint of condensed milk a day, but vomited constantly after being fed. Bowels constipated and child very fretful. I ordered one-third the amount of milk, and directed mother to dilute it more. Also ordered one drop of Fowler's solution of arsenic three times a day, and one grain of calomel at a single dose; locally I used nothing, but directed child to be watched and prevented from scratching its head or face.

In a week there was great improvement. The diseased surface, instead of being moist and bleeding, had dried up, and in many places the scabs had fallen off, showing a sound surface beneath. I then ordered the arsenic to be increased to five drops a day, and one grain of calomel once a week. I have increased the Fowler's solution until he has taken three drops three times daily. In four weeks the child was cured. I have had a number of these cases both in Dispensary and private practice, and have found arsenic act so well that I look upon it as a specific.

**CARRON OIL IN ANAL FISSURE.**—This painful affection, which has heretofore resisted almost all forms of treatment by local applications, has been successfully managed by Carrère, who states in *Annales de la Med. de Gand* that he applies the mixture of lime and water and linseed oil, so commonly used in burns. This is done several times daily and in all cases he has obtained a cure in at farthest, eight days.—*Allg. Med. Cent.-Zeit.*, No. 2, 1878.

### Original Communications.

To the Corresponding Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

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

SIR,—The comments on the provisions of this Bill which appeared in the March number of your Journal are fair and satisfactory, with the exception of the remarks which you make upon section iii. In condensing the Ontario Medical Act into the shape in which it appears in the Revised Statutes of Ontario, which condensation has been done with great spirit and fairness on the whole, the fact was overlooked by the revisers, that the Act of 1874 was not an original Act, but a very slightly altered renewal of the Act of 1869; and in view of this, the interpretation to be put upon section xxii., subsection iii., was that which was embodied in section iii. of the Bill to Amend the Ontario Medical Act; and this is the opinion of the most eminent legal authorities to whom the matter has been submitted. This view of it, moreover, received the unanimous assent of the Executive Committee of the Council, under whose instructions the measure was drawn up and laid before the Legislature.

It is matter for regret that the Session of the Ontario Legislature closed before this Bill could be passed through all its stages; but there is little doubt that a similar and improved measure will be carried into law at the next Session of Parliament.

As all claims upon the public treasury must originate with the Government, it becomes necessary to take out of our Bill the clause referring to the payment of medical witnesses in criminal trials; but we received the assurance of the Ontario Government that next Session a measure will be submitted to Parliament making provision for this purpose, and almost in the same terms as our section viii.

I am, Sir, yours faithfully,

D. CAMPBELL, M.D.,

Member of Parliamentary Committee of Executive Committee, College of Physicians and Surgeons, Ontario.

## Translations.

From *Le Progrès Médical*.

### REMEDIES RECENTLY RECOMMENDED IN PULMONARY PHTHISIS, KOUMYS, GLYCERINE, CREASOTE.

The number of *Le Progrès* for 26th January contains an editorial on this subject, from which we make the following extracts. Dr. De Boyer says, "It has not been the object of the observers, whose suggestions we are about to compare, to find a specific for phthisis, but they have all sought to modify the course of denutrition which is at once the characteristic and the danger of tuberculosis."

*Koumys*.—"The employment of koumys in phthisis is not recent in France as appears to be supposed, but it is only since its propagation amongst us by M. Landowsky that its use has become generalised. As early as 1865 Schnepf pointed out the good results obtained from this remedy which he borrowed from the Russians; in 1866 M. Fonssagrives in his Treatise on Special Therapeutics pointed out its happy effects; and in 1874 MM. Edwards and Landowsky, and later MM. Urdy, Labadie-Lagrave, Gubler and other observers have employed it successfully in the hospitals. Koumys only differs from milk in the addition of three new elements—products of fermentation: alcohol, carbonic acid, and lactic acid. \* \* \* Applied in the treatment of phthisis it is found that koumys very speedily produces increase of body-weight, diuresis is augmented, sleep and appetite are improved, and lastly the vomiting, cough, and sweating are diminished. \* \* \*"

*Glycerine*.—The employment of glycerine is more recent, but no more than koumys or creasote, is it a new remedy, although the application and physiological study of these medicines are of recent date. In 1856 Lindsay, (*Edinburgh Med. Jour.*) proposed it as a succedaneum for codliver oil in phthisis and scrofula, in 1869 Davasse employed it to promote the digestive functions, later it was employed in Glycosuria by Bouchardat (1875), Pavy, Jacobs, Harnack, and in 1877 M. Catillon published his physiological study of it, from which it appears that glycerine in small

doses favours nutrition, as evidenced by an increase of weight (an account of his conclusions will be found at page 207 of the CANADIAN JOURNAL MEDICAL SCIENCE for June, 1877. The dose should be  $\bar{3}$  ss— $\bar{3}$  i per diem. \* \* \* M. Fremy at l'Hôtel Dieu employs the following formula: Glycerine  $\bar{3}$  iii, syrup of iodide of iron  $\bar{3}$  iii, syrup of morphia  $\bar{3}$  vi. Each phthisical patient should take one or two tablespoonfuls a day, which would correspond to  $\bar{3}$  iss— $\bar{3}$  iii of glycerine. It may also be combined with chloral, dissolved by heat, as a hypnotic.

*Creasote*.—Has been highly recommended in phthisis in a recent work by MM. Bouchard and Gimbert (of Cannes), and also by M. Hugues. It was discovered by Reichenbach in 1830 in the course of his experiments with wood tar, and its therapeutic properties studied. In 1833 (*Bull. de Therap.*) Mignot, Breschet, and Grandjean applied the new remedy in the treatment of phthisis, but they desired to make too much of it and vaunted it as a specific, in consequence of which an undeserved abandonment succeeded the too great enthusiasm of the moment." The difference between koumys, glycerine, and creasote, is that the two former exert an influence upon the healthy as well as the diseased body, but the latter acts only in pathological conditions "The essential condition for the proper administration of creasote is to give it as dilute as possible and in perfect solution, for it must never be forgotten that it is an energetic caustic. MM. Bouchard and Hugues employ creasoted alcohol and creasoted wine; M. Gimbert has proposed creasoted oil: Cod-liver oil  $\bar{3}$  ix, pure creasote of wood-tar  $\bar{3}$  ss— $\bar{3}$  i. This oil may be administered in the same dose as the ordinary cod-liver oil. The alcoholic solution is employed in the following formula: Pure creasote of wood tar *m* xl, alcohol  $\bar{3}$  iv, water  $\bar{3}$  iv. A tablespoonful half an hour before meals, diluted with half a tumblerful of water. An analysis of 120 cases so treated is given by Bouchard, Gimbert, Hugues and Maurice Reynaud. Twelve cases in the first stage were all apparently cured, the amelioration persisting up to the time of publication. Seventy-five cases in the second stage gave twenty apparent cures, and twenty-six

ameliorations (i.e. 46 out of 75), seventeen failures, and twelve deaths. Thirty-three cases in third stage gave thirteen ameliorations (more than 33%), nine failures, eleven deaths, and no cures. Dr. de Boyer combines creasote and glycerine in the following formula: Pure creasote of wood tar ʒ ss, pure non acid glycerine ʒ ii, syrup of gooseberries ʒ iv, essence of peppermint gtt xx. Each tablespoonful contains 2½ minims of creasote and nearly two drachms of glycerine. Two to four tablespoonfuls should be given per day, each spoonful being diluted in a glass of water or carbonic acid water.

From *La France Médicale*.

