

Technical and Bibliographic Notes / Notes techniques et bibliographiques

Canadiana.org has attempted to obtain the best copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

Canadiana.org a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

Dominion Medical Monthly

EDITORS:

W. H. B. AIRNS, M.D.

W. B. NESBITT, B.A., M.D.,

WITH THE ACTIVE COLLABORATION OF

A. R. AFFRISON, M.D.

J. J. CASSIDY, M.D.

A. A. MACDONALD, M.D.

J. R. BURNS, M.D.

J. FERGUSON, M.D.

VOL. I.]

TORONTO, ONT., AUGUST, 1893.

[No. 2.

ORIGINAL ARTICLES.

(No paper published or to be published elsewhere as original, will be accepted in this department.)

CHOLELITHOTOMY, WITH CHOLE-DUODENOSTOMY FOR THE RELIEF OF JAUNDICE DUE TO IMPACTED GALL STONES.*

BY ALBERT A. MACDONALD, M.D., TORONTO.

That cholelithians may exist for an indefinite period without giving rise to any symptoms capable of leading to a diagnosis of the exact condition, is a fact which is commonly recognized by those who are engaged in making *post mortem* examinations. But when incarceration of gall stone, or stones, takes place in the common duct, a number of symptoms are produced, and definite diseased conditions follow, which give rise to so much pain and peril to life that our aid is sought for relief.

Treatment of such cases has not been completely satisfactory, for whilst it is true that a certain amount of palliation may follow some plans of medical treatment, we are not aware of any remedies which can produce uniformly good results. Surgical treatment has been both harsh and unsatisfactory until within the last few years, when the efforts of some surgeons seem to give grounds for the hope that an unscientific operation may give place to one which will prove alike scientific, practical and satisfactory. Chronic jaundice, depending as it does upon some interference with the flow of bile, may be said to be caused either by pressure from without, by a tumor, impacted stones, stricture of the duct, or an abscess.

"In the cystic duct and in the common duct, stones are present in from 4 to 13 per cent. of the cases, whilst in the hepatic duct they are only found in from three-tenths of 1 per cent. to 1 per cent of the cases."—C. T. PARKER.

From impaction of stones, either choicæmia, with its attendant symptoms of degeneration, hæmorrhages, coma, and death must result, or perforative peritonitis may take place and so hasten the end.

Diagnosis of the exact cause of continued jaundice is only possible when the greatest care is taken to obtain the fullest history of the case, and to weigh every sign

* Read at meeting of Ontario Medical Association, June, 1893.

and symptom, and even after the utmost caution a correct knowledge may only be obtained by submitting the patient to a *cœliotomy*, which, under the circumstances, is not without its dangers.

Where the jaundiced condition is due to a new growth, obstructing the flow of bile through the common duct, we may expect to find that the jaundice is persistent, coupled with emaciation, dyspeptic symptoms, flatulence, an absence of bile in the feces though it is present in the urine. If vomiting takes place, bile is not found in the vomited matter. There may be dilatation of gall bladder. The spleen is not hypertrophied. Death usually occurs inside of a year from the commencement of the attack.

Where impacted gall stones are the cause of obstruction to the common duct, or where stricture is present, the symptoms are not so constant. We find a history of repeated attacks of colic, with extreme pain, chills, fever, vomiting and jaundice, which is persistent or not according to whether or not the obstruction is complete. In the same way bile may or may not be present in the feces. It is found in the urine at times. Pruritis of a very annoying character is usually present.

The gall bladder is usually atrophied, though it may be distended. Enlargement and tenderness over the region of the gall bladder may or may not be present.

Death may not take place for years. Though gall stones occur with great frequency towards the after part of life, and though it is known that they are found in about 25 per cent. of all women who die aged over sixty, and in a smaller proportion of men, we are at a loss for a satisfactory way of accounting for their presence. Some of the causes assigned are sedentary habits, constipation, eating too much starchy food, tight lacing and pregnancy. The amount of bile secreted in each 24 hours is about 40 ounces. It is most actively secreted during digestion—the extra amount being retained in the gall bladder, mixing with its mucous secretion. It has a moderate emulsifying power, and though it soon undergoes putrefaction on exposure, it is said to retard the process of putrefaction in the intestine and plays an important part in the progress of digestion. Though that part is not well understood, it is quite evident that it is *important*, as has often been proved by experiment.

“When the total amount of bile secreted escapes by external fistula, the patients die. When even a large (though not the total) quantity escapes, the patients become sick. Therefore a safe way of allowing the bile to re-enter the intestine should be welcomed by the surgeon and the patient.”—J. B. MURPHY.

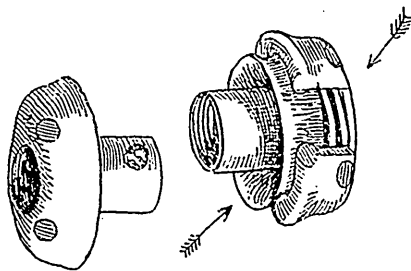


FIG. 1.—Appearance of button with spring-cup attachment.

An ingenious method of accomplishing this has been devised and put successfully into practice by Dr. J. B. Murphy, of Chicago, from whose writing I have quoted the last two or three paragraphs, and to whose masterful way of dealing with the subject I

am indebted for much of my information bearing on the present case. His method is by the use of his anastomosis button, which I here show you, and for a full description refer you to his publication in the *New York Medical Record*, of December 10, 1892. He claims that it differs from all other previous devices, in the following particulars :

- " 1. It retains its position automatically.
- " 2. It is entirely independent of sutures.
- " 3. It produces a pressure atrophy, and adhesion of surface at the line of atrophy.
- " 4. It insures perfect apposition of the surfaces without danger of displacement.
- " 5. It is applicable to lateral as well as end-to-end approximation.
- " 6. It produces a linear cicatrix, and thus insures a minimum of contraction.
- " 7. And in the extreme simplicity of its technique which makes it a specially safe instrument in the hands of the every-day practitioner as well as the more dexterous specialist."

Dr. J. B. Murphy gives the first "one-sitting" operation for gall-bladder intestinal anastomosis in the human subject as having taken place May 4, 1887. Up to December 10, 1892, thirteen operations were reported. Of these, *four* died as the result of operation, *five* died as the result of malignant disease from which they were suffering, and *four* survived, viz., Ferrier's, Curvoisier's, and two of his own. Since that time other operations of the kind have taken place, some of which have not yet been reported and others cannot be classed with "one-sitting" operations.

To those interested in the subject the details of my recent case cannot help but prove instructive, for we often learn most from our own or from the failure of others.

Mrs. J. H., a widow aged 57, had always been strong and healthy until within the last four or five years, during which time she had been troubled with repeated severe attacks of colic, followed by jaundice, dyspeptic symptoms, flatulence and pruritis, which was so severe that it gave almost as much trouble as the pain.

Muscular wasting had taken place, and her general appearance was that of suffering. Neither liver nor spleen were enlarged, and her heart and lungs were normal.

Her attacks were of an intensely aggravating character. Coming on abruptly, there would be first agonizing pain in the right hypochondria region. This would be followed by a severe rigor and vomiting of mucous from the stomach ; then a slight raise of temperature, 101°-102° F.; this would be followed by perspiration, usually of a cool, clammy character. The jaundice, from which she was never entirely free, would be intensified, and pruritis of a general nature would be redoubled to such an extent as to seriously interfere with her sleep. Gaseous eructations and flatulent distensions were more marked and troublesome at these times.

Physical examination in the region of the gall bladder gave no evidence of enlargement. Pain on deep pressure was severe. The feces had the appearance, as a rule, of an absence of bile, though at times their colour indicated a slight amount.

The urine contained a large amount of bile, but no other abnormal element.

Medical treatment, at first by copious doses of olive oil, then by gentle laxatives and by anodynes during the attacks, gave some relief for a time, but the jaundice could not be made to disappear, and at last, after more than a year of patient trial of medical and dietetic treatment, the attacks became so persistent and severe that the patient begged for the operative treatment, which she had declined when I first undertook her case.

In making my diagnosis, malignant disease was excluded owing to the absence of cachexia and dilatation of gall bladder and length of time she had been subject to the

attacks. Malignant cases usually live only about a year, whilst we had a history of at least four years of intermittent suffering.

The character of the attacks, her general symptoms, with the history of the case pointed directly to obstruction of the ductus communis by gall stones. I therefore resolved to operate for their removal, and at the same time make an anastomosis between the gall bladder and the duodenum, in order that if the operation were successful she might gain the entrance of the bile into the intestines, and with it gain her health. Dr. Temple saw the case with me, and concluded that it was right to give her the chance of an operation which might relieve her, whilst if left to herself she could live but a short time.

May 30, 1893.—For the past three or four weeks the patient has suffered so much from pain and obstruction to the flow of bile through the common duct that intense cholemia precluded the possibility of successful operation, her general condition being low and her temperature 97.4° F.

Now a slight improvement having taken place, I determined to give her what seemed to be her only chance, namely, an operation for the removal of the obstruction.

May 31.—After due preparation of the patient, chloroform was given by Dr. Primrose. Assisted by Dr. Temple and his son, Dr. Chas. Temple, I made a cœliotomy by vertical incision below the cartilage of the tenth rib, and on a line with the right border of the right rectus abdominalis muscle. After stopping the bleeding, which was more abundant than usual, the peritoneum was divided, the gall bladder searched for and found, somewhat atrophied and containing very little bile, but many stones of moderate size. Drawing the gall bladder into the wound, I passed a silk

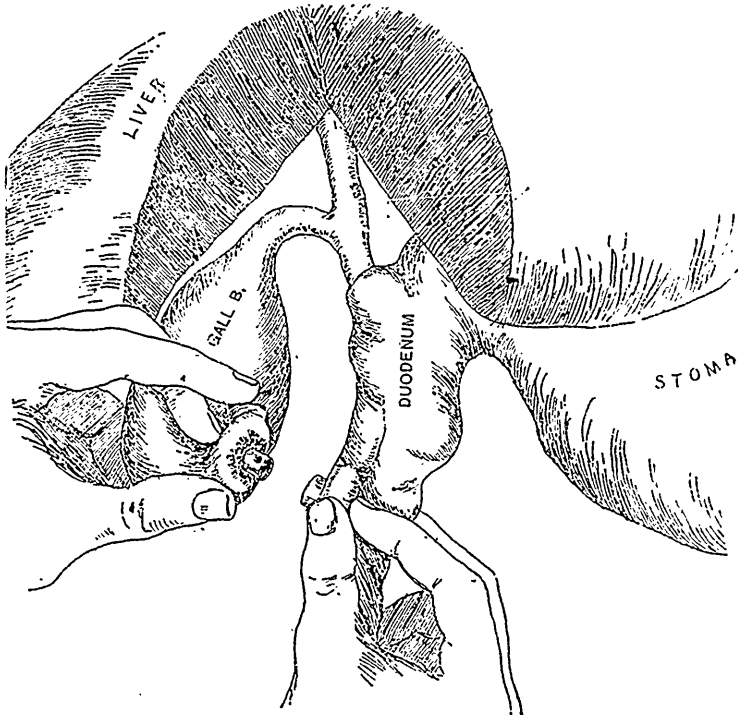


FIG. 2.—Button as held when pressed together performing Cholecysto-entostomy.—(*Medical Record*.)

ligature through all its coats, bringing the needle out and reinserting it in the same line in such a way as to make the two stitches take up a portion of the coats of the bladder about an inch long. Then turning, I passed the needle again, making two stitches parallel to the first two. Now I cut through the walls of the bladder, making an opening sufficiently large to pass the female portion of the button. A few gall stones were removed. Then tying the drawing string tightly around the stem of the button, I had an assistant use it to hold the button in an angle of the wound until the duodenum could be found, drawn into the wound, the drawing string passed and the bowel opened at the point nearest the gall bladder. The male portion of the

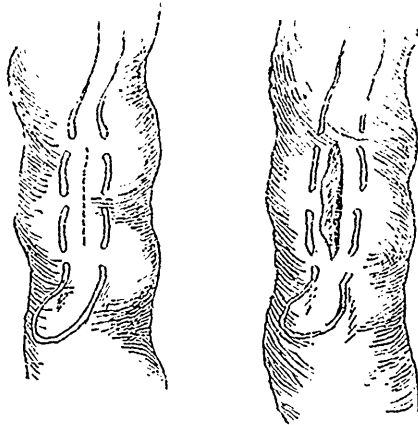


FIG. 3.—Showing running thread before and after incision in bowels.—(*Medical Record.*)

button was then passed in and the drawing string tied and cut short. The peritoneal surfaces which were intended for approximation were now vivified by scraping with the knife, and the two portions so pressed together as to bring the two peritoneal surfaces into close contact. The abdomen was now closed, a pad and bandage applied, and the patient removed to bed. She had very little shock. Bile was vomited an hour and a half after operation.

