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# CANADA

# MEDICAL & SURGICAL JOURNAL

SEPTEMBER, 1887.

Original Communications.

## ABSTRACT OF A CLINICAL LECTURE ON A CASE OF CIRRHOSIS OF THE LIVER.\*

BY R. L. MACDONNELL, M.D.,

Professor of Hygiene in McGill University: Physician to the Montreal General Hospital.

In the second bed on the left, as you enter No. 11 ward, you will have before this noticed a patient to whom, since his admission, unusual attention has been given, and in whose case we have all taken much interest. You have noticed at first sight the yellow face and jaundiced tinge of the conjunctiva, and perhaps have had occasion to ask the cause of the dark brown color of the urine sample at the head of his bed. He presents the three symptoms of jaundice in a marked degree. Moreover, on counting the pulse-beats, you will find that they are uncommonly slow, taking into consideration the weak condition of the patient. The skin, too, is itchy. Again, you cannot fail to perceive the fact that the abdomen is largely distended, and that both legs are dropsical to an extreme degree. Consider the causes of these three main features of the case—*jaundice, ascites, dropsy of the feet.*

Jaundice you must invariably regard as a symptom, never as a disease. To diagnose a case as jaundice is as inaccurate and insufficient as to mention cough as a cause of illness, or to describe a disease of the organs of locomotion as "lameness."

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\* Delivered in May, 1887, as one of the ordinary clinical lectures of the summer session.

The theory of jaundice, clinically, is two-fold, viz., obstructive and non-obstructive.

*Obstructive.*—The bile ducts and the gall-bladder become distended with bile, which is absorbed into the blood by the lymphatics and the veins.

*Non-obstructive.*—To account for this condition is by no means so easy; various theories having in turn been proposed and in turn rejected, so that were I to attempt to tell you about them here I should soon be lost in the fog of speculative pathology, and the safe and sure path of clinical medicine would with difficulty be regained.

For clinical purposes, the causes of obstructive jaundice may be thus divided:

1. Causes acting from within outwards—gallstones, hydatids, foreign bodies.

2. Condition of the ducts themselves; tumefaction of the duodenum or of lining membrane of the duct; stricture of duct; congenital deficiency; stricture from peri-hepatitis; closure of orifice of duct from ulcer in duodenum; stricture from cicatrization of ulcers; specific stricture.

3. Obstruction from causes without—tumours, enlarged glands, tumour of spleen, tumour of the pancreas, tumour of kidney, omental tumour, abdominal aneurism, accumulation of fæces, uterine and ovarian tumours.

The causes of a non-obstructive jaundice have been thus stated:

1. Poisons in the blood, chloroform and ether, animal poison, specific fevers; cirrhosis and other forms of chronic atrophy of the liver.

2. Impaired innervation, mental emotion, concussion.

3. Deficient oxygenation of blood—*e.g.*, pneumonia.

4. Excessive secretion of the bile, more of which is absorbed than can undergo the normal metamorphosis.

Now what we must determine is, which of this long catalogue of ills is the cause of this man's jaundice. We will therefore look carefully into the history of the case. (The history of the case was here read.)\*

\* See Canada Medical and Surgical Journal, Vol. XV, p. 730.

Now there are many points in the case which direct to a common enough cause, viz., cirrhosis of the liver, nearly all the symptoms of which are plainly present, and which is, in my opinion, the true cause of all we see. The history separates itself into that clinical and practical division observed by Murchison, viz., alcoholic dyspepsia and portal obstruction.

*Alcoholic Obstruction.*—1. Distinct alcoholic history. 2. The outset was markedly insidious. He cannot definitely make it clear when the disease began—when he first felt that his health was beginning to fail. 3. The early symptoms were morning retching and vomiting, a sinking at the epigastrium, loss of relish for food, furred tongue, bad taste, flatulence, disordered bowels, urine loaded with lithates.

Now, let us consider some of these main causes. There is no evidence of the presence of any of the ordinary causes of non-obstructive jaundice. There was no fever, no blood-poisoning, no injuriously-acting metallic influence was at work. The jaundice came on gradually and slowly, and was first noticed by the patient's friends. He had been at a funeral, when one of his friends, whose mind being wholly unoccupied in the pauses of the dismal ceremony had time to observe the personal defects of his neighbors, whispered to our patient here, "What makes you so yellow?" He felt very uncomfortable at this disquieting question, and on his return home immediately consulted a mirror, with the result that he distinctly perceived that the conjunctiva was yellow, so that the onset could not have been sudden. Nor was there ever any pain in the hepatic region. Now in gall-stone passage there is severe and sudden colic, with tenderness over the fundus of the gall-bladder, rigors, vomiting—all followed in twelve to twenty-four hours by intense jaundice. Could it be due to a malignant tumor obstructing the duct? There was no physical sign of tumor; pain was absent, and in malignant tumor death occurs early. "The very circumstance of jaundice lasting in any case longer than six months would be an argument against its being due to a cancerous tumor." There is a distinct history of dram-drinking carried on persistently and uninterruptedly for many years, and

what is most significant, he drank his spirits raw and habitually on an empty stomach.

Then we arrive at a point in the history of the case where well-marked evidences of structural change are observed.

1. *The size of the liver.*—The liver is enlarged and painless. It measures 9 inches in right mammary line instead of the normal  $4\frac{1}{2}$  inches. Such a condition is not uncommonly present in the early stages of cirrhosis, and should the patient live long enough, is followed by diminution; but it must be remembered that all the urgent and dangerous symptoms may present themselves and the patient be carried off long before the liver has time to assume the characteristic shrinkage. Or, again, the condition of cirrhosis may not be alone-present. Waxy or fatty deposit may also exist.

2. *The occurrence of ascites.*—This occurs more frequently in cirrhosis than in any other form of liver disease, and is due to obstruction of the portal veins. The peritoneum contains a great deal of fluid, so much that, as you see, it is giving rise to that extreme œdema of the feet by pressing upon the inferior vena cava, and is pressing upon the diaphragm and causing the distress of breathing, the symptom of which the patient makes most complaint. The retarded blood-current gives rise to the enlargement of the superficial abdominal veins.

