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ABDOMINAL NEPHRECTOMY FOR  
HYDRONEPHROSIS, WITH A  
REPORT OF TWO OPERA-  
TIONS.\*

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There can be no doubt that the past years have been progressive ones in abdominal surgery; nevertheless most practitioners who have attempted any operating in this region will have felt on many occasions, not only lack of precision in diagnosis, but grave difficulties arising during the operative procedures that become necessary in most of these cases. In studying the operative surgery of the kidney, it is interesting to observe that while fifteen or twenty years ago a large proportion of the operations were performed after an error in diagnosis, during the last few years a correct diagnosis before operation has been the rule, although many exceptions are to be noted. The difficulty, it would appear, is increased in cases of great enlargement of the organ where the patient, when seen for the first time, presents a tumor filling the whole abdomen. In the two cases of advanced hydronephrosis that I am now about to report, the making of a correct diagnosis appears to me to be singularly difficult. This is owing chiefly to the size of the

tumor and the great similarity in each to ovarian cyst. In both cases I have to admit an error in diagnosis, and in both I commenced operation on this wrong opinion. Whether a second error was committed in treatment I leave to the judgment of the Association, as there is diversity of opinion in the profession as to the operation to be performed in hydronephrosis.

*Case I.* Mrs. P., æt. 31, married six years and the mother of two children. Residence, Thamesford, in county of Middlesex, but a native of England. Parents living and healthy; no family history of ill-health or hereditary disease. Patient below the average in height and weight, and of pale complexion. She gives a history of fair health in childhood, but during the past fifteen years has suffered from pain in the right side beneath the liver, and before coming to Canada she attended the out-patient department of St. Bartholomew's Hospital, but got no relief from treatment. About the first week of May, 1889, she discovered an enlargement in the abdomen, which steadily increased in size.

On the 18th June, five weeks after this, she was admitted into St. Joseph's Hospital, and presented a letter from her family physician, Dr. McWilliams, who examined her and made the diagnosis of ovarian cyst. There was dullness in the median line, fluctuation resonance in the flanks. The measurement, greatest below the umbilicus; distance from umbilicus to iliac spines equal on the two sides. The tumor occupied all the abdomen from the pubes to the

\*Read at the meeting of the Ontario Medical Association, June, 1891.

sternum, but the patient said she thought it was more to the right side at first; no tumor could be felt in the pelvis. Examination of the heart, lungs, and liver, negative; catamenia, regular. Uterus normal in size, and movable. Specific gravity of urine, 1028; no albumen or sugar.

The patient was carefully examined by Drs. Moore, Macarthur, and Waugh, and the diagnosis of Dr. McWilliams confirmed. I wrote him saying the disease appeared to be ovarian, but the tumor seemed to me to be a little higher up than other cases I had operated upon.

On June 20th chloroform was given and an incision made in the median line and an enormous cyst of the right kidney discovered, which, fortunately, had no adhesions to surrounding parts.

The incision was enlarged upwards, the intestine drawn towards the left side, the peritoneum divided over the tumor, and enucleation commenced. The ureter was tied and cut off. There was much difficulty experienced in securing the vessels and separating the upper end of the tumor from surrounding parts. At this point in the operation the cyst burst, and considerable fluid escaped into the abdomen. This had a peculiar urinous odor, but was quite clear. The abdomen was sponged out with warm water, the edges of the peritoneum adjusted over the raw surface, and the wound stitched up in the usual manner with silk. No drainage tube was used, and the sublimate gauze dressing was secured with plaster and a binder of flannel. All went well for the first week; the sutures were removed on the eighth day and the wound found united. The highest temperature recorded up to this time was  $101\frac{1}{2}^{\circ}$  F.

On the tenth day the temperature reached 103, later on  $104\frac{1}{2}$ , with occasional chills and delirium at night, hay odor of the breath, and for almost three weeks her life was in considerable danger. On the 21st day, fearing that an abscess had formed, I passed the aspirator needle beneath the twelfth rib into the abdomen, but nothing came through. After this recovery was slow, but continuous, and the patient was able to leave the hospital on the 1st September and attend to her duties.

*Case 2.* Mrs. T., æt. 43; a widow, and mother of seven children. Residence, Goderich. Admitted to St. Joseph's Hospital, July

11th, 1889, and gave the following history: She always had good health and led an active life; never was confined to her bed except during her confinements. Six months ago the abdomen commenced to enlarge, and this had continued to the time of admission. There never had been any pain, but the tumor now began to cause discomfort from its size.

Two physicians in Goderich had made an examination, she informed us, and both had recommended operation. The abdomen showed a large fluctuating tumor extending from the pubes to the ribs, dull in the median line, resonant in the loins; measurement greatest below umbilicus. No tumor could be felt in the pelvis. Examination of the heart, lungs, and liver, negative; uterus movable and normal in size; catamenia, regular.

The tumor was much larger than in the case just related. The patient was well nourished and rather stout in figure. Drs. Woodruff, Waugh, and Macarthur were called in consultation, and, as the last case of mistaken diagnosis was still in the hospital, a very careful examination was made in order particularly to exclude hydronephrosis. The diagnosis of ovarian cyst was made and an operation recommended. Specific gravity of urine, 1030. No albumen or sugar.

On 13th July chloroform was given and the usual incision made in the median line. The opening revealed an enormous cyst of the left kidney, filling the whole abdomen. The peritoneum over this was incised and the tumor enucleated, the ureter cut off and tied, and the renal vessels secured with silk ligature. The operation, as in the last case, was difficult, and the wall of the cyst gave way notwithstanding all my care. The clear fluid escaped, much of it getting into the abdominal cavity. Warm water was poured into the abdomen and the peritoneum adjusted over the bed of the tumor. There were no adhesions, but the bleeding was considerable and difficult to control. The patient had no bad symptoms; the silkworm gut sutures were removed on the eighth day and the wound found healed. On the tenth day the temperature ran up to 103, the pulse quickened, the tongue became coated, and the abdomen swelled. These symptoms continued, the temperature varying somewhat, but always being

above normal. This was followed by a discharge from the vagina, described by the sister in charge as composed of blood and pus, and very offensive. Injections of carbolized water were ordered twice a day, and nothing more was heard of this symptom.

After this, improvement took place slowly, and the patient had completely recovered by September 10th, when she left the city for her home.

In the early stage, before an abdominal tumor is noticeable, hydronephrosis has to be diagnosed from renal abscess, perinephritic abscess, and extravasation of blood. When of small size it may be mistaken for hydatid or serous cyst of the liver or spleen. Between hydronephrotic and pyonephrotic tumors the diagnosis is sometimes impossible. In some cases of the latter disease, however, pus appears in the urine. The treatment being similar in the last two, an error in diagnosis would not endanger the life of the patient, and no doubt, in many cases, suppuration is set up from accident, so that pyonephrosis is simply an advanced stage of hydronephrosis. The greatest difficulty is experienced in excluding ovarian cyst, and my object in this paper is to show that this is almost impossible. I mean in advanced cases where the cyst fills the abdominal cavity, as in the two last operations reported. In the first we have a history of pain in the side and an enlargement commencing, the patient tells us, in the lower part of the abdomen, a little to the right side. This enlarges in the short space of four or five weeks until it fills the abdomen. The measurement is greater below umbilicus, and the distance from this point to the iliac spines is equal on the two sides. There is fluctuation, dullness on percussion in the median line, and resonance in the flanks. Examination by the sound shows a healthy and movable uterus. In the first case, the smaller of the two, the tumor appeared to me to be just a little higher than the average ovarian cyst, but this was accounted for by an elongated pedicle. The absence of the cyst by a vaginal examination is explained in the same manner. The rapidity of growth, the size, and absence of urinary symptoms, together with the healthy condition of the urine, point to ovarian tumor, and negatives, we might also say, hydronephrosis. I can-

not think that the mistake in diagnosis is due to carelessness. The first case had been examined by Dr. McWilliams, who sent her to me; then by three other physicians of experience and reputation, who all came to the same conclusion. The plea of carelessness certainly cannot be argued in the second case. This one came into the hospital while the first was in bed and not yet recovered from the operation. She was examined by two of the consultants called in the previous case. I mentioned to them to be sure and exclude hydronephrosis this time, and the examination was made with the probability of cyst of the kidney constantly in view and the diagnosis of ovarian tumor made. In this case the history of an enlargement of six months' duration, giving rise at first to no symptoms, and later on only those of pressure, measurements alike from umbilicus to iliac spines, girth greatest below umbilicus, fluctuation distinct, dullness in the median line, and resonance in the flanks; uterus movable, normal in size, and healthy; tumor filling the whole abdomen from the pubes to the ribs, and reaching to the same position on the two sides. I find from reading that there are at least fifteen cases on record in which hydronephrosis or simple renal cyst have been mistaken for ovarian tumors and laparotomy performed on the erroneous diagnosis. Out of the twelve cases in women collected by Morris, no less than seven of these were diagnosed as ovarian, and three of the seven were submitted to abdominal section on the strength of this wrong opinion. From a study of the literature of this subject and my experience of these two cases, I arrive at the conclusion that a diagnosis between advanced hydronephrosis and ovarian cyst is, to the average practitioner, an impossibility. If I am correct in taking this view, it has an important bearing on the subject of treatment, for the question the surgeon has to answer is not what is the best treatment for hydronephrosis, but, the abdomen having been opened on the supposition that an ovarian tumor exists, and a cyst of the kidney discovered, what are we to do? Shall we close the abdomen and call it an exploratory incision, or cannot we stitch up the wound after opening the cyst and drain from the loin? Can we perform nephrectomy by enucleating the tumor? I must confess that I am not partial to explora-

tory incisions for diagnostic purposes in private cases. My patients call them operations. The friends imagine a mistake has been made, and say they do not want to be cut open to satisfy the curiosity of the doctor. I am of opinion, therefore, that something should be done to get rid of the disease. If the distension increases, death will result from the effects of pressure on neighboring organs, from rupture into the peritoneum, or suppression of urine or uræmia. I might here revert to the views of different operators in the treatment of hydronephrosis in general.

