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THE

MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. IX. HALIFAX, NOVA SCOTIA, FEBRUARY, 1897. No. 2.

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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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CONTENTS FOR FEBRUARY, 1897.

The Subscription Rate for the Maritime Medical News is $1.00 per annum.

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Medical Therapeutics

Various Neuroses of the Larynx

In a "Note on Codeine," in the *Lancet*, Dr. James Braithwaite, of Leeds, says: "Codeine seems to have a special action upon the nerves of the larynx; hence it relieves a tickling cough better than any ordinary form of opium. One-half of a grain may be given half an hour before bedtime. It was in my own case that I first began to use codeine. For more than twenty years, usually once every winter, I have been seized with a spasmodic cough just before going to sleep, which becomes so severe that I am compelled to get up and sit by the fire. After an hour or two I return to bed and am free from the cough till the next winter. In other respects I enjoy good health. Many years ago I found that one-half grain of codeine, taken about two hours before bedtime, absolutely stops the attack and leaves no unpleasant effect the next morning. In cases of vomiting from almost any cause, one-quarter grain doses of codeine usually answer exceedingly well. In the milder forms of diarrhœa one-half to one grain of the drug usually answers most satisfactorily, and there are no unpleasant after-effects."

We find, however, that where there is great pain, the analgesic effect of codeine may not be sufficient, and a combination with antikamnia is required. It is best given in the form of a tablet, the proportions being 4¾ grains antikamnia and ¼ grain codeine. Sometimes chronic neuroses may be cured by breaking the continuity of the pain, for which purpose we have found this combination peculiarly suited.

Clinical reports in great numbers are being received from many sections of this country, which, while verifying Dr. Braithwaite's observations as to the value of codeine, place even a more exalted value upon the advisability of always combining it with antikamnia in treatment of any neuroses of the larynx, coughs, bronchial affections, excessive vomiting, milder forms of diarrhœa, as well as chronic neuroses; the therapeutical value of both being enhanced by combination. The tablets of "Antikamnia and Codeine," containing 4¾ grains antikamnia and ¼ grain codeine, meet the indications almost universally.—*The Laryngoscope.*

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MARITIME MEDICAL NEWS,

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VOL. IX. HALIFAX, N. S., FEBRUARY, 1897. No. 2.

Original Communications.

DYSMENORRHŒA.*

By J. CLARENCE WEBSTER, M. D., Montreal.

By this term is meant pain associated with menstruation. In normal conditions usually no pain is felt; in a number of these cases only slight pelvic discomfort: and in others only a dull backache.

When there is distinct pain it is sharp, dull, dragging, down-bearing or labour-like. It may be felt in the loins, in the small of the back, in the pelvis: and from these regions may radiate into the thighs.

Great variations are found as regards the time of onset and the duration of the pain. Thus it may be felt only for a day or two preceding the menstrual flow, ceasing at the commencement: for a day or two before, as well as for the first day or two of the flow; during the first day or two of the flow only: during the whole extent of the flow: during the last two or three days: during the day or two succeeding the flow.

At present we cannot satisfactorily distinguish the factors which determine these variations. The pain varies greatly in intensity. It may in no way interfere with the woman's regular life, or it may entirely incapacitate her for her duties.

Before considering the conditions in which dysmenorrhœa occurs, it is well shortly to recapitulate the physical factors in the pelvic phenomena of normal menstruation, so far as we know them.

* Read at meeting of St. John Medical Society, Dec. 30th, 1896.

1. According to LINDBLOM, the uterus enlarges slightly prior to the menstrual flow, and during the period is felt to be somewhat soft and lax, continuing so for a short time after the bleeding stops. The mucosa becomes congested and swollen.

2. HERMANN has shewn that some widening of the cervical canal occurs during the flow, reaching its maximum on the third or fourth day. The widening is not at all proportionate to the quantity of blood lost.

3. The chief loss is in blood, small portions only of the epithelial covering of the mucosa being shed, and possibly very minute bits of the sub-epithelial connective tissue stroma. The blood does not clot in the uterus in normal conditions, owing to the alkaline reaction of the uterine mucus, which is abundantly poured forth during the period, and owing to the continual passage outwards of the flow.

4. There is general congestion of the pelvic viscera.

5. Ovulation is not an essential part of the process, and may or may not accompany it.

Dysmenorrhœa is found in two sets of conditions :—

1. Associated with various pathological or abnormal conditions in the pelvis, recognisable on physical examination.

2. When no pelvic lesions, or only slight ones, can be made out.

1.—IN RELATION TO CHANGES IN THE PELVIS RECOGNISABLE ON PHYSICAL EXAMINATION.

(a) Associated with chronic pelvic peritonitis and cellulitis :—

These varieties of pelvic inflammations are related to dysmenorrhœa in the following ways: In some cases there is no dysmenorrhœa. In other cases they lead to the formation of areas of resistance to the congestion which is general in the pelvis in connection with menstruation. The pressure of the congested vessels affects the nerves in the inflamed and rigid parts, causing pain. In other cases the dysmenorrhœa may be related chiefly to the effects produced in the uterus or appendages by the inflammation.

That variety of inflammation which is most often associated with dysmenorrhœa is utero-sacral cellulitis. I shall consider this in relation to pathological anteflexion of the uterus. In all conditions of pelvic inflammation the association of neuroses must be borne in mind.

(b) Associated with disease of the Fallopian tubes :—

Salpingitis is often the cause of severe dysmenorrhœa. The pains in the worst cases begin two or more days before the period, and are of a

spasmodic, agonising character. When the flow begins there is very often considerable relief, though often the pain lasts through the whole period. The explanation of the dysmenorrhœa, and of the variations which occur, is difficult. When the walls of the tube are thickened, it is possible that the pre-menstrual congestion causes the pain, owing to the resistance to the dilatation of the salpingeal vessels due to the inflammation. Yet there are cases of well marked interstitial salpingitis in which there is no increase of pain in relation to menstruation. Probably the worst dysmenorrhœa is found with tubes moderately distended with pus It is believed by some that the intense pain in these cases is caused by expulsive efforts set up in the wall of the tubes under the stimulus of the pre-menstrual congestion. It is remarkable, however, that some cases of marked pyosalpinx occur in which there is little or no pain at or between the menstrual periods. This is also markedly true of hydrosalpinx and hæmatosalpinx. Moreover, the amount of pain is not at all proportionate to the degree of distension of the tubes. Of great importance in these cases is the influence of the pelvic condition in inducing neurotic symptoms.

(*c*) *Associated with disease of the ovaries*:—

Inflammation:—The relation of pelvic pain and of dysmenorrhœa to ovaritis is little understood. It is impossible to eliminate the influence of periovaritis, or of perisalpingitis and salpingitis, with which the former condition is so often associated. There is no doubt, however, that ovaritis, especially if associated with periovaritis, may give rise to dysmenorrhœa, of varying degrees of intensity in different cases: though, sometimes, it may not be marked by any special pain in relation to the menstrual period. Perhaps the most common type is that characterised by the exacerbation of the already existing pain a day or two before the flow, continuing throughout the period. Very often, however, the dysmenorrhœa develops only at the beginning of the flow: in some cases it is continued for some days after the period.

As far as we know, the exacerbation of pain in connection with menstruation in cases of ovaritis can only be explained on physical grounds by the occurrence of congestion in an isolated organ whose expansibility is interfered with by inflammatory changes in or around it.

For a long time the term "ovarian dysmenorrhœa" has been applied especially to the cases in which the pain is most marked before or just at the beginning of menstruation, it being supposed that the pain is due to the process of ovulation. I object strongly to the use of this term in

such a connection. In the first place there can be no doubt that the special type of pain here referred to is found most marked in cases where severe tubal inflammation exists, so that no distinction whatever can be drawn between salpingeal and ovarian dysmenorrhœa. In the next place, while it is no doubt true that the escape of an ovum in marked ovaritis or peri-ovaritis is associated with an exacerbation of pain, there is no reason whatever to believe that this process goes on in the majority of the cases of inflamed ovaries in which this special type of dysmenorrhœa is found. Ovulation may sometimes happen to coincide with the beginning of menstruation, but in most cases it does not. There is no necessary coincidence in the occurrence of the phenomena.

It is necessary to point out with great emphasis that the most marked cases in which reflex neurosis is established or aggravated are those in which the ovaries are the seat of troublesome inflammation. It is, therefore, difficult in any given case to establish a proper relationship between the physical and the neurotic.

(*d*) *Associated with affections of the uterus* :—

i.—*Malformations.*—In uterus septus and uterus bicornis, if one-half does not open into the cervical canal, dysmenorrhœa occurs in association with the accumulation of menstrual blood in the part which is shut off. The same symptom is met with when accumulation occurs in the rudimentary horn in a case of uterus unicornis. Dysmenorrhœa begins in the pelvis on the affected side at puberty. With succeeding periods the pain usually becomes more marked and more prolonged : it is often like labour-pains.

ii.—*Stenosis of the cervix.*—For a long time one of the most common causes of dysmenorrhœa has been thought to be a narrowing of one part or another of the cervical canal, causing a mechanical obstruction to the escape of the menstrual flow. In some cases the os internum, in others, the os externum, may be the special seat of contraction. Sometimes both may be at fault or, indeed, occasionally the whole cervical canal may be narrowed.

The most erroneous ideas are prevalent in regard to this matter. No definite standards have been set up as regards the size of canal necessary to a painless passage of blood. No account has been taken of the fact that during menstruation the whole cervical canal becomes somewhat dilated. Measurements made, therefore, between the menstrual periods will not apply to the uterus during their progress.

It is interesting to note that one observer, BURTON, passed the sound into the uterus at the menstrual periods in six cases of dysmenorrhœa said to be due to stenosis of the cervical canal. In each instance he found that the sound passed very easily, the canal being much more patent then than between the periods.