3. *Hæmorrhages* have occurred from the vessels of these mucous membranes in which the portal obstruction has produced engorgement. You remember that the gastric veins terminate in the portal vein. An over-distended circulation in the stomach relieves itself by hæmatemesis, and of this he suffered a severe attack before he came under our notice. Moreover, the intestines suffered in a like manner, and for the first two days of his residence here he passed jet black stools.

4. *Jaundice.*—As a rule, jaundice is a rare symptom of cirrhosis, and when persistent, it may be set down to some complication; but in this case it was not persistent, it has now almost entirely disappeared even from the urine, and he presents at the moment merely the sallow appearance and the venous stigmata which mark the face of the habitual dram-drinker.

These considerations now fairly enable us to arrive at a diagnosis. Now a word as to treatment.

Had we advised the patient in an earlier stage of the disease, we should most probably have been able to considerably lengthen his days. We should, in the first instance, have stopped, once and for all, the liquor supply. I believe that no harm is ever done by cutting off stimulants. Regard a man who is habitually taking too much alcohol, or a man who has been lately drinking hard, as a man who has poisoned himself. So he has; he has taken alcohol instead of chloral, arsenic or prussic acid. This rule I have invariably followed, and no bad results have ever fallen under my notice, in spite of the gloomy predictions of the "tapering-off" system.

In addition, we should also have assisted nature in relieving the portal congestion by prescribing saline purges, assisted occasionally by calomel, blue pill or podophyllin, of which, to my way of thinking, the blue pill is by far the most effectual. Patients are prejudiced against the use of blue pill, and much has been said against mercurial purges. Don't believe it. It has never yet fallen to my lot to observe any injurious effect from the use either of blue pill or calomel in digestive disorders.

But now that the disease is in full swing, what has been done? It was thought advisable, owing to the great debility and weak cardiac action, to allow some stimulants, and on account of its diuretic action gin was administered. Purgatives, too, have been given with a view to relieve the congestion of the intestinal circulation. At first a mixture of digitalis and broomtops was taken, but finding that the daily quantity of urine passed remained small (20 ozs.), I put him on the old-fashioned pill of squill, digitalis and blue pill. This producing no better result, we prescribed acetate of potash with infusion of digitalis. It became evident that medicinal diuretics were not of much advantage. The ascites was increasing, the feet and legs were becoming enormously swollen, the infiltration spreading to the scrotum. Accordingly on the 14th of April I aspirated the abdomen, but, unfortunately, some obstruction blocked the flow of serum in the aspirator, and but six ounces were removed. On the following

day we were more successful, and drew off 40 ounces. I did intend to draw off more, but the aspirator having again become blocked, I thought it best to watch the result of a small tapping. You will see by this urine card that what was hoped for did occur. The pressure of fluid removed from the abdomen has allowed the kidneys to act more freely, and for the last week 50 to 60 ounces of urine have been daily passed. You must remember that in tapping in ascites it is by no means necessary to empty the abdomen; relief to pressure is the object sought for, and so far our efforts have been successful.

*Prognosis.*—No permanent improvement can be expected. The abdomen will most probably fill again, and will have to be tapped repeatedly.\*

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### MYXŒDEMA APPEARING DURING THE COURSE OF CHRONIC TETANY.†

BY JAMES STEWART, M.D.,

Professor of Pharmacology and Therapeutics, McGill University.

The patient whom I exhibit this evening has been suffering from chronic tetany for the past seven years. Two years ago I presented him at a meeting of this Society as a case of simple chronic tetany, but since then other symptoms have developed, and to a certain extent have taken the place of the tetanic symptoms. The patient appears now to be in the beginning stages of that remarkable trouble known as myxœdema. His principal complaints at the present time are general weakness, slowness of thought, and a general troublesome numbness. At times he has diarrhoea, but only at long intervals does he suffer from any "spasms" of his hands or feet. During the late American civil war he served as a private soldier through a number of the Virginia campaigns. While in the army he had three attacks of malarial fever, and for eighteen months he suffered from chronic dysentery. He never had either syphilis or rheumatism; never drank to excess; worked at his trade (stonemason) until about

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\* Aug. 18th, 1887.—I saw the patient on the street a few days ago. He reported himself well and comfortable, though it was evident that the legs were swollen.

R. L. McD.

† Read before the Medico-Chirurgical Society of Montreal.

four years ago, until he was no longer able on account of gradually increasing general weakness and "spasms" (tetany) in the muscles of his hands.

In 1880 the first symptoms of tetany showed themselves, and have continued with great regularity up to within the past year, but since then he has had only three attacks, each lasting not longer than three days, while previously he had attacks of tetanic contraction of his muscles monthly, and they generally lasted from ten to twelve days. The following account of the mode of onset and course of the muscular contractions may be taken as representative of the majority of these attacks: While in his ordinary health, he would notice that he had double vision; quickly following, there would be stiffness of his thumbs, which became gradually adducted until they were opposed to the base of the first phalanx of the little fingers. No amount of voluntary effort could remove them from this position, neither could they be forcibly extended on account of the severe pain occasioned. At times other muscles were involved tetanically, especially those of the upper arms. When this was the case, the upper arms would be adducted and cross each other in front of the chest. The fingers were also usually adducted and semi-flexed. The muscles of the face also suffered at times, especially those of the upper and lower lips, causing a curious deformity, those of the upper lip being usually drawn to the left, and those of the lower to the right. The muscles of the lower extremities were only occasionally the seat of these spastic contractions (plantar flexion).

The electrical reactions of the nerves during the tetanic period and during his ordinary health were several times taken, and the following may be taken as the usual average result:

	NORMAL PERIOD.	TETANY PERIOD.
Facial, . . .	3.0 milliampères.	.25 milliampères.
Radial, . . .	5.00	1.00
Median, . . .	4.25	.50
Ulnar, . . .	3.50	.50

Five milliamperes is sufficient to produce tetanic contraction on the shutting of the kathode (K S T E) and on opening the



anode (A O T E). There is no change in the normal formula, the K S Z < A O Z.