"Puncture," writes Knowsley Thornton, "may also be tried as a means of treatment, though I believe there is no good evidence that cures are often affected by it. It should be performed by the aspirator, the needle being introduced far back in the loin to avoid risk of puncturing the colon, peritoneum, or allowing extravasation of urine into the cavity of the latter. If relief follows, it may be repeated from time to time; but if the fluid reaccumulates, some more radical operation must be undertaken. I have completely failed in two cases with incision and drainage, and I believe that nephrectomy is the proper treatment in all cases which do not improve after one or two tappings." Mr. Morris writes thus of drainage: "This practice has been very successful, and ought certainly to be adopted when aspiration fails and before nephrectomy is dreamt of. In a few cases a complete cure will be affected and the wound will quite close. In the majority, however, a fistula must be expected, but this gives very little inconvenience to a person of ordinary intelligence and patience." Barker writes that "free drainage for hydronephrosis is not much more successful than aspiration, and not devoid of risk. Of course a large sac will be in a better position to contract if freely and continuously drained than if occasionally emptied, but time is consumed in the process of drainage, the necessity often lasting for months for constantly changing the wet dressings; again, there is always the risk of suppuration in the sac, with subsequent septic infection." Mr. Barker therefore favors early nephrectomy. Jacobson recommends that "in healthy patients nephrectomy should be had recourse to after two months' trial of drainage, providing the other kidney be healthy."

Spencer Wells, in his work on abdominal tumors, records the case of a woman, æt. 43, who was operated upon at the Samaritan Hospital for supposed ovarian tumor, and an enormous renal cyst found. This was tapped, but no attempt at removal was made. The wound was closed, and the patient died thirty hours after operation. The authors quoted are evidently discussing the treatment of hydronephrosis in the early stages, when a diagnosis is possible, and when we are able to say not only that a cyst of the kidney exists, but likewise the side of the body it is on. In the class of cases under consideration, we approach the subject from a very different standpoint. We are expecting to find an ovarian tumor, and an incision has been made in the median line at least four inches long; preparation has been made for an operation and the patient has gone under chloroform with the understanding, no doubt, that she will be rid of her disease.

Under these circumstances, two operations might suggest themselves to the operator: Nephrectomy, by somewhat enlarging the incision, and at the same time making an examination of the other kidney to insure its soundness, or drainage by incision in the loin. It might be well for the operator to consider the age and general condition of his patient in weighing the merits of the two operations and deciding which to perform. The immediate danger of nephrectomy is much greater than after ovariectomy, and is certainly much more to be dreaded than tapping from the loin and stitching up the abdominal wound. In one case, however, the disease is removed, the patient rid of the useless organ, and recovery is complete. In the other, a cyst is being drained which is larger than the patient's head; there is little prospect of a complete cure. At best there remains a fistulous opening, the patient requires to wear a urinal, there is always the danger of suppuration being set up and septic infection following, and the danger of lardaceous disease from the former is not to be lost sight of. In either case we must constantly bear in mind the fact that the patient has only one kidney, which renders any operation more dangerous to life.

On looking up the literature of hydronephrosis, I find that about one-third of the cases are

congenital. The affection is due to obstruction somewhere between the kidney and meatus urinarius. It is most commonly situated in the ureter. Among the causes mentioned are twists or contractions of the ureter, impacted calculus, stricture of the urethra, enlarged prostate, tumors of the ovary, bladder, or uterus. Of thirty-two cases recorded by Roberts, the cause was found to be impacted calculus in the ureter in eleven. From the records of *post mortems* in the Middlesex Hospital, it appears that in every eighteenth case there was sufficient hydronephrosis in one or both kidneys to be mentioned in the report.

Although the disease is quite common, the proportion of cases in which the enlargement of the organ is sufficient to form an abdominal tumor is very small. The fluid is usually clear and almost odorless, but there are many exceptions to this rule. The disease is twice as frequent in females as males, occurs at any period of life, and affects each kidney about equally, but may occur in both. The quantity of fluid is sometimes enormous. One case is reported where the woman measured 6 feet 4 inches around the abdomen and the cyst contained thirty gallons. The enlargement may lessen in size or intermit from escape of the fluid into the bladder.

Morris says: "Up to the present time there have been at least twenty-seven nephrectomies for hydronephrosis, of which sixteen were abdominal and ten lumbar. Of the sixteen abdominal cases seven recovered, and of the ten lumbar cases seven recovered. In one the character of the operation is not stated, four of the fatal cases were diagnosed ovarian, and three of the successful abdominal cases are also diagnosed ovarian or broad ligament cysts." It would appear, therefore, from reading this author, that up to the present time abdominal nephrectomy has been more fatal than lumbar. We must recollect, however, that most of the abdominal cases were ones of mistaken diagnosis: In fact, cases supposed to be ovarian, and therefore advanced cases, were removed at a time when any operation, abdominal or lumbar, would have been hazardous.

I am firmly of opinion, however, that in those cases where a large tumor fills the abdomen, the lumbar operation cannot be entertained, as it is

difficult or impossible to say which kidney is the diseased one, and the cyst is too large for this plan of operation.

In closing this very imperfect survey of the subject of hydronephrosis, I would beg leave to submit the following conclusions:

(1) That in a large proportion of cases of advanced hydronephrosis, where the tumor fills the abdomen, it is impossible for the average operator to say whether he has a cyst of the kidney or an ovarian tumor.

(2) That, supposing hydronephrosis is suspected, it is not possible to say which kidney is the diseased one.

(3) The last two propositions being admitted, it follows that, in all these advanced cases, incisions in the loin and drainage cannot be advocated, as the surgeon is unable to say which side to incise.

(4) In view of these difficulties in diagnosis, it would seem preferable to make an incision in the linea alba and complete the diagnosis with the hand. If the case be a cyst of the kidney, carry the incision upward and complete the operation by enucleating the tumor.

(5) This operation is suitable alike for cases of hydro- or pyonephrosis, the danger of course being greater in the first.

(6) That abdominal nephrectomy by the median incision is a difficult operation, owing to the high position of the tumor, the close relations of the aorta and vena cava, the large size of the renal vessels, and the fact that the tumor is behind both layers of peritoneum.

(7) If a correct diagnosis could be made, I am of opinion that abdominal nephrectomy by incision along the linea semi-lunaris is the best operation for the class of cases under consideration, but I do not think it possible to remove such large cysts by incision in the loin.

(8) In the case of a weak patient, or one advanced in years, supposing the abdomen to have been opened, it might be the safer procedure to open the cyst and drain from the loin. This operation is safer than nephrectomy, but it usually leaves a permanent fistula.

(9) In view of the symptoms observed in the two cases reported, I think it would be advisable in completing the operation of abdominal nephrectomy to secure drainage by making an opening in the loin.

## Selections.

THE POSSIBILITY OF HASTENING SUCCESSFULLY THE CRISIS IN PNEUMONIA.—Undoubtedly, with our present methods of handling disease, many of the ordinary illnesses which make up the large part of the routine work of every practising physician are treated in as thoroughly a scientific and successful manner as they ever will be. If advancement is to be made, it must be done through radically different channels. Bacteriology seems to be at present the great field through which general medicine is to receive its impetus for the future.

In this connection it is encouraging to note the increased report of inoculation experiments with the toxine and antitoxine of the various pathogenic germs found in different diseases. The use of the ptomaines of the hog-cholera bacillus received notice, editorially, a year ago. Since then there have been many other reports, notably on the establishment of immunity from tetanus and diphtheria from inoculations with the chemical products of their bacilli.

One of the latest contributions to this subject is concerned with the possibility of conferring immunity against pneumonia in man by the injection of the products of the pneumococcus. G. and F. Klemperer (*Berliner klinische Wochenschrift*, August 24th and 31st, 1891) have been guided in their experiments by the knowledge that, in most instances, pneumonia, after a course lasting from five to seven days, terminates abruptly by crisis. In the course of a few hours the patient becomes remarkably better; the temperature comes down and the pulse becomes slower and firmer. Yet there has been, during the occurrence of this phenomenon, practically no change in the condition of the lungs, which still remained filled with fibrinous exudation. Pneumococci are still found after the crisis in great numbers in the sputa, and still retain all their virulence.

It seems, therefore, to these observers that the crisis in pneumonia does not depend on any change in the condition of the lungs or in the micro-organisms which are found in the disease, but that the improvement is due to the fact that the products of the pneumococcus modify their virulence in some manner after a certain period.

These German pathologists claim that the

pneumococcus, when introduced into the body of an animal, gives rise to a *pneumotoxine* which can be isolated. This pneumotoxine is able to produce a febrile reaction lasting several days, after which another substance, *antipneumotoxine*, is produced, which has the property of neutralizing pneumotoxine.

The manner in which immunity is conferred is explained by these observers in this way: Antipneumotoxine, which is found after the crisis in patients suffering from pneumonic infection, has the power of neutralizing the active poison of the disease, and allows nature to reassert herself.

These observers have tried the injection of antipneumotoxine in a few patients suffering from pneumonia. The antipneumotoxine which they use for this purpose they obtain from the blood-serum of animals in the stage of pneumonic crisis. They found that in all these patients a hypodermic injection of four to six cubic centimetres of serum was followed, in from six to twelve hours, by a considerable fall in the temperature, with slowing of the pulse and respiration.