#### ON THE THERAPEUTIC EMPLOYMENT OF ARSENIATE OF GOLD.

Arsenical preparations now-a-days reckon amongst their advocates physicians of all countries. It will suffice to mention the names of Zeller, Smalz, Lefébure, Fodéré, Valentin, Cazenave, Boudin, &c. On the other hand, the valuable observations, collected through half a century, upon the application of gold and its compounds in the treatment of syphilis, of phthisis, and of strumous affections are known to every one. Cullerier and Bard have declared that gold has been able, in certain cases, alone to destroy the venereal virus. Lalouette has vaunted in scrofula a compound of which gold forms the base. Ramazzini, repeating the opinion of Fallopius, says: "That nothing is preferable to the power of gold when it is desired to arrest the bad effects of mercury upon the organism." Legrand has published a work showing its happy influence in the constitutional symptoms of syphilis, such as ulcers of the nasal fossæ, pharynx or larynx, cutaneous eruptions, exostosis, necrosis, caries, &c. Trousseau and Pidoux have noted in their *Traité Classique* the advantages which they have sometimes derived from dressing unhealthy ulcers with an auric ointment, or from friction of syphilitic engorgements, with such an unguent. Chrestien says Fabre's *Grand Diction. de Méd.*, has tried auriferous preparations in the various forms of strumous affections, and has derived from them marked advantages. Duhamel, in the words of

the same author, has obtained unhoped-for results. Niel has employed them in tinea and elephantiasis, Biett in Syccosis, and Gorzi in Scorbutus. If to these affirmations there be added those of Pelletier, of Duportal, of Pierquin and other practitioners not less affirmative, we are justified in concluding that the ancient renown of preparations having gold for a base now-a-days rests upon established facts. To Dr. Chrestien is due the credit of being the first to use a combination of gold and arsenic. \* \* \* Chrestien having treated phthisical patients with the muriate of gold and arsenic alternately, immediately discovered the similarity of their action. The first applications in France were made by Dr. Massart, who administered the arseniate of gold in cancer and in phthisis, and who had the honour of seeing his remarkable work approved by the *Sociétés de Médecine* of Lyon and Toulouse. Last year at the Congress of German Surgeons Prof. Esmarch reported two striking observations in which the employment of arsenical preparations had been successful in suspending the effects of a cancer at a period when useful surgical interference was out of the question. \* \* \* In the arseniate of gold the practitioner has at his disposal, in a small compass, two active substances which are synergic in their action. \* \* \* Italian and American observations have established beyond a doubt that diseases, such as lupus, depending upon scrofula are rapidly ameliorated and ultimately cured by the arseniate of gold. The first effect of the arseniate of gold is a rapid increase of appetite. As Harless, Biett, and Cazenave have already remarked, the peristaltic contractions of the stomach and intestine are excited, and absorption occurs with greater rapidity. The arseniate of gold then directly involves the nutrition of the anatomical elements and consequently exercises a direct effect upon the different varieties of anæmia and chlorosis.

Nitromuriatic Acid should always be prescribed by itself. Recently a very damaging explosion occurred in a mixture ordered by a physician, of nitromuriatic acid and tincture of cardamom.

From *Rivista Clinica di Bologna*.

RETROPHARYNGEAL ABSCESSSES.

This Journal for December contains a long account of 144 cases of retropharyngeal abscess and 43 cases of retropharyngeal lymphadenitis which had fallen under the observation of Prof. Bókai, from which we make the following notes:—

Of the 144 retropharyngeal abscesses there were

Idiopathic abscesses . . . . .	129
Secondary to infiltration of pus from abscesses of the neck . . . . .	3
Secondary to spondilitis cervicalis . . . . .	4
Occurring in course of Scarlatina . . . . .	7
Traumatic, caused by foreign body . . . . .	1

Total . . . . . 144

Of these, 102 were opened with bistoury in the throat; 5 were opened by finger pressure in the throat; 19 opened spontaneously in the throat; 18 remained unopened. Total, 144.

Of these 11 died; 120 were cured; and 13 were lost sight of.

Besides these he has observed 43 cases of retropharyngeal lymphadenitis and of these, he says, "Every such case gives rise to a suspicion of retropharyngeal abscess, but it does not always run on to suppuration, sometimes it undergoes complete resolution after a longer or shorter duration.

The author regards idiopathic retropharyngeal abscess as only one termination of retropharyngeal lymphadenitis.

Of the 129 Idiopathic abscesses . . . . .	5	died.
" 3 Secondary to abscess of neck . . . . .	0	"
" 4 Secondary to spondilitis cervicalis . . . . .	3	"
" 7 Secondary to Scarlatina . . . . .	2	"
" 1 Traumatic . . . . .	1	"
" 43 Retropharyngeal Lymphadenitis . . . . .	0	"

Total . . . . . 11 died.

CAUSES.—*Age*.—Author observed it as early as the 8th week—more frequent between 3rd and 12th month, gradually decreasing up to 14 years. Scrofula stands at the head of the predisposing causes, and season and local irritations at the head of the exciting causes. Most frequent in January, February, March, April, May, October, and November.

*Treatment*.—If suppuration have not occurred Dr. Bókai employs cold compresses, and directs ice to be sucked. He thinks the suggestion of Gautier and Schmitz to print the pharynx with iodine or a solution of iodide of potash worthy of trial.

If decisive signs of the formation of abscess be present he uses hot fomentations, and punctures with a narrow straight bistoury, carefully avoiding the vicinity of the great vessels. He remarks that retropharyngeal abscesses secondary to disease of the cervical vertebrae present but a thankless field for therapeutic measures.

From *Gazette des Hôpitaux*.—*Hôpital des Cliniques*.

ANEURISM OF THE ARCH OF THE AORTA TREATED BY THE APPLICATION OF COLLODION.

M. BROCA.

I propose to speak to-day about a mode of treatment which you have very recently seen me employ upon a patient in our wards. She was a woman of about fifty years of age in whom you could very readily discover the existence of an aneurism of the arch of the aorta making projection on a level with the sternum with very manifest pulsation and *bruits de souffle*. Not desiring to employ a debilitating regimen, we caused the patient to observe a somewhat restricted diet and to remain absolutely at rest; then, hoping by lightly pressing the fibrine into the sac, to make it serve as a nucleus for the deposition of new fibrous layers, we applied over the tumour ordinary, non-elastic, and consequently retractive collodion, which would compress it and force it into the thoracic cavity. In fact, the next morning the tumour was reduced by two-thirds. The patient felt in the beginning a little constrained, but this sensation of malaise has not continued. On the following day there was no longer any *bruit* and the pulsation had considerably diminished; the pulse previously equal on both sides, although very small, was less affected on the left side than on the right, where it was almost imperceptible. Nevertheless the two pulses again became equal a little later. In view of these signs we may suppose that the tumour is situated upon the anterior wall of the arch in the neighbourhood

of the brachio-cephalic trunk; before the application of the collodion, the pulse was very weak on both sides on account of the interposition in the course of the blood stream of a large derivatory pouch; then the collodion, by pressing back the tumour, produced compression of the brachio-cephalic trunk, and consequently, notable diminution of the right pulse; lastly, clots being formed in the tumour, and these becoming contracted, the vessel has again become permeable, and the disappearance of the pouch has restored to the pulse on both sides its full force. We may therefore regard this woman as being in the way of recovery. Unfortunately she has expressed a desire to leave the Hospital. This is not the first time that collodion has been employed in cases of this kind. M. Lelong successfully employed elastic collodion in a case of aneurism of the aorta to form a cuirass to prevent extension of the tumour. But in this case the end which M. Lelong proposed to himself was not the same as that which we followed here.

From *Lyon Medical*.

#### COLD LOTIONS IN TUBERCULOSIS.

BY POGACNIK.

The use of cold water in the treatment of Phthisis is much preferable, according to the author, under the form of lotions than under that of douches, such as are employed by Brehmer and Sokolowski. Here is how Pogacnik directs them to be used: on getting up in the morning the patient himself sponges the entire body with a sponge dipped in water at 10° to 20° Réaumur (54½°—77° Fabr.); he ought afterwards to rub himself energetically for five minutes with a large glove and to wrap himself up to dry in a linen sheet. He should afterwards get into bed for half an hour or an hour, and keep himself well covered until a little perspiration occurs; during this time it is necessary that the movements of the lungs should be reduced to a minimum.