It is extremely rare, as JOHN WILLIAMS states, to find a case in which, in intermenstrual periods, a sound cannot be passed into the uterine cavity. The percentage of cases of dysmenorrhœa attributable to contraction, however, is very much greater. Moreover the results of treatment based upon the prevalent hypothesis are very unsatisfactory, i. e., dilatation or division in a very large proportion of cases causes no improvement. In some cases of cure there can be little doubt that the operation has acted, not by its direct influence on the uterus, but by its influence in counteracting a neurotic condition from which the patients have been suffering. In other cases in which the dilatation has caused an improvement, the dysmenorrhœa has been due, not to the attributed stenosis, but to the fact that there is an abnormal tendency to clotting of blood *in utero*, to fibrin-formation, or to the shedding of abnormally large portions of the uterine mucosa.

I wish particularly to emphasize the latter point. It is a well-known fact that occasionally a complete cast of the mucosa of the body may be expelled during a menstrual period, and though the cervical canal is normal and undergoes considerable dilatation, the most intense dysmenorrhœa is induced. Now, there is, I believe, a proportion of cases in which bits of the mucosa of various sizes are expelled as a regular or irregular habit. And it is to these that the narrowing of the canal is due, interfering with the free escape of the menstrual blood. It does not take a large portion of tissue to block the cervical lumen at the upper or lower end.

It is extremely likely that in cases of dysmenorrhœa said to be due to spasmodic contraction of the os internum or os externum, the contraction is induced by the presence of a portion of mucosa within the circle of muscle. This can be easily understood when one remembers how, in passing a sound into the uterus, it may often be held very firmly by a spasm of the musculature at the os internum. I am, therefore, of the opinion that a considerable proportion of cases of dysmenorrhœa should be classed as "membranous dysmenorrhœa," using this adjective to apply to portions of mucosa great or small.

While in Edinburgh I had under my observation for over a year a most interesting case of severe dysmenorrhœa, in which in successive periods portions of mucosa, varying in size from a complete cast of the cavity of the body to a piece not larger than a ten-cent piece were passed. The menstrual discharge was carefully collected and examined at each period. She had suffered for over two years, the pain varying in intensity from time to time. At some of the periods, had not the discharge been most carefully examined the true nature of the case would not have been made out.

In another set of cases, dysmenorrhœa is attributed to a narrowed cervical canal, when it is really due to an inflammatory condition in or near the uterus. Also the element of neurosis is undoubtedly overlooked in many instances, as an important factor in producing the dysmenorrhœa.

There is, therefore, but a very small residuum of cases in which it can be held that dysmenorrhœa is directly and solely due to a stenosis of the cervix. These are probably instances of congenitally elongated, conical cervix of abnormally small calibre, or of rigidity of the cervix induced by inflammatory changes, conditions interfering with the dilatation which occurs in the cervical canal normally during menstruation.

iii.—*Inflammation in the uterus.*—Dysmenorrhœa is frequently found in association with endometritis. Under this heading must be included all the cases to which I have referred, under the name of "membranous dysmenorrhœa." When a complete layer of the mucosa is shed, it is due to the wide-spread interstitial inflammation rendering the superficial portion of the mucosa impermeable to blood. The latter escaping into the substance of the mucosa dissects a portion off. The loosened portion is expelled by the uterus, and as it is forced down it either breaks across or pulls after it part or the whole of the remaining superficial layer of the mucosa. The passage of the membranous masses through the cervix causes reflex spasms of the musculature, especially at the os internum: this further interfering with the downward progress of the uterine contents. The uterine wall is thus further stimulated to contraction, and so great pain is produced.

As I have already stated, apart from the shedding of complete or very large casts of the mucosa, there is probably a considerable number of cases in which small portions of different sizes are expelled, the severity of the dysmenorrhœa varying greatly.

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There is one uncommon form of endometritis, the villous or papillary in which projections of granulation-tissue extend into the cavity. These may cause dysmenorrhœa either by becoming swollen with the congestion of menstruation and thus stimulating the uterus to contraction or by being broken off and expelled, causing pain in the the manner just described.

No doubt many cases of dysmenorrhœa attributed to endometritis are really due to chronic metritis. In this condition, the indurated condition of the uterus, owing to the increased amount of fibrous tissue in its wall, opposes the softening and relaxation of menstruation, and the increased congestion leads to greater pressure on the nerve fibres in the wall.

Great variations are found as regards the occurrence of dysmenorrhœa in metritis. In some cases it is not present at all. These variations are probably dependent upon the extent and situation of the inflammation, the size of the lumen, and the amount of fixation of the uterus by outside inflammation. The latter point is of considerable importance. Given a uterus in a condition of metritis, firmly fixed by peritonitic adhesions or cellulitic deposits, and there is the most favourable combination for the occurrence of dysmenorrhœa. The condition is exactly analogous to chordee in the male, in which intense pain is produced owing to the opposition to congestion of the penis caused by the inflammation.

This combination is most frequently found in woman in the diseased state known as pathological anteflexion, associated with utero-sacral cellulitis or posterior perimetritis. Here the dysmenorrhœa is due, not to the flexion in the uterus, but to the inflammation in and behind the organ opposing the congestion of the menstrual period, thereby leading to marked pressure on the nerves.

Finally, in all cases of metritis the importance of an accompanying neuritis as a factor in causing pelvic pains must be kept in mind.

iv.—*Displacements of the uterus.*—It is probable that in the great majority of cases, displacements of the uterus *per se* have nothing to do with dysmenorrhœa. If the condition of the escaping of menstrual blood be normal, there is no reason why the existence of an abnormal degree of version or flexion of the uterus should prevent the downward progress of the blood.

Schultze and Scanzoni demonstrated in a number of cases of intense dysmenorrhœa associated with anteflexion, that there was no

retention of blood in the cavity whatever. The passage of the sound was in no instance followed by any relief or by any escape of blood.

Neither is there any ground for believing that a flexion interferes with the congestion of the uterus at menstruation. The blood-vessels in the uterine wall run towards the mucosa mainly at right angles or obliquely from the vessels outside the the wall, derived from the ovarian and uterine arteries, as WILLIAMS has shown. No flexion alone, therefore, can affect the circulation in the wall.

The explanation of dysmenorrhœa in cases of flexion is as follows: In some cases the cause is metritis and fixation of the uterus, as held by SCHULTZE, *e. g.*, in the condition already referred to where marked anteflexion is associated with inflammation in the uterus and behind it. The same thing may be found in a marked retroflexion, where the fundus uteri is deeply placed in the pouch of Douglas.

It is a common clinical experience that many of these cases are improved by treatment of the inflammatory conditions present. Exact observations on this point have been made by SCHULTZE, who points out that the dysmenorrhœa may be cured as the inflammatory products are absorbed, even though the flexion of the uterus may remain exactly the same.

In another set of cases, where a very acute flexion exists, and where there is a tendency to fibrin-formation or blood-clotting *in utero*, or to the exfoliation of portions of the mucosa owing to endometritis, it is not difficult to understand why there may be obstruction to the escape of the uterine contents and consequently dysmenorrhœa.

In a considerable number of cases also, the pain is referable to a neurotic condition.

That many cases of marked displacement exist in which there is no dysmenorrhœa, is a well established clinical fact. Such examples indicate clearly that other factors are necessary to the production of the dysmenorrhœa.

In inversion of the uterus there may be great pain at the menstrual periods. In the slowly produced variety it is easy to understand why this should be so. The inverting portion becoming congested at the menstrual period stimulates the rest of the organ to contractions, which tend to increase the extent of the inversion. In chronic conditions there are usually marked inflammatory changes in the uterine wall, which tend also to induce the dysmenorrhœa.

v.—Fibro-myoma of the uterus.—Dysmenorrhœa is a common symptom in fibro-myoma of the uterus, and it occurs under different conditions.

In cases of submucous fibroids which are tending to project into the uterine cavity, the pains are usually severe and labour-like. The polypus swells with the menstrual congestion, thus acting as a stimulus to uterine contractions.

In large, pediculated, subperitoneal fibroids, there may be dysmenorrhœa of a stretching or dragging nature, due, according to GUSSEROW, to the distension of the tumor with blood. Great pain may also be produced when such tumors have fallen within the true pelvis, the congestion due to menstruation causing pain by increasing the weight of the tumour, by causing pressure symptoms on surrounding structures, and possibly by stimulating the uterus to contraction. Similarly, dysmenorrhœa may be caused when large interstitial fibroids cause the uterus to increase so that it fills the pelvis.

II.—Dysmenorrhœa Associated with Slight or Without any Recognizable Pelvic Lesions.

A very large percentage of cases of dysmenorrhœa occur in women without distinct pelvic lesions sufficient to explain them. In these the predominant factor is disturbed innervation in one or other of its various manifestations. Notwithstanding the great increase in neuroses among women during the present generation, it must be confessed that in the gynæcological world scant attention has been paid to them.

Owing to the marked surgical trend in gynæcological practice during the last twenty-five years, a narrow and debased specialism has been evolved which has resulted in the establishment of a school whose motto is "*Le bassin c'est la femme*," and whose remedial measures are limited to different forms of mechanical procedure—from passing a sound to extirpating the appendages.

Too strong a protest cannot be urged against the centralization of attention on the local pelvic condition, without regard to wider physical and psychical relationships. PASCAL has a chapter, in his famous book, entitled "Man's Disproportion." The term might justly be applied to the mechanical school of gynæcologists, who have done so much harm by their failure to give to the various symptoms related to the pelvis, their proper proportional values.

The accusation of the broad-minded physician, that the gynæcologist works in ignorance of the neuropathies and organic diatheses in that

region of the body where they are of chief importance, is a well merited one, and the majority of specialists will, be they honest, acknowledge its force and humbly confess "Peccavi." I do not say that there is no truth in the counter-charge, brought by the specialist against the general physician, of a narrow sciolism which is incapable of estimating the significance of local pelvic phenomena; yet I firmly believe that the specialty of gynæcology will never reach a position of highest repute until it is established "broad-based" upon the philosophic attitude, the wide culture, and the extensive knowledge which formed the *summum bonum* of attainment among the great masters of medicine in past generations.

These defects in us lead to error both in diagnosis and in treatment. In considering a case of pelvic pain, we must bear in mind the following points:—

1. The pain may be directly due to distinct pelvic lesions, sufficient in themselves to produce this symptom.

2. Pain may exist with minor degrees of pelvic trouble, insufficient in themselves to cause more than a small amount of suffering.