The above measurements were taken by Edelmann's galvanometer. There is no marked differences in the two periods to induced current. The following notes were taken two years ago, and represent still his state, with the exceptions to be presently mentioned: The muscles are in a fairly nourished condition. The patellar reflexes are greatly exaggerated during the period of tetany, while after it has passed away it is frequently impossible to produce any contraction of the quadriceps when the patellar tendons are struck. The triceps and biceps reflexes are exaggerated during the tetany period, and absent after the muscles have become normal. No ankle clonus at either period. There is nothing definite to be made out in regard to the superficial and organic reflexes. The tongue is constantly in a raw-looking state. The appetite, however, is usually fair. He is seldom free from diarrhoea, the average number of stools in the twenty-four hours being usually about six; only very seldom is there one stool in the day. The diarrhoea always moderates when the tetany makes its appearance. The abdomen is constantly distended; stools are large, frothy, semi-fluid, and look like pea-soup. The urine is acid, but normal in quantity; specific gravity 1.030; contains great excess of both urea and indican, but is free from albumen and sugar. At times he becomes deeply jaundiced. There is no further evidence, however, physical or subjective, of disease of the liver. The apex of the heart is in the normal position. There is no increase in the cardiac dulness, neither is there any other evidence of cardiac disease. Nothing abnormal in the respiratory system. There is no relative increase in the number of the white-blood cells; the red appear to be normal. There is no enlargement of the spleen.

After coming under observation, the attacks of tetany occurred less frequently and were much shorter in duration than they previously were. This improvement was attributed at the time to the treatment employed (galvanism), but in the light of the subsequent changes, I think that it is more likely due to a more

advanced stage of the trouble, the tetanic symptoms gradually disappearing and giving place to those of myxœdema. Still he is far from free from tetany. The attacks, however, are slight and the intervals prolonged. It was about a year and a half ago that my attention was particularly called to a commencing difficulty in speech which was quite noticeable, and about the same time there was a complaint of numbness all over the body and slowness in his movements. Since I first saw this patient there has been a gradual and marked change in his appearance. His face has become bloated and his lips thick. There is more or less general œdema, more marked in face and hands; no pitting, however, on pressure. The hands are broad and clumsy looking, as generally seen in cases of myxœdema. There is also the supra clavicular swellings and the disappearance of the thyroid gland. When this took place I am unable to say. It may have been absent long before the present symptoms of myxœdema came on. His skin is dry and harsh. There is profound anæmia. Formerly he was much troubled with diarrhœa, but only occasionally for some time past. The urine is free from albumen and sugar; specific gravity 1.020; urea is about normal in quantity. There is no relative increase in the number of white cells. The red appear to be normal. There is no enlargement of the spleen or lymphatic glands. No evidence of any respiratory or cardiac disease. He has always been somewhat pale, but it is only during the past year that the anæmia has become so marked as it is at present. The immobility of the features seen in this disease is here present.

There are many features of interest in this case.

It is the first case recorded, so far as I have been able to find, where idiopathic tetany has been followed or attended by myxœdema. Dr. W. Ord, about a year ago, read the details of a case of myxœdema before the Medical Society of London, where there was persistent contraction of the arms in flexion; but persistent contraction is not tetany, the contractures in this disease being essentially intermittent. Where the thyroid has been removed from animals, tremors and contractures set in, provided the animal operated on lives two or three weeks, and

symptoms closely resembling myxœdema set in later; the muscular tremor and contracture being an early stage, while the myxœdematous symptoms appear later and belong to the second stage. The case reported is very like those cases operated on by Horsley on monkeys, with this exception: that here the course has been years in place of months. We have first tetany of several years standing, gradually getting less, but still not disappearing, followed by the symptoms of myxœdema. Horsley was able to keep monkeys alive for some time by keeping them at a temperature of  $105^{\circ}$ . When they lived for several months the myxœdematous symptoms disappeared and were replaced by general atrophy.

Myxœdema may be (1) idiopathic, (2) surgical, and (3) experimental.

Tetany may be idiopathic and surgical, but it is doubtful where there is a true experimental tetany.

That there is a very close and intimate connection between atrophy or removal of the thyroid and these two diseases is undoubted. Nearly all animals from whom the gland is removed suffer from either the one or the other, and occasionally people from whom the gland has been excised for goitre or other formation suffer subsequently from either tetany or myxœdema.

It has been asserted very recently by more than one great observer that myxœdema is essentially due to loss of the thyroid gland, and starting with this assumption as an ascertained fact, the functions of the gland have been determined without any trouble—that is, that its great function is to prevent mucin from accumulating in the tissues; that its removal or atrophy causes mucin to accumulate in the subcutaneous and other tissues, and all the symptoms of myxœdema are attributed to this accumulation of mucin. If the functions of the thyroid are such, why, then, does not its removal always entail the same results? It is only in a small percentage of cases that myxœdema follows even the complete removal of the gland. In about forty complete removals performed by Billroth, myxœdema or the cachexia strumipriva of the Germans was never once observed; and many other surgeons have had a proportionate similar experience. If

the thyroid has such all important influences over metabolism as is alleged, then its removal while still functionally active should always bring about like results. The occurrence of myxœdema in old people in whom the gland has ceased to perform any work is another strong reason why we should not accept the statement so freely made now-a-days that the essential cause of myxœdema is removal or atrophy of the thyroid gland.

Operative or experimental myxœdema is much more likely due to injury of the sympathetic nerves in the neck, while the idiopathic form is in all probability also of a nervous origin, whether central or peripheral we have not sufficient data to come to a conclusion; even taking the neurotic view of the origin of the disease, it is difficult to explain satisfactorily all the symptoms.

### ACUTE TRAUMATIC TETANUS—RECOVERY.

BY NORREYS WORTHINGTON, M.D., SHERBROOKE, P.Q.