Twelve hours after operation there was pain over the region of gall bladder. Hypodermic injection of one-eighth of a grain of morphia gave relief and sleep. Pulse, 100; temperature, 99° F.

Vomiting troublesome. Temperature remained about 99° F.

On the sixth day a slight raise of temperature, with increased pain, led me to look for pus, which I found in the abdominal wall, which had not healed properly. After draining and washing the pus away the temperature came down, but pain, vomiting, flatulence and distress gave evidence of serious internal trouble.

Peritonitis had commenced, and it increased in severity until her death on the eighth day after operation. The jaundice showed signs of abating on about the third day.

Post mortem examination revealed a state of general peritonitis. Absence of sufficient adhesive repair at seat of approximation of gall bladder and duodenum had allowed escape of their contents into the peritoneal cavity (probably on the sixth day). A number of gall stones remained, and one large one was in the common duct. The liver was cirrhotic.

CONCLUSIONS.

In this case the patient was evidently in too grave a state of chokemia for repair at either seat of approximation or at wound in abdominal wall.

The buttons are ingenious, and so simplify the operation as to greatly improve the chance of success.

From careful consideration of this case, I am satisfied that her death was fast approaching before operation, and that to operate gave her the only chance for prolongation of a life which otherwise could only have been continued in misery.

A FEW BRIEF REMARKS ON SOME OF THE DETAILS WHICH LEAD
TO SUCCESS IN ABDOMINAL SURGERY.*

BY J. ALGERNON TEMPLE, M.D., TORONTO.

IN the following few remarks I propose to make to-day, I feel I have nothing new to offer you, but facts old and tried which will bear repetition.

For an operator to become successful in abdominal surgery, it is necessary for him to pay the strictest attention to every detail in connection with this special branch of surgery, and to profit by the experience of those who have gone before him.

The mere removal of a tumour from the abdominal cavity does not constitute the whole operation; he may be a rapid operator, dexterous in all his work, but unless he is careful in the minor details of his operation it does not follow he will be a successful surgeon; neglect of some minor details may be very disastrous to him in the end, and it is particularly with this object in view that I am induced to offer a few remarks on some of these points. With all the circumstances which tend to success I don't intend to deal; time will not permit of this, nor do I wish to weary you by going over them all.

I think we will all admit that experience of the individual operator is no small factor in success. It surely goes without contradiction, that the more a man sees of these special operations the more dexterous he becomes; and the more he profits by his own past experience. But individual experience is not the only element in success, methods of treatment both at the time of operation and after undoubtedly play a very important part in success.

It appears to me that no man should open the peritoneal cavity unless he fully understands the delicate nature of the peritoneum itself, its structure, relations, intricate folds and its functions; he should never lose sight of that important layer, the endothelial coat which covers over the surface of the peritoneum, and endeavour as far as possible to preserve this intact; the more injury inflicted on this endothelial coat, the greater will be the chances of subsequent inflammation.

The surgeon should regard this peritoneal cavity as one huge lymph sac, ready at any moment to take on fatal inflammatory action on the least provocation. To avoid any such serious result he must first of all endeavour as far as possible to prevent the introduction from without of any septic matter, and this is best accomplished by the strictest attention being paid to every antiseptic precaution.

Just immediately previous to the operation, the pubes should be shaved and well scrubbed with soap and water, and the abdominal skin well cleaned by some antiseptic

* Read at a meeting of the Ontario Medical Association, Toronto, June, 1893.

solution. The patient should be placed thoroughly and completely under the anæsthetic, and she should be so kept till the completion of the operation, and this duty should be intrusted to some competent person whose whole and sole attention should be given to this most important part of the operation; nothing should distract his attention from his patient for one single moment, and if he does his part well he will find he has all he can attend to in the midst of a severe operation. It is very embarrassing to the surgeon operating to find his patient coming from under the influence of the anæsthetic and straining or vomiting or half conscious. Every instrument and sponges to be used should have been previously carefully prepared and disinfected and placed conveniently to the hand of the operator where he can secure them himself, and he alone or his assistant should be the only ones to handle them. Plenty of boiled water should be on hand.

His own hands and those of his assistants and nurses must have been thoroughly cleaned and disinfected; too much attention to this important part cannot be paid. To effect this I am satisfied by careful washing in hot water with the free use of soap and nail brush, and after, the immersion of the hands either in a solution of carbolic acid or bichloride solution. I think if proper care is taken the hands may be got clean, in spite of the statement of some that this is not sufficient and that the hands are still not clean.

All the instruments to be used should be placed in a solution of carbolic acid and water and kept in this throughout the operation, except when being used. The water in which the sponges are to be cleaned need only be boiled water, though some advise it should be also filtered. With regard to the use of antiseptics, there is a division of opinion amongst some of our most noted operators. For my own part I am still a believer in carbolic acid; I think it is the best we possess, and we all know that once again Prof. Lister is returning to its use, and Mr. Thornton even still uses the carbolic spray; this I some years ago abandoned. There are many operators to-day who do not use antiseptics at all, and claim they get as good results without them as they did when using them. This may be true, yet for all I think it a safe precaution to use them, and it is my opinion that those who do use them get the best results with the fewest complications after the operation, particularly in those cases which have already septic matter in the peritoneal cavity previous to operation, such as suppurating ovarian cysts, pustules, abscesses, or dead and putrid extra uterine cysts, etc.

Another point of great importance is the cleansing of the peritoneal cavity after the operation, particularly in those cases where the adhesions have been many and extensive, as also in all cases where pus is found at the time of the operation. It is not many years since we were taught the necessity of careful sponging of the peritoneal cavity so as to remove every drop of fluid and leave it perfectly dry. Experience has taught me not only the uselessness of this practise, but further, that it is positively injurious.

I would advise the peritoneal cavity to be thoroughly flushed out with plenty of plain boiled water, moderately hot. I have noticed that patients who have gone through a very severe and prolonged operation, and who are much depressed with feeble pulse and cold extremities, are greatly benefited by the hot water—it stimulates the heart's action and revives them. Use plenty of water; allow it to flow out of its own accord, carrying with it any blood clots or any particles which may have escaped at the time of operation. This not only will thoroughly cleanse the cavity, but it will also favour the arrest of hæmorrhage which so often oozes from many small points. But the

greatest of all benefits is that it inflicts the least injury to the endothelial coat of the peritoneum, and I believe it to be absolutely necessary to avoid all injury to this important layer. Every time you brush a sponge over this layer you inflict just so much injury to it, and thereby favour subsequent peritonitis. Depend upon it, the less sponging the better is it for the patient, and moreover, continued sponging favours bleeding by breaking up the clots around the small vessels. I am never careful to sponge out all the fluid; the presence of some bloody water left behind does no harm; it rapidly becomes absorbed by the greedy peritoneum. It is only clean water with fresh blood and it is harmless. I cannot too strongly urge this point on operators: the less sponging done the better will it be for the patient ultimately. See to it that the cavity is carefully flushed out, and that is all that is necessary.

Another point of great importance is as to the use of the drainage tube. I only advocate its use in those cases where the adhesions have been many, and more or less oozing continues after the operation is over, and also in those cases where pus is found at the time of the operation, and possibly some has escaped into the peritoneal cavity through rupture of the cyst attempting its removal. In such cases it should always be used, but it should also be removed as soon as possible, say within the next twenty-four or forty-eight hours. The objection raised against the use of the drainage tube is that it favours ventral hernia, and also is a channel for the admission of germs. As to the first objection my experience is that the danger of hernia is very remote if the tube is removed early. It is not at all necessary to leave it in till the fluid becomes colourless, it may be safely removed if there is still a slight reddish tinge to the fluid. I am guided to remove it not so much from the colour of the fluid removed as the quantity of the fluid; and when I find I cannot get out more than three or four drachms in the twenty-four hours, I remove it, and this is usually within the forty-eight hours after the operation. Immediately after the operation, especially in those cases where there is considerable oozing, the tube should be sucked out every fifteen or twenty minutes so as to prevent the blood clotting, and very soon the oozing will all cease. As to the second danger of admitting septic germs from the air, I can only say I have not as yet lost a patient I can attribute to this cause.

Another point of importance I consider to be the withholding of opiates from the patient; they are decidedly injurious, preventing the full action of the skin and kidneys and confining the bowels.

Another important point is the diet of the patient. Give no food whatever for twenty-four hours, so as to avoid the chances of vomiting. There is very frequently a distressing craving for a drink of water which, if allowed, is likely to produce vomiting. To relieve this I find the use of one or two ounces of warm water with a very small quantity of common salt injected into the rectum every three or four hours answers admirably.

The promotion of the action of the skin and kidneys by keeping the patient comfortably warm with blankets and hot bottles is very desirable; and lastly, the procuring of an early movement of the bowels is very important. With the first symptoms of distension of the bowels, as shown by fullness and distension of the epigastrium, I give my patient three grains of calomel, followed by repeated small doses of magnesia sulph. A free movement of the bowels will usually relieve the patient and ward off an attack of peritonitis, whereas the administration of opium will generally increase the distension.

There are still a great many minor points I have not touched upon. The summary of my paper is this:

1. Thorough antiseptic precautions before, during and after the operation.
2. Flushing the peritoneal cavity in preference to sponging.
3. The use of the drainage tube in all suitable cases.
4. Secure early movement of the bowels.
5. Withhold opiates.

CLINICAL NOTES.

COMPLETE FRACTURE OF THE THIGH IN AN INFANT AGED SIX MONTHS AND TWENTY-THREE DAYS.

BY FRANK COWAN, M.D., TORONTO.

On the 29th June, 1893, a mother, in great state of excitement, brought to my office a male infant, suffering from the effects of a fall, caused by the perambulator holding the infant being pushed down a flight of stairs by some child. When half way down fell from the carriage and onto the rest of the way. The mother, in her excitement, nursed the child for nearly half an hour before making any examination; upon careful observation, she noticed that the left leg "dangled," as she expressed it. She then brought the child to me hurriedly. Without any difficulty, whatever, I examined the child, and, to my surprise, I found a complete fracture of the thigh at the junction of the upper and middle third; distinct crepitus, and evident shortening; no apparent bruising or swelling. Upon consideration, I thought it advisable to have assistance. Dr. A. A. Macdonald came to my office, and we then and there applied a temporary appliance, made up of absorbent cotton, wrapped thickly around the limb; then poro-plastic felt heated and moulded to the limb. Bandages were then firmly applied, yet not tightly, and the limb flexed upon the abdomen. It was certainly pleasing at this time to see how immensely relieved the infant was—laughing and cooing, as if nothing had happened. We placed the infant upon his left side in his carriage, and gave instructions that he was not to be removed therefrom (except for cleansing purposes), until we applied permanent splints.