The author has been led to employ this treatment in tuberculosis by reason of the good effects he had obtained from it in engorgements of a scrofulous nature. By means of the cold water a regular action of the skin is provoked,

and the patient is ultimately strengthened and rendered less susceptible to atmospheric variations.

Little by little the appetite increases and the forces are restored, unless the lesions are too advanced.

Hæmoptysis is not a contra-indication and Pogacnik prescribes the lotions even when the douches cannot be borne.

The lotions have the advantage over the douches of being more agreeable for the patients; of having a more prolonged and consequently more useful effect; of being very easy of administration, even amongst the poor, no apparatus being necessary; lastly, and above all, of not necessitating, like the douche, a walking exercise to procure reaction, an exercise which produces fatigue of the pulmonary apparatus — (*Rev. des Sciences Médicales*.)

From *La France Médicale*.

#### DISARTICULATION OF THE HIP BY THE GALVANO CAUTERY AND THERMO CAUTERY.

At the *Société de Chirurgie* on the 7th of February, M. Tillaux described the manner in which he performed this operation upon a patient in the *Hôpital Beaujon* for a sarcoma of the left femur which had been twice broken. "I passed into the thigh, at the point where we usually enter the knife in the flap operation, a long trocar by means of which I introduced a platinum wire. I was able, easily and rapidly, in two or three minutes, by a to and fro movement, to graze the anterior surface of the femur up to the point where I wished to make the flap. Before removing the wire, I placed a ligature *en masse* upon the vessels; I then had a little hæmorrhage on cutting the femoral, not having sufficiently flattened the lumen of that vessel. It would be preferable to compress the artery by an instrument similar to an enterotome. After having thus cut this flap, I laid down the galvano cautery, and took up the thermo cautery, which I used like a knife to detach the head of the femur and cut the posterior flap. During all this disarticulation I did not draw a drop of blood, except the little lost on cutting the femoral artery." The alcoholic dressing was employed, and the woman subsequently died from purulent infection.

From *Gazzetta Medica Italiana*.

ON THE USE OF COLLODION AS A MEANS OF COMPRESSION IN ANEURISMAL TUMOURS.

Dr. Selion in a case of double aneurismal tumour of the arch of the aorta with external swelling employed a new method of compression, by applying to the skin in the region of the tumour, a dense layer of ricinated collodion, for which he gives the following formula: gun cotton, 8 parts; ether, 100 parts; alcohol, 33 parts; castor oil, 8 parts.

Under the influence of the compression exercised by the collodion the author obtained, in the space of a few weeks, such a reduction that one of the tumours had completely disappeared. As for the second tumour, the larger one, it had attained to about two thirds of its previous dimensions, although the patient, while under treatment, continued his ordinary occupation. He afterwards died suddenly from external rupture.—*Ann. di Chim.*

*Note by G. Polli.*—We have applied the ricinated collodion, with more lasting success, in a case of very painful aneurism of the arch of the aorta, which had also already determined a periosteal inflammation of the corresponding part of the sternum. After a local leeching, and the application of emollients, and keeping the young patient at perfect rest, we applied several layers of the ricinated collodion over the pulsating region of the subjacent aneurism; in a few days the pain ceased, the pulsation was lessened and the patient was permitted to resume his occupation (literary). Now, five months after, he enjoys good health, is able to take a long walk every day, spends several hours at his table (writing), eats with appetite, and experiences no other inconvenience than the feeling of considerable beating at the base of the neck.

From *L'Union Médicale*.

At the *Académie de Médecine* on 19th Feb. a memoir was presented by M. Roche, student in medicine, upon a means, which he describes as certain, of distinguishing between real and apparent death. This means consists in introducing into a vein a cotton thread, allowing it to remain for six minutes, and then withdrawing it and observing—first, if it is covered with fibrine, life certainly exists; second, if the thread contains no trace of fibrine, death is certain.

From *Lyon Médical*.

NOTE UPON A NEW PROPERTY OF ARNICA

Dr. F. Planat, of Nice, in consequence of certain physiological experiments with arnica, has been led to apply this substance in all cases of superficial acute inflammation, such as boils, anginas, erysipelas, &c. Moreover, from his various experiments he believes that he has complete evidence that arnica arrests every furuncular eruption with extraordinary rapidity, except only the diabetic furuncle. In order to render its action upon the small vessels more energetic it is applied directly upon the phlogosed parts in the form of an ointment, of which the following is the formula:

Extract of fresh arnica flowers, 10 grammes; honey, 20 grammes. If too liquid a little lycopodium or althæa powder may be added to give it the cohesion of a rather consistent but sufficiently adhesive paste. A certain thickness spread upon a piece of oil-skin or diachylon is applied to the boil. It is generally necessary to renew this dressing only once in the twenty-four hours. Two or three applications generally suffice to cut short a furuncle no matter what its stage of evolution. A curative effect is also obtained in the same cases by the administration of twenty-five or thirty drops in a tumbler of water of which a tablespoonful should be taken every two hours. M. Planat believes that the special electivity of this remedy can not be denied.

From *Gazzetta Medica Italiana*.

ON PHOSPHORUS IN THE TREATMENT OF CHRONIC ALCOHOLISM.

We append the conclusions of a long paper on this subject, which appeared in the above journal.—

1. That phosphorus may be a most useful remedy in the treatment of chronic alcoholism.
2. That it is well borne by these patients even in doses hitherto unusual ( $1\frac{1}{2}$  grains of phosphide of zinc, or  $\frac{3}{10}$ ths of a grain of phosphorus, even when long continued.
3. That it acts by producing in the drinker a sensation of well-being and stability which takes the place of that which previously necessitated a recourse to alcohol to obtain that equilibrium without which he could not stand upon his feet.

## SUBPLEURAL ECCHYMOSES OF THE NEW BORN

Dr. Pinard has lately communicated to the *Société de Médecine Légale* a number (14) of observations relative to this subject. His conclusions are:—

1. Punctate subpleural and subpericardial ecchymoses are not met with as well in infants dead in consequence of arrest of the circulation, either in the beginning or the later stages of labour, or even some minutes after birth, as in infants killed by suffocation.

2. In children who have died some days or hours after birth in consequence of the conditions in which they were placed during the labour, we may meet with, even associated with lungs fully penetrated by air, ecchymotic stains upon the lungs, the pericardium, the thymus gland, &c. These M. Tardieu admitted to occur very exceptionally, but were met with in ten out of Dr. Pinard's fourteen observations. They are important in view of their having been regarded as evidences of infanticide by suffocation, a view sustained by M. Tardieu with so much ability; but Dr. Pinard's experience of their occurrence in consequence of difficult labour simply directly contradicts Tardieu's opinion and confirms that of Liman of Berlin.

From *Gazzetta Medica Italiana*.

## INJECTIONS OF NITRATE OF SILVER IN SCIATICA.

In the same number of the same journal we find injections of nitrate of silver recommended in obstinate sciatica by Dr. Dureau. He says:—

Dr. Damaschino always employs a solution of one in four and injects five drops.

Dr. Luton usually employs a solution of one in five and injects five, twenty, or twenty-four drops.

Dr. Bertin (di Gray) employs a one in five solution and varies the amount of injection from fifteen, twenty, twenty-five drops.

Dr. Gerin-Rose adopts the one in five solution and uses fifteen drops. We may say that out of twelve cases this physician obtained several cures, some were improved, and some remained stationary, but he assures us that he has not observed the slightest accident to arise from them.

From *Gazette des Hôpitaux*.

## DIPHTHERIA IN PARIS.

In 1872 there were	1135	deaths from	Diphtheria
1873	“	1164	“
1874	“	1008	“
1875	“	1328	“
1876	“	1521	“
1877	“	2393	“

That is to say that between 1872 and 1877 the annual number of deaths in Paris from Diphtheria was more than doubled. These figures are taken from M. Ernest Besnier's Quarterly Reports of the *Maladies Regnantes* and the following remarks of M. Dujardin-Beaumetz may throw some light upon the cause of this enormity. “There are, at this moment, in the crib-ward at St. Antoine out of fifteen patients, twelve infants affected with measles, two women with puerperal fever, and one child with diphtheria. All these patients are in the same ward without any kind of separation. Such are, adds M. Beaumetz, the conditions which are imposed upon us by the administration of the *Assistance Publique*.”