On the night of the 24th May I was sent for to see M. M., aged 11 years, living seven miles from town. She first complained of not feeling well on the 23rd, and on the 24th had considerable pain in her back and right side, paroxysmal in character, and which towards evening grew worse, severer in character, and with shorter intervals of ease. When I saw her she was lying on her side in bed, the head thrown back, muscles of neck and back contracted and rigid, jaws locked, so that she could not put out her tongue, muscles of the abdomen hard as a board, spoke with great difficulty, and any attempt at swallowing brought on a paroxysm, during which the opisthotonos was more marked, the head being jerked violently backwards, and the flexors of the limbs rigid and contracted, with the exception of those of the wrists. There was also considerable fever and increase in rate of pulse.

Upon inquiry I found that some two weeks before, a small splinter of wood had entered her left foot at the junction of the tarsal with the metatarsal bone of the big toe; her father extracted this, the wound healed without any trouble, and the whole affair had been forgotten.

I gave her some chloral hydrat. and bromide of potassium,

but having no means of weighing the doses, and wishing to be on the safe side, am afraid the quantity was rather small, about 3 grs. of chloral with 6 grs. of bromide every two hours, alternated with a mixture containing one drop of Tr. Aconite (Fleming's) and two drops of Liq. Opii Sedat., and all the milk, beef tea, etc., she could take. On the morning of the 25th I again saw my patient in consultation with my father, Dr. E. D. Worthington, and found she had not changed much; the spasms were, if anything, more severe and frequent. We then gave her 6 grs. of chloral with 12 grs. of bromide in a tablespoonful of water every two hours, to be followed, in one hour after each dose of the above, by a quarter of a grain of the Ext. Cannabis Ind. The doses to be given at shorter intervals if necessary. So great was the difficulty of administering medicine by the mouth that it frequently took as much as ten minutes to get down the tablespoonful of the first solution, even though the little sufferer showed the greatest bravery in doing her share in the treatment. It may be mentioned here that attempts to administer per rectum caused even more suffering to the patient than the slow administration by the mouth, and as this royal road was faithful to its trust, hypodermic medication was held in reserve.

*May 26th.*—Patient about the same. She had slept well at intervals during the night. There is a suspicion that perhaps the jaws are less rigid and the spasms less severe and frequent, though continuing even during sleep. The slightest touch or noise induces spasm, with a shriek, and opisthotonos. This is her routine state: a few minutes after taking the chloral she drops into a quiet sleep, awakening about the time for the Cannabis Indica, and the spasms getting severe just before time for the chloral again, there being in the intervals of sleep slight spasms every five minutes or thereabouts. Takes beef-tea, milk and egg beaten together, through a tube, in considerable quantity, but with great difficulty. Nourishment is ready for her the instant she awakes.

*27th.*—Patient not so well; spasms more severe and frequent; opisthotonos much more marked; jaws very rigid; tongue bitten during spasms. Increased the dose of chloral to 10 grs. and

bromide to 15 grs. As the bowels had not been moved since the 23rd, gave two drops of croton oil rather unwillingly; good evacuations. Increased difficulty in swallowing medicine and food. Sleeps soundly at short intervals.

Afternoon of 28th and forenoon of 29th the spasms increased in severity and frequency, the paroxysms having only one minute and sometimes only an interval of a few seconds between them.

30th.—About one o'clock in the morning the little patient dropped into a quiet sleep, which continued, with a few interruptions, until about nine, when the spasms returned with equal severity. I saw her in the afternoon, and during the period of my visit of half an hour she slept soundly and had no spasms whatever. Evening of same day very quiet, very weak, and inclined to sleep. Pulse 100 (it had never been more than 100), and, with the exception of the first day, the temperature was but little above normal.

31st.—Patient slept well during the night, but for an hour in the forenoon and again in the afternoon had very severe spasms, with complete opisthotonos. At each accession had an extra dose of chloral. Slept well during the night.

For the next few days she remained much the same, complaining bitterly that the medicine burned her tongue where it had been bitten, but still preferring this to any other mode of administration.

June 2nd.—Gave croton oil again with satisfactory results. Continued the chloral and bromide, with the Cannabis Indica, without any interruption or modification.

June 6th.—Symptoms gradually improving; spasms less severe; jaws less rigid, but it is imprudent to make a remark or any noise in the room. On this day as I was leaving I ventured to say to her, she looked so very comfortable, "Good-bye," when she immediately went into a terrific well-marked tetanic spasm, as severe as any she had had.

Towards the end of June she was able to sit up, but moved her legs with great difficulty.

During her illness I had procured some Curara and Ext. Calabar Bean, but determined to let well alone and trust mainly

to the chloral; and to the chloral alone, in my opinion, is entitled the marked influence in controlling tetanic spasm and producing sleep.

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## EMBRYOTOMY AT EIGHTEENTH WEEK OF PREGNANCY.

BY T. JOHNSON ALLOWAY, M.D.,

Gynæcologist, Montreal Dispensary; Assistant Surgeon, Montreal General Hospital.

The following case is somewhat unique, and exemplifies what the uterus will bear without retaliation, when judiciously treated:

E. P., aged 38; married fourteen years. Five children at full term; one miscarriage. She does not nurse her children. Her youngest child is eight months old, and since its birth she did not menstruate before becoming again pregnant. It has therefore been difficult to arrive at the exact date when the present impregnation took place.