Before proceeding, I may state that the child was one of twins, the other having been still-born. The mother is a well-developed girl of twenty summers, having had one child before the twins—a girl in perfect health. However, the appearance of the infant would lead one to believe that a "taint" existed somewhere, either in the father or the mother.

June 29th.—Dr. Macdonald and myself called with the intention of applying plaster of Paris splint, but when we saw how comfortable the infant appeared to be, we decided to leave it in that condition for a few days.

I watched the child carefully then for five days, never disturbing once the temporary appliances. However, upon the 5th July, Dr. Macdonald saw the infant again in consultation with me. After removing the temporary splints, and washing the infant carefully with antiseptics, and seeing that there was very little swelling and no bruising whatever, we applied the plaster of Paris—from the anterior superior spine, carefully moulded in the groin and on the buttock; we extended it to the condyles of the femur, leaving the knee-joint free, taking precautions to protect the skin by using ordinary "cotton batting." After the splint had properly dried we again flexed the thigh upon the abdomen, making it fast in that position, and left the infant as before, upon its left side and in its carriage. I saw the infant from day to day, and,

as the mother expressed herself, she never saw a "child pick up in flesh and appearance as it had." At the end of two weeks the mother brought the child to me again, this time, however, without the "splint," and you can readily imagine my consternation. After censuring the mother freely, I ascertained that the splint had become foul in odor from the urine and feces, and, thinking that the splint was on long enough, she undertook to remove it upon her own responsibility. Examining the limb, I certainly was surprised at its condition; the anterior surface revealed a hard, callous thickening at the junction of the fracture; upon measuring, there was no shortening, and, to all appearances, the limb looked as well as the other. I again put the fracture up in splints, this time of hard moulded cardboard, applying it the same way as the previous ones, and at the same time warned the mother. To make sure, I asked her to bring the baby to me every other day. However, she was called away to Brantford. Upon her return, I called upon her, and found that again she had removed the splint. Upon examination of the limb, I found the thickening had increased over the seat of the fracture, still no shortening; and what's more, no deformity whatever.

In conclusion, I may say that I thought the case a fit one to report,

Firstly.—Because of the age of the child.

Secondly.—The continued interference by the mother in our treatment.

Thirdly.—Because the child improved considerably in general health, whilst under such restrictions.

It is now about six weeks since the fracture occurred, and there is every indication of success.

CASE OF TUBERCULAR MENINGITIS.

Reported by J. N. HARVIE, B.A., M.B., Resident Assistant Toronto General Hospital.

(UNDER CARE OF DR. W. H. B. AIKINS.)

On the 29th June, H — D—, aged 45, was admitted to the Toronto General Hospital. At this time patient complained of cough, expectoration, night sweats, gradual emaciation and other symptoms of pulmonary phthisis. Physical examination of the chest disclosed well-marked evidences of consolidation and softening over the right apical and sub-clavicular regions. For the first two weeks after admission, the clinical picture was that of an ordinary case of phthisis, there being nothing worthy of remark excepting the patient's vigorous appetite and morose and taciturn disposition. The temperature range was not high, there being an evening elevation of 1° to 2° , with slight subnormal morning remissions. The pulse ranged from 80 to 100; respirations, 18 to 24.

About the middle of July, patient began to complain of severe headache, which he did not attempt to localize. Various remedies were administered, but relief was slight and only temporary. Counter-irritation over the nape of the neck proved more effectual than the internal administration of drugs. The headache continued with unabating severity for about ten days, the patient meanwhile becoming still more taciturn, and indisposed to physical exertion. The temperature during this period showed more irregularity, reaching at times to 101° in the evening, and falling to 97° or 96° in the early morning, and on one occasion remained subnormal for forty-eight hours. The pulse varied from 60 to 80, and was full, strong and regular; respirations about 20, appetite still good.

Meanwhile the cough, expectoration and night sweats entirely ceased, the physical signs in the lungs became less marked, and the patient began to evince symptoms of

mental derangement and physical weakness. Suspecting tubercle of the meninges, the patient was sent to the eye department for examination, but the evidence from this source proved negative. For purpose of diagnosis, and also with a slight hope of relieving the intense cephalalgia, on the afternoon of July 27th, tuberculin was injected by Dr. Nesbitt in company with Dr. Aikins, but the reaction was not obtained, the temperature falling gradually from 101 $\frac{1}{2}$ to 97 $\frac{1}{2}$ on the evening of the following day, and subsequently resuming its former character.

During the last week of patient's life, the symptoms of mental derangement were unmistakable, the insanity being of the melancholic rather than the maniacal type. Headache was no longer complained of, and the patient maintained for the most part a moody silence, interrupted occasionally by slight exhibitions of maniacal excitement. In this condition he continued until the afternoon of August 2nd, when a sudden change occurred: patient began to manifest signs of severe abdominal pain: the pulse, from being full, strong and regular, when seen about one p.m., was found when called at five o'clock to be small, weak, irregular and beating 175 or more to the minute. The lips and extremities were cold and cyanosed, and the chest filled with ædematous rales. Stimulants were administered, and external heat applied, but patient sank rapidly, and died at half past one on the following morning.

The post-mortem examination was conducted by Dr. E. E. King. The dura mater was found to be thickened, and so firmly adherent to the brain substance on either side of the longitudinal fissure, that in its removal portions of cortical grey matter were torn away with it. The pia lining the fissures of Sylvius and adjacent convolutions was studded with small greyish-yellow miliary tubercles, following chiefly the course of the blood-vessels. The vellum interpositum also showed the tubercles lying along the vessels of the choroid plexus. The tubercles were largest and most numerous in the Sylvian fissure of the left side, where there existed definite small caseous nodules. Lymph covered the surface of the convolutions over the base and sides of the brain. Each lateral ventricle contained about one ounce of serous fluid, while the brain substance in parts, especially in the neighbourhood of the corpus callosum, was pale, soft and almost diffuent.

Reports of Societies.

ONTARIO MEDICAL ASSOCIATION.

(Continued from last number.)

We are indebted to Dr. J. N. E. BROWN for report of this meeting.

THURSDAY MORNING.

The Association, after the opening business, listened to an instructive paper by Dr. Holford Walker on the subject of "MESSAGE, AND ITS APPLICATION IN GENERAL PRACTICE."* He defined massage to be "the communication of motion to the tissues of the body, 'at best accomplished by the hands,' the motion con-

trolled by the various movements adopted, and the force used." Strange to say, it would help directly opposite conditions: it would fatten the thin and reduce the fat. Unlike drugs, it did not unpleasantly affect the system. Its effects were mechanical, reflex, thermal, and electrical. The Doctor explained how the body cells were stimulated, the movement of the blood quickened, the absorbents stimulated by the first; how the nervous system was soothed by the light stroking used in the second; how the muscular exercise induced the thermal effects; and, lastly, how the electrical effects were manifested in effecting cures in an unexplainable way of various paralyses of the body. Massage

* Will be published in this journal.

was particularly useful in neurasthenia, rheumatism, rheumatoid arthritis, fractures, sprains, constipation, sciatica, and many other diseases. Even the weakest patients can stand it.

The President said that he had once used massage in his practice, but had let it fall into disuse. He would again make it a study.

Dr. Hunter endorsed all that Dr. Walker had said. He had tried it with gratifying success in fractures. It had given splendid results in the various neuralgias.

Dr. McKinnon, of Guelph, then followed on the subject, "ACUTE GENERAL PERITONITIS: LAPAROTOMY, AND RECOVERY." He gave a history of the case. The subject was a pale girl, and the attacks sudden and severe. Morphine gave only partial relief, and, after consultation, operation was decided upon, pulse being 100, temperature 101, and tympanites great. After incision it was discovered that upon the lower anterior wall of the stomach, about two inches from the left extremity, adhesions were found, which, on being separated, disclosed an old ulcer. The distension made it extremely difficult to close up the incision; so much so that the prepared silkworm gut broke, and unprepared silk was used. A drainage tube was left in until the second day. The patient subsequently developed an attack of pneumonia, followed by phlebitis, occurring successively in the left leg, the right leg, and the left arm. These attacks he considered were septic, and due to the suppuration arising from the stitch holes of the unprepared silk. The question, when to operate, is a serious one. In idiopathic and some forms of puerperal peritonitis, the opium treatment was sufficient; but in the perforated variety, unless considerable shock be present, operation was indicated.

Dr. Graham asked his opinion of laparotomy in perforation of typhoid fever.

Dr. McKinnon replied that he had had

no experience in operating for that condition.

"THE FAILURES AND SUCCESSES OF BROMOFORM IN THE TREATMENT OF WHOOPING-COUGH," by Dr. Duncan, was the next paper read. He cited cases where it had been used with little or no effect, and some cases where it had had a toxic effect. Being narcotic, it somewhat unfavorably influenced the general condition of younger children. It was found by some who tried them that bromide of potassium and chloroform did better. The Doctor then gave some reports of its successful use among Toronto and outside men. Some reported that it did not shorten the disease, but cut short the paroxysms. In his own practice he had found, where a small dose was ineffectual, that increased doses gave great relief. It should be carefully prescribed, as there was a case reported where one drachm had been prescribed with four ounces of water, a teaspoonful being the dose. The last dose killed the patient.

The Association then divided into Sections, the discussion on whooping-cough going on in the Medical Section.

Dr. Stalker, of Ridgeway, said that he had had an epidemic of pertussis in his practice, and that he had tried bromoform, but he found quinine to be better. His treatment was quinine and fresh air.

Dr. Hunt, of Clarksburg, said that he agreed with Dr. Duncan. He had gone through an epidemic of pertussis and found bromoform exceedingly useful, especially in shortening paroxysms.

Dr. Duncan closed the discussion by saying that he would not use bromoform to the exclusion of all other drugs. He would not give it more than three times a day and once during the night.

"THE NATURE OF FEVER, AND ITS PHENOMENA AND TREATMENT," was the subject dealt with by Dr. Holmes, of Chatham. He said that this subject was at the present time employing the atten-

tion of some of the ablest men of the profession. The processes which govern the maintenance of the temperature, he said, were but imperfectly understood, and that heat loss was not always uniform, neither was heat production; and, in order that a uniform temperature might be kept, the mechanism governing it must be in intimate relation with heat production and heat loss. Heat production was the result of retrograde tissue change. Four-fifths of the body heat was generated in the muscles. The increased respiratory and cardiac action he explained to be dependent on the increased temperature of the blood. There might be rise of temperature without fever, and also fever without rise of temperature. Dr. Holmes wondered why the profession were hunting around for new remedies when the cold bath was at their disposal. By using it in one hundred cases of typhoid fever, his death rate was only two.

In discussing this paper, Dr. McPhedran said that cold baths were a means but not a specific in fever. He then gave an account of how he would use the cold baths in the various fevers. This, he said, was excellent treatment in the summer diarrhoea of children. The baths ameliorated the symptoms in typhoid, but did not eliminate the poison.

Dr. Hunter fully agreed with Dr. Holmes and Dr. McPhedran.

Dr. Bromley said that he had used jars filled with cold water placed about the patient, but did not use the bath. In typhoid fever, he used the cold bottles and antiseptics.