Of course, further investigation of these conclusions, especially in the hands of other observers, is necessary before deciding on their practical value.—*Univ. Med. Mag.*

CHROMIC ACID IN THE TREATMENT OF CYSTS.—Within the last few months I have treated with chromic acid three cases of ranula and seven of cystic goitre with such satisfactory results that I venture to make them known. The three cases of ranula occurred in two males and one female; the former had received previous treatment without any benefit; the latter had not sought advice before. All three had large cysts, and the mode of treatment followed was the same in each. A portion of the cyst was cut away, and the contents washed out. A saturated solution of chromic acid was then freely applied with a chromic acid carrier to several points of the cyst wall. At the end of the week, the cavity having much diminished, the acid was again applied, and in from a fortnight to three weeks the wound had healed and all signs of the tumor had disappeared. There were no bad symptoms. The seven cases of cystic goitre were in females. The tumors

were tapped in the usual manner and the contents washed out. After all hemorrhage had ceased, the saturated chromic acid solution was applied with a carrier through the canula to the walls of the cyst, in the same manner as with the ranulas. Six of the seven cases healed rapidly after from two to three applications, but the seventh and second of the series resisted for a long time all attempts, and it was not until three months had passed and some half-a-dozen applications had been made that the tumor disappeared. But neither in this nor in any of the other cases was there a bad symptom, and I attribute the length of time the last-mentioned case took to heal to the fact that there was a considerable amount of hemorrhagic oozing, which to a certain extent neutralized the action of the acid. It is therefore advisable to see that hemorrhage is, as much as possible, arrested before applying the acid. I cannot too strongly recommend this mode of treatment (first suggested by Dr. Woakes in the *Lancet* about two years ago), and though the evidence I have been able to offer is not very great—ten cases in all—still the persistent favorable results obtained are, I think, strongly in favor of a good trial being given to it, not only in the same class of cases as those I have quoted, but in every case of cyst that is inadvisable or impossible to remove. In cystic goitres it seems entirely to do away with the most dangerous part of the ordinary treatment—viz., the conversion of the cyst into a large abscess.—*W. R. H. Stewart, F.R.C.S. Edin., etc., in Lancet.*

PYÆMIA FOLLOWING SUPPURATION OF THE MIDDLE EAR ARRESTED BY LIGATURE OF THE INTERNAL JUGULAR VEIN AND CLEANING OUT THE LATERAL SINUS.—J. F., æt. 25, was kicked in the left ear when 14, foul discharge having only occasionally issued during eleven years. Pain arose in the affected ear on the 10th of August, 1891, followed four days later by daily rigors and vomiting. On the ninth day he was admitted into the Liverpool Royal Infirmary, where, in spite of antiseptic syringing, he became worse. During two days he had at least four rigors, the temperature varying between  $102^{\circ}$  and nearly  $105^{\circ}$ , a fetid discharge issuing from the ear, and swelling and tenderness being perceived over the upper half of the site of the

left jugular vein. The patient was drowsy, irritable, and at times delirious, and it was thought that septic thrombosis of the lateral sinus and jugular vein existed. On the 21st of August, 1891, eleven days after the onset of illness, the internal jugular vein was exposed for more than the upper half of its length, found firmly plugged in this extent, tied below where healthy, and cut between two ligatures; raised out of its bed and removed up to the skull along with a portion of the facial vein, similarly plugged in continuity. The lateral sinus was exposed by chiselling through the skull in the mastoid region, and found occupied with fetid purulent material. This was scraped out and partially cleansed, the stump of vein being opened and also scraped clean. The lower part of the wound healed by first intention, the upper being plugged and dressed daily with cyanide gauze. The symptoms disappeared and continued absent for two days, when the temperature having risen again, the lateral sinus was further cleansed under chloroform, after which steady improvement went on and the patient was up and about after 16 days. He has continued well ever since, and attended a meeting of the Liverpool Medical Institution for inspection by the members on the 22nd of October, 1890. The procedure adopted was that initiated by Mr. Arbuthnot Lane in 1888, and successfully practised by him and by Mr. Ballance on several subsequent occasions.—*Med. Press and Circular.*

RANKE AND STEFFEN: INTUBATION OF LARYNX (*Rev. Mens. des Mal. de l'Enf.*, June, 1891).—Published statistics of all operations of this character which have been done in Germany show the number of cases to be 413, and of this number 364 were for primary diphtheria with laryngeal stenosis. The number of cures was one hundred and thirty-two, or thirty-six and two-tenths per cent. There were also forty-nine operations for secondary diphtheria, with nine cures—that is, eighteen and three-tenths per cent. In the first 843 operations of tracheotomy, which were performed for primary diphtheria, there were 336 cures, or thirty-nine and eight-tenths per cent. In the first twenty-three cases of tracheotomy for secondary diphtheria, there were four cures, or seventeen and three-



tenths per cent. Gay reports 327 tracheotomies from 1880 to 1886, with twenty-nine per cent. of recoveries, and 107 intubations (period not mentioned), with twenty-four per cent. of recoveries. Ranke has thirty-seven and five-tenths per cent. of recoveries from 327 tracheotomies for primary diphtheria, and thirty-two and seven-tenths per cent. of recoveries from 113 intubations. *Schluck-pneumonia* and pulmonary gangrene rarely follow intubation, while lobular or croupous pneumonia is more frequent, the proportion being about the same as after tracheotomy. Necrosis of the larynx and trachea occurs with considerable frequency. The tube should always be removed at the end of ten days, and tracheotomy should be performed if laryngeal stenosis persists. In thirteen autopsies after intubation, Wiederhofer found six cases of necrosis of the larynx, and in two other cases in which intubation was performed a cicatricial process resulted which required the performance of tracheotomy. It is preferable that the tube be kept in position four or five days, as its repeated introduction irritates the larynx. In a general way intubation is more advantageous than tracheotomy, the duration of treatment being shortened, the operation being neither severe nor bloody, and the danger of cicatricial stenosis being less than after tracheotomy. Pauli has recently reported eleven cases of intubation for croup, all of which ended fatally. One great objection to intubation is the difficulty of alimentation which attends it.—*Archives of Pediatrics*.

**DIPHThERIAL INFECTION OF TRACHEOTOMY WOUNDS.**—Dr. Spronk, of Utrecht, has discovered in the case of three children who had been tracheotomised for diphtheria a condition which has not hitherto been described, but which he thinks is far from rare. This consists in an inflammatory œdema of the subcutaneous and fatty tissue around the tracheotomy incision, caused by the invasion of diphtheria bacilli. He points out that in ordinary diphtheria the bacilli are confined to the epithelial surface and the false membrane, and never penetrate into even the uppermost layers of connective tissue so long as the mucous membrane is free from necrosis. Nor are the bacilli ever found in the internal organs and blood of infected individu-

als. Nevertheless it has been shown experimentally that these microbes can multiply in the subcutaneous tissues, especially of some animals, guinea-pigs for example. The cases he examined had died a few days after tracheotomy, and although the wound itself was free from membrane, and looked healthy, yet there was a more or less widespread diffuse œdema, without any change in the superjacent skin. This œdema was obviously inflammatory, but there was no necrosis. In two cases it occurred not only in the vicinity of the wound, round the trachea and in the intermuscular tissue, but extended for some distance over the chest and upwards to the supra-clavicular regions. He found by tube-cultures that the serum taken from different parts of the œdematous area contained abundant bacilli, which were almost as numerous at a distance from the wound as near to it. The possibility that they may have multiplied after death was slight, seeing that these organisms require a temperature of at least 20°C. to grow. Other bacterial colonies were produced from the serum, but in one case this yielded almost a pure culture of Klebs' bacilli, and the capability of these organisms to cause this type of inflammation was proved experimentally. Dr. Spronk lays especial stress on the fact that, although of course the infection takes place through the tracheotomy wound, yet its margins appeared natural. This he ascribes to the use of iodoform and the short time that elapsed between the operation and death. The importance of the discovery lies in the additional risk of the rapid absorption of the toxine produced by the bacilli when these are lodged in connective tissue.

**MEDIASTINO-PERICARDITIS IN CHILDREN.**—Dr. Henry Ashby puts on record (*Medical Chronicle*, Dec., 1891) two cases of mediastino-pericarditis in children, aged two years and seven years respectively. The cases illustrate strikingly the grave interference with the functions of circulation and respiration which this condition entails. Dr. Ashby points out that inflammation of the lax cellular tissue of the mediastinum may arise from inflammatory processes in the bronchial glands, lungs, or pleura, and that the pericardium is almost always implicated, either primarily or secondarily. The

consequent matting together of the important structures in these regions must necessarily seriously impair the free action of the heart, obstruct the venous flow, and diminish the arterial pulse. Hence, among the effects of mediastino-pericarditis, œdema, ascites, and chronic hepatic congestion are prominent. Clinically, the initiatory symptoms, he says, are often overlooked: there may be a history of measles or bronchitis, cough, and pain in the chest, and perhaps pericardial friction can be detected: but, as a rule, the child is first seen for ascites, for the existence of which it is difficult to account, and associated with which the liver may be found to be enlarged. In the more chronic cases cirrhosis may be suspected; but eventually general dropsy supervenes, and examination of the chest will show an increased area of dullness in the sternal region and front of the chest, provided that the anterior margins of the lungs are involved in the adhesions. The effect of deep inspiration in weakening or even obliterating the pulse, upon which stress is laid by some writers, is not always present. It was not observed in the two cases that Dr. Ashby reports. The condition is, therefore, one which may easily be overlooked: but it may be well to bear its characters in mind in the presence of cases of ascites with hepatic enlargement in young children.—*Lancet*.

ARTIFICIAL TEETH FROM A HYGIENIC POINT OF VIEW.—It is a common experience amongst dentists that a very large majority of artificial dentures worn are discolored and by no means devoid of unpleasant odor. This lack of cleanliness, which arises sometimes from neglect, but often from want of instruction on the part of the dentist as to the necessary *modus operandi*, is a fruitful cause of inflammatory conditions. Débris of food mixed with saliva and mucus accumulating on a plate rapidly undergo decomposition, with the result of irritating the mucous membrane and producing a general inflammation of the oral cavity. The oral secretions become altered and vitiated, so as to cause dyspepsia, and caries of the remaining natural teeth is set up, which proceeds with great rapidity, especially in "clasp" dentures, not from the friction, but because the inside of the clasps most generally escape the brush. The materials

used in the construction of artificial dentures differ widely in their effect upon the tissues with which they come in contact. A larger number of cases of inflammation of the oral tissues occur where vulcanite is used as a basis than with gold or other metals, and so prevalent is this inflammation in the case of vulcanite that it has received the distinctive appellation of "rubber sore-mouth." Several reasons have been assigned for the effects produced by vulcanite. Nearly all this material is colored with mercuric sulphide (vermilion), which ingredient has been accused of being the cause of trouble; but an exhaustive investigation did not substantiate this view, one particular point being that "rubber sore-mouth" often occurred where black rubber was used, which contains no vermilion. The porosity of vulcanite, especially when not sufficiently vulcanized, renders it liable to retain deleterious material if not kept scrupulously clean.—*Lancet*.