3. Pain may be a pelvic symptom in association with some condition which in itself cannot directly produce this symptom.

4. It may be a prominent symptom in cases in which no local changes of any kind can be made out.

It is, therefore, very evident that other than local factors must be taken into account as explanatory of the subjective phenomena which we are considering. Of chief importance among these is the neuropathic state—neurosis, in the widest meaning of the word. This condition is related to the pelvis in various ways.

In one set of cases, a local lesion, capable or not in itself of causing pain, may be the primary cause of development of a neurotic condition manifested by diverse phenomena. The more marked these become, the more is the pelvic pain intensified—a reactionary exhibition of the neurosis, as it were, on the seat of the primary affection.

In another class of cases, there may be a slight pelvic lesion causing very little discomfort. A neurotic condition may be developed from causes foreign to the pelvis, and this may manifest itself in intense pain, referred by the patient to the pelvic lesion.

In another set, the symptom of pelvic pain is developed as one of the phenomena of a wide-spread neuropathic state, there being no local lesion of any kind.

There is another interesting class in which the local symptom is practically the only neurotic feature in the patient. In some of these cases the condition is somewhat like that in which the possession of a "fixed idea" is characteristic. In others, it is of the nature of a "secondary reflex action," induced by a former continuity of habit when there was an actual painful local lesion which has since been cured. The patient's nervous system has so registered the former habit that it is reproduced apart from all contact of the higher inhibitory centres. This power of impressing the nervous system is a well recognized biological truth. It is well exemplified in the case of the gouty man whose foot has been amputated, and who continues to have attacks of pain in the same toes as of old. Of similar nature is the remarkable instance of the mare, which, on being crossed with a stallion, bore a foal striped like a quagga—as a result of the influence of a previous conception following crossing with a male quagga.

By the neuropathic or neurotic condition I do not mean hysteria. This is only one of a variety of neuroses. Yet too often are women turned away from the mechanical gynæcologists, whose pelvic manipulations have failed to cure her, as a wretched hysteric.

One of the greatest services rendered to medicine has been the establishment of the distinction between neurasthenia and hysteria. This we owe to the work of men like WEIR MITCHELL and CLIFFORD ALBUTT, who have taught us that these terms are not synonymous, though often certain phenomena are common to both conditions.

That neuroses should be so common in women is not to be wondered at. Though MICHELET'S dogma is not true, that "woman's life is a history of disease," it must be admitted that it is one of physiological unrest, except in youth and old age. When we remember the great disturbances which mark the advent and departure of the reproductive era of her life, the profound changes taking place during ovulation, menstruation, pregnancy, labour and lactation; the subtle and complex activities of her physical life in its various diastaltic functions, it is not remarkable that neuroses should manifest themselves particularly in relation to her reproductive mechanism. That they are increasing *pari passu* with the advance in our higher civilization cannot be denied, among the poor, the inducing factors being over-work, over-worry, ill-regulated and poor nutrition; among the well-to-do, educational strain, over-indulgence, the stress of modern life, emotional excitement.

Another important factor in explaining the prominent part which the pelvic organs play in the neuroses, is the widespread habit among women of centralizing their attention upon these organs, because they are led to regard them as the primary cause of most of their ills. There is a fascination in the mystery of the sexual mechanism, and a morbid introspectiveness is easily engendered by an undue attention to it, too often passing into a condition of hypochondria. This mischievous habit is due, also, partly to the influence of the narrow, mechanical school of gynæcologists, partly to the work of quack pamphleteers and vendors of patent medicines—wouldbe saviours of suffering womankind. Much less attention has been paid to the influence of gout, malaria, rheumatism and other general conditions in relation to pelvic disease. They are of considerable importance and must be kept in mind in the treatment of pelvic pains.

In the treatment of dysmenorrhœa, the failure to consider the existence of relationships between local and general conditions, between pelvic suffering due to and commensurate with pelvic lesion, and that which is due to neurosis, and the fixation of the attention upon the local state, have resulted in a form of practice very often fraught with disappointment both to physician and patient, not to speak of the evil consequences to which I have above alluded.

In one of the very latest articles on the treatment of dysmenorrhœa, by one of the recognized leaders among English gynæcologists, not a single word is given to indicate that it is at all necessary to pay attention to neurotic complications, whereas I make bold to say that, taking all sorts and varieties of dysmenorrhœa into consideration, it is *the* factor which is most common to all, which requires most careful attention and in many cases sole attention.

The narrow and mechanically minded specialist, on coming into contact with his dysmenorrhœa case, at once proceeds to establish a *locus standi* in the pelvis. He argues, "the patient complains of pain in the pelvis: it must be in the pelvis: its cause is in the pelvis: its treatment must be by measures directed to the pelvis." He then has a choice of procedures. Probably he thinks first of uterine flexion and a stem pessary may be brought into requisition: or he may diagnose a stenosis of the os, and proceed to a dilatation or to a cutting operation; or he may deem the ovaries at fault, and decide heroically on their removal.

It may be that he will carry out these different operations *seriatim* in the chance that he will at last hit on the successful one. Sometimes

he cures the patient—sometimes he does not. When he is successful, he attributes the good result directly to his operation, forgetting that very often benefit is obtained either through its indirect effect on her nervous system, or by the influence of the rest, change of scene, diet, etc., with which the operative treatment is accompanied.

The history of gynæcology is one of a succession of periods of concentrated attention to one after another of the pelvic contents. Before the days of the bi-manual examination, when every gynæcologist wielded the tubular speculum, the supposed great source of pelvic trouble was the so-called "ulceration of the cervix," and there are well-founded traditions of fabulous fortunes made by those who devoted their lives to the touching of these diseased spots with various applications.

Then, with the discovery of the uterus, came the period of displacements and contractures, when nature's mistakes were remedied by pessaries, and dilators, and scissors. Then, the era of the ovaries, and finally, that of the tubes. Now, at the end of the chapter, what can the *fin de siècle* gynæcologist do but practice upon the whole gamut of his predecessors, giving special attention to one or another according to his particular bent or predilection. And so we find the country getting filled with women nursing a grievance against their wombs, their ovaries or their tubes, and in many instances possessing diagrams of their pelvic topography furnished by their zealous gynæcological physician, in order, I suppose, that they may, in their leisure hours, exercise their already over-stimulated introspective faculty with more scientific exactness.

Who that has read CLIFFORD ALBUTT'S lectures on visceral neuroses, has not smiled at his account of the woman "entangled in the web of the gynæcologist, who finds her uterus, like her nose, a little on one side; or again, like that organ, running a little: or as flabby as her biceps, so that the unhappy viscus is impaled upon a stem, or perched upon a prop, or is painted with carbolic acid every week in the year except during the long vacation when the gynæcologist is grouse shooting, or salmon-catching, or leading the fashion in the Upper Engadine."

Should the gynæcologist's moral sense become somewhat blunted, it is not difficult to understand why he may fall into the reprehensible habit of trading on the fears which naturally fill the minds of women when their reproductive apparatus is out of order, and of elevating into an unnecessary importance conditions which are but trifling.

Let me not be misunderstood. I am not denouncing local and operative interference, only irrational and injudicious interference. We are

all subject to this temptation. We all like short cuts to success. We are all prone to try, sometimes, like ALBUTT'S *bete noir*, "to stem the tides of general and diathetic maladies with little Partington-mops of cotton wool on the ends of little sticks." It is much less troublesome to make a few cuts and to put in a few stitches, than to patiently analyse a subtle and puzzling case, and to exert our whole energy in overcoming an obstreperous or aberrant nervous system.

Yet it is this latter practice that must be our constant study throughout gynæcological work: our chief study in many cases where pelvic pain and discomfort are prominent symptoms.

Throughout the orthodox medical fraternities of the most advanced modern civilized countries, there has been a widespread neglect of all remedial measures of a tangible and physical kind. This attitude has no doubt been developed in antithesis to the ridiculous pretensions of the mystics of the dark ages in Europe who were the representatives of Eastern occultism.

We are taught to denounce with academic scorn, and rightly in most cases, faith-healers, Christian scientists, hypnotists, religious miracle-workers, *et hoc genus omne*. Yet, if a man will but take the trouble to study this interesting congerie of empirics, with an unbiased and absorbent mind, he will discover that amid their extravagant claims and sententious philosophies, they have all been nursed upon one common germ-idea, viz.; that the transcendant power in the human organism is that of mind, and that the effects of diseased conditions, especially of those due to neuropathic changes, may be enormously modified by influences brought to bear upon the higher centres.

If one investigates, for example, miracle-working in sacred shrines, one will easily be convinced that striking cures are there wrought, often in cases which have baffled the best medical skill. The great mass of these cases are examples of neurosis, and they are chiefly manifested in women. That the marvellous transformations which are brought about are due to the special interference of Deity, is a pretentious assumption. One can see as remarkable cures affected through the agency of hypnotism.

With these various methods of empirical procedure, the medical world can have nothing to do, save in the case of hypnotism. It is our duty, however, not to rail against them in aimless talk, but to sift their claims thoroughly, and to demonstrate with scientific surety wherein

lie their errors. It is only in this way that the race of pretenders and charlatans can be eliminated from the earth.

Let us not, moreover, fail to recognise that all these healing-methods have emphasized the fact that the supreme factor in altering neuropathic conditions is the power of conviction and auto-suggestion, acting on the dominant cortical control centres, and through them on the whole nervous mechanism of the body.

Realizing this, it is our duty, in the treatment of pelvic pains in women, to impress strongly upon the mind of the patient the necessity of taking her thoughts from pelvic conditions, to teach her ever to practice self-control, encouraging her sympathetically, removing from her anxiety and fear as to the gravity of her state, and insisting upon the importance of counteracting every development of neurosis that may become manifest in her.

Success in this will vary according to the personality of the physician. In the present century, perhaps the two best marked examples of the healing influence of personality were CHARCOT and Sir JAMES Y. SIMPSON. Remarkable as were their powers as clinicians, investigators, expounders and teachers, they were equalled by their great gifts as healers. For twenty years the house of the latter was the chief medical shrine in the whole world. Though he revolutionized the local and operative treatment of pelvic disease, he is not remembered as a great operator, and of the thousands who consulted him, comparatively few underwent operations. He had a fascinating and impressive personality, and was able in a remarkable manner to stimulate and inspire his patients. His results were obtained partly by the unconscious and subtle power which suffused his whole being, influencing strongly those who came into contact with him, and partly by the words and helpful and sympathetic encouragement which he spoke to them.