Dr. Rice asked Dr. Holmes if he would use the bath in a case of summer diarrhoea with a cold surface and an internal temperature of 103° or 104° .

Dr. Holmes closed the discussion by saying that the cold bath shortened the duration of the disease and prevented many nervous symptoms arising. As to Dr. Rice's question, he stated that he had

always got excellent results from the cold bath in all cases of summer diarrhoea; he also used massage of the extremities. It had always stopped the convulsions, in his experience, also.

Dr. McPhedran then presented a case of "ABDOMINAL ANEURISM." After giving the patient's history and showing the members the area of the tumor and of the pulsations, he proceeded to describe the treatment. The patient had come to the General Hospital a year ago last March, and had been kept in bed until October. The treatment was that adopted by Balfour, of Edinburgh—iodide of potash and nitro-glycerine. The nitro-glycerine was increased until the pulse became very small and soft. He began with a 1-100th of a grain and increased it to 1-50th. The diet was light and nutritious, and as little liquid was given as possible. The tumor gradually lessened in size until August, but from August until October there was little change, when he was allowed to go home, with the injunction that he was to do no hard work. However, he worked hard all winter. Now the tumor was somewhat larger than it was. However, the patient was very materially relieved, if not absolutely cured.

Following this was a paper on "THE PREVENTION OF TUBERCULOSIS IN ONTARIO," by Dr. E. Herbert Adams, of Toronto. In opening his paper, Dr. Adams gave some statistics showing the immense death rate occasioned by this disease. In Ontario it had claimed 24,437 victims between 1880 and 1890. Thirty-four per cent. of the patients admitted into the Sick Children's Hospital, Toronto, for the same period were tubercular in character. Then, too, the Doctor spoke of its ravages among the lower animals, and the danger of their transmitting the poison to human beings; for there was no doubt, in the minds of those who had studied the matter, in regard to its contagiousness. The speaker then dwelt on the predisposing cause of

the disease, heredity and unsanitary surroundings being the principal. To lessen this scourge, Dr. Adams recommended the reporting of all cases to the public health department, the inspection of milk and meat by qualified men, the death of all affected animals, receptacles for sputa in public places, such as railway stations, thorough disinfection of houses after the death of patients, the complete separation of first cases in prisons, etc., and the erection of special hospitals for patients suffering from this disease.

Dr. Burns reported a case of "POLYMASTIA" in a woman who, in her third confinement, complained of swelling in both armpits. She had observed it after her second confinement, but not after the first.

On examination, supernumerary mammary glands were found on each side, well within the axillary folds, and quite distinct from the glands proper. One gland was provided with a rudimentary nipple about the size of a pea. The other opened through the skin by a small slit. Both secreted fluid which, after examination, was found to contain colostrum corpuscles.

Dr. Primrose said that he had examined the patient, and had found the supernumerary glands quite distinct. He had also examined the secretion from them under the microscope, and had found colostrum corpuscles. The mammary gland, he said, was of the same origin as the sebaceous gland.

Dr. Howitt, of Guelph, next addressed the Association on "APPENDICITIS."*

Dr. Temple then said that he had only the highest words of commendation for Dr. Howitt's paper. He (the speaker) thought that the diagnosis was at times very difficult. He agreed that it was also very difficult to say in some cases whether one should operate. If the abscess were

allowed to rupture into the peritoneum, it was a most serious matter.

Dr. McFarlane also referred to the excellence of the paper. He said that he was much interested in the subject. He agreed with Dr. Temple in the difficulties he had referred to. The Doctor then gave a brief history of a typical case, pointing out the most interesting points. Very many cases would recover if left alone.

Dr. Hillary then outlined the history of two cases he had had. In the one he had refrained from operating, and the patient had died; in the other he had operated and found nothing. But, in the latter case, the abscess burst into the bowel, and the patient recovered.

Dr. Howitt then closed the discussion by indicating some of the symptoms which would lead him to operate. They were the increase in the size of the tumor after the third day, accompanied with pain which opiates failed to control, and the appearance of the septic temperature chart.

Dr. A. B. Osborne, of Hamilton, followed by reading a paper on "GONORRHOEAL OPHTHALMIA, INCLUDING OPHTHALMIA NEONATORUM." He described the peculiar manner in which the gonococcus attacked the conjunctiva, how its virulence depended upon the amount or the invading poison, how the conjunctival secretion was inimical to the poison, and how the quickness with which the eye could close, making it difficult for the finger to touch the conjunctiva, was the reason it often escaped infection. He gave an elaborate description of the various symptoms, both of the earlier and later stages, and also of the sequelæ and complications. He advocated general as well as local treatment. At first, he would treat with antiseptic lotions and cold, and later by astringents, if called for. If the cornea became infiltrated centrally, he would advise atropine; if circum-corneal,

*This paper appeared in the July number of this journal.

eserine would do good. Opium should be given if the pain called for it. Antiseptic midwifery was doing much for the prevention of ophthalmia neonatorum. Its treatment was similar to that of the other. Prevention in both was better than cure. Doctors should advise all patients to be exceedingly careful as to cleanliness. The pregnant woman, if she has any discharge, should be treated before delivery. This was the most fruitful cause of blindness. In the Institution for the Blind in Brantford 16 per cent. of all cases of blindness were traceable to ophthalmia neonatorum.

SURGICAL SECTION.

The next paper handed in was written by Dr. Groves of Fergus. It dealt with a case of "LAPARO-ELYTROTONY."*

Dr. P. P. Burrows, of Lindsay, then read a paper on "TREATMENT OF TALIPES VARUS BY CONTINUOUS EXTENSION." It was unnecessary, he said, to enter into an anatomical description of this deformity, as he had entered fully into the question in the case reported in the *Canada Lancet*, June, 1887. In the case reported he divided the contracted tendons, the plantar fascia, and muscles. Next morning he applied a plaster of Paris splint, with cotton batting padding. After ten days a small portion of the split below the ankle joint was removed, the foot over-corrected, and fresh plaster supplied to secure it in the new position. In thirty days he removed the splint and found the limb perfectly straight. He then had a laced boot put on, stiffened on its inner side.

Dr. Powell, of Ottawa, asked what age the child should be before the tendons should be cut.

Dr. Burrows said that in the child reported the age was four.

Dr. Bryans asked how long the plaster of Paris splint should be left on in a marked case.

* Will be published in this journal.

Dr. Burrows replied that he left it on thirty days.

Dr. Sullivan, of Kingston, asked Dr. Burrows how many cases he had used traction on. He also wanted to know if he would operate before the fourth year. He (Dr. Sullivan) thought that great deformities could not be overcome before the fourth year by traction; nor could talipes varus be overcome where there was contracture of the tendons, etc., without section.

Dr. Burrows said that a moderate case of talipes, if left untreated, became much worse if left long as a result of contraction. He thought counter-extension rational treatment.

Dr. B. E. McKenzie then stated that different specialists had different modes of treatment. He thought no one line of treatment could be adopted for all cases. He said that in children he was cutting less than formerly, and that he never cut the tendon under one year. Often in talipes time was lost in extension when the knife should be used.

Dr. Temple's paper came next: "A FEW BRIEF REMARKS ON SOME OF THE DETAILS WHICH LEND SUCCESS IN ABDOMINAL SURGERY." (See page 38.)

Dr. Barrick said that he fully endorsed what Dr. Temple had said.

Dr. Atherton said that he agreed with Dr. Temple except in one point: he would not use hot water to wash out the abdominal cavity if there was no pus or other deleterious matter present. When he did use water he would not use it very hot, as in one of his cases he feared the peritonitis which followed the operation was due to it.

Dr. Howitt asked Dr. Temple if he would remove all the fluid from the cavity after the operation before he sewed up. In regard to the drainage tube, he thought that the walls of it should be thick and the holes small, so as to prevent the soft tissues protruding into the opening.

Dr. Powell, of Ottawa, asked Dr. Temple how he would treat the pedicle, and how he treated the abdominal wound externally.

Dr. Powell, Toronto, asked if salt might be advantageously added to the flushing fluid, and what the temperature of the water should be—whether near the highest or lowest allowable temperature.

Dr. Cameron gathered, although he had not been present, that the points of discussion referred to the use of sponges and the drainage tube. The practice of making the "toilet" of the peritoneum had fallen into disuse, and he thought, to some extent, unmerited disrepute. This was, perhaps, on account of the way in which the sponging was done—there was danger that the delicate lining of the peritoneum might be rubbed off. He thought it well to leave it as clean as possible, as any blood clots left would make a nidus for germs. If there was much irrigation, his practice was to pass a sponge into Douglas' pouch and also one into the anterior cul-de-sac, which he removed just before the completion of the operation. Regarding drainage tubes, he said they might be a source of infection. Kelly had pointed out that the tube was a septicode. Therefore, he advised that it be removed as soon as possible; and in regard to its use he would reverse the old maxim, "When in doubt, use the drainage tube," to "When in doubt, do not use the drainage tube." He found that if left in for a period not exceeding forty-eight hours, it did not militate against the closure of the wound. For the immediate purpose of getting rid of deleterious material from the operation, or for warning one of the presence of hemorrhage, the drainage tube was very serviceable. If there were any holes in the side of the tube, they should be as small as possible. If one feared that the lower end would be plugged by soft tissues, it might be obviated by filling the tube with iodoform

gauze, allowing the end of the gauze to extend beyond the tube. It would then also establish capillary drainage.

Dr. Temple closed the discussion by saying that he would not use hot water, but warm water. In the case of a simple cyst, he would not use any. He used silkworm gut in stitching up; then he sprinkled on the wound dry iodoform and applied a dry dressing.

In reply to Dr. Powell, of Ottawa, he said that the treatment of the pedicle did not vary much now; that he treated it by simply dropping it back into the cavity after ligation. He ligated by the transfixion method, and did not sear the stump in simple cases.

Respecting Dr. N. A. Powell's point, he said he thought salt might be added without the slightest injury.

With regard to Dr. Howitt's question, he said he allowed most of the water to run out, and squeezed a good part of the rest out by pressure on the sides of the abdomen. If there was a little left, he would draw it off through a drainage tube by means of a glass sucker. He advised the use of a small drainage tube. He could not tell the exact temperature, as he merely tested it with his hand.

Dr. Sloan, of Kingston, asked in what proportion of cases did hernia follow the use of the drainage tube.

Dr. Temple replied that it had followed in none of his cases.

Dr. Mackenzie followed by reading a paper on the "MECHANICAL TREATMENT OF TUBERCULOSIS OF THE KNEE-JOINT." The Doctor had four patients present in varying stages of the disease wherewith to show the nature of the splints used. He first described the mechanism of the joint. It was the joint most often affected by this disease. Fortunately, it (the joint) could be put at rest without confining the patient to bed. The two points in the treatment were to allow the patient to walk without putting the foot of the af-

fectured limb to the ground, and in cases of flexion with sub-luxation to correct them. The first was accomplished by the use of a Thomas splint, which the speaker described. The second was accomplished, if the case had not gone far enough for operation, by employing continuous traction from the bottom of the splint. When convalescence had taken place pretty well, the Doctor showed how to modify the splint so that part of the body weight might be transmitted through the affected limb to the ground. The cases, whose histories were given fully in the paper, were very instructive.

Progress of Medical Science.

THE RELATIVE POSITION OF THE ASEPTIC AND ANTISEPTIC METHODS IN MIDWIFERY.

Upon this subject, Dr. T. Arthur Helme, of Edinburgh, has read a paper before the North of England Obstetrical and Gynecological Society, from a report of which in the *Medical Chronicle* we make the following extracts :

"The object of our obstetric art is the preservation of our race, and with this in view we eagerly seize upon and apply in practice each and every scientific advance; but in so doing we sometimes overstep the mark.