CONVULSIONS TREATED BY COMPRESSION OF THE CAROTID.—Dr. Leopold Roheim, of Budapest, publishes in the *Gygyaszat* a case of eclampsia which he had, after the failure of all ordinary remedies, successfully treated by compression of the carotid. The case, which is quoted by the *Pester Medicinisch-Chirurgische Presse*, was that of a robust man of fifty-six, who had been suffering for years from cancer of the bladder, with occasional hæmaturia. The man had been attacked by a most violent eclamptic paroxysm, which was mainly confined to the left side. Dr. Roheim prescribed in vain musk, valerianate of zinc, bromide of potassium, assafœtida, hypodermic injections of morphia, enemata of hydrate of chloral, and frictions with mustard, and at last employed compression of the carotid. After constant compression for some time of the right carotid the convulsions were suddenly arrested, the patient recovered normal respiration, and very soon felt quite well. Two or three slighter attacks followed, which were soon arrested by properly instructed attendants. The effect of the compression was so remarkable that Dr. Roheim earnestly recommends this treatment. He compressed the carotid with the index and second finger between the larynx and sterno cleido-mastoid muscle backwards towards the spine, just as Trousseau and Blaud

had recommended. He was equally successful in the case of a girl nine years old. He considers the *rationale* of the treatment to be that by compressing the carotid and at the same time necessarily the sympathetic nerve fibres, which closely follow the course of the artery, the excitability of the brain is allayed.

**RAT-TAIL SUTURES.**—About five years ago, while resident physician in the Presbyterian Eye and Ear Hospital, of Baltimore, I saw Dr. Chisholm use fibers from the tail of an opossum for sutures in some of his eyework. I thought such fibres a good substitute for silk, and spoke to my brother, Dr. A. M. Belt, about it. Shortly afterward a rat was caught at his residence; he had the tail skinned and soaked for several days in water, after which, upon slight manipulation, it separated into perhaps a hundred fibres, each about eight inches in length. These were placed in alcohol and presented to me, upon request, for use in eye surgery. I found the fibres strong and much finer than those of the opossum tail, or any other animal suture, and have been using them quite extensively in suturing the conjunctiva in pterygium operations, and in advancing the recti muscles in correcting strabismus. These sutures have been most satisfactory. As soon as moist they become agreeably soft to the eye, and have never to be removed, while silk sutures are rough and irritating as long as they remain in the eye, and their removal is somewhat painful. Patients from a distance are often detained five or six days to have the silk stitches removed, when rat-tail sutures might be used and the patient allowed to depart immediately. These sutures will no doubt be found useful to the general surgeon and gynecologist when they need strong and fine animal sutures. About once a month, for two or three days, I soak the fibres in a corrosive sublimate solution (1 : 5000): and as I have never had any trouble whatever from their use, I think it probable that this suffices to render them aseptic.—*E. Oliver Belt, M.D., in Medical News.*

**ANTISEPSIS: PUERPERAL MORTALITY IN PARIS HOSPITALS.**—Our own correspondent in Paris last week gave interesting particulars confirmatory of the immense benefits conferred on

parturient women by the application of antiseptics to obstetrics. We commend the account to the careful attention of our readers. He says, out of 1340 women delivered in Prof. Tarnier's wards during the past academical year, only fourteen died, thus giving the very satisfactory mortality of 1 in 95, or 1.04 per cent. Eight years ago the mortality calculated on the same number of cases reached 2.50 per cent.; while, thirty years ago, one parturient out of eleven, or 9 per cent., died. These figures prove conclusively that modern methods of conducting labor are responsible for the saving, in his wards alone, of 100 valuable lives per annum. This is a very gratifying report of progress and advance, and perhaps our correspondent is right in thinking that the virtue of antiseptics can go no further. Puerperal fever is now unknown in the wards of M. Tarnier, whose memory goes back to a time when he witnessed five deaths in one day from puerperal peritonitis; but there is still room, perhaps, for better results if we may judge from the experience of some of our London lying-in hospitals. In one of these, during the years 1888 and 1889, there was but one death in 1272 successive deliveries.—*Lancet.*

**THE BICYCLE AND OLD AGE.**—The *Lancet*, in describing a military bicycling trip in which the party made one hundred miles in about ten hours, says in conclusion: The most interesting part of the narrative has still to be told. The veteran cyclist, Major Knox Holmes, at the near close of his eighty-third year, mounted on a tandem with Mr. Males, a young rider under eighteen years of age, accompanied the corps, and arrived at the termination of the expedition five minutes in advance of the rest. He was a little distressed on dismounting, from too hard riding the last few miles, but he soon threw off his fatigue and joined his companions at dinner with thorough zest. His condition is physiologically peculiar. In twelve weeks' new training he has, in the most striking manner, "developed muscle" in the external and the internal vasti, the rectus, and the muscles which form the calf of the leg. It has become so entirely a part of physiological doctrine that after threescore years and ten there is no new development of muscle that if we had not seen

with our own eyes, as we have, this actual development in one whose age exceeds by thirteen years the traditional span of human life, we should have doubted the possibility of its occurrence.—*Med. Record.*

THE  
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

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TORONTO, JANUARY 16, 1892.

BACTERIOLOGY.

The treatment of tuberculous disease in the manner recommended by Koch has fallen into disfavor, but the grand work done by him, and his attempt to adapt the facts known of the physiology and chemistry of bacteria and their products to the uses of practical medicine, has initiated a vast amount of work along definite lines, which will undoubtedly be productive of valuable results. We have, even now, only a very limited amount of knowledge concerning one of the most important factors in the production of disease; the science of bacteriology is only in its infancy, and the developments which will yet be forthcoming may, and probably will, completely revolutionize our ideas concerning the etiology and pathology of many of the morbid conditions met with in our practice. It seems imperative that every medical practitioner should make himself thoroughly conversant with the advances made in this branch of medicine, and we are glad to know that an opportunity for a course in the practical study of bacteriology will be afforded the practitioners in this province, at the close of the present session, when Professor Rainsay Wright will conduct a series of demonstrations on the subject at the Biological Department of Toronto University.

Our knowledge of micro-organisms is becoming

more definite and more complete. Not only is the morphology studied, but of late greater attention has been paid to the physiology of bacteria and their effect upon the living tissues of the human body. We have now to deal with hard facts when we attempt to value the influence of micro-organisms in disease; formerly, *facts* were few and *theory* prevailed. Lister, when he first introduced the antiseptic system into the practice of surgery, had discovered most important facts, but many of his deductions were, at that time, from pure theory, and this gave such practical men as James Spence an opportunity to scoff, and, by contrasting the results of the two systems, Spence attempted to prove that antiseptic methods were not called for. When, however, more knowledge was gained, and facts began to displace theory, Lister and his pupils were able to bring their methods to greater perfection, until now very few men of thorough education and insight dare deny the necessity for antiseptic methods. Of the opponents of the antiseptic system, Lawson Tait may be looked upon as the most influential. For some years he fought well; he is naturally a practical man and prefers fact to theory. Whilst the antiseptic system was founded chiefly on theory, Tait made a brilliant fight, but he has been driven from corner to corner, as facts have been unearthed, until now his attempts to keep above water are pitiable. He has now solid facts to deal with, and his recent attempts to combat irresistible facts are comparable to a man battering his head against a stone wall—the process will surely result in the utter annihilation of Tait, so far as his competency to judge of the merits of the use of antiseptics in surgery is concerned.

THE TORONTO GENERAL HOSPITAL.

The equipment of this institution is becoming more complete year by year. Fifteen years ago, when the demand for hospital accommodation in Toronto was not very great, the hospital was a very unpretentious institution, and consisted of a building in which patients suffering from all classes of disease, medical and surgical, were admitted. In 1878 the eye and ear infirmary was built, and in the same year the Burnside lying-in hospital. A few

years later a separate pavilion was erected for use in treating patients requiring abdominal section. Last year an important addition was made to the hospital in providing a building for gynecological work only, with ward accommodation for in-patients, and rooms for the reception and treatment of out-patients. We are glad to learn that there is at present in process of completion a number of rooms to be devoted exclusively to general out-patient work, and that here ample accommodation will be provided for both physician and surgeon, so that patients will now be able to receive treatment in apartments well adapted for the purpose. We understand that ample space will be afforded for waiting rooms, and that a limited number of students will be able to attend the out-door clinics. It is difficult to exaggerate the importance of utilizing the material presented at the out-door clinic of a large hospital for the benefit of the student. The facilities for doing this at the Toronto General Hospital have been inadequate in the past; and whilst the conditions have been such that the students have been unable to gain much good in the out-door department, the patients, too, have suffered much inconvenience from overcrowding. The constant growth of the city, and the increasing number of medical students in our schools, demand increased facilities for hospital work, and the managers of the hospital are to be congratulated on the energy which they have displayed in providing from time to time the necessary means for carrying on the work efficiently.

There are yet certain directions in which improvement is urgently called for. The arrangements for conducting *post mortem* examinations are at present far short of what is needed. It is a very great advantage to have, in connection with a large hospital, a properly equipped theatre and a well-arranged laboratory for the examination and demonstration of morbid anatomy; this is, indeed, an absolute necessity. The present means afforded for the conduct of such examinations are far from being satisfactory; this fact is no doubt fully recognised by the authorities, and we trust that, as soon as circumstances permit, this feature, so necessary in the equipment of the institution, will receive due attention, and that our hospital will ere long rival the finest institutions of the

kind on the continent. The Toronto General Hospital has at present 360 beds, and the number of patients seen in the various out-door clinics is large.

#### THE INTER-CONTINENTAL (OR PAN-) AMERICAN MEDICAL CONGRESS.

In July last Dr. James F. W. Ross, of Toronto, was appointed the Executive Committee-man for British North America.

Foreign Executive Committee-men are expected to organize the profession in their respective countries in the interest of the Congress. They are asked to

(1) Nominate one vice-president for the Congress.

(2) Nominate one secretary for each section of the Congress.

(3) Appoint auxiliary committee-men in local medical societies, or in considerable towns and cities where no medical societies exist.

Dr. Ross, we are pleased to state, has his district, from the Atlantic to the Pacific, well in hand. Many of the selections have been made, and when the list is completed the names will be published. Dr. J. E. Graham, of Toronto, has been nominated for a vice-president, and he, with several others, has assisted Dr. Ross in making the Ontario selections. Drs. F. J. Shepherd and Lachapelle, of Montreal, and Ahern, of Quebec, have given valuable assistance in the Quebec selections; and Dr. Muir, of Truro, Nova Scotia, has done similar work for the Maritime Provinces. These auxiliaries are nominated for the purpose of creating an interest in the Congress among the members of the profession in each city, town, or district. To them will be sent all the official literature printed from time to time by the Committee on Permanent Organization. In his letter to those nominated Dr. Ross says: "I have endeavored to secure progressive practitioners of good standing in the profession. The Congress will be composed of members of the medical profession living in the 'western hemisphere.' It is the first time that Canadians have been asked to take an official part in any American congress of medical men."