Five weeks, however, before the performance of the operation to be presently described she had a uterine hemorrhage, rather profuse, and accompanied with some hypogastric pain. On examination at this time I found the os closed and the uterus enlarged to probably the size of one at three months gestation. It was freely moveable, somewhat retroverted, low in the pelvis, and parts free from tenderness. I confined the patient to bed and gave her no medicine. There was no hemorrhage on the next day, and after a week's rest she left her bed and resumed household duties as usual. She remained well only for the following few days, when hemorrhage again took place. Still the os remained closed, and I felt convinced, from the size of the uterus, judged after a careful bimanual examination, that no part of its contents had escaped, and that interference under such circumstances would not be justifiable. Had I any evidence of escape of the embryo the course to pursue would have been clear and simple,—clean out the uterus with curette and decidual forceps. Under the existing circumstances, however, I had nothing for it but to order the patient back to rest in bed and await developments. Three weeks after this I was asked to see this lady again. She had some hypogastric

pain. She stated that the hemorrhage did not completely cease since my last visit; that the discharge was more foetid, and that she had a severe chill that morning, lasting half an hour, which she attributed to having taken cold. Her temperature and pulse were slightly affected. She had a pinched, irritable cast of features, and I felt the full force of her impending dangerous condition. I arranged to return that afternoon with assistants and remove the contents of the uterus.

Under ether and in Sims' position I drew down the uterus as far as possible and began rapid dilatation with Sims' and Goodell's heavy steel dilators until the extreme limit of the latter was attained ( $1\frac{1}{2}$  inches). With the forceps the amniotic sac was opened and the fluid allowed to escape. One of the legs of the embryo was next seized and brought out through the cervix. I here thought to continue the delivery by Barnes' method after version, but unfortunately, the part gave way at the hip-joint. The next part seized was the thorax, by the ribs and sternum, which latter came away with some of the costals attached. Next came the other leg, which also disarticulated at the hip-joint; then an arm was removed with scapula and part of some of the ribs. The ribs were very troublesome, as they had to be removed in small fragments, and there appeared to be no end of them. Next the other arm, and by this time the cervix had very considerably contracted, so that I had to again forcibly dilate with the Goodell instrument. The next part seized was the palate and frontal bones, which allowed the brain matter to escape; then the lower jaw and base of cranium. The parietal bones were removed separately, as they had in some way become detached from the other bones of the cranium. The last part to be removed was the vertebral column, with part of ribs attached. This was probably the most tedious extraction, as it was with some difficulty that the cervical end was drawn into the bite of the forceps. The decidual remains were then carefully curetted from the wall of the uterus, and the cavity well irrigated with 1-4000 solution of sublimate.

During the extraction Dr. Arthur Browne compressed the uterus with his left hand and kept the organ well down in the



pelvis. From time to time he would warn me when any particular part of the uterine wall appeared to be dangerously thin between his hand and my instrument. This point rendered in assistance is very necessary and valuable.

The convalescence of this patient has been very satisfactory. She continued to improve from the day following the operation, and was up and about quite well on the tenth day afterwards.

The moral in connection with this case is important, and we may well ask ourselves the question, Have our predecessors been correct in leaving, and are we justified now in leaving, such cases *to nature*? I think the strongest evidence against such a course is the fact that nature utterly fails in her endeavor to complete the cycle of pregnancy, and that she calls upon art to come to her rescue as a drowning person would to an approaching life-boat. And it appears to me to be as reprehensible for us to stand by inactive, as it would be for the life-saving crew to do likewise in the case of the drowning being; it is indecision and cowardice in both cases, no matter how we view it. I do not mean by this illustration that every physician should be a whole life-saving crew in himself, but that he should not waste valuable time in fruitless consultations in the interest of moral support. Upon rare occasions these patients escape scott-free, as good swimmers do when in peril, but the majority of them, if they do not die outright, become so damaged in health after months of protracted illness, that they pass into a life of suffering and chronic invalidism.

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### CASES IN PRACTICE.

BY J. M. ELDER, B.A., M.D., C.M., HUNTINGDON, QUE.

CASE I.—*Pyothorax; Paracentesis; Recovery.*—N. R., aged 8, French-Canadian, with good family history. Saw patient first on April 6. *History*—Always healthy until two weeks ago, when he had a rigor, followed by high fever, dyspnoea and cough. A medical man was called in, who told the parents that the boy had “inflammation,” and as he was costive, they concluded he had “inflammation of the bowels,” and treated him with castor oil and abdominal cataplasms! The pain left him and he was

pronounced cured a week ago. I found the lad propped up in bed; anxious, hectic countenance; rapid (40), shallow respirations; pulse small and wiry (160); temperature  $103^{\circ}$ ; no appetite, with hard, dry, painful cough; no expectoration.

Examination showed left side absolutely dull below third costal cartilage, with absence of respiratory murmur and fremitus over dull area; above level of third cartilage, a peculiar, high-pitched metallic note, which alternates with dull note on change of posture. No succussion. Intensified breath sounds over right lung. Left side measured one inch more than right. Had a slight rigor while examining him. Introduced hypodermic needle into seventh intercostal space in posterior axillary line, and withdrew syringe-full of creamy, laudable pus. Could not get parents' consent to make incision and drain pleural cavity, so unwillingly promised to aspirate, which I did on the following day, using Dieulafoy's useful little instrument. From eighth interspace in posterior line I withdrew four ounces of thick pus, not fetid. *En passant*, I always use a broad bandage around chest when aspirating, so that I can compress the chest as fluid escapes, and I have never been troubled with that annoying coughing and tendency to syncope which so often complicates these little operations. Another point in aspirating, often overlooked by beginners, is failure to turn off the exhaust before withdrawing the needle, thereby aspirating fluid into the intercostal tissues, and causing abscess of site puncture.

Put patient on Syr. Fer. Iod., good diet, and an additional mixture of Pot. Chlor., Tr. Fer. Mur., and Acid. Sulphurous, which I am very fond of in cases of septic fever. Next day I found him improved (respirations 36, temperature  $101\frac{1}{2}^{\circ}$ , and pulse 100), but on next day again much worse, so I again tried "moral suasion" with parents, but without success, and aspirated again, with a temperature of  $103\frac{1}{2}^{\circ}$ . Removed six ounces of pus, with evident relief to patient. For twelve days subsequent to this the history of the case is much the same—that of septicaemia. Recurrent rigors, night sweats, fever and serous diarrhoea, with rapid emaciation, in spite of symptomatic treatment. Aspirated twice in the interval, and noticed pus getting fetid.