"There is no more striking example of this than that afforded by the so-called antiseptic method in obstetrics; no sooner is it discovered that fever during the puerperium is often due to the growth of germs in the genital tract and the poisoning of the system by their products, and that these germs succumb to certain potent poisons, than the most deadly concoctions that can be devised are poured into all the unhappy individuals who chance thereafter to be confined, and who not infrequently in consequence suffer the

fate intended for their parasites—not, bear in mind, because there *is* poisoning, because lethal germs *are* there, but forsooth, in case there may be! And so it has come about that many of the leading teachers to-day would lay it down as an inviolable rule, as a law of the Medes and Persians which changeth not, that *every lying-in woman, as routine practice*, shall be douched or squirted with noxious drugs; and as for him that doeth it not, let his name be proclaimed from the house-top, that it may stink in the nostrils of the people.

"For, with many a man, the idea that he is using antiseptic materials which, he thinks, no germ can withstand, bolsters him up with a feeling of over-confidence, with a false feeling of security, the result being that those very details are neglected which are essential to the success of any method. The argument, unconscious, but evidenced by his actions, runs something in this fashion: 'The vagina contains germs which must be checked in their gay career or killed outright; this deadly douche will settle all invisible foes, therefore, what matter if an odd one or two more are introduced unseen on hands or instruments—more the merrier?' This feeling of strength and security is the very source of the weakness and insecurity of the system, but equally dangerous is the false assumption that all vaginas contain germs, the latent cause of puerperal septicæmia. This doctrine I resist most strenuously; it has been abundantly proved in our every-day clinical experience (and that of the laboratory confirms it) that such a state of affairs is not the fact. The genital canal of a healthy normal woman may contain some harmless germs, but does not contain those of the pathogenic variety either before labour or in the puerperium."

After devoting considerable attention to bacteriological and clinical observations,

and concluding that in the conduct of labour in a healthy, normal woman, the aseptic method, so far as the two systems relate to each other, offers, undoubtedly, the best results, he gives the details of the aseptic method.

The details are considered in two categories :

"I. *Subjective Asepsis*.—Under this I include all relating to the physician and nurse, especially the hands and arms, and the instruments, of all matters the most important.

"(1) Hands and arms : There are two methods of cleaning—i., the chemical ; ii., the mechanical.

During a visit to Leipsic, this winter, Professor Singer told me one fact (among many) of value, viz., that he found washing the hands with common sand a most efficient means of disinfecting ; it removes all odours, all dirt, and all germs. This is an important and useful thing to know, for even in emergencies common sand may generally be had.

"The plan I advocate is, first, thorough scrubbing of the hands (after paring the nails) in soap and warm water, with brush and sand, followed by soaking the hands for a minute in a strong antiseptic solution, either one in fifty carbolic, which is very irritating ; or corrosive sublimate, one in a thousand, which is not sufficiently penetrating ; or best of all, in a saturated solution of permanganate of potash, till the skin attains a deep walnut or black colour, immediately transferring them to a strong solution of oxalic acid for half a minute, when the skin assumes a rosy colour. They are then washed in warm or sterilized water.

"(2) Instruments : The plan I employ at present is to boil my instruments immediately after use in water, to which a little common washing soda is added (one teaspoonful to a quart), for one hour, then to quickly rub them over and dry them, and put them immediately into a linen bag,

which has been boiled and dried previously, in which they remain until they are required. They are then taken out and used at once, or if they have to stand any time, are placed in a two-per-cent. solution of lysol or creolin or carbolic.

"(3) Clothes : It is the duty of every medical man whose duties lead him into rooms where cases of suppurating and other diseases are lying, to cover his ordinary suit with a linen coat freshly boiled and dried, or at least a mackintosh apron that has been thoroughly cleansed, and to keep away from the patient sleeves which have come in contact with septic matter. These remarks apply equally to the midwife and the nurse.

"(4) Examination of Patient : It must not be forgotten to cleanse the hands immediately before and after each vaginal examination. It is not uncommon to see a man standing or sitting by a patient's side, his fingers wet and covered with vaginal discharge, with which, at the interval of a very few minutes, or even less, he does his best to inoculate the vagina. This is dreadful ; after and before each examination the hands should be cleansed. And further, the vaginal examination must be discarded as much as possible ; in many cases it is our undoubted duty to examine frequently, but in the majority of cases, once we have made up our minds, after careful vaginal examination, that all is normal, we should rely more on abdominal palpation than upon repeated vaginal examinations.

II. *Objective Asepsis*.—This has reference to the patient and her surroundings.

(1) *The surroundings* :

(a) In private practice, wherever this is practicable, patients should be educated to purify and prepare beforehand the special room which they intend to lie in. Perhaps exposure to sulphur fumes is not necessary, but at any rate by thorough scrubbing and ventilation.

(b) The bed. Fresh, clean sheets must

be insisted upon, and inspected by the practitioner himself, and immediately beneath the patient should be placed a smaller drawsheet which has been *thoroughly sterilized* by boiling.

(2) *Preparation of the Patient:*

(a) External Cleansing: The patient, if possible, should have a bath; but in every case, without exception, the buttocks, external genitals, and thighs must be thoroughly scrubbed for at least five minutes with soap and warm water, and after that washed with a solution of 1 in 50 carbolic or 1 in 1,000 corrosive sublimate, immediately before labor.

(b) The Internal Douche: As to the "prophylactic" douche, or the extremists' "vaginal sterilization," as I have before said, in normal cases it is not only useless but harmful; while attacking a bogey enemy it does actual harm; by removing the normal secretion it delays labor, and by detaching the epithelium it favors excoriation and bruising, and in consequence invites those very dangers it was designed to prevent.

If the premises were correct, viz., that all vaginas contain germs which produce puerperal fever, we should be mad if we did not push the argument to its logical conclusion, and act upon it fearlessly—namely, by procuring perfect sterilization of the vagina, as indeed has been advocated by Döderlein, of Leipsic, and others, who recommend, for example, the following: "Douching of the vagina every two hours during labor with corrosive sublimate, scrubbing the vagina and the cervical canal with the fingers," and this indeed for routine practice! But such, thank heaven, is not the case. Bökelmann is right when he says, "the healthy normal puerperal woman is *a priori* to be regarded as aseptic."

(3) *After treatment:*

(a) The vaginal douche is just as useless and just as harmful, or more so, in a

normal case, post-partum as ante-partum; therefore, shun it; and the less said about the intra-uterine douche the better. Indeed, a great deal too much attention is paid to the cleansing of the patient, and a great deal too little to the cleansing of the practitioner and nurse. If only half the nurse's energy were let loose upon her own and the doctor's hands, instead of being devoted exclusively to the squirting of the woman's internal parts, more benefit would result.

Therefore, I would altogether avoid the use of intra-uterine and vaginal douches in all labors in healthy women. The safeguard is "prevention."

(b) External Cleansing: Sepsis, in a previously healthy, normal woman, must come from without; its process begins at the vulva.

If we keep the doorstep clean (and the door closed) the hall will be clean. To ensure this, I have the external genitals washed two or three times a day with warm soap and water, and then with Condy's fluid, lysol, or corrosive sublimate solution. The vulva is then covered with a pad, only to be removed for the next dressing.

(c) The Perineal Pad: This pad I consider of the greatest importance. It should be made of wool, absorbent, that all discharges may be taken up; sufficiently large, that the outer layers are never saturated, and medicated. I myself use boval-tissue (*i.e.*, sublimate wool), covered next to the vulva with a few layers of five per cent. iodoform gauze (where necessary), to prevent irritation from the mercury of the wool. (In hospital, where the appliances are at hand, a layer of sterilized gauze may with advantage be substituted for the layer of iodoform gauze.) This dressing should be secured by a perineal bandage, and changed at least every three to six hours. By this means we effectually prevent the entrance of any pathogenic germs to the lochia.

The method I have sketched I claim to be a rational and natural one. It has taken long to go over the matter, and perhaps this, together with the lack of arrangement in the manner of the narrative, has obscured the simplicity of the method.

May I briefly recapitulate the chief headings:

(1) The vagina of the healthy normal pregnant, parturient, and puerperal woman must be regarded as *aseptic*. Our object is to prevent inoculation during and after labor: to attain this object, we look to—

(a) Thorough cleansing of the hands and arms and instruments, with attention to the clothes and infrequency of examination.

(b) Healthy surroundings, pure air, clean sheets, thorough cleansing of the external genitals before and after labor. No internal douching; the use of the perinæal pad.

(2) The vagina of a woman suffering from chronic discharge is *a priori* to be regarded as *septic*; our object is to destroy the germs already present, and to prevent fresh inoculation. In addition to the above treatment, therefore, we must here make use of internal antiseptic douching, before, during, and after labor, aiming at sterilization of the vagina.

And among the second group of cases I would include those to which we are called in emergency, or after they have been for hours, or, may be, for days, in the hands of a midwife, and those where labor has lingered for hours with continuous bloody discharge or under other doubtful conditions.

With all our precautions there will, however, always remain a third series of cases where danger comes from a part not to be reached even by the douche—I mean the tubes—cases difficult of treatment, and still more difficult of diagnosis. But the question of vaginal antiseptics or asepsis does not materially affect these.

Puerperal fever will occur, and its cause will probably be discovered post mortem.

In this communication my purpose has not been to condemn the practice of douching indiscriminately. Far from it; but what I do wish most emphatically to condemn is—(a) Unnecessary douching of the normal healthy woman; (b) the faulty manner of douching, when the unhealthy conditions of the patient necessitate its employment; (c) the use of imperfectly cleansed napkins.

Two other points, in conclusion, I again urge:

(1) Too much attention is directed to disinfection of the patient, and too little to disinfection of the doctor and nurse.

(2) Throw aside "routine" practice: judge a case on its own merits: let us diagnose whether we are dealing with a healthy or a diseased vagina, just as we look for a healthy or diseased heart or kidney, and choose our treatment accordingly—the aseptic method in the former, the antiseptic method in the latter.