These marked powers are no doubt born, not acquired by study, and they are rarely found in a high state of development. Yet it is open to each of us in some measure to improve what nature has given us, and to do much good in helping to restore to a more healthy and balanced condition a disorganised nervous system.

Along with this method of mental toning, I do not forget those adjuncts which are so often necessary, viz.; improved nutrition, freedom from over-work and care, change of scene and occupation, etc.

In some cases, operative procedures of one kind or another are necessary. But it must be insisted upon that these shall not be placed in the forefront of the remedial measures at our disposal, nor shall they be undertaken until the entire state of the patient has been investigated and every effort made to improve her condition on the lines which I have laid down.

Moreover, it is important to bear in mind that when local treatment of a recognisable pelvic lesion is necessary, the cure will be hastened and more firmly established by careful attention to the improvement of the neuropathic complications with which it is so often associated.

SOME PRACTICAL POINTS IN THE APPLICATION OF PLASTER-OF-PARIS JACKETS.*

By M. A. B. Smith, M. D., Dartmouth, N. S.

Of the different methods employed for the mechanical treatment of Pott's disease and lateral curvature of the spine, that by means of the plaster-of-Paris jacket is preferred in a large majority of cases. As applied by Phelps, of New York, it is the most successful method of treatment. It is true that the Taylor or other braces made by the instrument makers may also succeed when the treatment is employed in an orthopœdic hospital, and when the surgeon has at his call a competent instrument maker. But out of a hospital it is almost impossible to induce patients to keep the different straps so tightened, and the instrument so adjusted, that real support is given and rest secured to the injured vertebræ. Their weakness, too, in Pott's disease, lies in the fact that they exert pressure on the back only by means of two small pads each side the spine, while a plaster jacket exerts equable pressure all over the back. Pott's disease is of an inflammatory nature. The condition of the bone is the same as in hip-joint disease. Absolute rest is the treatment. If rest and support are not maintained by the appliance, the surgeon is sadly deceived about what is going on, and the patient instead of improving is growing worse.

When we consider that there is authority for the claim that every patient with Pott's disease if properly treated, should, if recovery takes place at all, recover with as little deformity as he has when he consults the surgeon, a great responsibility attaches to the matter of treatment of this disease. A plaster jacket may either prevent the dreadful deformity of this disease: or it may be worse than useless, excoriate the skin and be a burden to the patient. The result all depends upon whether or no the surgeon utilizes enough gray cerebral substance in its application.

It looks very easy to apply the jacket, especially after one has seen it done a few times, but the ordinary practitioner will certainly not succeed unless he has come to consider certain leading points which I propose to set down in a list, not because they are new or original, but because they are apt to be neglected, some of them especially, during the operation, in the hurry caused by the discomfort of the patient and the rapid setting of the plaster.

*Read at meeting of Nova Scotia Medical Society, 1896.

1. Gauze for bandages should not contain indigo or glue, which prevent setting, and should be fairly open or the jacket will be very long in drying.

2. Bandages for a patient of say 12 years should be six yards long, six inches wide, and six in number, and loosely rolled.

3. T. S. White's dental plaster-of-Paris should be used. Don't purchase by the barrel, but in 50 lb. tins, as it is soon damaged by exposure to air.

4. Pads of saddler's felt, of suitable size and thickness, should be placed over bony prominences, as the kyphos in Pott's disease, and the iliac crests in lateral curvature.

5. A dinner pad should be placed under the singlet or stocking net. For this purpose one may use a large towel folded lengthwise in fours, and doubled on itself twice.

6. Arm pieces, for suspension, should be used in Pott's disease, but not in lateral curvature. In the latter case the patient's hands should grasp the suspension cords above the head, the hand on incurved side being placed above the other, thus himself maintaining traction of block and tackle.

7. Bandages should be immersed in warm water, one by one, as needed.

8. Turns of first bandage should begin around the waist, and then be carried as low as the trochanters and continued up regularly, each turn overlapping the other one-half. The jacket should extend from the great trochanters nearly to the top of the sternum in front.

9. The upper and lower edges of the jacket should be firm—especially the lower.

10. Immediately the bandages are applied, pressure should be made over upper part of patient's chest and over the knee, with counter pressure by an assistant over the dorsal region on the lower part of the back. Jacket should be sprung away from iliac crests by pressure of the hands, front and back, and pressed down on gluteal muscles on each side of sacrum. Thus the jacket is moulded.

11. Before the patient is let down, the jacket should be trimmed with a penknife below in front, to allow the flexion of thighs, and also under the arms.

12. In cases of lateral curvature the jacket should be cut down the front, opened and removed, and again bound together with cotton

bandages, and set aside to dry. But it should not be removed or opened in Pott's disease.

13. When a jury mast is used, it should be well arched back, to draw back the head, and not used as a weight bearer. At night the pillow is placed between the jury mast and the head.

ADDITIONAL NOTES.

Good plaster should be quite firm by the time the surgeon is ready to remove the suspension apparatus.

The bandages are as wide as six inches so that fewer may be needed, and each bandage is not more than six yards long so that it may not set before its application is finished.

For a small child, a 5½ inch bandage is better, and five bandages are sufficient. For such a child the jacket when dry should weigh 2½ pounds, for one of twelve years, 4 pounds.

Although a knitted singlet is the usual covering for the body, over which the plaster is applied, stocking-net which comes in indefinite lengths cut off to suit, drawn over the body, tacked temporarily on the shoulders, and, after the jacket is completed, drawn up, and down over the outside forming a neat, soft surface for it, is the most satisfactory.

It is very important to protect bony prominences by felt of suitable thickness, to avoid excoriation of the skin under the plaster.

The arm pieces for traction should only be tightened to the extent of comfort, and the traction adjusted till the patient is on the ball of the foot.

The application of the jacket in lateral curvature often increases the patients height 2½ inches. Although its effect is much weakened by opening it and lacing it up, the need of its removal to allow of gymnastic exercises makes this procedure necessary.

Jackets should generally be removed and renewed every three months, and the treatment continued for say three years.

A corset made of pine wood shavings, brown Holland cloth and Cologne glue, which is very light, neat and accurate, may be worn for some time longer, or, in lateral curvature, may be used from the first.

In conclusion, the main point which I wish to emphasize is that neither the jacket nor the jury mast is intended as a weight-bearer. Their object is to throw the weight upon the undiseased posterior articular surfaces of the vertebræ. It is for this reason that pressure and counter-pressure should be made on the chest and knees and on the back, in moulding the jacket, namely to arch the body backwards sufficiently, as I have indicated.

Clinical Note.

CASE OF MALFORMATION OF FOETUS.

By T. C. Lockwood, M. D., Lockeport, N. S.

On the evening of Dec. 29th, I attended in confinement Mrs. N. W—, multipara, who was delivered of a healthy female child of more than average weight.

As the shoulders were born I noticed that the right arm of the child was missing and a closer examination revealed a somewhat curious instance of malformation.

The right clavicle and scapula are apparently normal the right humerus, radius, ulna and carpal bones are absent.

Projecting from the point of the shoulder and joined to it by a muscular attachment, corresponding almost exactly in size and shape to the normal carpus, may be found a perfectly formed forefinger and thumb, with their corresponding metacarpal bones. The child apparently has no motive and but slight sensory power over this partly developed hand.

The mother attempts to account for the missing arm in the following manner:—One evening sometime between the fourth and fifth month of her pregnancy an intoxicated man entered the house and violently assaulted her husband. In the alarm she stepped between the two: the drunken man seized her by the right shoulder with great force, and she became almost unconscious from fear and excitement.

Although not altogether a doubter in the theory of "maternal impressions," especially in regard to inherited dispositions and constitutional tendencies, I do not think the incident related above, occuring as it did at a late period of foetal development, could be held accountable for the absent member.

Distinctions Between Human and Animal Blood.—On mixing the blood in question with a little bile, there are formed crystals not exceeding 0.003 meter in size. Those of man are right rectangular prisms; those of the horse, cubes: of the ox, rhombohedrons; of the sheep, rhombohedric tablets: of the dog, rectangular prisms; of the rabbit, tetrahedrons; of the squirrel, hexagonal tables; of the mouse, octahedrons; of common poultry, cubes modified at their angles; etc.—*Scientific American.*

RETROSPECT DEPARTMENT.

Dermatology and Syphilology.

UNDER THE CHARGE OF
JAS. ROSS, M. D., Halifax.

REINFECTION OF SYPHILIS.

During the meeting of the Dermatological Congress in London last summer, a spirited discussion took place on the above subject. Medical observers of great experience arrayed themselves in direct opposition to each other. Though the weight of evidence substantiates the belief that reinfection is possible, several noted authorities, particularly among our French brethren, denied the possibility of any such occurrence.

COOPER AND COTTERELL, of London, (*Journal of Cutaneous and Genito-Urinary Diseases*), opened the discussion in which the following conditions were laid down as necessary before the case can be admitted:

1. A previous attack of syphilis, its history taken not from the patient's account, but from the physician who attended him.

2. A second infection following the usual course. The initial lesion must be followed by secondary symptoms, however slight. The authors believe that immunity acquired in the first attack may be lost, and that reinfection is possible. Many published examples must be taken *cum grano salis*. Mercury, properly used, will cure syphilis, as proved by reinfection. Hereditary syphilis, as a rule, confers immunity.

DR. FITZGIBBON, (Dublin,) drew an analogy between syphilis and the fevers, stating that the former, if uncomplicated by constitutional cachexia or coexistent sepsis, runs a definite course and is followed by a period of immunity, after which infection is again possible. The period of immunity is not an evidence of the presence of the disease any more than is the case with variola. Second attacks of syphilis are apt to be more violent and complicated, as well, by sepsis. From the latter is derived the virulence. The effects of syphilis are not necessarily persistent during life, but elimination is slower and subject to interrup-

tions not seen in the fevers. The majority of syphilities are completely cured, and proofs are not lacking that after five years the disease has not only disappeared from the organism, but its protective influence is weakened. A second infection is not however indubitable proof of the absolute cure. Experience shows that after three years the syphilitic, with rare exceptions, is free from every sign of his disease, and incapable of transmitting it.