## ALIMENTATION OF INFANTS.

M. Bouchut of the *Hôpital des Enfants Malades* has lately published in the *Gazette des Hôpitaux* a long and continued article on the enumeration of the milk globules in human milk in the selection of a wet nurse. We subjoin his conclusions:

“If the milk globules of a nurse be counted, four samples being taken in a day, we can, from the mean of these four analyses, determine the richness of her milk, *i. e.* the quantity of butter it contains, which approximately gives the density. So much for the *quality* of the milk. By weighing the infants before and after the various nursings of the day, we may learn how much milk the child drinks in the twenty-four hours. So much for the quantity. Lastly, if during the first months the child be weighed every ten days, and if its weight have increased by from 250 to 300 grammes, we may know that the milk is good and easily assimilable. So much for digestibility. In this way, nothing in the alimentation of infants is left to chance or empiricism, and the whole is conducted upon rigorous scientific principles well applied.”

CATARRHAL DIARRHOEA CURED BY SULPHATE OF  
QUININE IN LARGE DOSES.

M. Guyot reports a case in which he had to do with a man aged 66 who for several years had suffered from a catarrhal diarrhoea against which all means employed had failed and under the influence of which the man was visibly dying. Upon the advice of M. Potain, M. Guyot caused him to take every hour a tablespoonful of the following mixture :

Sulphate of quinine  $7\frac{1}{2}$  grains  
Syrup of codeia  $\bar{z}$ i  
Gum Julep  $\bar{z}$ iii

The dose of sulphate of quinine was gradually increased to 9, 11, 12, and 15 grains. Under the influence of this medication, which was continued for a long time, all symptoms disappeared and the patient recovered perfect health. There was not found in him any trouble inherent to the employment of the quinine.—*Gazette des Hôp.*

ANEMO-SPASMODIC CARDIAC BRUITS

M. Constantin Paul lays down the following directions for the differential diagnosis between these *bruits* and extra-cardiac *bruits*.

1. The anemo-spasmodic *bruit de soufflé* of the pulmonary artery is always accompanied by a jugular *bruit*.

2. Sometimes it is diffuse and is propagated towards the apex.

3. The anemo-spasmodic *bruit* is always systolic, whilst extra-cardiac *bruits* are sometimes systolic, sometimes diastolic.

4. The anemo-spasmodic *bruit* is never transformed into the *bruit saccadé* (jerking), as happens with the extra cardiac *bruit*.

5. The anemo-spasmodic *bruit* is heard with each cardiac revolution, and is not, like the extra-cardiac, wanting in some revolutions.

6. The anemo-spasmodic *bruit* is much less transitory than the extra-cardiac, and is less liable to disappear under the influence of slight cardiac modifications.

From *Revista Médico-Quirúrgica* (Buenos Aires.)  
SALICYLIC ACID IN LEUCORRHOÆAS.

We have employed this remedy as an injection in chlorotic women and those of lymphatic constitution, in cases of vaginitis and in leucorrhœas from the uterine mucosa in which the irritant liquid produces erosion of the thighs and vulvar inflammation, and in all cases with the best result. We have used the following formula :

Salicylic acid . . . . .  $\bar{z}$ jss.  
Glycerine . . . . .  $\bar{z}$ ij.  
Dissolve in a waterbath and add 1 quart of water.

This is enough for six injections of which one should be employed each day.

From *Gazzetta Medica Italiana*.

CURE OF A SCIATICA BY PHOSPHORUS.

Dr. Volquardsen reports in Schmidt's Dictionary a case of sciatica which had lasted two years, and in which all remedies had failed. Then the idea occurred to him to have recourse to phosphorus internally. The remedy was prescribed in the dose of fifteen milligrammes, ( $\frac{3}{8}$ ths of a grain) per day, to be divided into three doses. In three days a notable amelioration was obtained, and in three weeks the cure was complete.

In the *Revista de Medicina y Cirugía Prácticas* for 7th of February, we find reported by Dr. D. Pedro Gallardo of the Hospital Provincial de Toledo, a case of successful extraction of a living child by cesarean section five minutes after the death of the mother.

TABLE-SALT IN MILK FOR CHILDREN.—Dr. Q. C. Smith, of Cloverdale, conveys a valuable hint in the following note: "When cow's milk is found to disagree with hand-fed babies or small children, it may in many cases be rendered entirely wholesome to them by adding to it a small portion of table-salt; just enough to be perceptible to the taste. I have for years directed the practice of this expedient among our people, and know it to be of real value.—*Pacific Med. and Surg. Journal*.

THE CANADIAN  
*Journal of Medical Science,*

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by sending their addresses to the corresponding editor.*

TORONTO, APRIL, 1878.

ON THE PROGNOSIS IN VALVULAR DISEASE OF THE HEART.

Through the kindness of our esteemed friend and former teacher, the author, we have received a copy of a revised reprint from the St. Thomas's Hospital Reports of a paper on Prognosis in Valvular Disease of the Heart, by Dr. Peacock, Honorary Consulting Physician to that Hospital. We have endeavoured to give a summary of the salient points in the article, the paper being too long to be inserted *in extenso* in our columns.

The chief sources of danger in valvular disease of the heart are

(1) Failure of muscular power, from atrophy and disorganization of the walls of the heart, causing dilatation of the cavities, and frequently leading to sudden death by syncope.

(2) Congestion of the organs behind the seat of obstruction, causing effusion into the pericardial and pleural cavities, bronchitis, œdema of the lungs and hæmorrhages, congestion of the liver, and through it of the portal system; congestion of the kidneys and of the cerebral system; general dropsy.

(3) Thrombosis and embolism of various organs.

In estimating the risk from the above causes, the different forms of valvular lesions must be separately considered:

*Obstruction of the Aortic Valves.*—Many persons have for years loud aortic obstructive murmurs without any other serious symptoms arising. If by hypertrophy of the left ventricle,

the power remain equal to the resistance, no obvious symptoms may be produced. In consequence of compensation, the slighter degrees of aortic obstruction are not in themselves of very great importance, though there is danger of embolism and the secondary diseases arising from it: there is too great a predisposition to active inflammatory and hæmorrhagic affections, especially of the cerebral organs.

*Incompetency of the Aortic Valves.*—This may arise acutely from disease causing breaking down of the segments of the valves, or it may be due to contraction and induration of valves that have been inflamed; or it may be congenital, or due to gradual stretching of the valves from severe muscular exertion, or direct injury during violent muscular effort; or the aperture may close imperfectly from expansion of the orifice from dilatation or aneurism of the ascending or transverse portion of the aorta. Incompetence whether it arises acutely or be chronic is most serious. If acute the ventricle cannot stand the additional labour suddenly thrown upon it and death often rapidly ensues. In chronic cases the constant strain on the ventricle frequently causes sudden death from syncope.

*Obstruction of the Mitral Valves.*—Arises from the same causes as aortic disease—in it there is greater danger than in aortic obstruction: the pulmonary capillaries are distended, and aeration is interfered with. Pulmonary complications are frequent, and readily induced by exposure to cold. Often we have hæmorrhage and thrombosis.