Professor Pepper, of Philadelphia, has been elected president of the Congress, and he has never yet done anything by halves. Under his

leadership, the Pan-American Congress will be a great scientific union of professional brethren—each of them a link in a chain extending from pole to pole.

This will be the first Pan-American Congress, but its success will no doubt necessitate other similar meetings in the near future. The meeting will be held in the year of the Columbian Exhibition, 1893. Washington has been selected as the place of meeting, and the time appointed is the first Tuesday in October.

## Meeting of Medical Societies.

### PATHOLOGICAL SOCIETY OF TORONTO.

Nov. 28th, 1891.

The society met in the Biological Department of the University of Toronto, the president, Dr. J. E. Graham, in the chair.

Dr. J. T. Fotheringham, Toronto, was introduced as a visitor, and by request presented specimens and read a paper on a case of

#### CIRRHOSIS OF THE LIVER.

(See page 1, CANADIAN PRACTITIONER.)

In the discussion which followed various views were expressed as to the point of origin of the pathological changes in the organ, as to the correctness of the term "hypertrophic" in this and similar cases, and as to whether this disease is ever due to any other cause than the use of alcohol.

Dr. Graham thought that the early occurrence of jaundice in this case was remarkable, and believed that the unusual features present here might be explained by the rapid and widespread nature of the inflammatory process.

Dr. A. B. Macallum said the jaundice was caused by the early destruction of the periphery of the lobules by the new connective tissue.

Dr. Acheson thought that long continued use of phosphorus, arsenic, and other metallic irritants, would produce cirrhosis as well as alcohol.

Dr. Oldright presented the following specimens:

#### (1) HEMORRHAGE INTO THE PANCREAS.

I was called to see Miss H. on Monday, 5th Oct., 1891. The pain was so intense that two messages had been sent within fifteen minutes,

but when I arrived, about 11.30 a.m., it had subsided. The pain was in the epigastrium. After an ordinary breakfast, the patient had eaten some ripe green grapes. She said she might have swallowed some of the skins; did not usually, but might have taken a few. I diagnosed acute dyspepsia, and left a prescription for a mixture containing morph. gr.  $\frac{1}{8}$  and some form of pepsin. I was summoned again about 1.30 p.m.: intense pain in epigastrium, extending to the back and up under the shoulder; patient had vomited a quantity of grape skins and seeds. I gave a hypodermic of morphia and tried to get the bowels moved by hydrarg. submur., Seidlitz powders, and enema of castor oil, turpentine, soap, and starch. Got a slight passage containing some solid matter, but not very satisfactory, as I had to continue anodynes. Gave, during the next 24 hours, morphia, chloral, and chloroform, essence of pepsin, bismuth, in alternations and combinations which it is not necessary to state in detail: also applied counter-irritants and hot applications. On Tuesday afternoon she appeared somewhat better. Up to this time there was no rise of temperature or pulse. On Tuesday evening the temperature rose to 101° F. and the pulse to 100; there was some tenderness on continued pressure in the lower part of the abdomen. Used opium in large doses and bags of hot hops. On Wednesday morning the pain and tenderness was much less, and there was nausea and distress. I now took advantage of the almost complete cessation of pain and tenderness to omit the opiate and get the bowels opened. Gave hydrarg. submur., Seidlitz, and enemata. The bowels were moved three times between 12 and 3 p.m.: Many grape skins and seeds were passed. I was telephoned for shortly before 3 p.m., on account of a loss of power in the limbs, complete in the upper and partial in the lower. I tested sensation during the afternoon and found it impaired, more so in the right arm than in the left and the legs. I thought these symptoms due to hysteria from exhaustion, but, the case being peculiar, I asked for a consultation, and Dr. Graham saw her with me about 8 p.m. Condition about the same; pupils not affected; pulse slow, about 50; paralysis of muscles of neck; power of sphincters not affected. The patellar reflex was

not obtained, but the test could not be very satisfactorily made; no reflex gagging from tickling the fauces, no paralysis of muscles of the face or tongue; voice like that of person with very much swollen tonsils or edema of soft palate. No albuminuria. We moved her to a larger room, and immediately after she had a severe hysterio-epileptic attack, which threatened suffocation; much contortion (hysterical in appearance) of the muscles of the face, but she afterwards appeared more comfortable. We gave pot. bromide and assafoetida by mouth and rectum. Her friends desired a further consultation, and Dr. A. J. Johnson saw her with us about 11 p.m. Her pulse had risen to 120. Drs. G. and J. left about midnight, and shortly afterwards I went down stairs. I was seated a few minutes when the nurse came down to ask a question, took her answer, and went up stairs: called me immediately, and immediately I went up, and found the patient dead. A friend who was with her said an attack had come on similar to the one previously described. I should have stated that there was never any pain of head or neck, and no vomiting except of grape skins on the first day, as stated.

Dr. Graham had seen this patient four or five hours before death. She was then in bed, partly propped up by pillows, and had motor paralysis of the legs and arms, with some facial paralysis, and there was loss of sensation in one arm. She was, however, quite conscious, and apparently in distress, though her attention could be drawn off and she would then forget about her condition and apparently enjoy the conversation of those about her. He thought the paralysis must be hysterical; for a central lesion, to occasion so extensive peripheral changes, must be a pretty severe one, and consciousness would in all probability be interfered with. It was certainly an obscure case for diagnosis, and its pathology seemed equally obscure. He asked whether the hemorrhage into the pancreas was recent or not.

Dr. Cameron asked what was the cause of the hemorrhage in such cases. That point seemed to be studiously avoided in the reports. Perhaps it might be aneurism of the pancreatic artery. These are really not cases of sudden death, for in most cases there is a history of illness extending over several hours.

At this point further discussion was postponed till next meeting, when there will be a report on the microscopic changes in the pancreas.

### (2) ACTINOMYCOSIS.

Gross and microscopic specimens from a cow's jaw were presented. The slides had been prepared by Mr. J. J. McKenzie, of the Provincial Board of Health laboratory.

### (3) FIBRO-MYXOMA OF THE NASO-PHARYNX.

Gross and microscopic specimens from a boy *æt.* 14. The growth had been removed by the wire snare with great difficulty by Dr. McDonagh in the Toronto General Hospital. The tumor was largely dense fibrous tissue, with patches of myxomatous tissue throughout it.

Dr. Peters was present and assisted at the operation for its removal, and spoke of the almost uncontrollable hemorrhage which complicated the operation, and called attention to the very large vessels, mostly dilated veins, ramifying through the growth.

A discussion then ensued on the pathological nature of myxomata. Drs. A. B. Macallum and Acheson held that myxomatous tissue is always a degeneration product of previously existing connective tissue. The real nature of the so-called mucoid substance has not yet been fully worked out. Mucus from different sources does not contain the same chemical constituents.

The society then adjourned.

## NEW YORK ACADEMY OF MEDICINE. SECTION ON ORTHOPÆDIC SURGERY.

*Stated Meeting December 18th, 1897.*

SAMUEL KETCH, M.D., *Chairman.*

Dr. Myers presented a case of

### CONGENITAL DEFORMITIES OF THE UPPER AND LOWER EXTREMITIES,

and asked the opinion of the section as to the value of operative procedures for the relief of the constrictions caused by amniotic bands.

Dr. Kelly thought the phalanges of the great toes were perfect in this case, but that the digits had been suppressed, and development had taken place beneath the skin.

The chairman referred to a child he had seen in which there had evidently been an attempt at amputation in utero. There was a well-marked constriction just above each ankle, more marked, however, on one side. The mother of this child, quite early in pregnancy, was tripped by a cord

which some boys had tied across the street, and it was thought that this maternal impression was responsible for the deformity. The child was able to walk with the aid of ordinary ankle supports.

Dr. Townsend did not favor operating upon these constricting bands, for the resulting cicatrix would cause further contraction.

A CONSIDERATION OF SOME OF THE AFFECTIONS OF TENDON SHEATHS AND BURSAE, AND THEIR RELATIONS TO INJURIES AND DISEASES OF THE JOINTS.

Dr. Royal Witman read a paper with the above title. He briefly described the structure and anatomical relations of bursæ and tendon sheaths, their diseases, and appropriate treatment, calling attention to the fact that chronic disease of tendon sheaths was usually tuberculous in character, for which early removal was the only remedy.

The relation of the tendon sheaths to the ankle and wrist joints, and their liability to injury in sprains and fractures, explained the symptoms—weakness, local pain, and limitation of normal motion, often persisting after such injury.

The importance of local massage and stimulation in the early stage, in order to prevent the formation of adhesions after secondary inflammation of tendon sheaths, was urged.

In chronic and neglected sprains a careful examination should be made, and if adhesions or contractions were present treatment should be directed to a recovery of the normal range of motion. This result might often be accomplished by a forcible overstretching under ether, followed by massage and support. By such treatment, patients disabled for many months might be quickly and permanently relieved.

In conclusion, attention was called to the importance of slight injuries in childhood, which might be the starting point of tuberculous disease, the diagnostic value of chronicity, and the necessity of careful observation and early treatment in suspicious cases.

Dr. Judson said that he had seen a case of tumor of the semi-membranosus similar to the one shown in the model. The child was about six years old, and under a purely expectant treatment the tumor disappeared in the course of a few months, leaving no deformity or disability.

Dr. Townsend said that he had seen many of the cases referred to by the author, and he had been struck with the many and varied diagnosis which had been made upon them before they came to the dispensary. The diagnosis in the early stages is often difficult, especially when there is only a meagre and often misleading history such as accompanies most dispensary cases. The importance of differential diagnosis could not be too strongly emphasized, particularly as upon it depended a correct prognosis.

Dr. C. A. Powers said that he inferred from the author's remarks on injuries at the lower end of the radius that he recommended confining the flexor and extensor tendons of the fingers in the treatment of Colles' fracture. He saw a large number of these cases with functional disability following this method of treatment, and he therefore preferred to use the long anterior splint for the first five or six days, and then to shorten both the anterior and posterior splint to the first row of the

carpus, directing the patient to make very active use of the fingers. Four or five days after this, he expected them to be able to shut the fingers well down into the palm.