Dr. OGILVIE, (London,) stated that one case, thoroughly authenticated, was better than sterile discussion. He related the case of a physician who suffered from two typical attacks, separated by an interval of two years.

Mr. HUTCHINSON, (London,) remarked that he had published fifty-four cases of syphilitic reinfection in his Archives of Surgery. Of these, thirty-four seemed to him incontestable.

MRACEK, (*Wiener Klin. Rundschau*), has investigated this subject, and relates two cases, in one of which the second attack developed ten years, and in the other four years, after the apparent cure of the first. He concludes that there are unmistakable cases of syphilis in which the disease is completely cured, and hence can be again acquired: it is, however, to be noted that the physician has no criterion which will permit him to say definitely when the patient is free from it. The author questions the currently accepted doctrine, that a second attack of syphilis is milder than the first: one of his own cases, and many others in literature, directly contradict this view. (This observation was borne out by Fitzgibbon, as already mentioned, at the Dermatological Congress)

In the August number of the *Journal of Cutaneous and Genito-Urinary Diseases*, Dr. Collings gives the history of a case of reinfection, whom he exhibited before the Hot Springs Medical Society. Nearly nine years after the first chancre and twenty-eight days after exposure, there appeared a chancre on the dorsal surface of the penis. Six weeks from the appearance of the sore mucous patches developed about the anus, to which he applied various salves without relief. Two weeks later, an eruption appeared on the scalp, the spots being as large as a one-cent (American) piece and moist. At the end of the tenth week a mucous patch developed on the under surface of the tongue. This disappeared under treatment, but another appeared afterwards on the tip of the tongue. Towards the close of the thirteenth week there developed two spots on the left calf and one over the right gluteal region, which were dark, excoriated, and moist. These healed under treatment

though leaving behind considerable pigmentation. When Dr. Collings first saw him, at the beginning of the seventeenth week of the disease, the epitrochlear, suboccipital, and inguinal glands were markedly enlarged.

The patient, who was a very intelligent man, gave a perfectly clear history of the first attack, nine years previously. The resultant scar of the chancre was still visible. The roseolar rash, alopecia, and mucous patches in the mouth and throat followed in turn. In all, his treatment at the time extended over two years, during which time he made two trips to the Springs, taking a thorough mercurial course, in conjunction with the baths, and under the direction of competent physicians who are well known. After the lapse of two years from the appearance of the first chancre, he went west to the Pacific slope, and for six years he remained absolutely free from any syphilitic manifestation.

TREATMENT OF CUTANEOUS EPITHELIOMA.

Dr. Gaucher (Paris) at the Dermatological Congress, remarked that epithelioma of the skin being an auto-inoculable affection, all methods of treatment which are liable to give rise to grafts or epitheliomatous emboli must be rejected. An open operation with the aid of the bistuory or cutting curette presents the inconvenience of opening the vessels, and of favouring recurrences *in situ* and generalization at a distance. The only method, therefore, which is free from objection, is, he believes, cauterization. Potential cauteries or chemical caustic substances frequently irritate the lesion, without destroying it: when sufficiently energetic, they cause a considerable loss of substance. The method of election is actual cauterization by the use of either the thermo or the galvanocautery, as this permits of regulating the effect exactly as may be desired in each case. In the interval between the cauterizations, recourse should be had to permanent applications of potassium chlorate, the particularly beneficial effect of which in cancroid has long been known. Instead of powdered or dissolved potassium chlorate, he prefers an ointment in the proportion of 1 : 6 or 1 : 3.

This treatment is curative only in cutaneous and superficial epitheliomata: in epithelioma of the mucous membranes, it is not very efficacious, and when the lesion has extended to the deeper strata, it is as a rule only palliative.

Selected Article.

THE THERAPEUTICS OF DISEASES OF THE HEART.

Dr. W. H. Thomson believes that the treatment must be determined chiefly by the consideration whether the affection be primary or secondary in its causation. In the treatment of primary affections the first indication is the prophylaxis of rheumatism. Particular attention should be paid to the tonsils, and prompt use of the salicylates internally should be made at the first signs of tonsilitis, together with local applications of tincture of iodine. The habitual employment of hot-water douches, with oil of peppermint to the throat, is an excellent measure. Rheumatic patients should always protect the skin with flannel, both by day and by night. Rest in bed is of great importance in the primary affections. When the symptoms are rather aggravated by digitalis, strychnine, and similar drugs, aconite will often lessen the dyspnœa, relieve the anginose attacks, and make the pulse fuller and steadier. In dyspnœa, the result of adhesive pericarditis, firm strapping of the right side of the chest is of undoubted service. For the dyspnœa of mitral stenosis, especially when it occurs in paroxysms, belladonna in combination with compound spirit of ether is much the best remedy. In mitral stenotic cases digitalis is often inferior to strophanthus, sparteine, or caffeine. Anæmia should always be considered, but the administration of iron is mischievous in rheumatism. In this disease the best remedies are cod-liver oil with small doses of arsenic: or calcium sulphide in from one-half to one-grain doses four times daily, apparently hastens the convalescence from acute rheumatism. In secondary disease of the heart one should consider the whole circuit of the circulation. The remedial agents may be divided into the constitutional and symptomatic. Of the first class, and the most important and continuous in its operation, is fresh air. Iron is the most effective among drugs, because it is our respiratory food, and has no other function in the body but as the carrier of oxygen. Next to continuous breathing in the open air is properly applied massage, especially that form in which the patient exerts a carefully regulated resistance to the flexion and extension of his muscles by the operator. The nature and seat of the peripheral obstruction which reacts upon the heart will modify the symptomatic medication. In the vicious circle of dilatation of the right heart, with resultant

dropsy, due to chronic bronchitis, the heart-affection is one of the most curable, if one can cure the bronchitis first. In such cases hours spent in a dry, equable air, help the weakened bronchial muscles and the weakened right ventricle as well.

Among medicines, tincture of ferric chloride with strychnine does more good to the cough than any cough mixture. Here, also, arsenic and potassium iodide are useful. The most serious of secondary cardiac diseases are those dependent upon arterial disease. The rapid pulse of secondary cardiac dilatation should be treated by digitalis and not by aconite. In secondary cardiac dilatation digitalis takes the lead of all other drugs; but it should be administered with nitroglycerin, which, by dilating the arterioles enables us to ease the heart of the peripheral obstruction, against which it had to contend before, on account of the increased arterial pressure caused by the digitalis. Digitalis also causes much gastric disturbance. When much dilatation obtains with cardiac arrhythmia, general dropsy, and pulmonary œdema, the infusion in ounce-doses four times daily should be administered for two or three days; then the permanent dose of a half-grain of the powder may be given thrice daily with benefit for a long time. Prior to these smaller doses and during the administration of larger doses, calomel, in a dose of from one-half to two-thirds of a grain thrice daily is of very great benefit; but it should be discontinued at the first signs of mercurialization. As a modification of the digitalis treatment, equal parts of the tincture of strophanthus, nux vomica, and digitalis may be given in twenty or thirty drops of the mixture thrice daily, particularly in aortic regurgitant and mitral stenotic cases. In chronic interstitial nephritis the high tension of the pulse and the low specific gravity of the urine seem to be favorably affected by small doses of corrosive sublimate. In cerebral derangements short of apoplexy both the cerebral and cardiac affections seem to be improved by a pill containing two-thirds of a grain of sparteine sulphate, one-half grain of powdered digitalis, and one-twenty-fourth of a grain of corrosive sublimate. In all cardio-renal cases with extensive dropsy a milk diet should be avoided. Opium is a powerful heart stimulant, and in nocturnal dyspnœa chloral is of great advantage.—*The Medical Record.*

SYR. HYPOPHOS. Co., FELLOWS,

CONTAINS

The Essential Elements of the Animal Organization—Potash and Lime.

The Oxidizing Elements—Iron and Manganese;

The Tonics—Quinine and Strychnine;

And the Vitalizing Constituent—Phosphorus; the whole combined in the form of a Syrup, with a **Slight Alkaline Reaction.**

It Differs in its Effects from all Analogous Preparations; and it possesses the important properties of being pleasant to the taste, easily borne by the stomach, and harmless under prolonged use.

It has Gained a Wide Reputation, particularly in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs. It has also been employed with much success in various nervous and debilitating diseases.

Its Curative Power is largely attributable to its stimulative, tonic and nutritive properties, by means of which the energy of the system is recruited.

Its Action is Prompt; it stimulates the appetite and the digestion, it promotes assimilation, and it enters directly into the circulation with the food products.

The prescribed dose produces a feeling of buoyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

NOTICE—CAUTION

The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, FINDS THAT NO TWO OF THEM ARE IDENTICAL, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen, when exposed to light or heat, IN THE PROPERTY OF RETAINING THE STRYCHNINE IN SOLUTION, and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing to write "Syr. Hypophos. FELLOWS."

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles: the distinguishing marks which the bottles (and the wrappers surrounding them, bear can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

FOR SALE BY ALL DRUGGISTS.

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A Palatable Laxative Acting without Pain or Nausea.

Wyeth's Medicated Fruit Syrup.

THE NEW CATHARTIC APERIENT AND LAXATIVE.

There is no medicine for which physicians feel so great a need as an effective cathartic and aperient, one that will act promptly, without pain, griping or nausea, as some action on the bowels is required with almost every ailment or indisposition.

We make many hundred cathartic formulas of pills, elixirs, syrups, and fluid extracts; and for that reason, our judgment in giving preference to the MEDICATED FRUIT SYRUP, we feel is worthy of serious consideration from medical men.

The taste is so agreeable that even very young children will take it without objection; the addition of prunes and figs having been made to render the taste agreeable rather than for any decided medical effect. It is composed of Cascara, Senna, Jalap, Ipecac, Podophyllin, Rochelle Salts and Phosphate of Soda, being treated separately, enabling us to deprive the vegetable drugs of the bitter and disagreeable taste, inherent in nearly all of them.