*Incompetency of the Mitral Valves.*—Is either acute, or ensues on obstruction, or arises from rupture of the valves or their chordæ tendinæ after strain. Sometimes it follows enlargement of the aperture from dilatation of the ventricle. In this disease we have tendency to bronchitis and œdema of the lungs: pulmonary apoplexy, engorgement of liver, spleen, kidneys and brain, and the secondary affections of these organs arising from this engorgement may occur. Finally, we get general dropsy. Still, in many cases, careful treatment prolongs life for many years and even renders it comfortable. Incompetency is more serious than obstruction. Incompetency of

the aortic is more dangerous than the same lesion of the mitral valves. The former lesion causes great impediment to the circulation, and imperfect blood supply to the brain, and death by syncope is a frequent termination. In mitral insufficiency, death is brought about more slowly, not usually by syncope, but as the result of imperfect aeration of blood and from its impurity due to the changes in the viscera brought about by congestion, and from dropsies. Obstruction of the mitral valve is more serious than when the aortic are thus diseased. In the former case the left auricle and right ventricle are unable to propel the blood and the lungs become engorged. In the latter case the left ventricle long resists, and compensatory hypertrophy is set up.

We have then in the order indicating relative danger, beginning with the most serious—

- Aortic Regurgitation,
- Mitral Regurgitation,
- Mitral Obstruction,
- Aortic Obstruction.

The rarity of disease of the right side of the heart renders comparison as to the relative danger, difficult. These affections are most frequently congenital, and patients thus afflicted rarely survive many years. In the prognosis of valvular disease, the limitation of the disease to one set of valves or its extension to others influences the result. The complications and the individual's circumstances must also be taken into consideration. The complications are diseases of the lungs, liver, spleen, kidneys and brain, dropsies, gangrene, rheumatism, gout and dyspeptic troubles, anæmia, purpura, extravasations. Cold often excites more active symptoms in cases hitherto almost latent, causing bronchitis, and aggravating congestion of the viscera and its secondary complications. Also in quite chronic cases, cold will congest the kidneys, and sudden dropsies set in. In cases of renal and cardiac symptoms combined it is very important to decide which is the primary disease. If the kidneys be primarily affected, the cardiac trouble must almost necessarily advance; if the contrary, the congestion of the kidneys may admit of great alleviation, and the patient will comparatively recover. The con-

dition of the urine is important in deciding the above question: in simple renal congestion, though the quantity of urine is small the specific gravity does not fall generally below the healthy standard; whereas when renal disease is primary, the specific gravity is generally low whatever be the quantity of the urine passed. Brain complications of cardiac disease, though serious, are not necessarily fatal, or the cause of permanently impaired functions. Eubolism is frequently recovered from.

Rheumatic affections are of serious import in persons with cardiac trouble, especially if that be due to previous rheumatism. Gout and dyspepsia aggravate the disease.

Anæmia is a frequent complication of old heart disease, and both aggravates it, and makes the extent and nature of organic trouble difficult to diagnose.

Cases of excessive irregularity in cardiac action without any murmur indicating valvular change are probably dependent on mitral incompetence from dilatation, and failure of muscular power, of the left ventricle; and when the irregularity is very great such cases are always of grave import, very generally terminate unfavourably and often run a rapidly downward course in spite of any treatment. In cases of less marked irregularity, great benefit often follows treatment, especially the use of iron.

Individual circumstances, such as age, occupation, residence and previous habits, influence the prognosis in all cardiac affections. In men valvular troubles are most commonly from active inflammation, or from overstrain from violent and long-continued exertion, and they generally follow an active and rapid course soon causing hypertrophy. In females though rheumatism is a frequent cause, yet a considerable portion are due to emotional influences. The disease is more passive, and dilatation, interstitial change, and atrophy of the walls more readily occur. In early life valvular disorders are almost always congenital or rheumatic. In middle life, inflammation, injury, and strain stand as causes—in advanced age, fatty and atheromatous change, renal disease, and gout are the starting point, and dilatation generally occurs; at this period of life the disease is passive and often latent. A hot climate

and a malarious district, the occupation, amount of exposure and of bodily and mental exertion, and the habits of the individual have all to be considered in forming a prognosis. In estimating the probability of temporary or permanent benefit from treatment in a particular case, we must consider—

1. The cause of the disease, duration of symptoms, and the rapidity of their advance as indicating activity or passivity.

2. Degree of impediment to circulation and the power of the heart to overcome it, as indicated by the force and regularity of its beat, and the relation it bears to the pulse at the wrist; the amount of congestion of the lungs and other organs and of the general system.

3. The presence or absence of serious complications, as of lungs, liver, brain, and kidneys, and the existence or not of dropsical symptoms, and of a gouty or rheumatic condition.

4. Circumstances in which the individual is placed, as affording means of obtaining rest, bodily and mental, protection from atmospheric changes and proper regulation of diet and facilities for medical treatment.

The intensity and character of a murmur affords little information as to the extent of the impediment to the circulation. We may have a loud murmur with but little obstruction or regurgitation and *vice versa*. Slight puffiness of the face and swelling of the lower limbs, if the heart be not seriously embarrassed and the viscera not much involved, especially if the kidneys be free from disease is often readily recovered from; but considerable anasarca, effusion into the lungs and pleural, pericardial and peritoneal cavities involve immediate danger and afford but little prospect of even temporary relief. The causes of the greatest suffering in chronic cases, tending to aggravate the malady and accelerate a fatal result, are pulmonary congestions and renal complications resulting from cold; also digestive disorders, mental excitement, over-exertion of body.

With care and proper treatment many chronic cases enjoy a fair measure of health and comfort during many years. It is necessary that a patient should be so far informed of his state as to see the importance of the regimen directed, but it would be unwise and unkind abruptly to tell him that he was labouring under serious cardiac disease.

## REPORT OF THE MEDICAL SUPERINTENDENT OF THE TORONTO ASYLUM FOR INSANE, FOR THE YEAR ENDING 30TH SEPT., 1877.

The recently issued annual report of the Toronto Asylum is an unusually interesting and instructive public document, for the production of which the talented and energetic medical superintendent, Dr. Daniel Clark, is entitled to the gratitude and respect of the medical profession, and of the general community. It is truly refreshing, in these days of weak-kneed subserviency and moral dwarfdom, to meet with an official brochure so signally free from all odour of red tape formalism, as that which Dr. Clark has had the courage and good sense to submit to the "high and mighty powers" who now control the affairs and dispense the patronage of this great little Pedlington, which honest old Dr. Dunlop was wont to call the fat end of the Canadian quarter of mutton.

We cannot devote to our review of Dr. Clark's report all the space which we would desire to appropriate to it, nor half so much as its merits should command; we must, therefore, restrict our observations to but a few of its more salient points, recommending our readers to possess themselves, if obtainable, of the entire document.

Dr. Clark has devoted no less than seven pages to the exposition of an awfully prevalent evil, which he designates very fitly under the title awarded to it many years ago by his predecessor, Dr. Workman, to wit:—

*"An enshrouded moral pestilence."* We need not apprise our professional readers that the terrible factor of physical deterioration and mental dethronement, to which Dr. Clark has here been constrained to draw attention, is the early acquired practice of self-abuse, or masturbation. Every physician who has had even but a brief practical experience, must be able to endorse all that Dr. Clark has stated as to the extent to which this evil prevails, and as to the sad results which ensue from its continuance.

Though it may be questionable whether self-abuse, *per se*, is an efficient factor of insanity, in so large a measure as some alienists seem to

regard it, we have the reliable testimony of the entire body of superintendents of American asylums, that it is the most obstinate antagonist of mental restoration with which it is their wearying task to contend; and, if we are rightly informed, it underlies, among the hopeless cases which crowd their wards, mental incurability to a most lamentable extent. Most justly has Dr. Clark said, "Many know not where it leads to, and were they enlightened in time could successfully resist and overcome the vice. It is often" (always) "too late when they enter the portals of a madhouse to expostulate and entreat."

The movements of patients in the year appear to us as very satisfactory. The total admissions were 232; the total discharges, 112; of the latter, however, 15 are reported as "unimproved," and 22 as "improved," thus making the nett number of "cured," 75.