Dr. Kelly said that in Dublin, the home and birth-place of Colles' fracture, the keel-shaped splint, which avoided injurious pressure on the thenar and hypothenar eminences, was almost universally employed. The mode of development of the bursa, found on various points exposed to pressure is difficult to understand unless we remember that the peritoneum, which is the great areolar inter-space of the body, has had a similar development from the connective tissue structures.

He was glad that the author agreed with him as to the position of the foot, viz., slight adduction, with the foot at right-angles to the leg. This slight adduction produces what he called "artificial talipes varus."

The chairman said that he inferred from what the author said that he considered these bursal tumors of tubercular origin. He wished to dissent from this opinion, for many of them were benign, and the result of injury.

Dr. Whitman explained that he had spoken of slow chronic enlargement of the sheaths of the tendons of the wrist and hand as tubercular. The deep-seated bursæ were favorably located for tubercular inflammation, and accordingly when they underwent chronic enlargement he preferred to treat them radically. He had only incidentally referred to the treatment of Colles' fracture. He did not consider the confinement of the fingers with vigorous massage and local stimulation the same as the confinement treatment which had been criticised during the discussion.

TUBERCULAR DISEASE OF THE VERTEBRÆ IN ITS EARLY STAGES.

Dr. R. H. Sayre presented the second, third, and fourth lumbar vertebræ of a patient, showing a very early stage of tubercular disease. There was a cheesy mass in the third lumbar vertebra, which had not yet broken down and ulcerated through into the cartilage. The points of junction between the second and third, and the third and fourth vertebræ were apparently normal. There was an extravasation of blood into the vertebra. The history of the patient from whom these specimens were taken was quite interesting. A child, suffering for some time from chills and high temperature, began to have a peculiar posture and mode of locomotion, and to suffer from abdominal pains. This led to a diagnosis of spinal disease, but in a consultation with an orthopædic surgeon this opinion was not confirmed, the latter believing that the child was suffering from malaria. The symptoms not subsiding under the administration of quinine, the child was brought to Dr. L. A. Sayre, who concurred in the diagnosis of disease of the spine. At this time there was some psoas contraction on the right side, with spinal rigidity and very slight pains. It could hardly be said that there was a kyphosis; the lumbar spine was straight instead of concave. The child was placed in a wire cuirass. About a month later he suddenly developed a temperature of 104°, with vomiting, photophobia, phonophobia, stiffness of the neck, and a rapid pulse. He was then seen by the speaker, who found an abdominal enlargement near the left side of the umbilicus,



which could be separated by percussion from the spleen. It was quite freely movable. Small doses of bichloride of mercury were administered, and in a few days the temperature fell to 100°, and remained at this point, and the other meningeal symptoms disappeared. There was no colic indicating tubercular peritonitis. The child became now even more anæmic than before, and the abdominal swelling increased in size. It seemed hardly possible that the mass could be a psoas abscess pointing in such an unusual position. After some time the mass became larger, and moved towards the posterior surface of the abdomen. In consultation with Dr. W. T. Bull, it was decided to be inadvisable to operate. The child died six days ago, and for a few days before death there was slight jaundice. The *post mortem* examination showed that the abdominal tumor was formed by a tubercular mass which united the intestines into one large mass. There were no small miliary tubercles scattered over the peritoneum. One little band pressed upon the gall bladder, and so accounted for the jaundice. The kidneys were firmly bound down with adhesions, and the left one was very large and waxy, and its pelvis was much dilated. There was a large quantity of fluid in both plural cavities, and cheesy nodules at the apices of the lungs. The heart was enormously thickened; the brain was not examined.

The chairman thought the symptoms described were more like those of an acute non-tubercular meningitis, as in the initial stage of the tubercular variety a high temperature was usual, and the pulse was ordinarily slow or intermittent. Then, again, the subsidence of the symptoms was not in accordance with such a diagnosis.

Dr. Kelly called attention to the fact that in the early and late stages of tubercular meningitis the pulse was rapid, while in the intermediate stage it was slow.

Dr. Kidlon said that he inferred from the remark of the chairman that he shared in the general feeling in the profession that if a child survived it was proof that the meningitis was not tubercular, and *vice versa*. He desired to dissent from this opinion. Eight or nine years ago he had treated a boy who had suffered from a form of meningitis which several eminent consultants considered to be tubercular; and they had an opportunity of seeing the patient a good many times. The patient was still alive, but he did not believe this proved that the diagnosis was incorrect.

The chairman said that he had never seen one undoubted case of tubercular meningitis recover, although he believed there were a few such cases on record.

Dr. H. W. Berg was not aware that there was any symptom, either subjective or objective, which would enable one to make a diagnosis between simple and tubercular meningitis. He thought that where there was a high temperature at the beginning of a meningitis, it was due to a series of eclamptic seizures, which, by paralyzing the heat centre of the body, allowed of a sudden rise of temperature.

Dr. Townsend had had an opportunity of seeing a considerable number of cases of tubercular meningitis, almost all of which had been proved by autopsy to be tubercular, and he could not recall any case where there was an extremely high temperature at the beginning.

Dr. R. H. Sayre said that he had looked upon the meningitis as tubercular because of the very general tubercular infection. The child looked as if it would die within a few days after the onset of these meningeal symptoms, and he was much surprised when the acute symptoms subsided so rapidly. The high temperature might have been due to the abdominal lesions. The extent of the abdominal lesions was remarkable, as they were younger than the disease in the spine.

#### CLINICAL SOCIETY OF MARYLAND.

WM. T. WATSON, M.D., *Secretary*.

Baltimore, December 4th, 1891. The 258th regular meeting was called to order by the president, Dr. Robert Johnson.

Dr. Thomas Opie read a paper on

#### THIRTY-TWO UNSELECTED ABDOMINAL SECTIONS.

These cases were operated upon by Dr. Opie at the Baltimore City Hospital in the twelve months ending October 31st, 1891. The conditions for which the operations were performed were as follows: Ovarian tumors, 6; chronic ovaritis, 7; fibroid tumors, 4; pyosalpinx, 5; retroflexions, with adhesions and dysmenorrhœa, 3; exploratory incisions, 3; extra-uterine pregnancy, 1; cyst of broad ligament, 1; cystic degeneration of ovary, 1. The number of deaths was four; as follows: Oophorectomy for double pyosalpinx, 1; shock from ovariectomy, 1; oophorectomy for acute mania, 1; abdominal hysterectomy for fibro-cystic tumor, 1.

Stitch abscesses occurred nine times, most frequently in cases where the drainage tube had been used. Early opening of the abdominal dressings favor their occurrence. When the dressings remained intact for seven days, there seemed to be greatest immunity from the stitch abscess. Dr. Welsh says that the staphylococcus epidermidis albus is the most common cause of stitch abscesses in wounds treated aseptically and antiseptically.

Drainage was used in but three cases. In one case it retarded convalescence; in another it seemingly did no good, and a small superficial abscess at the entrance of the tube followed its withdrawal. In the third case an abscess also occurred at the site of entrance. A plentiful supply of fine properly-prepared elephant-ear sponges will do away with the necessity for flushings in most cases, and remove the need for drainage. They are efficient helps in keeping the abdomen free from infection. They can be utilized in keeping back the intestines, in occupying the cul-de-sac, in positions below the pedicle, in taking up blood or secretions, in staunching hemorrhages, in separating adhesions, in protecting the intestines while closing the abdomen.

Drainage is doing more harm than good, and ought to be abandoned by the abdominal surgeon. The oft-repeated removal of dressings of the patulous drainage tube must of necessity be a very great danger; surely it favors decomposition and invites germs. After an anæsthetic, restlessness and jactitations are not wholly restrainable, and it is easy to see how physical injury may accrue to the patient during this time from these smooth but not at all innocent glass tubes. When the laboratory physician says that bruised tissue is a paragon

field for the cultivation of germs, let us heed the warning and cast aside the drainage tube.

Dr. Parkes says as to drainage: "Views and practices concerning drainage have materially changed even since the antiseptic era began. Our predecessors drained to permit the escape of pus, which they knew would form. Until lately we have drained in order to prevent its formation. We seem now to be on the eve of an era when we need to drain but little or not at all. We resort to drainage now only of necessity in septic or infected cases. In other cases we drain mostly from habit or from fear. Indeed, when we start afresh, as it were, without previous infection, the practice of drainage is a confession of fear or of weakness, both of which are alike unscientific and unfortunate. It even seems to me that in many cases where all other aseptic requirements have been met, we do much more harm than good by the use of drains."

Dr. W. S. Thayer spoke of the treatment of

#### FIVE CASES OF MALARIAL FEVER

at the Johns Hopkins Hospital with methylene blue. Immediately after the appearance of the article in the *Berliner Klinische Wochenschrift* for September, 1891, in which Guttman and Ehrlich described the successful treatment of two cases of malarial fever with methylene blue, this treatment was begun with the cases of malarial fever entering the hospital. So far only five cases have been treated.

One case of tertian ague yielded immediately to methylene blue, 0.1 five times a day. No rise of temperature after beginning of treatment; no organisms in the blood after the third day.

A severe case of quotidian ague had one chill twenty-six hours after the beginning of the treatment (methylene blue, 0.1 every four hours), and a lesser rise of temperature without chill on the two successive days. After this the temperature was normal. No plasmodia seen after the ninth day.

In a case of chronic malaria with pigmented crescents and small intracellular hyaline bodies in the blood, no organisms were seen after the ninth day under methylene blue, 0.2 four times a day.

In two cases of severe chronic malarial remittent the temperature fell to normal in a few days, but there were occasional returns of slight fever, and the organisms—hyaline bodies and pigmented crescents—had not entirely disappeared in forty-one and twenty-three days respectively. In the former case, after eleven days' treatment with quinine, a moderate number of organisms were still present.

In all the cases the drug was given as a powder in capsules. Slight burning sensations with micturition were usually present after taking the drug, and were relieved by small quantities (1/5 of a teaspoonful) of powdered nutmeg several times a day. The urine, under treatment, was of a deep blue color. The faces when passed were not colored, but on exposure to air turned rapidly blue. The sweat and saliva were not colored.