On the 20th, at spot where last aspirated, a small tumor had appeared, and patient feels better since noticing it. I made a free incision into the tumor, and let out two pints of fetid pus; put in tube, and dressed with dry sublimated dressings. Patient made a rapid recovery, and is to-day as well as ever, with no retraction of side.

The lesson from this case is that aspiration in empyema is merely palliative treatment, and, at best, only keeps disease where it is; but, contra, it may be useful in cases of cachexia, or (as in this case) where no more radical operation will be permitted. The case forcibly recalled to my mind an expression of Clifford Allbutt's: "If pus or septic material be present in the body, one must not rest until it is removed. I therefore dislike and reprobate all tampering with an empyema."

CASE II.—*Aneurism of Abdominal Aorta*.—About a year ago I was called to see a patient at some distance, and found a middle-aged, anæmic man suffering excruciating colicky pain. A hypodermic relieved him somewhat, and he soon after vomited, when he became perfectly easy. I then found out that for six months he had been treated for "dyspepsia," and lately his physician had suspected "cancer of the stomach." He would starve himself as long as possible, knowing well that when he did eat he would be tortured until his stomach was again empty. He was very weak and much emaciated. Examination showed a pulsating tumor, easily grasped through the flaccid abdominal parietes, and feeling as large as a man's fist. It was situated in the median line, midway between umbilicus and ensiform cartilage. It felt hard and uncompressible, and had a very distinct systolic bruit. I told him that he had aneurism, warned him of his danger, and enjoined strict rest in bed, with dorsal decubitus. His feet were very cold and bloodless, and I could not count the pulse in the tibial artery. I gave a very guarded prognosis, as the man's habits had not been strictly temperate. I put him on Pot. Iod. gr. v, t.i.d., gradually increasing to gr. xii; ordered a liquid diet, *to be taken in small quantities and often*, so that it might escape easily from the stomach. His

colicky attacks I presumed to be due to pressure of the tumor on the third part of the duodenum, thus forcing its contents back on the stomach. The only solid food allowed was half a dry soda biscuit at a time. This mode of feeding "acted like a charm"; he did not have another attack of his old pain, and his health and strength gradually improved. I saw him at intervals during two months, and found the size of the tumor slowly decreasing, with rapid diminution of the pulsation and bruit. I allowed him to sit up then, and shortly after to walk about a little, cautioning him against any straining effort. I saw him again this spring, and scarcely recognized the hearty-looking man. The tumor had gone down to a comparatively small hard nodule, his feet and legs felt warm, and he was so well that he wanted to know if he could go to work again. I allowed him to do so, and have just seen him again after doing his haying and harvesting, none the worse for his work. I attribute his cure principally to the faithful observance of the condition of rest, though I do not despise the possible influence of the iodide. The sad fate of a neighbor, who had also been under my care for aneurism of the arch of the aorta, but who had fallen down dead while attempting to lift a bag of potatoes, though warned of the danger, no doubt had a salutary effect on this patient, as it enforced the lesson of rest in a way that no cautions of mine would probably have done.

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## REPORT ON PHARMACOLOGY AND THERAPEUTICS.

BY JAMES STEWART, M.D.,

Professor of Pharmacology and Therapeutics, McGill University.

### THE TREATMENT OF CHOLERA.

In the *Journal of the American Medical Association* for July 30th there is an abstract of a lecture on Cholera and its Treatment by Prof. Ziemssen of Munich. Ziemssen bases his therapeutic procedure on the now generally accepted view that cholera is due to a specific mycotic process in the mucous membrane of the small intestines, that the great serous transudation into the intestinal canal is due to the exuberant culture of the comma bacillus, and that a poison arises from this culture which

profoundly affects the whole organism. The above being accepted as the true origin and course of the disease, Ziemssen concludes that the indications to be fulfilled are (1) antagonizing the culture of the bacillus in the intestines, (2) the use of measures which prevent the blood thickening reaching an extreme degree, and (3) the employment of means which counteract the poisonous influence of the absorbed products from the intestines.

Naturally, the sooner the treatment is commenced the better. As cholera has an incubation period lasting from twelve hours to five days, it is during this period that it is specially important that the first indication should be endeavored to be fulfilled. So long as the initial symptoms are simply diarrhoea we may hope to exert a destructive action on the rapidly-growing bacillus. If, however, vomiting is present, our prospects of being able to carry this out are small indeed. In the prodromal stage, Ziemssen considers that there is no drug to be compared with calomel. He begins the treatment by giving it in two or three doses of eight grains, and follows these large doses by small ones ( $\frac{3}{4}$  gr.) every two hours.

There is a general consensus of opinion that calomel can do no harm in inflammatory conditions of the intestines, and as it has been proved that a small portion of it is changed into sublimate in the intestines, we can readily understand its antimycotic action. There must, however, be an additional action obtained from calomel in these cases, for we know that sublimate is not nearly so efficacious.

Rossbach recommends naphthalin made into pills with keratin. Ziemssen is not favorable to the use of opium. Long and bitter have been the disputes during the past fifty years over the comparative usefulness of calomel as compared with opium in cholera. During the prodromal stage, where there is restlessness, no doubt the hypodermic use of morphia will be beneficial, but there is nothing directly curative in this action. During the algid stage, the use of this drug in any form is not free from danger. As cholera in its incipient stage is only distinguished from simple catarrhal diarrhoea by finding the comma bacillus in the discharges, the safest plan is to treat all cases of this character in