The deaths numbered 58, which, as taken against the total number of patients under treatment (863) in the year, is about  $6\frac{7}{8}$  per cent. This is a larger proportion than was exhibited in some by-gone years; but when we take into consideration the greatly increased number of admissions in the last two years, amounting to no less than 529, many of which were of acute and unpromising form, we may regard the mortality as very moderate. It must be remembered, too, that the newly admitted patients largely replaced chronic cases transferred to the new asylum at Hamilton, the great majority of which had passed long over the critical period of asylum life risk, and had very fair promise of prolonged life. Any comparison of either the death, or the recovery, statistics of two institutions so very differently peopled as these two, must be utterly absurd, and reciprocally unjust to each. Just as surely as the Hamilton asylum will show a comparatively low mortality, must it show a signal poverty of recoveries;—and as surely as the Toronto asylum turns out many cured, must it also hand over to the undertaker many defunct. This is a fact which some figure-head zealots seem either incapable of appreciating, or obstinately bent on ignoring.

Dr. Clark, under the section appropriated to "deaths," has ventured on an assertion

which we are unprepared to regard as tenable, with regard to the frequency of concomitancy of phthisis and paresis, in the same cases. If we are rightly informed the *post-mortem* records of the Toronto asylum, which were by no means meagre, will not bear the Dr. out in the enunciation of this new theory; nor indeed does his own death tabulation give much countenance to it; for in a total of twenty-two deaths from phthisis, he has given only one, in which paresis co-existed, and in seven deaths from paresis, only one in which phthisis co-existed. We cannot but regard generalization of this sweeping order, based on so narrow a surface of facts, as over hasty, and we have full reliance on Dr. Clark's veracity and candour to warrant the expectation that he will either retract the assumption, or possess himself of facts adequate for the establishment of its correctness.

We are pleased to see that Dr. Clark is able to record a number of "*improvements*," both in the interior and exterior of his establishment. Some of these were certainly much needed, and the fact that Dr. Clark has been able to draw much more freely on the fiscal liberality of his masters than his timid predecessor was, proves that he is the right man for the situation, and that it was high time for a change of incumbence. Parsimony in the disbursement of the public funds is a very silly modern virtue, and any public officer who dreams that by this kind of service he will earn any large measure of public gratitude, will, in the end, find that he has been "reckoning without his host." We therefore heartily endorse Dr. Clark's exposition of the further "requirements" of his asylum. By all means let him persist in his demand for "*a decent entrance*" to the building. The present "*basement entrance*" is verily a *base* and disgraceful thing; but we would fondly hope the design of this improvement will be intrusted to some architect of good taste, who will project something better than a pile of empty soap boxes.

In closing our hurried observations, we would, with all becoming tenderness and respect, suggest to the excellent and accomplished writer of this report, the expedience of a little closer attention, in future reports, to grammatical

correctness, and a little less free indulgence in metaphorical excursions. We feel assured that Dr. Clark will not fail, on a careful reperusal of his very valuable report, to detect several syntactical errors, which must have crept into his manuscript in consequence of hurried construction. It is a pity that a public document of such high merit, should pass from the press with any blemish which may offend the good taste of the generous critic, or afford pretext for the ill-natured censure of those who are more anxious to find fault with the form, than to discover merit in the substance.

**THE MEDICAL COUNCIL EXAMINATIONS.**—In the last annual announcement of the Council of the College of Physicians and Surgeons of Ontario, it is stated that "The written portion of the next professional examination will commence in Toronto and Kingston towards the end of May, 1878, the precise day to be fixed by the president." We are informed that Dr. Clark has named April 29th as the day upon which the written examinations shall begin. Doubtless this change of date has not been made without good and sufficient reason, but it is unfortunate that it was not announced sooner, as many students complain of an injustice having been done them, in thus shortening the time they expected to have to prepare for examinations. Though we think that with two month's notice, no student who has worked faithfully during the winter will suffer by the change of date, still, it would have been far better, if even the shadow of a grievance which is always eagerly seized upon and made capital of, had been avoided. Whether the president has exceeded his powers or not, in fixing for the examinations a time before the end of May, we cannot decide; but we feel confident that he will justify his action in this matter before the council.

**JOURNALISTIC.**—We have received the first number of *The Scholastic News*, an eight-page monthly journal of interesting information on educational and other subjects, published by G. Maynard, Manager of the Educational and Scholastic Agency, Montreal. Subscription, One dollar per annum. We wish the *News* all success.

## TORONTO SCHOOL OF MEDICINE AND VICTORIA UNIVERSITY.

We have been asked to contradict a statement that has been industriously circulated through the country during the last year by some unscrupulous persons who are much exercised by the popularity and progress of the above school, and who evidently fear its influence as the largest and most successful Medical School in Ontario.

A lie persisted in may gain the force and momentum of truth, and it has been well said, "that a man may tell a falsehood and repeat it so often that he finally believes it to be true."

On no other hypothesis can we account for the persistence with which certain parties repeat the falsehood, that the Toronto School of Medicine is advertised by Victoria University as its Medical Department, while they know perfectly well that the statement was untrue at the beginning, was repeated without any foundation, reasserted with all the assurance and circumstance of truth, until it is probably believed by its author, because he has told it so often without contradiction. Nothing but the most wilful perversion of truth could enable any one to draw such an inference from the plain language in which the calendar of the University of Victoria refers to the discontinuance of its own Medical Faculty in Ontario, and advises intending students "to pursue their studies in the Toronto School of Medicine, in affiliation with the University of Toronto." One of the chief propagators of the slander says, "This school is now and has been for the past three years advertised in the Victoria College calendar as the medical department of Victoria University," a statement that certainly has the merit of being explicit; but what a pity 'tis not equally true.

The paragraph in the Victoria College calendar for 1875, (the first published after the disruption of her own Faculty,) reads thus:—

"The lectures in the Victoria Medical School having been discontinued, students intending to graduate in Victoria University are recommended to attend lectures in the Toronto School of Medicine, from which school certificates will be accepted by this University."

We do not see how language could be more

clear in enunciating the distinctness of the two Institutions, and if on the above it can be established that the Toronto School of Medicine is the Medical Department of Victoria University, most assuredly it might claim to be the Medical Department of Toronto University, with which it has been affiliated for so many years, but the Toronto School of Medicine has never claimed a closer connection with the Provincial University than that accorded it by law, and it is now, as it always has been, willing to stand or fall by its own merits. Again in the calendar of Victoria College for 1876, under the "Medical Department, Province of Ontario," almost the same language is used, and "Students intending to graduate in Victoria University are recommended to attend lectures in the Toronto School of Medicine, from which school certificates of attendance will be accepted by the medical examiners of this University"—a piece of information hardly worth publishing, if it were true that the Toronto School is really the Medical Faculty of Victoria.

That the Toronto School of Medicine has ever been true in its fealty to the Toronto University, the most sincere friends of that institution have always been ready to admit, but, if it should be to the advantage of the school, or if it would enable it more effectually to accomplish the great work it set out to do, (that of giving the country a good supply of well educated, thoroughly practical men), we have no doubt it *would* extend its usefulness by forming those connections which *now* only live in the imaginations of some, and seem to disturb the quiet sleep of others.

ONTARIO MEDICAL ACT.—The Bill to amend the Ontario Medical Act was not passed, owing, we are informed, to the fact that it came just before the Orange Bills, and the weak-kneed government and their supporters talked against time, to avoid dealing with them. That part of the Bill relating to remuneration of the medical men must, as it contains a money clause, be introduced by the government. This we are informed Mr. Mowat has promised to do next session.

## NECROLOGY.

Want of space last month forbade our noting the serious losses to the profession recorded in our foreign exchanges.