The number of cases yet treated is of course too small to give a sufficient basis for any legitimate opinion as to the relative value of this drug and quinine. The experience is sufficient to show that methylene blue has a definite curative influence on malarial fever, and to warrant its further trial.

Dr. I. E. Atkinson said that the discouragement

which one nearly always finds in treating malarial diseases with other remedies than the derivatives of cinchona bark is due to the extreme usefulness of cinchona bark itself, for it is so promptly antidotal in its effects in these disorders that we are apt to be discouraged, and not persist in the treatment by other agents. The testimony given to us by Dr. Thayer seems to show that in methylene blue we have another agent in the treatment of these disorders. The effects of the use of quite dissimilar drugs in these diseases is remarkable. Of course we all know the value of arsenic as an anti-malarial remedy; and we know that iodine possesses properties in this direction inferior to quinine, but still pronounced. Some years ago, prompted by some papers published by a physician connected with the English army in India, who claimed that iodine had properties equal to cinchona bark, Drs. Atkinson and Hiram Woods made some observations on the treatment of malarial intoxication with iodine. The results of these investigations showed that while iodine has undoubted anti-malarial properties, yet in a large proportion of cases it will fail absolutely. There is a wide range of remedies that possess this anti-malarial property, and which would be valuable if we did not have cinchona bark to use. The investigation reported by Dr. Thayer is most interesting and important, and further progress will be awaited with interest.

## Therapeutic Notes.

### TREATMENT OF PUERPERAL ECLAMPSIA.—

In the *Journal de Médecine et de Chirurgie*, Oct. 25th, 1891, Dr. Dubost's views upon this subject are given. During the last three months of pregnancy it is absolutely necessary to examine the urine of every woman, without any exception whatever. Only in this way it is possible to meet the exigencies of albuminuria and puerperal eclampsia. The examination must be made every fortnight, regardless of the fact that there may exist no subjective or objective symptoms pointing to albuminuria. Two things are to be considered in dealing with this condition, prophylactic treatment and the treatment of the disease when confirmed. The instant albumin is detected, the patient must be treated accordingly, throughout pregnancy, during confinement, and afterward until the last trace of albumen has disappeared. A milk diet is the treatment *par excellence* of albuminuria, and constitutes equally a sovereign prophylaxis against puerperal eclampsia. Tarnier and Budin state that women put upon milk diet always escape convulsions, and other observers confirm this. This simple precaution of exclusive milk diet would eventually exclude puerperal eclamp-

sia, except in those rare instances wherein albumin precedes it by a few hours or a few days. When the convulsion declares itself, treatment depends entirely upon whether the woman is in labor or not. If not, all obstetrical methods are discarded, and only medical measures are used. Of these, preference is given to chloral and chloroform. Chloral may be considered the specific in puerperal eclampsia. There are several ways to administer it, though not all are equally favorable. Large doses by the mouth produce serious irritation of the gastric mucous membrane, and at the same time are but slowly absorbed. Hypodermic injections are also objectionable. The best method of administering chloral is by the rectum, in the following form of enema :

Chloral hydrate	- - -	4 grammes.
Milk	- - - - -	100 grammes.
Yolk of one egg,		

This enema must be given with great care and precaution, for the patient is often in much motion. A syringe used for hydrocele is the one to employ, the extremity capped with a soft rubber sound of eighteen or twenty calibre. This is anointed with borated glycerine and introduced high into the rectum, and the enema gently given. In this way danger of injuring or perforating the rectum is averted. The injection is rarely expelled. If it is, it must be administered in the same way a second time. This rectal injection should always be given when, at the commencement of labor, there is agitation, restlessness, frontal headache, difficulty of vision, or pain in the epigastrium. It will often avert an eclamptic attack. If, at the end of three hours, the seizure continues and the temperature remains high, another enema may be given, containing, as before, four grammes of chloral. As many as fourteen, sixteen, or even eighteen grammes may be given in twenty-four hours. The milk and egg render the drug less irritating, and these large doses are well supported. Chloroform is the next best agent in eclampsia. It is a powerful remedy, to be used while waiting for the action of chloral whenever a woman is in an eclamptic seizure. Often chloroform will ward off an attack that is imminent, and should be given on a handkerchief whenever such a catastrophe is suspected. Inhalations must

be kept up until there is complete muscular relaxation. It is well borne, and may be used when necessary for several hours, even for twenty-four hours, to keep the body in a state of relaxation. Because there have been no accidents is no excuse for neglect of any and every precaution. The physician should never leave the bedside of an eclamptic patient for any pretext whatever. The patient should be isolated in a warm room, far from noise or shock, and kept in half darkness. Every movement and examination should be avoided as far as possible, for even a touch may suffice to bring on an attack. It is necessary to sit by the bed to keep the woman covered and prevent her from falling out. If she strikes or attempts to do herself harm, the hands must be held by persons in attendance. Tying the woman, or putting on a strait-jacket, impedes respiration and is a source of great danger. To prevent biting the tongue, a thick wad of rolled linen may hold it back of the dental arches. Wood or metal thus introduced may break the teeth. Drinks should not be given in porcelain or glass that easily breaks and thus becomes a cause of serious injury, but from a tin nursing-bottle. The attack once passed, the dose of chloral in the enemas is reduced, and these are decreased in number. Four grammes of chloral a day are soon sufficient. Purgatives, even drastics, or purgative enemata, every two or three days until convalescence is established. During labor, when there is a convulsion, these same precautions and rules are to be followed. But vaginal examinations are essential, for there is nothing to tell how matters are progressing except the touch, and the child may be born and smothered. Particular care must be given to the perineum, which is weak in all albuminurics and specially liable to great damage. When dilatation is complete, and not an instant before, the child must be delivered rapidly by the forceps. Naphthol may be used as an antiseptic. The perineum must always receive special attention, and the physician must be constantly on his guard against hemorrhage. Never consider a woman cured because puerperal convulsions are over. They may return at any moment. The urine must be examined daily and milk diet kept up until albumin has entirely disappeared.—*Med. Record.*

ICHTHYOL VARNISH.—Unna (*Monatsheft für prakt. Derm., and Boston Med. and Surg. Journal*), who has made extensive use of ichthyol in the form of ointments, pastes, ichthyol-collodion and ichthyol-gelatine, recognized the need of an ichthyol varnish that would not have the disadvantages of the collodion and gelatine in being somewhat irritating to an abraded skin, and that would not possess the hygroscopic qualities of the pure drug. He believes that a good many specialists have been less successful in the treatment of rosacea and lupus erythematosus with ichthyol because they have used the drug in the form of ointments and pastes.

For this purpose he experimented with various substances, and found that if starch were added to ichthyol the mixture was not hygroscopic, and that to this mixture albumen must be added in order to keep the starch in suspension. The formula for this ichthyol varnish reads:

Ichthyol.	40 parts
Starch.	40 "
Sol. albumen.	1-1/2 "
Water, ad.	100 "

The starch is first thoroughly mixed with the water, then the ichthyol added, and lastly the solution of albumen. Another formula, in which carbolic acid is incorporated, is:

Ichthyol.	25 parts
Carbolic acid.	2.5 "
Starch.	50 "
Water.	22.5 "

This varnish is intended especially as a dressing in minor surgery, as it dries quickly, and can easily be removed by water. The soluble ichthyol varnish combines all the advantages of the various ichthyol preparations without their disadvantages. It dries quickly and is not dissolved by the perspiration. It is valuable in acne in persons with a very sensitive skin, in rosacea, and in lupus erythematosus. In some forms of eczema and in erysipelas it is of great service.

This varnish is also made the vehicle for other drugs. For example, 2 to 5 per cent. of chrysarobin may be added to the ichthyol varnish for use upon the face. Certain circumscribed forms of eczema, psoriasis, and other affections may be treated by combining pyro-

gallol, resorcin, and sulphur with the ichthyol varnish. It is to be noted that, in order to obtain a suitable consistency, an amount of water or oil equal to that of every new medicament added should be mixed with the varnish. For this purpose linseed oil is used, as a rule.—*College and Clinical Record.—Lancet-Clinic.*

PARISOT, in the *Bulletin Gén. de Therap.* for Sept. 15th, 1891, highly commends, in diphtheria, irrigations of salicylic acid (1-1000), and affirms that whereas before resorting to this method the mortality in his practice was large—ten cases out of every fourteen—in a recent epidemic in which he has relied on the irrigations, there were only five fatal cases out of every twenty-four. The formula which this writer employs is as follows:

R.—Acid. salicylic	1 gm.
Water	980 gms.
Alcohol (90°)	20 gms.—M.

Dissolve the salicylic acid in the alcohol, and add the water. The apparatus which he uses is simply a fountain syringe with the "fountain" of tin; this fountain is hung on the wall over the patient: the rubber tubing which is connected with the lower extremity of the fountain ends in a small glass tube tapering at the point like a dropping-tube. A spring "catch" on some part of the tubing interrupts the current of liquid at will. When the fountain is charged with the solution and ready for action, the head of the child is held by an assistant, the tongue depressed, and the jet directed into the mouth and posterior pharynx with sufficient force to detach and remove the false membranes, if they happen to be loose. Parisot likes best the position in which the child is held with the head forward and a little downward. Where the child is very feeble, it may be supported upon the arm of the assistant, with the face turned toward the floor. In this position it may be more difficult to perform the irrigations, but there is more certainty that the liquid will flow back again, and not be swallowed in any quantity. The quantity of the liquid to be used in each irrigation may not amount to more than three or four ounces, but in grave cases the oftener the irrigation is practised the better. The use of the irrigations does not make unnecessary other re-

medial measures, such as the frequent administration of stimulants. Parisot makes some remarks as to the action of salicylic acid on false membranes which, if true, are of great practical importance: In distilled water, the false membrane was simply disaggregated, and this disaggregation took place slowly, while in solutions of different strengths of salicylic acid the exudate disappeared rapidly; at the end of a few minutes nothing was found but the meshes of the network serving for support to the cells of the exudation. The stronger the solution of salicylic acid, the more prompt and complete was the disappearance of the exudate. Parisot has, moreover, noticed that in diphtheritic throats that have been irrigated with the salicylic solutions, false membranes, when once detached, are reproduced more slowly and imperfectly than when the throat is cleared by any other process: he hence concludes that the mucous membrane is favorably modified by the salicylic acid.—*College and Clinical Record.*

TREATMENT OF BRONCHO-PNEUMONIA IN CHILDREN WITH HYPODERMIC INJECTIONS OF MURIATE OF QUININE (St. Philippe, *Jour. de Méd.*, June 21st, 1891).—It is necessary to differentiate carefully between pneumonia complicated with enteritis and typhoid fever, between central pneumonia and the prolonged variety which is suggestive of tuberculosis. There are two indications for treatment: one due to a constant element, bronchitis; the other to an occasional element, the pulmonary lesion. The latter is by far the more important, for the existing congestion may be sudden, extensive, and so interfere with hæmatosis as to cause death in a few hours. Quinine acts upon the congestive element whether administered by the mouth, the rectum, or subcutaneously. Sulphate of quinine may be given in black coffee or with extract of licorice. With small and unruly children, one must administer it by rectum or endermically. Such methods are slow in action and unreliable. It is far better to use it hypodermically, employing the following formula:

R.—Quin. mur., 2 to 4 grammes;

Glycerina:

Aque, aa, 10 grammes.