—
CAN LABOUR BE CHECKED AT WILL.—Tarnier (*Journal des Sages-Femmes*), who maintains that voluntary efforts by contraction of the abdominal muscles play an important part in labour, further believes that the patient may, consequently, check the processes to a certain extent, just as feces and urine may be voluntarily retained for a time. He was once called into a labour where the patient had deformed pelvis with coxalgia; she, like many such invalids, had been spoilt, and was very sensitive. He found the membranes ruptured, and the head presenting at the vulva. Delivery seemed a question of a few minutes, the pelvic contraction having clearly offered no check to the passage of the head. The patient asked for chloroform. Tarnier said that it was not necessary; she insisted and declared that if the anæsthetic were not given she would "hold in." He waited twenty

minutes, but the labour did not proceed; the patient remained obstinate, so he yielded and gave a little chloroform. At the first pain the child was born. He wishes it to be understood that the contractions of the uterine muscular fibres cannot, of course, be controlled by the will.—*British Med Jour.*

ACTINOMYCOTIC PERILARYNGEAL ABSCESS.—Poli (*Gazz. degli Ospitali*, March 14th, 1893) records an interesting case of actinomyces at the back of the pharynx in a man, aged forty-five. The patient when first seen had his larynx displaced forward and to the right by a swelling in the neck situated just to left of the thyroid cartilage. The tumour had been gradually increasing for about four months, and had led to the suspicion of the existence of a postpharyngeal abscess. The tumour presented marked fluctuation, and on being opened was found to contain a sero-sanious fluid, in which floated sulphur-yellow particles. These were recognised microscopically as being actinomycotic in nature. The cavity was then laid freely open, its walls thoroughly scraped, and packed with iodoform gauze. Recovery took place, and perfect healing resulted in a short time, and it is probable that the original circumscribed nature of the disease contributed largely to the successful result.—*British Med. Jour.*

GASTRIC DILATATION.—Aufrecht (*Centralbl. f. klin. Med.*) draws attention to two signs hitherto undescribed, and which it is thought will be useful in the early diagnosis of dilated stomach. Almost everywhere over the stomach a hyper-resonant note is obtained, but in some places a distinct dullness may be found which gives way later to a tympanitic note. The dullness, it is said, may sometimes be followed from the cardiac to the pyloric end. The second sign is a clanging note like the

cracked pot sound. It is associated with the former, and is best obtained at the margin of the above-named dullness. These signs are not absolutely constant, but this should not much impair their value. The dullness is caused by the voluminous contraction wave passing over the stomach in early stages of gastric dilatation, especially when due to obstruction of the pylorus. The clanging sound is caused by the mixture of air and fluid in the neighbourhood of the increased peristaltic wave.—*British Med. Jour.*

BORATE OF SODA IN PARALYSIS AGITANS.—Borate of soda, which has been found useful by various authorities in epilepsy, has been tried with remarkable success by Dr. Sacaze, *chef de clinique* in Professor Grasset's wards in Montpellier, in a case of paralysis agitans where the actual, cautery, electricity, suspension, iodides and various other forms of treatment had proved fruitless. The drug was given at first in 4-grain powders three times a day, and after a few days the dose was gradually increased to about double that quantity. An improvement was manifest by the end of the first week, and after that the patient's condition continued to improve still further. After a time he was able to walk, to speak distinctly, to feed himself, and to write, none of which things he could accomplish before the borate of soda was commenced. No disagreeable effects were produced by the drug.—*London Lancet.*

PETROLEUM IN VAGINAL INFLAMMATION—Després (*Gaz. des Hôp.*, June 15th) has great belief in petroleum as a dressing. First, he found that it was preferable to coal tar and charcoal in the treatment of scirrhus ulcers in the breast. Then he obtained good results in cases of advanced uterine cancer, by injecting petroleum into the vagina. The foul discharges ceased at once. Now he finds that the same com-

pound answers well for vaginitis. He uses 100 to 150 grammes of pure petroleum for one injection; it is in no sense a caustic. Two or three injections, one daily, will cure recent vaginitis. The petroleum adheres to the mucous membrane, and soaks into the tissues, so that it acts as a permanent dressing. The patients do not complain of the odour of the compound, and it in no way affects their health.—*British Med. Jour.*

THE TREATMENT OF THE NAUSEA AND VOMITING OF PREGNANCY.—Frommel reports, in the *Centralblatt für Gynaekologie*, 1893, No. 16, four cases of obstinate nausea and vomiting of pregnancy treated by orexin. The effect upon all was excellent, although during previous pregnancies some of the patients had been persistently sick. The dose of orexin was 5 grains given twice or three times daily in wafer or gelatin capsules.—*Medical Age.*

GONORRHOEA—ABORTIVE TREATMENT. To abort gonorrhœa, Dr. Jamin washes out the anterior portion of the urethra several times daily, for about four days, with a solution of potassium permanganate to the strength of 1:4:1000 of water. The first three washes are made at intervals of about five hours; the subsequent ones, only every twelve hours. After the first injection, it is claimed, there are no more gonococci in the urethral discharge; the other washes are intended to destroy the latent germs in the urethra.

The injections of potassium permanganate, when made according to Pezzer's method, are reported to succeed very well. The liquid is injected through a red rubber catheter with thin walls and lateral perforations throughout, through which the injected fluid emerges and thus bathes the mucous surface of the urethral canal maintained dilated.—*Merck's Bulletin.*

GUAIACOL.—Liebreich (*Therap. Monatsk.*, May, 1893) states that whereas guaiacol has hitherto been described as a liquid, the latest researches have shown that when pure and synthetically produced it is a solid body, crystallising in colourless prisms, which melt at 28.5° C., boiling taking place at 205° C. It is most readily dissolved in pure, undiluted glycerine, the solubility in water being only 1:50. Both this preparation and its derivatives have hitherto rarely been produced absolutely pure, and this is said to account for the different descriptions published, many of the trade samples of the preparation containing only about 50 per cent. of guaiacol.—*Br. Med. Jour.*

DOUBLE OVARIOTOMY WITHOUT CHLOROFORM.—Largeau (*Annales de Gynec. et d'Obstét.*, May, 1893) read, at the recent French Surgical Congress, notes of a double ovariectomy performed on a patient with heart disease. No chloroform was given, local anæsthesia along the line of incision being effected by the application of chloride of ethyl in powder. He had already operated in the same manner in a case of adherent ovarian cyst, and in an abdominal hysterectomy. Largeau observes that these cases prove how abdominal section without general anæsthetics may be perfectly justifiable and practicable when the patient is subject to cardiac or renal disease.—*North American Practitioner.*

SUBCUTANEOUS INJECTIONS OF SALOL IN TUBERCULOSIS.—Grossi (*Centralbl. f. Therap.*, July, 1893) in early cases of tuberculosis recommends subcutaneous injections of salol as follows: Sterilized almond oil minims 900, salol grains 150; and of the solution thus prepared, at first one, and afterwards two to three daily injections with minims 75 should be made. The results were diminution of night

sweats, decrease of cough, a smaller number of bacilli in the sputum, and improvement in strength and general condition. Locally the injection is followed by induration of the skin.—*British Med. Jour.*

VALUE OF "ORGANIC EXTRACTS" (*Revue Internationale de Bibliographie*).—G. Bogden (de Jassy) has made a series of injections upon different patients with both testicular fluid and liquids procured from the gray substance of the brain. The results obtained, however, have only been minimal, and do not prove the efficacy of this mode of treatment. The author complains that these injections are unable to cure the affections against which they are directed, and that the slight amelioration experienced in certain instances, he is satisfied, was due purely to simple "suggestion."—*Medical Age.*

COCAINE FOR LOCAL ANÆSTHESIA.—Dr. John Edwin Rhodes (*North American Practitioner*) writes: In experimenting with different drugs to use in a combination so that the constitutional effects of cocaine would be lessened, and the quantity decreased, Dr. Ingals and myself, in modifying a solution which was suggested by Dr. Witherstine, of Rochester, Minn., fixed upon the following, which we have used constantly for the past two years with much satisfaction:

- ℞ Atropinæ Sulphatis gr. ½
- Strophanthin gr. 1-5
- Cocaine Hydrochloratis gr. xx
- Acidi Carbolicæ gr. v
- Aquæ Destillat. q. s. ad ʒ
- M. Sig.: Local anæsthetic.

This solution has served on three or four occasions for tracheotomy, five to eight minims being injected, and producing almost complete local anæsthesia with no constitutional disturbance. It has also been used in aspiration of the chest, two to four minims being injected at the

site of puncture just before using the aspirator. On several occasions the solution has been used by injection beneath the skin of two or three minims after having used it topically over the mucous membrane in operating for the removal of cartilage in marked anterior deflexion of the nasal septum close to the nostril. Some of these patients were children ten to twelve years of age, and affirmed that the operation was painless in most cases.

TREATMENT OF ERYSIPELAS OF THE FACE.—The following method of treatment is very successful in the hands of Dr. Petri (Galatz), Clinical Professor of Syphilography and Dermatology at the Medical Faculty of Bucharest, in cases of erysipelas of the face:

In the first place a purgative is administered:

- ℞ Calomel gr. xij
- Resin of scammony gr. vj

Mix and divide into two cachets to be taken on an empty stomach in the morning, with an interval of half an hour.

The affected part is painted night and morning for three or four days with a solution of corrosive sublimate in collodion:

- ℞ Corrosive sublimate gr. iss
- Collodion ʒij

F. S. A.—External use.

The collodion is spread on a thick layer over the margin of the erysipelatous patch, and for some distance over the surrounding healthy skin.

Since in cases of erysipelas of the face the infective organisms frequently gain admission through the nasal mucous membrane, Prof. Petri recommends the irrigation of the nasal cavities with boracic acid lotion.

The patient is kept on a milk diet. As early as the second day of the attack two of the following pills are administered every two hours:

℞ Sulphate of quinine gr. xxx
 Iodoform gr. vj
 Balsam of tolu }
 Extract of gentian } aa ℥. s.

The administration is continued until the temperature comes down and a favourable change is observed in the local manifestations, the desired result being generally obtained in a comparatively short time.

Should the patient show symptoms of cerebral congestion, these usually disappear on the application of a few leeches behind the ears.

According to Prof. Petrini, so completely is the patient disinfected by this method that he is incapable of communicating the disease to those around him. This does away with the necessity for isolation even in the case of hospital patients.—*North American Practitioner*.

GONORRHOEA.—A committee of the Therapeutical Society of Paris reported favourably on the use of the urethral bougie of M. Weber in incipient gonorrhoea. This bougie is prepared as follows :

℞ Gum arabic in powder . . 15 pts.
 Lactose 5 pts.
 Glycerine 1 pt.
 Iodoform 2 to 4 pts

M. Make ten bougies 13 cm. long.

Bougies thus prepared are soft and supple. They should be introduced at night, on retiring. They melt in the urethra, and are expelled without effort in urinating.—*Med. Review*.

CHOLAGOGUE PILLS.—Huchard's formula is (*La Revue Méd.*) :

℞ Extr. hyoscyam.,
 Podophyllin.,
 Saponis āā gr. v.
 Extr. rhei gr. xv.

M. et ft. pil. no. x.

Sig.: One or two pills daily.—*Medical Bulletin*.

DIGITOXIN IN HEART DISEASE (*La Médecine Moderne*).—M. Masius warmly recommends digitoxin, in the dose of $\frac{1}{4}$ to $\frac{1}{2}$ grain daily in single doses of $\frac{1}{16}$ grain. This is said to rapidly produce the effect of digitalis without ill effect upon the digestion. It produces no subcutaneous irritation. He employs the following formula :

℞ Digitoxin gr. 13
 Chloroform f ʒss.
 Alcohol (94°) f ʒiiss.
 Distilled water f ʒiiss.

M. ft. sol.

This is enough for eighty subcutaneous injections. Fifteen minims of the solution are injected three times during the day, at intervals of three hours.—*Medical Bulletin*.

CREASOTE IN TUBERCULOSIS PULMONUM.—Dr. J. T. Whittaker (*Therapeutic Gazette*) says :

1. Creasote, when pure, is harmless.
2. It has no direct action upon the tubercle bacillus.
3. Tuberculosis pulmonum is chiefly a secondary infection by a streptococcus.
4. Creasote has no direct action upon this streptococcus ; hence none whatever upon hectic fever.

5. It destroys lower organisms, especially those which produce fermentation, without affecting the process of digestion.

Hence, 6, the virtue of creasote, which is undeniable in most cases, is chiefly, but not wholly, upon nutrition.—*American Lancet*.

FOR ACUTE RHEUMATISM.—

℞ Acidi Salicylici
 Lanolini
 Ol. terebinthinae aa ʒijss
 Axunge ʒijss

M. S.—Apply freely to joints. Give no medicine internally.—*Times and Register*.

Dominion Medical Monthly.

All literary communications, exchanges, and books for review, should be addressed to the DOMINION MEDICAL MONTHLY, 50 College Street, Toronto.