The preparation has been carefully tested, largely and freely in hospital, dispensary and private practice, by a number of physicians (many of whom were interested in determining satisfactorily if the combination deserved the claims urged upon them by us), for quite a year previous to asking attention to it from the medical profession at large, being unwilling to bring it to their attention until we were confident of its merits, and had exhausted every effort to determine by satisfactory results.

The absence of any narcotic or anodyne in the preparation, physicians will recognize is of great moment, as many of the proprietary and empirical cathartic and laxative syrups, put up and advertised for popular use, are said to contain either or both.

It will be found specially useful and acceptable to women, whose delicate constitutions require a gentle and safe remedy during all conditions of health, as well as to children and infants, the dose being regulated to suit all ages and conditions; a few drops can be given safely, and in a few minutes will relieve the flatulence of very young babies, correcting the tendency of recurrence.

JOHN WYETH & BRO.,

DAVIS & LAWRENCE CO. LTD., General Agents,

MONTREAL.

THE

MARITIME MEDICAL NEWS.

VOL. IX. FEBRUARY, 1897. No. 2

Editorial.

THE CHOLERA.

Recent cable information to the effect that France and Italy are taking strict precautions against England and India on account of cholera and "plague," coupled with the news of the late arrival at Plymouth of a steamship with cases of cholera aboard, serves to reawaken cis-Atlantic interest in the Asiatic pest. The intimate communication between our own land and Japan, where an especially virulent type of cholera is at present epidemic, renders the importation of the disease quite among the possibilities, and calls for zealous watchfulness on the part of the medical officers in ports entered by vessels from Japanese and other Asiatic waters. India suffers not alone from the "plague," but retains its pre-eminence as a cholera centre—Bombay on the west, and Calcutta on the east, having furnished many victims during the year recently ended. So that from this source, too, the disease may readily come to us.

In these days of advanced sanitation, we feel that there is small likelihood of this disease gaining any foothold on our shores. But it would be scarcely prudent to court an invasion by the disease, and perhaps we should not be too well satisfied with our hygienic arrangements. It is always well to be cautious, and to permit no laxity which may possibly involve loss of human life. We therefore urge upon health authorities the necessity for eternal vigilance, and especially urge that there be no relaxation of precautionary measures at the present time.

The success which has attended the efforts of the Plymouth authorities against the spread of cholera, evidences the utility of prompt action by an organized service. As the *British Medical Journal* says:—"The

circumstances afford a striking proof of the efficacy of the measures, founded upon pathology and common sense, which are now taken in British ports in dealing with infected ships."

DR. WEBSTER'S PAPER.

We have much pleasure in presenting to our readers in this issue a paper on "Dysmenorrhœa," read before the St. John Medical Society a few weeks ago by Dr. J. CLARENCE WEBSTER.

As many of our readers are probably aware. Dr. WEBSTER is a New Brunswick boy, who after a noticeably successful college career in his native province went to Edinburgh university, where his industry and talents not only obtained the reward of a good degree, but led him on to original researches, and obtained for him recognition amongst eminent gynæcologists of Great Britain and the Continent. For six years he was the Assistant Professor of Midwifery and Diseases of Women at the University.

He has now returned to Canada, making his home in Montreal. His colleagues and friends in these maritime provinces will be delighted to have this clever Canadian back again, and will be pleased to note the future success of a man conservative alike of the interests of a class of patients that we fear are sometimes treated more in a manner calculated to add kudos to the operator than for their own ultimate benefit, and of the reputation of the profession for thorough and conscientious devotion to all that tends to alleviate and cure.

The paper will be found full of interest and instruction, and will throw a new light on many things connected with dysmenorrhœa, while the ideas advanced with regard to the non-connection between ovulation and menstruation must be considered distinctly modern.

BRITISH MEDICAL ASSOCIATION.

MONTREAL MEETING.

Owing to the fact that the meeting of the General Council of the Association was delayed until January 20th, we are still ignorant of the names of those selected to give the general addresses and to be office holders in the various sections in the forth-coming meeting. We can only here repeat that the local executive in Montreal has throughout felt that it will be highly conducive to the success of the meeting if

leaders of the profession in the old country, rather than Canadians, be chosen to occupy the leading positions in connection with the forthcoming meeting. This, not from any disbelief in the abilities of Montrealers and other Canadians being able to prove themselves worthy occupants of the positions, but from a belief that the known presence of well-known men will attract to Montreal a greater number both of Canadians and of practitioners from Great Britain and the colonies in general.

Since our last issue the excursions sub-committee has obtained most favorable terms from the G. T. R. and the C. P. R companies. They offer to the association and its guests to convey them at half-fare as far west as Sarnia on the one system and Port Arthur on the other. In addition, the C. P. R. will give the same rates to those wishing to cross the continent. Return tickets will be given from Montreal to Vancouver for one single fare, and the privilege of stopping over at the leading places of interest along the route. The committee has not as yet received absolute information from the railway companies as to whether these terms apply to Canadian members of the Association as well as to members from other parts, but the inference is that this is the case.

The local entertainment sub-committee has also been busy and proposes to give members fond of exercise opportunities of showing their powers in golf, tennis, etc., against the visiting members from Great Britain. It is quite prepared also to have a lacrosse match, provided a sufficient number of members from the other side are acquainted with the game. Lacrosse, we may add, has of late years made considerable strides in the north of England and of Ireland, and again around London.

Arrangements have already been made for a ladies committee to entertain the wives and daughters of visiting members.

We learn from Toronto that a most attractive excursion through the Niagara peninsula, Kingston and the Thousand Isles, has been arranged for those attending the meeting of the British Association for the Advancement of Science, and intending to be present also at the Montreal meeting.

A recent cable message from Dr. RODDICK, who has been in England for some weeks, announces that among other distinguished medical men who intend being present at the Montreal meeting, is Lord LISTER.

Correspondence.

THE DOSAGE OF ANTITOXIN.

DEAR MR. EDITOR: —THE MARITIME MEDICAL NEWS of January, on page 30, gives the details of a case of pseudo-membranous laryngitis, in which antitoxin was given, first an injection of 400 units, followed the next day by one of 600 units. Turning to page 40, I was much pleased to see a reprint of the recommendations of the American Paediatric Society, wherein the minimum dose of antitoxin is given as 1000 units, and the statement made "that for a child over two years old, in all severe cases, 1500 to 2000 units should be used for the first injection," to be repeated once or twice if needed.

Remembering the fact that antitoxin contains *no inherent poisonous properties*, the physician should, if he expects good results from its use, administer it as early as possible after making a clinical diagnosis, and use the serum in sufficient unitage to overcome the toxin against which he is waging battle. Should a culture determine later on that his case is not diphtheria, but tonsillitis, he will be in the same safe situation as the man who, when in doubt as to the condition of an injured joint, treats it as a fracture, and thus protects both himself and his patient.

Experience in the use of this serum is, I think, constantly proving its benefit in protecting from an attack those exposed to the diphtheritic poison, and I would strongly urge upon your readers—more particularly those in remote country districts, where this dreaded disease is often found at its worst—to use antitoxin in immunizing doses of say 250 units upon every member of an exposed household, just as they would vaccinate the same should the case be one of small-pox. My firm belief in the benefits of antitoxin is my chief apology for this letter, and in conclusion I repeat, use it early in the disease and in sufficient unitage to accomplish its work.

Very truly yours,

D. B. MYSHRALL, M. D.

Woodfords, Me., Jan. 22, 1897.

THE McGILL POST-GRADUATE COURSE.

DEAR MR. EDITOR:—You asked me some time ago to let you know something of the Post-Graduate Course of McGill, which was conducted for the first time last summer.

Personally I have nothing but a most favourable impression of it and perhaps as some of your readers may think of taking advantage of it next summer, it might be well to give a short resume of the course.

During the first fortnight Drs. ELDER and MCCARTHY gave a short course of surgical and topographical anatomy, and on every day for the remainder, Dr. R. C. KIRKPATRICK conducted a course of operative surgery, and as there was ample material, each member of the class had the opportunity of performing (or assisting at) most of the standard operations—Ligature of vessels, abdominal operations, amputations, etc. Dr. KIRKPATRICK certainly did his best, and succeeded in making this class of great practical benefit.

The course, however, which was probably most appreciated by the post-graduates generally, was that of bacteriology by Dr. ADAMI. This was to be expected, for as most of us had graduated before bacteriology was a recognised branch of medical education, we perhaps got more of what was actually new to us in this class than in any other. The course was just what it was advertised to be, clinical bacteriology. While not going into the technique, a comprehensive sketch was given of the characters, life history, etc., of the various bacteria, their methods of causing disease, etc.

This course was just what is required by physicians desirous of being up-to-date in the subject, and who wish a clinical knowledge rather than one which would be necessary for those making a special study of the subject.

The bacteriology course was well supplemented by a comprehensive laboratory course of clinical microscopy by Drs. MARTIN and WYATT JOHNSTON. In this was also taught methods of making cultures, staining and examining bacteria in sputum, etc., and individual members were taught how to do so for themselves. In this course, too, was taken up the examination of blood, urine, vomitus, etc.

Clinical material and opportunities were practically unlimited. The afternoons were fully occupied in attendance either at the Royal Victoria or the Montreal General Hospitals. At the former we had regular

clinics by Drs. BELL and STEWART, while at the General the work was taken up by Drs. FINLEY, LAFLEUR and ARMSTRONG.

Dr. BELL during the whole course gave special attention to genito-urinary diseases every Saturday afternoon. Drs. BELL and ARMSTRONG deserve special thanks for their courtesy in sending to the post-graduates notice of any special or urgent operations which had to be performed at irregular hours, and which might be of any special interest to members of the class.

Clinics were conducted also in gynæcology, dermatology and ophthalmology for those wishing to give special attention to these subjects.

Clinical chemistry was very fully taken up by Dr. RUTTAN, particularly with reference to the urine.

The evening lectures were a prominent feature of the course. Lectures were given by Dr. BELL on brain surgery; by Dr. ARMSTRONG on advances in abdominal surgery; also on medical subjects by Drs. LAFLEUR, FINLEY, STEWART and others. Dr. ADAMI gave several exceedingly interesting lectures on such subjects as immunity, pathology of the thyroid and the pancreas, referred pain, etc.

Unfortunately Dr. MILLS met with an accident early in the course, so we did not see much of him till near the end. However he gave several very instructive demonstrations and lectures on the nervous system, and my only regret was that we did not have more from him.