Sig.—One or two syringefuls may be injected, according to the requirements.

Blisters may also be used with advantage, being applied over the region where rales are abundant. Should suffocative catarrh occur, one must use sinapisms, large fly-blisters, scarification, or leeches, according to the age of the child. As supplementary medication, one may give five to twenty drops of the tincture of aconite-root in the course of the twenty-four hours, or one or two drops every hour, combining it with compound syrup of ipecac if the bronchitis is severe, or with syrup of quinquina or punch if the general condition is bad. To calm the excitement, warm baths and a little antipyrin may be used: but opium is inadvisable. If the cough is paroxysmal, fumigations should be used. In very severe cases, quinine and aconite should give place to subcutaneous injections of caffeine, to digitalis, and alcohol. Inhalations of oxygen are to be preferred to inhalations of ether.—*Archives of Pediatrics.*

THE method of raising children in bran was proposed by M. Pue at the *Société Normande d'Hygiène Pratique* (quoted in *Arch. of Pediat.*). It consists of a cradle which has the wooden bottom taken out, and is then lined with a strong cloth. In this is placed sterilized bran to nearly half a yard in depth. A hair pillow is used. The baby has only a short flannel shirt on, and is naked from the navel downward. It is covered with a woollen blanket, and a wool-lined dress is kept to put it in when taken up for nursing. It has thus full liberty of movement in all its limbs, while its dejections pass at once into the pure bran, keeping the child dry and clean even if there is diarrhœa. This method is a cheap one, the bran not costing as much as diapers.—*College and Clinical Record.*

A CLAIM THAT INFLUENZA IS CONTAGIOUS.—In his interesting work on "Epidemic Influenza," Dr. Richard Sisley claims that the cause of the disease is probably a microscopic organism, that it is contagious, and is chiefly, if not entirely, spread by contagion. In proof of his theory of contagion, he cites cases that show that influenza spreads from the sick to the sound; that isolated cases of influenza precede an epidemic; that influenza spreads along the lines of human intercourse; that prisoners and other isolated persons often escape influenza, although

the disease may be raging in the town in which the prison is situated. He claims that the local health board should be notified of cases of influenza just the same as in cases of scarlet fever or diphtheria, and that laws should be passed making such notification compulsory.—*Medical Record*.

In the clinic, for a case of *chronic Bright's disease*, in a woman aged fifty years, in which the prognosis was unfavorable, Prof. DaCosta gave, as palliative treatment: *To control the waste of albumin*, one drop of nitro-glycerin, one per cent. solution, and increased to grt. v, three times daily. *For the anæmia*: Ferri sulphas, 3 grains three times daily in pill. The diet to be as nearly as possible of milk, skimmed milk preferable on account of the disturbed state of her digestion. Patient might have green vegetables, fruit, fish, and oysters; the indication being to guard against nitrogenous foods.—*College and Clinical Record*.

MENTHOL FOR CHAPPED HANDS.—The following is recommended in the *Journal des Maladies Cutanées et Syphilitiques*:

R.—Menthol . . . . .	0.75
Salol . . . . .	1.50
Olei olivar . . . . .	1.50
Lanolini . . . . .	45.00

M.

Sig.—Apply once or twice daily.

The pain disappears after the first application, the skin is softened, and the fissures disappear very shortly. It is necessary, however, to continue the applications regularly for some time.—*St. Louis Med. and Surg. Jour.*

FOR FETID BREATH.—The following is recommended in the *Revue Générale de Clinique et de Thérapeutique* for the above:

R.—Saccharin,	
Acid. salicylic.	
Natri bicarbonate, aa . . . . .	gr. xv.
Alcoholis . . . . .	ʒj.
Ol. menth. pip . . . . .	gtt. x.

M.

Sig.—A teaspoonful in a wine-glassful of warm water, to be used as a gargle once or twice daily.—*St. Louis Med. and Surg. Jour.*

M. FAY, in the *Wiener Med. Blatter*, praises the beneficent action of sodium salicylate in the treatment of nephritic colic. He declares that under its influence the calculi are rapidly eliminated and the patients restored to health. If true, this is indeed a boon to suffering humanity, as few tortures are so acute as those of renal colic, and none have hitherto been more rebellious to treatment. Sodium salicylate has also been highly recommended in hepatic colic.—*Med. and Surg. Rep.*

THE following is recommended by a French writer as very efficacious in the relief of chronic prostatitis:

R.—Iodoform . . . . .	gr. xx.
Olive-oil . . . . .	ʒij.
Cocoa butter . . . . .	q. s.

Divide into twenty suppositories, one to be inserted at bedtime.—*N. Y. Med. Record*.—*Cincinnati Lancet Clinic*.

MALE-FERN is not an entirely harmless remedy, though long in use, and one of the best of anthelmintics. Dr. Eich does not favor the usual method of giving the drug fasting, since when the stomach is empty the absorption of the toxic principles into the general system is facilitated and poisonous symptoms may occur. Several fatal cases of poisoning are reported. The ethereal extract contains poisons which act upon the central nervous system, a tetano toxin or tetanus-producing body playing an important role. The dose of ten grains or two and a half drachms should not be exceeded.—*Med. Record*.

ANTIPIRYN ASTHENOPIA.—A writer in *The Lancet* relates a case of impairment of vision for distant objects coming on rather suddenly in a man, æt. 32, who had been using antipyrin pretty steadily for several months. The writer is inclined to put the blame for the impaired vision upon the antipyrin, and asks if any others have seen a similar effect from the use of the drug for long periods.

PHOTOPHOBIA, with dilatation of the pupil, is said by Huguin to be an early diagnostic sign in pertussis before the whooping stage comes on.

## Miscellaneous.

A LAW FOR THE PREVENTION OF BLINDNESS.—Following the example of the State of New York, the State of Maine has passed the following law, which was approved by the Governor on March 28: "Section 1. Should one or both eyes of an infant become reddened or inflamed at any time within four weeks after its birth, it shall be the duty of the midwife, nurse, or person having charge of said infant to report the condition of the eyes at once to some legally qualified practitioner of medicine of the city, town, or district in which the parents of the child reside. Section 2. Any failure to comply with the provisions of this act shall be punishable by a fine not to exceed \$100, or imprisonment not to exceed six months, or both. Section 3. This act shall take effect on the first day of June, eighteen hundred and ninety-one."—*New Orleans Medical and Surgical Journal*.

MORTALITY IN ENGLAND AND FRANCE.—Two hundred years ago the mortality in England was 80 in the 1,000, and fifty years ago 25 per 1,000, while in 1889 it had fallen to 17.85. This result is the more remarkable since the birth rate is so large, and it is well known that a large birth rate increases the annual death coefficient. In France the mortuary rate, which at the beginning of the century was 28, is to-day 22.29, but the coefficient of births has fallen from 30 to 25 per 1,000. If the births in France were in the same proportion as those in England, the increased death rate over this country would be still greater.—*Journal de Médecine de Paris*.

A SAD MISTAKE.—A writer in the *Hospitals Gazette* quotes the following story, said to have been related by Sir Richard Quain, M.D., which perhaps points a moral. He was attending the wife of an old patient, and at one of his visits the husband set him thinking by saying to the doctor, "I greatly appreciate the anxiety you feel for my poor wife, but do not let her see it again, for after you left the room she asked if you were the undertaker." As Dr. Quain rather prided himself on having a good bedside manner, he felt that he was being taken down a peg or two.—*Med. Record*.

*The Medical News'* visiting list for 1892, arranged for thirty patients per week and published by Lea Brothers, of Philadelphia, will be found to be one of the best of its kind. A special index facilitates speedy reference. Besides the usual tables of doses, incompatibles, poisons, and antidotes, it contains directions for examination of urine, ligation of arteries, and a brief résumé of the accepted treatment of the diseases most often met with.

MRS. C. P. HUNTINGTON has given the Directors of the Post-Graduate Medical School of New York city \$2000, a sum sufficient to defray the expenses of the lying-in department for one year. Professor Von Ramdohr will have charge of this department, at 543 East 13th Street, where instruction in obstetrics will be given to graduates in medicine only.

MATTHEWS DUNCAN MEMORIAL.—At the last meeting of the Aberdeen University Court, a letter was submitted from Professors Alex. Ogston and R. W. Reid, formally handing over to the court a bust of the late Dr. Matthews Duncan, to be placed in the Medical School, and a cheque for £140 to be invested to provide a gold medal to be known as the "Matthews Duncan Gold Medal in Obstetrics."—*Brit. Med. Jour.*

THE University of Lemberg is about to be blessed with a medical faculty, the Emperor of Austria having approved of the proposal to establish one. It is thought it will be ready and in good working order by the autumn of 1894. Well, we should hope so! Oklahoma will have two or three medical colleges in full blast by that time.—*Medical Record*.

A SUCCESSFUL case of bone-grafting is reported from Allahabad, a solution of continuity in the anterior layer of the frontal sinus having been induced to take on osseous repair by sprinkling the surface with "small fragments" of the hip-bone of a newly killed dog.—*Med. Press*.

THE annual dinner of the Medical Faculty of the Western University was held in the Tecumseth House, London, December 22nd.