Among these we regret to observe in the *Gazzetta Medica Italiana* the death of the eminent Giuseppe Repossi on the 9th of January; and in *Lo Sperimentale*, that of Dr. Serafino Vierucci, in Livorno, from apoplexy, at the age of sixty-two; also that of Dr. Giuseppe Pellizzari on the 17th of December at the age of fifty-one. He was Surgeon-in-Chief of the City Hospital of Padua. We also observe the death on the 12th January of Prof. Ranieri Bellini, from voluntary poisoning, at the age of sixty years. He was professor of Toxicology and Legal Medicine in the *R. Istituto di Firenze*. But it is especially amongst our French *confrères* that even thus early in the year, "that fell Sergeant, Death," has been so "strict in his arrest." Here we find the names of Hirtz, Becquerel, Regnault, Raspail, Claude Bernard, and Eugene Simonnet. The last-named, however, was not a medical man by profession, although he did good service to the art and science by starting *La France Médicale* twenty-five years ago. He was sixty-three years of age at the time of his death, and had handed over the Journal to Dr. Bottentuit in 1874. Hirtz (Mathieu Marc) born at Wintzenheim (Haut Rhin) died at Paris on 27th January, aged sixty-nine. One of the most learned and renowned professors of the Strasbourg School, where he occupied the Chair of Clinical Medicine from the time of Forget's death in 1861 up to the conclusion of the war in 1871, when he was nominated to the Faculty of Nancy. This he declined, however, and determined to remain in Paris, where in August, 1873, the Academy of Medicine elected him to the Chair made vacant by the death of Vigla, an honour which MM. Villemin, Jaccoud, and Peter contested with him. In the *Gar. Med. de Strasbourg*, of which he was one of the collaborators, he published a host of papers upon a variety of subjects; and to the *Nouveau Dictionnaire de Médecine et de Chirurgie pratiques* he contributed eleven articles. Hirtz was a Chevalier of the Legion of Honour.

Becquerel (Antoine-César) was born in 1788

and was educated in the *Ecole Polytechnique*. His early life was distinguished by brilliant feats of arms and in 1844 he was made a Chevalier of the Legion of Honour. He soon abandoned the profession of arms and devoted himself to the study of Physics, pure and applied. In 1838 he was appointed Professor of Physics at the Museum. His contributions to the *Annales de Physique et de Chimie* and to the *Memoires de l'Académie* were very numerous and important; and his chief work was a treatise on electricity and magnetism. He died at the advanced age of ninety, having preserved the laborious habits of his youth up to the last, and his loss will not be easily supplied to Physico-Chemical Science, to which he had devoted sixty years of his life.

Regnault (Henri Victor) was born at Aix-la-Chapelle in 1810. He was elected a member of the *Académie des Sciences* in 1840, at the early age of thirty years. He had been a Professor at the *Collège de France*, at the *Ecole Polytechnique* and Director of the manufactures of Sèvres. His son, the celebrated painter, was killed at the battle of Buzenval in 1871. During the siege all his scientific apparatus was broken up, and his manuscripts destroyed. The loss of his eminent son and this unjustifiable act of modern vandalism he could not long survive, but became afflicted with paralysis and died at the age of sixty-seven.

Raspail (F. V.) was a savant of another type, and a politician of much eminence. He first propounded the cellular theory which Schwann subsequently perfected, Raspail's political associations at the time preventing him from following it up. The versatility of his genius was remarkable and at the same time that he was engaged in physical and chemical researches he published his first work "On the Classification of the Grasses." He also made investigations in Microscopical Anatomy and Palæontology, and his views were always remarkable for their originality. His chief works were written while in imprisonment for political offences. These were "An Essay on Microscopical Chemistry" (1831), "Elementary Course of Agriculture" (1832), "New System of Organic Chemistry" (1833), "New System of Vegetable and Botanical Physiolo-

gy" (1837). As a physician he would not perhaps be regarded as *compos mentis*. He regarded all diseases as being of parasitic nature, and vaunted camphor as a panacea; his peculiar views he did not hesitate to carry out in practice, and his therapeutics consisted in the administration of camphor internally, externally, and eternally.

#### WARNER AND Co.'s PHOSPHORUS PILLS.—

We have, through the courtesy of Messrs. Warner and Co., received a sample lot of their pills, containing phosphorus in various combinations. The mass is soft, has the odour of phosphorus, is luminous in the dark, has no lumps of phosphorus, as it is combined when in solution, and, finally, it is perfectly protected from oxidation or the conversion into phosphoric acid. Mr. A. E. McLean, analytical chemist of New York, after examining the pills chemically and microscopically, reports the mass as being perfectly homogeneous, not exhibiting particles of undivided phosphorus, and thoroughly protected from the oxidizing influence of the air by means of the sugar coating. He says each pill is an example of what skill, care, and elegant pharmacy can do. He found them to contain  $\frac{1}{25}$  grain phosphorus, as expressed on the label, and regards them as a model of perfection. The pills may be had containing phosphorus alone  $\frac{1}{10}$  or  $\frac{1}{100}$  grain in each, or in combination with suitable doses of cannabis indica, cantharides, nux vomica, ferri-carb., ferr-redact., strychnia, digitalis and hyoscyam, aloes and nux vomica, quinine, &c., &c. We commend these elegant preparations to the notice of our readers.

*The Journal of Physiology.* We have received the prospectus of this Journal, which is to be published in parts, not at rigidly fixed times but according to supply of material. It is to appear as nearly simultaneously as is possible in America and England.

Dr. Michael Foster is the Editor and has as associates, Gamgee, Rutherford, and Burdon Sanderson in Great Britain; Bowditch of Boston and H. N. Martin of Baltimore, in America. From the prospectus and from the standing of the Editorial Staff, a Journal of very high literary and scientific excellence may be looked for.

AMYL NITRITE IN EPILEPSY.—In Dr. Daniel Clark's last annual report of the Asylum for the Insane, Toronto, very favourable remarks are made as to the controlling influence amylnitrite exerts over the frequency and violence of epileptic attacks. The remedy was given in half drop doses three times a day. We append a few extracts from Dr. Clark's report on this subject.

"It can be truthfully said of its medicinal effects, that the twenty-five or more persons who have taken it for a longer or shorter time, have almost, without exception, been benefited by it. In some cases the fits have ceased altogether; but of course there is often a periodicity in their invasion, which must be taken into account; and, it is possible, that although the intermissions of freedom from them may be longer than usual, the fits may after a time return with former intensity, or in a modified form. So far this class has been exempt. In other cases the attacks were, under the administration of the drug, as frequent as formerly, but not as severe, nor of the usual duration. Some of the patients tell me, that since taking the medicine, when they feel the fit coming on they can overcome it by a strong effort of the will. A third class still have fits, but much fewer and less severe than formerly. All these cases had been treated in the orthodox way before using this drug, without any decided benefit. Among other formulæ I used the much lauded remedy prescribed by Brown-Sequard in epilepsy.

"It is impossible to say, with any exactitude, what may be the condition of the brain in such typical cases, but in this asylum a large proportion of those afflicted are anæmic. The few of full habit who have been treated with the amylnitrite have not shown that susceptibility to the influence of the drug that the anæmic have done.

"It is my impression that it will not prove of permanent advantage in chronic cases, but if it modifies the fits in such, and reduces the frequency and strength of them in recent cases until nature asserts its powerful supremacy, a great good will be accomplished by this potent agency."

## Book Notices.

*Report of the Medical Superintendent of the Asylum for the Insane, Toronto, for the year ending 30th September, 1877.*

*Transactions of Eighth Annual Session of the Medical Society of Virginia.*

These transactions are published with the January number of the *Virginia Medical Monthly*, and as usual are a credit to the society from which they emanate. They contain an address from the President, Dr. Cabell, also one on the Study of Medicine, by Dr. Randolph, and reports on Advances in Chemistry, Obstetrics, Practice of Medicine, Hygiene and Public Health. A special Report on Poisoning by Custards and Ice Creams, and one on Epidemic Zymotic Diseases in Animals. These with three Volunteer Papers on Heart-Clots, Bony Union of Intra-capsular Fracture of the Femur, and on Iodoform as a local remedy, together with the report of the Necrological Committee, and of the proceedings of the Society, and a Report of the Discussion on the subject previously selected, viz., Instrumental Labour, form a volume of 190 pages, that will amply repay perusal. The paper on Heart-Clots, by Dr. Martin L. James, contains a full report of three cases with *post mortem*, two of them long existing, that were under his own observation. He also gives an interesting synopsis of our present knowledge on the subject.