Dr. GUNN gave a short course in normal histology, in which those desirous of refreshing their memory in this branch had an opportunity of doing so.

In conclusion I can only express my great satisfaction with the course, and I know I am voicing the unanimous sentiment of the class.

I can heartily recommend any one wishing to have a general "brush up" to go to McGill, because the medical faculty of that college have the means, the wish, and certainly the ability to make the course of great practical interest to the members of the class. We met with nothing but universal courtesy and desire to meet any individual wishes with regard to the kind of work taken up, suitable hours, etc.

As a graduate of an old country school, I went to Montreal perhaps just a trifle prejudiced in my opinion, thinking I might have done better by taking the London post-graduate course. Once there this prejudice was speedily dispelled. McGill is an "up-to-date," progressive college.

This departure of hers should be hailed with delight by Canadians, and should receive all encouragement at the hands of the profession in

Canada: and while I have no personal knowledge of schools on the other side of the line, and comparison would be odious, I would earnestly advise both young men entering the profession and those physicians desirous of becoming acquainted with the latest methods and learning, to be patriotic enough to think of McGill before deciding where to go. And while a British post-graduate course may be first class, that of the McGill medical faculty is not less so.

Yours very truly,

A. HALLIDAY.

Lower Stewiacke, N. S., Jan. 1897.

P. S.—For anyone wanting special laboratory work, the necessary arrangements are willingly made on application to the courteous and energetic registrar, Dr. RUTTAN, to whom the success of the course was in a very great measure due.

Matters Personal and Impersonal.

Dr. J. MACKENZIE, of Port Mulgrave, has been attending the courses of the New York Postgraduate Medical School and Hospital.

Mr. GEORGE S. DAVIS has been obliged to retire from the management of the firm of PARKE, DAVIS & Co., on account of ill health. He has been succeeded by Mr. W. M. Warren, who has had a long association with the firm, and who for ten years has been the assistant manager.

Dr. EDWARD R. SQUIBB, of New York, was recently compelled to submit to amputation of the left hand, on account of a condition which was said to be the remote effect of an accident sustained many years ago while experimenting with ether. Although well beyond the three-score-and-ten, Dr. SQUIBB bore the operation well and is progressing favorably.

The NEWS extends congratulations and best wishes to Dr. and Mrs. A. A. DECHMAN, who formed a life partnership on the 17th of December last. Dr. DECHMAN is a Dalhousie graduate, of the class of '94, and practices at Upper Musquodoboit. He married Miss McCurdy of Baddeck.

Society Meetings.

ST. JOHN MEDICAL SOCIETY.

J. H. MORRISON, M. D., President, in the chair.

DEC. 30, 1896.—In addition to the attendance of a large number of members, there were present Drs. J. C. WEBSTER (Montreal), MCLEAN (Norton), and WHITE (Moncton.)

A paper was read by Dr. J. C. WEBSTER on "Dysmenorrhœa, with especial reference to neurosis." This interesting paper appears in the current issue of this journal. Its reading gave rise to a general discussion, the neuropathic element of dysmenorrhœa being fully considered. Dr. JOHN BERRYMAN instanced cases due to local pathological conditions. In replying, Dr. WEBSTER referred to menstruation and ovulation as processes distinct, and not associated.

After adjournment, the members were entertained by the PRESIDENT.

JAN. 6, 1897.—Dr. GRAY read a paper on "Post-partum Hæmorrhage." Nine cases were related, illustrating this condition. One was that of an elderly woman with weakened uterine muscle; two were young women, of whom one died a few years later of phthisis, the other of peritonitis: one had an adherent placental site. All the cases recovered.

Dr. GRAY considered the most frequent cause of post-partum hæmorrhage to be atony of the uterus, following on great uterine distension, prolonged and deep anæsthesia, albuminuria, etc. He referred, regarding treatment, to compression (bimanual and external), compression of aorta, ergot, tampons, vinegar, and hot water. The use of ice, and pouring cold water on abdomen were deprecated.

DR. WALKER referred to the recent advocating of compression of aorta in all cases. He uses ergot, generally, just before labour is expected to terminate.

Dr. JAS. CHRISTIE considered ice useful. He gives ergot similarly to Dr. WALKER. Dr. DANIEL spoke of the application of sponge with vinegar. The paper was also discussed by Drs. TUCKER, SCAMMELL, ROBERTS, WETMORE, MCINTOSH, W. W. WHITE, SKINNER and MORRISON.

JAN. 13, 1897.—A paper on MAUNSELL'S method of intestinal anastomosis, by invagination, was read by Dr FOSTER MACFARLANE. This

method was used by Dr. H. W. MAUNSELL for the first time in Dec., 1886, and the case was reported in Feb., 1892, but it was not until 1894 that the details of the operation were fully published—shortly after MAUNSELL'S death. Dr. F. H. WIGGINS, of New York, has written a complete description of the method. There have been nine recoveries out of eleven cases.

Dr. MACFARLANE described the method, which consists in invaginating the intestinal ends and drawing them through a longitudinal incision made in one end of the intestine about two inches from the divided ends, suturing and returning the ends, and finally closing the incision. The advantages claimed over the use of the Murphy button were mentioned.

The paper was discussed by the members present.

JAN. 20, 1897.—A specimen of membranous cast, passed at menstrual period, was shown by Dr. EMERY.

Dr. EMERY also opened a discussion on "Diphtheria." He referred to:—

(1) The use of antitoxin—statistics seem to show a reduction of mortality by its use from 40 to 50 p. c. in 1893 and 1894 to from 12 to 20 p. c. in 1895 and 1896. Dr. EMERY referred to fourteen cases, all of which received antitoxin, with two deaths. One was successfully intubated by Dr. J. H. MORRISON. Another case showed a large membranous patch on the lower lip, and another had a patch on a cut on the finger. Following the use of antitoxin, in one was noticed erythema at site of injection; in two there was a rash resembling measles. Early injections gave the best result, improvement being noticed within twenty-four hours.

(2) Tracheotomy and intubation.

(3) The germs present, and bacteriological examination. The Klebs-Löffler bacillus, streptococcus and staphylococcus were referred to.

(4) Summary.

The paper was discussed by Drs. DANIEL, MOTT, SCAMMELL, WETMORE, T. WALKER, JAS. CHRISTIE, and MORRISON.

Books, Pamphlets and Exchanges.

THE INTERNATIONAL MEDICAL ANNUAL.—The announcement of Mr. E. B. Treat, 5 Cooper Union, New York, that the *Annual* for 1897 is now well in hand and will be soon ready for delivery, will be received with satisfaction by all those who have learned of the excellencies of that publication. Mr. Treat assures us that the new issue will be no whit behind any of the fourteen yearly issues which have already appeared, but on the contrary, will contain new features which will add value to the work. The price will be as usual—$2.75.

AUTOSCOPY OF THE LARYNX AND THE TRACHEA. (Direct Examination Without Mirror.) By Alfred Kirstein, M. D., Berlin. Translation by Max Thorner, A. M., M. D., Professor of Clinical Laryngology and Otology, Cincinnati College of Medicine and Surgery, etc. With Twelve Illustrations. One Volume, Crown Octavo, pages xi-68. Extra Cloth, 75 cents, net. The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street, Philadelphia.

This monograph shows how the larynx, trachea and the entrances into the primary bronchi can be seen under direct linear inspection, instead of the present method by reflected light. The necessary conditions to success are:

1. The body must be placed in such a position that an imaginary continuation of the laryngo-tracheal tube would fall within the opening of the mouth.

2. The imaginary straight line must be cleared of those parts of the body (epiglottis and base of tongue) which obstruct it, by the special manipulations described in the text.

The book is neatly gotten up and will be of much interest to those who engage in laryngeal work.

THIRTY-NINTH REPORT OF THE NOVA SCOTIA HOSPITAL FOR THE INSANE, FOR THE YEAR 1895-6.—DR. SINCLAIR'S reports of the doings of our principal provincial charity, and of the efforts being made for the restoration of our mentally afflicted, are always read with interest. We

note that the FLECHSIG treatment of epilepsy is under trial at the Hospital, but Dr. SINCLAIR does not express any opinion as to its merits. Thyroid feeding in stupor has not yielded him good results. Three cases are instanced where mental recovery followed upon the incidence of physical disorder attended with a febrile reaction, and one in which the sustenance of a comminuted fracture, with no resulting pyrexia, appeared to aid in bringing about mental restoration. One hundred and thirty patients were admitted during the year, a total of four hundred and sixty-eight being under treatment. The percentage of cures on admission was 35.4—the percentage of deaths on whole number under treatment, 5.1.

* *

WE welcome a new journal to our list of Canadian exchanges. It hails from Toronto, and promises to be a valuable acquisition to medical journalism. The *Canadian Journal of Medicine and Surgery* is edited by Drs. W. A. YOUNG, J. J. CASSIDY and E. HERBERT ADAMS, who have the assistance of a number of able department editors.

ALLEVIATION OF PAIN IN LABOR.—At the Pirogoff Congress in Cracow, Hr. BUKOEMSKI read a paper on the alleviation of pain in normal labor. After careful consideration he concluded that alleviating remedies did not retard labor, they never did harm and were sometimes of great service. By the toxo-dynamometer (ether forty-five cases, and chloroform eight cases), he determined that when ether was used the pulse and respiration were unchanged. The labor was shortened, albumen was never seen in the urine, the uterine contractions were more powerful, and involution was improved. Ether was a reliable and non-dangerous drug that did not require accurate dosage. Chloroform rather retarded labor, but was not injurious to either mother or child. Ether deserved the preference. Both were good and reliable.

Hr. SSAWITZKI had obtained good results from antipyrin, of which he gave ten grains along with fifteen to twenty-five drops of tr. opii. in enema, and repeated it from two to six hours.

Hr. DOBRONRAWOW proposed a collective inquiry into the alleviation of pain during labor. An inquiry of that kind was being carried on in Russia, and the report would be submitted to the twelfth International Congress of Medicine in Moscow. The proposal was accepted by the Congress.—*Medical Press.*

Therapeutic Suggestions.