the same way. Ziemssen strongly recommends rest in bed and that particular attention should be paid to the diet. For food and drink, only oat and barley water should be given. Where there is vomiting, ice with morphine subcutaneously. When the cold stage is reached, the method recommended and so successfully practiced by Cantani should, according to Ziemssen, be at once resorted to. This consists in the injection of a large quantity of fluid into the intestines and into the cellular tissue. The term enteroclysis is used to denote the former, and hypodermoclysis the latter. Enteroclysis is made with one to two litres of a one per cent. solution of tannin at a temperature of 39°C. or or 40°C. several times a day. It is contended for this solution that it acts by stimulating absorption and thus preventing anuria and that extreme degree of thickening of the blood which is the principal cause of death in cholera cases. It is considered also, that the tannin limits the transudation from the mucous membrane by its astringent action on the blood-vessels. Cantani maintains that the injection passes into the small intestines and sometimes even into the stomach. He alleges that he has removed it from the stomach by means of the stomach pump. The purposes of hypodermoclysis is to make up for the great loss of water and salts from the blood. The following is the solution used for this end : Sodium Chloride, 4.00 ; Sodium Carbonate, 3.00 ; Water, 1000.00. From one to one and a half litres of this solution at a temperature of 38° to 40° are injected every three or four hours. Ziemssen recommends a syringe of a capacity of about an ounce and a half, and he has found that a litre injected into two or three places can be dissipated in a quarter of an hour. The practice of massage greatly favors absorption. Frequently, even after one injection, there is marked change in the condition of the patient for the better. The extremities become warmer ; the pulse and respiration improve ; the cyanosis and anuria disappear. Keppler of Venice recommends the addition of a small quantity of alcohol to the solution, in the proportion of 10 to 1000. The alcohol acts as a cardiac stimulant. Camphor, however, is probably just as efficient for this purpose as alcohol. It should be employed hypodermically.

It is important to be exceedingly careful in laying down dietetic rules for the patient's guidance for weeks after his recovery, but there is nothing special in these directions.

Although there is at present little prospect of this country being invaded by this dread scourge, it is, however, very necessary that all practitioners should be thoroughly acquainted with those means that have lately been found most efficient in combating its deadly course. There is no doubt whatever that many cases of cholera have been saved by the treatment which Ziemssen so highly recommends, and the leading points of which we have sketched.

Cases of cholera morbus occur in this country frequently during the summer months of such great severity that place life in imminent danger. Here would it not be well to employ hypodermoclysis. The terrible drain that occurs in these cases must have a very serious effect, especially in broken down constitutions. As this procedure is free from danger, it certainly would at least prevent a very retarded convalescence. A modified hypodermoclysis might, we think, be an efficient means of relief in cases of true cholera infantum. The procedure is certainly worthy a fair trial. It is to be recommended as safer and more efficient than the old method of transfusion with saline solutions or milk.

#### ANTIFEBRIN IN THE FEBRILE DISEASES OF CHILDREN.

Widoritz, assistant in the Children's Hospital in Vienna, gives an account of the experience gained in that institution of the action of antifebrin in a large number of the ordinary febrile diseases of childhood. In all, fifty-three cases were treated; these included scarlet fever, measles, pneumonia, tuberculosis, bronchitis and facial erysipelas. The dose varied according to the age of the child from 0.1 to 0.3 ( $1\frac{1}{2}$  to 4 gr.). Invariably there was marked fall in the temperature in from ten to twenty minutes after the administration of the drug. The quickness of the fall depended more on the individuality of the patient and the disease than on the amount of the dose. The temperature of scarlet fever was less influenced than that of any

other diseases mentioned above. Simultaneous with the fall of temperature, there was a fall in the pulse-rate, but not always to the same degree. In only three cases was there observed any untoward effects from the antifebrin, in the form of slight and quickly disappearing cyanosis. In not a single instance was the course of the disease influenced. The author, however, says that there was a distinct improvement in the general well-being of the patients who received antifebrin.

From the experience accumulated up to the present, we have no grounds for hoping that the use of antifebrine or any of the other lately-introduced agents of this class do any good in febrile disorders. Much is said and written about their usefulness in cases of hyperpyrexia, and that their use should be reserved for this condition. It is, however, here where they fail to have any decided effect on the temperature. After all, the occurrence of true hyperpyrexia is an extremely rare condition in any disease of childhood, especially so among the list of those treated by Widoritz.

#### ANTIPYRIN AS A SEDATIVE.

Prof. Germain Sée, to whom we are indebted for our knowledge of the analgesic properties of antipyrin and allied substances, recommends the hypodermic injection of this drug in preference to its internal administration when used for the relief of pain. He advises it to be given in doses of half a gramme (8 grains) in the same quantity of water. For the relief of acute pain its action is nearly as prompt as morphia. It is free from the marked untoward effects so frequently seen following morphia. It causes neither vertigo, headache, constipation or vomiting; neither does it give rise to the somnolence and artificial stimulation of the latter.

Professor Sée claims for it a curative action in cases of pain of an essential nature. Time alone will decide whether these claims are extravagant or not.

#### IODOL, AN EFFECTIVE SUBSTITUTE FOR IODOFORM.

Dr. Norris Wolfenden describes (*Practitioner*) and highly recommends iodol as an efficient substitute for iodoform. This agent



appears to be as effective as iodoform, at least for all the external purposes of the latter. It has the great advantage, however, of being entirely odorless. It is only slightly soluble in water, but freely so in ether. It contains 88.9 parts of iodine, while iodoform contains 96.7. It liberates its iodine when brought into contact with any of the secretions much more readily than iodoform. This property may be taken as proof that it will seldom fail to act as an antiseptic. No doubt the sometimes alleged failure of iodoform is due to its not parting with its iodine.

Dr. Wolfenden has found iodol very beneficial in tuberculous ulcerations of the larynx. He uses it in the form of the pure powder once daily. Under this treatment the ulcers have healed. It has been found to remarkably diminish the cough and difficulty of swallowing present in cases of laryngeal phthisis. In the atrophic catarrhs of the naso-pharynx it acts pleasantly and effectively. It can be used either in the form of the powder or dissolved in ether or alcohol. Having no toxic properties, it can be used freely over an ulcerated surface.