KNEADING HÆMORRHOIDS.—Dr. S. W. Garwood, of Fort Scott, Kansas, writes to us as follows: "About two years ago, while riding, my horse threw me, bruising me considerably. Shortly afterward I observed a hæmorrhoid about the size of a cherry which gave me great annoyance for months. I one day seized it between my thumb and finger and, kneading it firmly, obliterated it. Since then I have destroyed numerous piles for others in the same way: sometimes it is necessary to repeat the process several times, but it is always successful."

### Miscellaneous.

Dr. J. Russell Reynolds, F.R.S., is gazetted Physician to the Queen's Household, in succession to the late Dr. Francis Hawkins.

Dr. David M. Young strongly recommends a teaspoonful of glycerine taken night and morning as a remedy for internal piles.

Dr. Thoulouse recommends as a vesicant a disc of fine cloth soaked in oil, and besprinkled with corrosive sublimate, in fine powder.—*Medical Press and Circular.*

PERSONAL.—We are informed that Drs. A. A. MacDonald, of Guelph, and Covernton, of Simcoe, intend shortly to remove to this city to practise.

ONTARIO MEDICAL COUNCIL.—We omitted to mention in January number that Dr. W. L. Herriman, of Port Hope, has been elected to replace Dr. Dewar, deceased, as representative of the Division of Newcastle and Trent.

CANADIANS IN ENGLAND.—R. B. Orr, M.B., Toronto, has passed the examination and received the certificate to practise of the Apothecaries Hall, London. H. L. Reddy, M.D., Montreal, has been admitted Licentiate of the Royal College of Surgeons, Edinburgh.

Dr. Jaillard, of Algiers, employs the microscope for the detection of butter adulterated with animal fats such as suet. Under the microscope butter globules are round, while other fats appear in needle-shaped or branched crystals.—*New York Medical Record.*

FIVE CHILDREN AT A BIRTH.—In the *Wiener Med. Presse* an Austrian Naval Surgeon reports that a woman gave birth, prematurely (eighth month), to five children, four boys and one girl. There were five placentæ. The bodies of the children have been preserved in the Pathological Museum of the Marine Hospital at Pola.

CAMPHOR-CHLORAL.—Mr. W. T. Toucher recommends the following formula for a camphor-chloral liniment, which has a powerful anti-neuralgic application: Chloral-hydrate and camphor, of each one ounce; glycerine, to six ounces; powder the camphor, using as usual a few drops of rectified spirit; then mix with the chloral, and allow to stand in a mortar until the mixture becomes liquid. Having poured this into a bottle, add the glycerine, and shake.—*London Med. Record.*

EXPLOSION OF A CHLORATE OF POTASSIUM MIXTURE.—A correspondent of *New Remedies* reports a case of explosion in the following circumstances. The following prescription was made:

℞  
Tinct. ferri chloridi  
Glycerinæ puræ  
Potassii chloratis āā ʒ ss. m.

The above was intended to be farther diluted for a gargle, being put in this compact form for convenience. The correspondent placed it in his satchel, where after a while it exploded with great violence.

MONOBROMATED CAMPHOR.—Great difficulty is often experienced in dispensing this useful remedy. According to M. Lepage, the following plan is advantageous:

Dissolve the monobromated camphor in six times its weight of almond oil by the aid of a gentle heat, emulsify the oily solution with gum arabic, and then suspend it in syrup or in water, according to the indications of the prescription. The emulsions obtained were as perfect as those with almond oil alone.

In consequence of the instability of the oil used as a solvent, the emulsion should be prepared as required: the monobromated camphor however, appears to keep without undergoing any decomposition, even after an interval of three months.

To emulsify seven grammes of the oily solution, containing one gramme of the active substance, the author employs three grammes of powdered gum arabic, suspended in double its weight of water. When the emulsion has been made, the necessary quantity of syrup or water is added in the usual manner.—*Phil. Med. Times.*

**CARBOLIC ACID SUBCUTANEOUSLY IN ERYSIPELAS.**—Dr. J. S. Whitmire of Metamora, Ill., advocates in the *Chicago Medical Journal and Examiner* for March, the use of carbolic acid hypodermically in the treatment of erysipelas. The following is his formula. Carbolic acid (crystals one ounce avoirdupois, pure glycerine fl. ʒj; mix and warm in a water bath till the acid is dissolved. To prepare the fluid for injection he uses the following proportions: Glycerine ʒss, water ʒss, of the mixture described above, drops xx. This contains  $1\frac{1}{2}$  drops in each drachm. He uses from one to three drachms, introducing the syringe at a dozen or more points, completely encircling the discoloured skin, and at half a dozen or more points over the diseased surface. The solution is warmed to 98° F. before being used. Dr. Whitmire has treated thirty cases in this way, and has in many of them succeeded in aborting the disease; he has seen no untoward symptoms following, and in no case has abscess or sores resulted. The value of the paper is greatly diminished by the fact that other means of treatment were combined with the carbolic injections, the author having been, as he states, "afraid to take the chances" with his remedy alone. He applies locally a solution of iodine gr. xv, iodide of potash gr. x, alcohol ʒij, castor oil ʒjv, and gives internally tinct. ferri chlorid. ʒss, pot. chlorat. ʒij, ammoniæ hydrochlorat. ʒij, syrup simpl., ad ʒjv. A tablespoonful every four hours. He also gives one of the following powders between each dose of the medicine. R pulv. opii gr. iij, quin. sulph. ʒss, pot. chlorat. ʒi; mix and divide into nine powders.

greater purity, on account of the manner of its manufacture. In Norway, the cod fishery ceases, by law, about the middle of April, and is not resumed until late in the fall. Great care is observed in the preparation of the oil, scarcely any heat being used, the absence of any high temperature preventing incipient rancidification. Only the very finest of that produced is exported, and for these reasons the Norwegian oil is almost invariably finer than our own. The discovery of the fact that ether increased the flow of pancreatic fluid, which emulsifies, and thereby assists in the assimilation of fatty food, suggested to some practitioners its use with cod-liver oil, and it was found that the addition of ten drops of ether to two drachms of the oil had met with very satisfactory results. Oil has usually been given in too large doses, and one drachm three or four times a day is now thought to be sufficient in a majority of cases. Dr. Squibb further stated that he did not think that pharmacists were overstepping the bounds of propriety by giving to the patients such directions regarding the administration of nauseous medicines as might make them more acceptable. He had found that cod-liver oil given in a five per cent. solution of gum arabic, previously poured in a small medicine glass, tended greatly toward covering the taste. Froth from porter was also an excellent vehicle, or some salt herring, eaten just before taking the oil, would make its taste imperceptible. Mr. Lillieschild said he had found that a little table salt sprinkled upon a spoonful of the oil would destroy its offensive taste, as well as assist in its digestion. Mr. Close prepared an emulsion with *glycerine* which had proven uniformly successful.

**PROCEEDINGS OF THE MEDICAL SOCIETY OF THE COUNTY OF KINGS.**—At the regular meeting, held, December 18, the subject of *Cod-Liver Oil* elicited some interesting remarks, from which we select the following:—Dr. Squibb said that the purity of cod-liver oil was a very important subject, on account of its very general use, and because the stomachs of those persons who needed the oil most were least able to retain it. He greatly preferred the Norwegian oil, not because it contained any medicinal property which ours did not, but because of its

## Births, Marriages, and Deaths.

### BIRTHS.

On March 1st, at 120 Peter St., Toronto, the wife of A. De La Haye, M.B., of a son.

### DEATHS.

At the residence of Dr. Geo. Wright, 243 Simcoe St., on the 4th inst., Mrs. Eliza Wright, widow of the late Joseph Wright, Esq., of Cooksville.

At Toronto, on the 7th of March, Elizabeth, wife of Winford York, M.D., aged 37 years.