Chronic Dyspepsia in Children.—Comby recommends the following powder in dyspepsia due to atony and dilatation of the stomach in children five to ten years old:

R. Pulv. nuc. vom. 0.01
Sod. bicarbon.
Magn. calcinat. ..... aa 0.2
Pepsin 0.1

M. Sig.—One to be taken before meals, morning and evening. This must be continued for ten days, then omitted for the same period and repeated. This remedy is contraindicated in severe pain of the stomach with accompanying great nervous irritability.—*La Med. Moderne, 1896, 26.*

Atropin as a Means of Mitigating Certain Inconveniences of Quinine.—It is suggested by Aubert *(Lyon Medicale, Jan. 3.)* that the ear-buzzing and kindred phenomena, which so frequently follow the administration of quinine, may be to a large extent controlled by the simultaneous use of atropin in small dosage. His experience has been limited to doses of from five to seven grains of quinine, so that it cannot be stated what influence the atropin would have when the quinine would be given in larger quantity.

For Epilepsy.—Prof. de Bechterew, of St. Petersburg, recommends the combination of potassium bromide with codeia and the infusion of Adonis vernalis. In English, his formula would be about as follows:—

R. Infus. fol. vernalis ..... ℥ss — ℥j ad. ℥vj
Adde:—Potass. bromid ..... ℥ij — ℥iij
Codeini ..... gr. ij — gr. iij M
Sig.—℥j — ℥ij in aq. q. i. d.

For this combination, de Bechterew claims a special power of controlling the frequency of the convulsions. The vernalis is said to exert a constricting influence upon the cerebral vessels, and is a cardiac tonic very like digitalis but without its cumulative tendency.

The Treatment of Warty Growths of the Genitals.—A paper on Epithelioma of the Penis, read by Gottheil before the Society for

Medical Progress, concludes as follows: (*International Journal of Surgery, January 1897.*)

1. Warty growths of the genitals, more especially in the male, are always to be suspected of malignancy, no matter how innocent they seem.

2. They should either be left entirely alone, or be thoroughly removed by knife or cautery.

3. Imperfect attempts at destruction, as with nitrate of silver, carbolic acid, etc., are especially to be avoided: there being many cases recorded in which they have apparently stimulated a benign growth into malignant action.

THE TREATMENT OF SCARLET FEVER BY ANTI-STREPTOCOCCIC SERUM. —MAMNORECK (*La Clinique, 1896, Vol. II., No. 2.*) From October 16, to December 31, 1895, ninety-five children were treated with the serum. Ten to thirty cubic centimetres were injected in ordinary cases, and forty to eighty in the severe ones. The effect on the lymphatic enlargements was especially noteworthy: nineteen cases resolved without suppuration.

Four cases of double otitis were promptly controlled by the serum injections; in one other the otitis developed in spite of the serum, but soon ceased. One or two doses were sufficient to re-establish the normal state of the kidneys after the appearance of albumen in the urine.

Grave complications were prevented and false membranes and delirium rapidly disappeared, the general condition being very much improved. No serious inconvenience resulted from the use of the anti-streptococcus serum; few transient erythemata only were noticed. Absolute asepsis must be insisted on in making the inoculations.

While the cases are too few in number to allow the drawing of positive conclusions, the author believes that the remedy will render real service in the treatment of scarlet fever.—*Archives of Pediatrics, December, 1896.*

ON THE ANTI-RHEUMATIC ACTION OF SALICYLATE OF STRONTIUM.—Pure salicylate of strontium made by Paraf-Javal process, occurs in white crystalline needles, which are slightly soluble in water and alcohol.

It is this salt only which should be administered internally. It increases the blood pressure, which is not diminished unless the dose is increased far beyond the amount required when salicylate of soda is employed.

Clinical observations show that in doses of 5 grains, its antiseptic properties are most energetic and that as an intestinal antiseptic, it is superior to Salol, Napthalin and similar antiseptics.

Doses of from 10 to 15 grains in gouty and rheumatic subjects, give the same results as other salicylate preparations; but its superiority lies in the fact that it does not interfere with the stomach; it is therefore especially indicated where digestive troubles occur in chronic rheumatism and gout. (Translated from the *Bulletin de Thérapeutique.*)

THE TREATMENT OF UNILATERAL AURAL CATARRH AND ITS CAUSE.—E. DAAZIGER (*Therapeut. Monatsh., 1896, x, 125.*) The relations of the nose, nasal cavities and the ear are so close that even the older authors recognized a relation between these parts in disease. DAAZIGER, therefore, draws attention to the fact that disease of the ear, particularly if unilateral, very frequently is dependent on anomalous conditions of the nose and naso-pharynx, on adenoid vegetations, enlarged tonsils, and hypertrophied turbinated bones. After the cure of these pathological conditions, the affection of the ear often becomes perfectly well without any other treatment. Particularly in children is this connection a very intimate one, and we should never neglect the examination of the naso-pharynx when called on to treat any aural complaint in the child.—*Pediatrics, Jan. 1, 1897.*

PUERPERAL ECLAMPSIA: ITS ETIOLOGY AND TREATMENT.—Dr. WILLIAM WARREN POTTER, of Buffalo, read a paper on this subject, at the 91st annual meeting of the Medical Society of the State of New York, Albany, Jan. 26, 1897.

He said, *inter alia*, that we seem to have arrived at the renaissance of eclamptic literature, that while the subject is being discussed in magazine articles and societies, it would not answer for this society to keep silent.

Though the pathogenesis of eclampsia is still unsettled, we are certain that it is a condition *sui generis*, pertaining only to the puerperal state, and that to describe as formerly, three varieties—hysterical, epileptic and apoplectic—is erroneous as to pathology and causation, as well as misleading in treatment.

The kidney plays an important office in the economy of the eclamptic. If it fails to eliminate toxins, symptoms are promptly presented in the pregnant woman. Renal insufficiency is a usual accompaniment of the eclamptic state. Overproduction of toxins and underelimination by

the kidney is a short route to an eclamptic seizure. However, many women with albuminuria escape eclampsia, and many eclamptics fail to exhibit albuminous urine.

The microbic theory of eclampsia has not yet been demonstrated. The toxæmic theory in the present state of our knowledge furnishes the best working hypothesis for prevention or cure.

Treatment should be classified into (a) preventive, and (b) curative. The preventive treatment should be sub-divided into medicinal and hygienic; and the curative into medicinal and obstetric. A qualitative and quantitative analysis of the urine must be made at the onset. If there is defective elimination, something must be done speedily to correct a faulty relationship between nutrition and excretion. One of the surest ways to control progressive toxæmia is to place the woman upon an exclusive milk diet. This will also serve to flush the kidneys and thus favor elimination. Distilled water is one of the best diuretics; it increases activity and supplies material, two important elements. In the pre-eclamptic state, when there is a full pulse with tendency to cyanosis, one good full bleeding may be permissible, but its repetition should be regarded with suspicion. If there is high arterial tension—vasomotor spasm—glonoin in full doses is valuable.

When eclampsia is fully established, the first indication is to control the convulsions. Full chloroform anæsthesia may serve a good purpose. If the convulsions are not promptly controlled the uterus must be speedily emptied. This constitutes the most important method of dealing with eclampsia. Two lives are at stake, and by addressing ourselves assiduously to speedy delivery of the fœtus, we contribute in the largest manner to the conservation of both.

Rapid dilatation first with steel dilators, if need be, then with manual stretching of the os and cervix, followed by the forceps, is the nearest approach to idealism. Only rarely can the deep incision of Duhrssen be required. Cæsarean section should be reserved for extreme complications, as deformed pelvis, or to preserve the fœtus when the mother's condition is hopeless. Veratrum viride is dangerous, uncertain and deceptive in action.

In eclampsia of pregnancy, *i. e.*, prior to term, the aseptic bougie, introduced to the fundus and coiled within the vagina, may be employed to induce labor. Finally, to promote the elimination of toxic material diuresis, catharsis, and diaphoresis should not be forgotten; neither should the hot air bath nor the hot pack be overlooked.

FOR INGROWING NAIL.—REGHI's new method has been very successful. After soaking the foot until the scab is loosened and the pus washed off, a piece of cotton dipped in a 50 per cent. solution of perchloride of iron is inserted, and the toe lightly wrapped up. This is repeated twice a day, the blackish scab that forms being removed each time. The patient remains in bed a couple of days, and the cure is complete in twenty, although a small piece of cotton should be worn between the nail and the flesh for some time.—*Bull. de Med.*

TO ABORT A COLD:—

R.	Sodii salicylat	ʒij
	Spirit. ammon. aromat.	ʒj
	Syr. aurantii ad	ʒij. M

S. : One teaspoonful every four hours.—*Practitioner.*

CASTOR OIL EXTERNALLY.—Castor oil heated and thoroughly applied to the abdomen, in children, will often move the bowels as effectually as when given internally.

NOSE BLEACH.—The *Revue Clinique* states that spraying with a 5 per cent. solution of boric acid is an effectual nose bleach.

FOR PIN WORMS.—Injections of lime water administered every morning for two or three days is said to be a positive cure for pin worms.

A NEW STYPTIC.—Antipyrin and tannin rubbed together produce a sticky compound very useful as a styptic. It may be applied with a sponge.

* *

THE UNTOWARD EFFECT OF SUBSTITUTES.

A. M. COLLINS, A. M., M. D., of Shelbyville, Ills., writes under date of November 2nd, 1896: "I never realized the vast difference between genuine antikamnia and the various substitutes that are being palmed off, until within the past few days: and the realization was all the more pronounced because I myself was the patient.

For four weeks I had been suffering with neuralgia of a very severe type and attended with considerable febrile movement. I tried the various compounds and other preparations, lauded as 'just as good,' but with no real advantage and with no little heart disturbance.

"On Saturday, I went to Arcola, and while there was taken very sick with one of my neuralgic attacks. I sent to the drug store for some genuine antikamnia and to be certain about it, procured an unbroken original package. I took it in eight to ten doses at intervals of two hours. The effect was magical, the first dose relieved the severity of the pain, while the second quieted it entirely, and I went to bed, sleeping all night with one awakening of a few moments only, a thing I had not done in four weeks. This experience on my own person, has thoroughly convinced me of the superiority of the genuine antikamnia."

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