Address all business communications to the Publishers, THE MEDICAL PUBLISHING CO., OF TORONTO, Box 418, Toronto, Canada.

TORONTO, AUGUST, 1893.

CANADIAN MEDICAL ASSOCIATION.

The twenty-sixth annual meeting of our national association will be held in London on Wednesday and Thursday, 20th and 21st of September. When selecting the place of meeting last year, it was thought well to decide on a western city, and one also directly on the route to Chicago, so that members could readily attend the meeting when going to or coming from the World's Fair. A large attendance is anticipated, and an excellent programme is promised. The address on Surgery will be delivered by Dr. Hingston, of Montreal, and that on Medicine by Dr. McPhedran, of Toronto. Dr. Sheard, of this city, will fill the President's chair, those who are acquainted with him know that he will preside with dignity and tact.

All members desirous of reading papers or presenting cases are requested to communicate with the Secretary, Dr. Birkett, of Montreal.

DOMINION REGISTRATION.

The present laws governing the medical men of this country carry with them some very great hardships. For example, a young man who has studied in Toronto fifteen years ago, and has practised suc-

cessfully in some town in Ontario ever since, for some reason, perhaps his health, wishes to remove to British Columbia; and on going there, he finds that he has to undergo another examination to qualify for practice in that province. It does seem very unfair that the Dominion should be chopped up into sections in this manner.

The mere passing of the examination is not the worst feature. It necessitates the practitioner reading up again much of his primary work, which during the years of busy practice he has been neglecting. In addition, it is a great indignity to heap upon any one who has already been found fully qualified.

The *New York Medical Record*, a short time ago, condemned this very thing in the United States. There is no reason why a qualified physician from Michigan should not be regarded as qualified in the State of New York.

Dr. Stephen Dodge, President of the Nova Scotia Medical Society, in his address strongly urges that steps be taken to further reciprocity in the Maritime Provinces, and thereafter throughout the Dominion.

It is also a matter of pleasure to chronicle the fact that Dr. Hillary in his address to the Ontario Medical Association took the same liberal view of the question, and it is well known that Dr. G. L. Milne, the energetic Registrar of the British Columbia Council, has been advocating the same reform for some time.

We look forward to the coming meeting of the Canadian Medical Association to hear what Dr. Sheard, the President, has to say upon this topic. He usually takes a broad view on such questions, and we shall be greatly disappointed if he does not urge upon the above influential Association that some steps should now be taken to change the present condition of things.

This journal strongly advocates some

arrangement being made for reciprocity of registration. There might be some common standard of qualification adopted for the Dominion, each Province holding its own examination. We will not enter into details at present. What is now urged is the broad principle, that once qualified in any part of the country the holder of such a qualification is entitled to practice his profession in any other part of the country.

THE LABORDE METHOD IN ASPHYXIA.

In July, 1892, Dr. J. V. Laborde communicated to the Academy of Medicine, Paris, a paper describing an operation called "rhythmic traction of the tongue," which he had used with signal success in several cases of apparent death from drowning.

Since that time the author and several of his imitators have published in the medical journals of France and Italy reports of cases in which "the Laborde method" has been used in treating the asphyxia of new-born children, and also of young animals, such as calves, etc., asphyxia due to emanations from sewer gas, spasmodic and tetanic asphyxia, and that arising from strangulation. The following exemplification of the method and its happy result is taken from an article by Dr. De Minicis Ettore, which is published in an Italian medical journal, the *Gazzetta degli Ospitali*. The writer proceeds to say that the child, which was delivered by forceps, was in a feeble condition, owing to the premature separation of the placenta before birth. The heart beat feebly, but the child gave no other signs of life. Being obliged to confide the child to a nurse, on account of dangerous post-partum hæmorrhage in the mother, he directed that it should be sprinkled with water and plunged alternately into basins containing hot and cold

water respectively. When enabled to leave the mother, he practised Schroeder's method of insufflating air into the trachea through a catheter, with subsequent expiration of the air, but in vain. Artificial respiration was subsequently used, but with no better success. Finally, to quote the physician's words, "having placed the infant in a half-sitting posture on the bed, where it was held by an assistant, I opened its mouth, and, taking the tongue between my forefinger and thumb, began to pull the tongue at short and regular intervals (about fifteen times in a minute). After about twenty tractions, the little thorax began to rise, and the child gave a wailing cry. The tractions were continued, aided by sprinkling the body of the infant with cold water: and in a short time regular respiration was established, and the infant cried vigorously."

Similar cases also successfully treated have been recently reported by Dr. Roux, of L'Orient, and Dr. Huchard, of Layrac, France.

A case of severe poisoning from bromidia, a proprietary preparation containing chloral and bromide of potash, yielded a very satisfactory result to Dr. Laborde's method.

Simple traction of the tongue out of the mouth has for years been employed by surgeons in cases where the tongue had dropped back while the patient was under chloroform, thus interfering with the entrance of air through the glottis. But, in Dr. Laborde's opinion, this will not suffice in cases of advanced asphyxia and apparent death after the use of chloroform.

To this plan must be added, reiterated and persistent rhythmic tractions of the tongue, which constitutes the real procedure we are now discussing.

Veterinarian M. Demernisse, Meat Inspector of Paris, has also published recently a paper showing the successful application of Dr. Laborde's method to two dogs which had been hanged.

Perhaps the most striking application yet recorded is given in a paper by Dr. Coutenot, Professor of Clinical Medicine at the Bésançon School of Medicine:

A young girl of thirteen years had just expired of tubercular meningitis, after seven days' illness in the hospital. Respiration and cardiac action had ceased; the extremities were becoming cold and livid. The Laborde method was applied, and after three minutes, to quote the words of Dr. Coutenot: "the livid color was less marked, and the nostrils began to move. The traction was continued. A slight guttural noise was heard, followed by a short quivering of the chest walls, then an ascensional movement of the ribs and an action of the diaphragm. In auscultating the heart, at first no sound was audible: but afterwards both sounds could be distinctly heard, respiration was re-established, thoracic and abdominal movements were as extensive as in the normal state. The respiratory murmur had not the usual character, it sounded more like short and frequent breathing. The pulse was felt, but very soft. Lividity disappeared, and the face acquired its usual pale brown complexion. After about five minutes, in spite of the continued employment of Laborde's method, the symptoms of life disappeared, quivering of the nostrils being the last sign of life noted."

Dr. Coutenot, being requested by his class to explain why this return of the functions of life in an apparently dead person had not really brought back life, replied: "The patient has succumbed to a disease; life is extinct. If it were only suspended, we could have saved her. It was not a case of apparent death, but rather death in its final stage. Death is not produced instantaneously; the organism is extinguished progressively. The last vestiges of life are found in the *medulla oblongata*, that is to say, reflex function, particularly in what relates to respiration.

So true is this, that the Laborde method may be employed in order to obtain a certain sign of real death."

We purpose on some future occasion to return to this highly interesting subject. Enough, however, has been said to show our readers that the Laborde method is a really valuable acquisition to modern medicine, and one which may often enable the physician to accomplish results, even in desperate cases of asphyxia, which could not be obtained by ordinary means.

TREATMENT OF CUTANEOUS EPITHELIOMATA. Dr. A. R. Robinson, in *International Journal of Surgery* for June, adheres strongly to his former views on the usefulness of different kinds of caustic paste in the treatment of malignant epitheliomata of the skin. In the case of cancer of the breast and infection of the axillary glands, the writer recommends that, after removal by the knife, the resulting wound should be treated with chloride of zinc, or caustic potash. This tends to destroy the outlying epithelia, either by the action of the paste or by the inflammatory reaction. The author objects to the term recurrence. All cases where the disease returns, at the site of the primary tumour, it is because all the diseased tissue was not removed. Where return takes place, there has not been a complete removal. For superficial epitheliomata, a mixture of arsenious acid and gum acacia is used in equal parts by weight. This is better than a stronger paste, as it can be left on the part longer, and its elective action on the diseased is more thorough and complete. This may be left on from fifteen to twenty-four hours. Where the tumour is more deeply seated, he uses a stronger paste, ʒii arsenious acid, ʒi gum acacia, and leaves it in contact for about thirty hours. This paste gives the best results as regards after deformity. On account of the fact that it destroys pathological cells much

earlier than the healthy cell, there is usually but little scarring. In papillomatous forms it is not so good as the zinc or potash pastes. The caustic potash paste is the best for epithelioma of the lip. If these cases are not too advanced, the results from this treatment are very satisfactory. The inflammation from the caustic, and from the action of the toxalbumins, destroys the pathological cell, and leaves the normal ones. If the paste necroses some of the corium *en masse* there will be some deformity. The chloride of zinc paste is greatly improved by the addition of ten or twenty per cent. cocaine. This acts as an anodyne, and renders the treatment almost pointless. In this way large masses of tissue can be destroyed without interfering with the sleep of the patient. If left on twenty-four hours, over one or two square inches, and about one-third inch thick, it will necrose the tissue to the depth of one-third inch. The dead tissue can be removed with a scalpel and forceps, and the paste reapplied. During the treatment patients can often attend to easy duties.

APPENDICITIS.—In closing the discussion on the treatment of appendicitis, at the meeting of the Surgical Society, Paris, held on the 12th ult. (*La Tribune Medicale*) Dr. Reclus said that in tubercular appendicitis, which was more common than was generally believed, an operation should be performed as soon as the diagnosis was made. It must be admitted, however, that the diagnosis of this variety is sometimes very difficult. It had been stated that in appendicitis complicated with peritonitis the mortality rose to fifty per cent. The speaker thought this unfavourable shewing was due to the fact that surgical interference was delayed too long. An early operation is the only means of lessening the mortality in this class of cases.

In recurring appendicitis the operation

is easy and not dangerous, and in proportion as the time since the date of the first attack is remote, the harmlessness of surgical intervention becomes more marked. This, however, is not a reason why a patient should be allowed to carry about him the "thorn," resulting from a first attack. The proper time for operation in such cases is after the first attack.

Speaking of the operative procedure itself, Dr. Reclus discussed the propriety of removing the appendix itself. The dissection of this organ is often useless, and in any case it is unnecessary to devote too much time to looking for it. When however, the work is easy, it is good surgery to examine the base of the appendix to discover if there is a deep abscess in addition to the superficial ones.

DIURETIN.—Dr. James B. Herrick, in the *Pacific Record* of July 15, remarks that this drug has a direct action on the renal epithelium, and lacks the unpleasant effects of caffeine. The best form for administration is the compound of the alkaloid with sodium salicylate. It should be dissolved in water when given. The maximum daily dosage is about one hundred and fifty grains.

The removal of dropsy under the action of this drug is so marked and prompt as to be attended by considerable disturbance and faintness. No irritation appears to be produced in the kidneys by its use. In cases of scarlatinal nephritis, both blood and casts have disappeared under its action.

In cases of cardiac anasarca, Hoffman and Erb have found the drug of special value. The amount of urine passed is in proportion to the amount of dropsy. As the urine increases in amount, its specific gravity falls. The only unpleasant effects in these cases were some vomiting and a little diarrhoea in a few cases. It has been shown that diuretin, in daily doses of forty-five to seventy-five grains, is a

much more certain and effective diuretic than caffeine. The drug is most useful the greater the amount of dropsy. In some cases of cardiac valvular disease, with albumin but no dropsy, the drug has failed to cause diuresis.

In dropsy arising from cirrhosis of the liver it usually fails to give relief. The great value of the drug is to be found in its active diuretic action in cases of dropsy cardiac or renal origin.

FIBROMA. — Dr. Marchand, of Paris, (*La Tribune Medicale*) has, during the past few months, had occasion to operate for the enucleation of thirteen sessile intra-uterine fibromata. From the clinical and operative standpoints, these growths may be divided into three classes: small, medium and large tumours. Small fibromata may be extracted by enucleation, after simple dilatation of the cervix uteri. Larger ones require section of the cervix, and breaking up of the tumour. In fibromata weighing from 90 to 650 grammes, dilation of the neck of the womb followed by enucleation, was successful in nine cases.

LIQUID SALOL.—Dr. Reynier, of Paris, states (*La Tribune Medicale*) that at 40° cent. salol liquifies, and remains so at temperatures ranging from 37° to 38°. At the latter temperature it may be injected hypodermically or into a cavity.

Another property of salol is that at 41° it mixes closely with iodoform, forming with it a homogeneous liquid which, after cooling, solidifies.

Dr. Reynier has injected liquid salol and iodoformed salol into fistulas and purulent cavities, where the salol, by crystallization and subsequently disintegrating, rendered the cavity or tract completely aseptic. In small cold abscesses the injected mass remains a sufficient time to bring about the cure of the abscess

on condition that the small quantity of pus which reforms is aspirated from time to time. Salol injections have also caused the healing of fistulas following the resection of ribs for tubercular lesions—fistulas which, up to that time, had resisted every other treatment.

Similar results have been obtained in large cavities in bone following osseous tuberculosis or in osteomyelitis.

Another application of liquid salol is as a dressing for sutures. Applied along a line of sutures it forms a really impermeable aseptic varnish.

CHOLERA INFANTUM.—L. B. Todd, in July number of *American Practitioner*, has an interesting article on the above disease. He ranks bad air, over-crowding, improper food, and exposure to the heat of the sun, as the leading causes.

For some hours at first he gives brandy or champagne with crushed ice every half hour. The whole of the stomach and bowels are covered with warm spice poultices. In the course of three or four hours after the stimulants have been ordered, one grain of calomel is given every hour, until five or six doses have been administered. With regard to foods, he attaches much value to Fairchild's peptogenic milk powder, which is the best substitute for mother's milk where there is great exhaustion. When the child is threatened with chilliness, the author speaks highly of the water bed partially filled with warm water at about 140 F. Woolen clothing should be worn during convalescence, to keep the surface warm.

PUERPERAL SEPSIS.—Dr. W. W. Potter, in *Buffalo Medical and Surgical Journal* for August, reviews this subject. With regard to prevention he lays down the following rules:

1. The physician should be thoroughly clean in his habits. He should take

baths frequently, and pay great attention to cleanliness in his clothing and hands.

2. The room should be well cleaned and aired before a confinement. If it is not thoroughly clean it should be whitewashed and well scrubbed. The attendant woman ought to be instructed on the necessity of care against every form of dirt.

3. When labor sets in the hips, lower part of the abdomen, and genitalia of the patient should be washed with warm water containing some antiseptic.

4. Great care should be given to the bed. The clothes ought to all be freshly washed. In no case ought the same bed or bedding be used that had been used by some sick person some time previously.

5. All perineal lacerations must be made thoroughly clean, and then carefully closed. There is no doubt of the fact that unrepaired rents in the perineum are a fertile source of puerperal sepsis.

6. In all cases where the hands or instruments have been introduced to assist the delivery of the child, the utero-vaginal canal should be douched thoroughly with warm water and some mild antiseptic.

REST IN THE TREATMENT OF CONSUMPTION.—Dr. Thomas J. Mays, in the *Dietetic and Hygienic Gazette* for August, claims that consumptive patients do much better when carefully fed and rested than when they are exercised. He contends that in the disease there is a steady wasting going on in the system, and that exercise only uses up some of the physiological capital that he is gaining from his food and air.

Careful attention should be given to keep the digestive functions in the best condition possible, while the utmost effort should be made to arrest expenditure of energy by the waste that takes place in the muscles under action. Many very eminent authorities, such as Keating, Bar-

tholow, Volland, Dettweiler, speak in the highest terms of the value of the rest treatment of consumption, especially in its incipient form. The idea of exercising a consumptive for strength is a fallacy.

Items, Etc.

DR. J. E. GRAHAM, M.R.C.P., LONDON.
—We learn that Dr. Graham of this city, has during his summer spent in England and on the continent had sufficient time to spare from his weeks of travel and pleasure, to present himself for examination before the Royal College of Physicians, and that he has been admitted to membership. We congratulate the doctor on this additional distinction to a career which has already been crowned with honour in college and clinical work. We understand that he sails for Canada at an early day in September.

SPELLING REFORM.—Dr. G. M. Gould, the able editor of the *Philadelphia Medical News*, read in Milwaukee, at the American Medical Association, an able paper in favour of spelling reform in medical words. We commend the paper for careful study, as published in the *News* and *Buffalo Medical and Surgical Journal*. Among some of the changes advocated are:

1. Dropping the "al" in such words as chemical, biological, parasitical, etc.

2. Dropping the old Greek diphthong œ or æ in æther, anæsthetic, orthopædic, and hæmorrhage, and making the letter "e" take their place.

3. Dropping the final "e" in all such words as iodine, bromine, iodide, bromide, etc.

4. Dropping out œ in diarrhœa, œdema, foetus, and employing the "e" instead, as edema, fetus, etc.

"Let us be sensible rather than conservative," says Dr. Gould. We wish Dr. Gould all success in his good work.

POSTPONEMENT OF THE ELEVENTH INTERNATIONAL MEDICAL CONGRESS.—Owing to cholera in Europe the International Congress which was to have opened in Rome, September 24th, has been postponed to April, 1894.

OUR EXCHANGES.—We with pleasure acknowledge the following exchanges received, in addition to those mentioned in our last issue:—*Medical and Surgical Reporter, International Medical Magazine, Medical Brief, The Pacific Record of Medicine and Surgery, California Medical Journal, North American Practitioner, Journal of the Medical Sciences, Buffalo Medical and Surgical Journal, Chicago Medical Times, Journal d'Hygiene Populaire, The Sanitarian, New England Medical Monthly, The Medical Press, The Medical World.*

Personals.

Dr. R. H. Barkwell (Toronto University, 1882), of London, Eng., is spending his vacation in this city.

Dr. W. J. Cross (Toronto University, 1880), of Horsham Australia, is at present on a visit to his friends in Ontario.

Prof. Osler, of Johns Hopkins University, has been spending a brief holiday among his friends in Toronto.

Dr. H. R. Elliott, of Brucefield, has retired from his extensive practice in that district in favor of Dr. Armstrong, and has opened an office on Indiana Ave., Chicago.

Dr. Abbott who is in charge of the Hygienic Laboratory of the University of Pennsylvania, is spending a portion of his vacation with his father-in-law, Mr. Justice Osler, of this city.

The following gentlemen were elected to office at the meeting of the Nova Scotia

Medical Society:—President, Dr. C. J. Fox, Pubnico, N. S.; 1st Vice-President, Dr. R. A. H. McKeen, Cow Bay, C. B.; 2nd Vice-President, Dr. H. A. March, Bridgewater, N. S.; Secretary-Treasurer, Dr. W. S. Muir, Truro, N. S.

Dr. G. Sterling Ryerson, M.P.P., Surgeon of the Royal Grenadiers, has been appointed by H. R. H. the Prince of Wales, with the sanction of H. M. the Queen, an Honorary Associate of the Order of St. John of Jerusalem. Dr. Ryerson is the first Canadian on the list, and is to be congratulated upon this well-earned distinction. Among the prominent men who have been thus honored we notice the names of Baron V. Esmarch, Sir Henry Acland, Sir James Paget, and Surgeon Parke (of Stanley fame).

The officers elected for the ensuing year at the meeting of the Maritime Medical Association, held at Charlottetown, P. E. I., July 12th and 13th, were:—Dr. Thomas Walker, St. John, President; Dr. Coburn, Fredericton, Vice-President for New Brunswick; Dr. D. A. Campbell, Halifax, Vice-President for Nova Scotia; Dr. F. D. Beer, Charlottetown, Vice-President for P. E. Island; Dr. G. M. Campbell, Halifax, Secretary; Dr. G. E. Dewitt, Wolfville, Treasurer (re-elected); Executive Committee, Drs. Emery, P. R. Inches, Murray McLaren, Wm. Christie, and Dr. Walker.

Correspondence.

DID THE CHILD LIVE?

EDITOR DOMINION MONTHLY:

SIR,—Medical men are often involved in a question of medical jurisprudence, as to whether a child is born still or living. Now, what argument or evidence could a medical witness adduce in contravention of the following proofs of vitality, however he might wish to shield' (as a modern

writer puts it) "some simple-minded girl who, passively yielding to persistent and oftentimes merciless and unfair temptation, fulfils, under pathetic circumstances, the beautiful and wonderful law of her being—the imperious law of nature, which at times she may be almost powerless to resist, unless protected from temptation."

We may infer that a child has lived before and after its birth:—1st, when the diaphragm reaches only to the fifth intercostal space; 2nd, when the lungs, more or less, fill the thorax; 3rd, when the ground color of the lungs is broken by insular marblings; 4th, when the lungs are found to be able to float in water; 5th, when a bloody froth exudes from the cut surface of the lungs on pressure; 6th, when the air cells are visible to the naked eye; 7th, the existence of milk, sugar, starch, or medicine in the stomach, determined by appropriate chemical tests, and by the presence of fœcal matter, other than meconium in the lower intestines, shows that the child has lived.

ask, what proof against all these combined can a witness advance that the child was not viable? He may challenge the hydrostatic test, that the lungs floated, through the agency of gas, from putrefaction only.

Yours, etc.,

H. B. EVANS.

Picton.

Book Notices.

The Popular Science Monthly. New York: D. APPLETON & Co., 1, 3, 5, Bond street.

Among the interesting articles in the July number of this excellent periodical are the following: "Private Relief of the Poor," by Herbert Spencer; "Moral Life of the Japanese," by Dr. W. D. Eastlake; "Structural Plan of the Human Brain," by Prof. C. S. Minot; "Recent Science,"

by Prince Kropotkin; "The Spanish Inquisition as an Alienist," by Henry C. Lea.

BOOKS AND PAMPHLETS RECEIVED.

Annual Announcement of Trinity Medical College, Toronto.

Calendar of the Faculty of Medicine, McGill University, sixty-first session.

Annual Announcement of the Detroit College of Medicine for session of 1893-94.

Annual Announcement and Catalogue College of Physicians and Surgeons, Baltimore, Md.

Clinical Notes on Chancre of the Tonsil. By L. DUNCAN BULKLEY, A.M., M.D. (reprint).

Harper Hospital Bulletin, a bi-monthly devoted to hospital work; edited by Dr. Geo. Duffield, 32 Adams Avenue, Detroit.

Report relating to the registration of births, marriages and deaths in the Province of Ontario for the year ending 31st Dec., 1891.

SUCCESSFUL OVARIOTOMY IN A CHILD, AGED TEN.—Vincent (*Lyon Méd.*) operated on April 14th on a girl, aged 10. She had recently been tapped in the country, and fever and vomiting followed. The wound in the parietes suppurated, and the temperature was 103.6° F. on the morning of operation. The ovarian tumour was very multilocular, and a long abdominal incision was found necessary. There were strong adhesions to the omentum and transverse colon, and much peritoneal effusion containing flocculent material. An iodoform gauze tampon was applied to the pelvis. On the evening of operation the temperature fell to 101.5°, and next day to 95.5°. At the end of a fortnight the tampon and sutures were removed, and the patient was in perfect health, able to walk three weeks after the operation.—*British Medical Journal.*