#### THE UNTOWARD EFFECTS OF COCAINE.

Recently renewed attention has been directed to the severe nervous symptoms which frequently attend the prolonged use of cocaine. Dr. Heimann, in the August number of the *Journal of Mental Science*, gives a very full account of the peculiar hallucinations caused by the excessive use of this drug. One of the first symptoms to be complained of is itching of the skin, which suggests to the patient the presence of vermin; failing to discover any, these patients think the itching is caused either by some invisible power or minute organisms which bore their way in and out through the skin. Often large insects were reported as having been seen making their way through the skin. Dr. Heimann mentions two cases, both medical men, where insects were seen under the microscope (microscopic visual hallucinations). The hallucinations of hearing would also make their appearance. Hallucinations of taste and smell are also not infrequent. At this stage the idea of persecution takes hold of the patient's mind, and may assume such a degree as to being

dangerous. The condition at times develops into acute mania. These patients have an inordinate opinion of their own importance. Heimann relates the case of another medical man who, on account of his violence, had to be isolated, and he construed this separation into a request, that he was required to work out a new cellular pathology.

If the drug has been used in large doses for a long time, recovery is very slow, and may be very imperfect. The disease being a recent one, it is difficult to say that any cases are incurable. Heimann, in a number of cases, has found that there is damage in the spheres of sensation and volition. "The patients lie when they open their mouths, they steal on the first opportunity, and they desire to do that which they are unable to perform. They are irresolute in their action, and should they have begun anything, their activity is of the shortest duration. In their being they become apathetic, indifferent to everything, untidy in their belongings, unclean in their person—in short, they are demoralized."

In the treatment of cocaine mania, it is recommended to withdraw the drug gradually, while others advise that this should be done at once. It is doubtful whether the usefulness of this agent, when given internally, will not be more than counter-balanced by its deleterious influences.

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## Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE  
MONTREAL GENERAL HOSPITAL.

CONDENSED REPORTS OF CASES IN DR. MACDONNELL'S WARDS.

### CASE I.

*Empyema with a Thoracic Sinus—Resection of Ribs—Death—  
The sinus is found to communicate with an abscess in the  
liver.*

Of all diseases, empyema is the one over which most errors of diagnosis are made. Essentially chronic in its course, obscure in origin, and deep-seated, it manages to deceive the physician at every turn, to accumulate pus in out of the way places, and to discharge it where least expected.

A cabman, aged 38, came to ward 11 on the 20th June, 1887, complaining of cough and emaciation. On examination of the chest, no definite physical signs were at first made out, beyond that the liver margin extended an inch below the edge of the chest wall. The breathing was hurried and exaggerated, and there were some bubbling râles, but at the first no dulness was noticed. The patient's general appearance was rather more indicative of long-standing abdominal disease. He was of yellow complexion, anxious, careworn expression, and very thin. The previous history was most obscure, the statements made being repeatedly contradicted. All we could arrive at was that the patient had been ill for two years, and that at some time an abscess had projected from the chest-wall near the lower end of the sternum, that a surgeon had opened it and permitted the escape of a large quantity of pus. There was a flat ulcer just above the ensiform appendix which had irregular undermined edges, with a general appearance suggestive of a syphilitic ulcer, but the discharge was greater than would be met with in the case of an ulcer. Moreover, this outflow was slightly, but perceptibly, increased when the erect posture was assumed. Dr. Roddick, of whose advice I availed myself, succeeded in passing a probe directly inwards about three inches, the sinus seeming to pass in the direction of the base of the left lung. Further examinations revealed the presence of dulness on percussion and very weak breathing at the left base from the level of a point two inches below the angle of the scapula. The temperature had now assumed a type distinctly septic, and the condition of the patient became one of danger. An exploratory puncture with a small trocar attached to a syringe demonstrated the existence of foul-smelling pus in the left pleura. Accordingly the patient was transferred to the surgical wards and a portion of the rib excised, allowing the escape of a small quantity of foul-smelling pus. For some days after this operation the patient's condition improved, the temperature at night fell, and all things seemed favorable. In about a fortnight, however, the temperature again assumed its former character, and the patient gradually sank.

*Post-mortem report by Dr. Wyatt Johnston.*—Body not much

emaciated. A small opening above xiphoid, in the mid-sternal line, into which a probe can be passed with difficulty in a direction inwards and downwards. In left side is an opening made in the thorax, the seventh and eighth ribs being cut through; the parts are covered with granulations, on which, however, no tubercle can be seen. In abdomen, just beneath xiphoid, there are local adhesions between the anterior wall and the liver, in a line with the sinus mentioned above. On opening thorax, lungs do not collapse from adhesions. Pericardium and heart normal. Left pleura thickened, closely adherent throughout, except near the opening of the incision, where there is a cavity about the size of a tea-cup, which appears to be closing up well; the granulations do not seem to be tubercular. The lung itself is crepitant everywhere, and contains numerous miliary tubercles. The right lung also contains miliary tubercles, and is somewhat emphysematous. On examining the track of the sinus, it is found not to pass near the empyema, with which it has no communication, but into the upper part of the liver, thence to the left side of the right lobe. Beneath the peritoneum, and adherent to the diaphragm, is a large, soft, white caseous mass, about the size of both fists, composed of innumerable small, softening tubercles, which are becoming confluent. It reaches to the immediate neighborhood of inferior cava. Other organs show nothing special.

## CASE II.

*Bright's Disease with Uræmic symptoms of great severity—  
Recovery—Disappearance of albumen from the urine.*

W. S., aged 17, admitted June 3rd, complaining of swelling of the legs, feet, face and eyelids and of very severe frontal headache. On the 25th of May the present illness began with rapid swelling of the feet, soon reaching to the knees. On the 29th May had two convulsive seizures, with loss of consciousness, and on recovery, noticed for the first time that his face was swollen. On the following day both eyes were completely closed by the puffy lids. Severe headache and dizziness then set in. At the age of five the patient had had a severe attack of scarlet

fever, and remembers having had "fits" at or about the same time.

*On admission*, there was extreme general œdema, the eyelids being greatly swollen and the skin of the face red and somewhat scaly. Pulse 65, full resisting, dicrotic, as shown by sphygmographic tracing. Temperature normal. The cardiac area of dulness is increased, the pulmonary second sound accentuated, but there is no murmur. There are a few bubbling râles at both the pulmonary bases. There has never been any vomiting nor any hemorrhages. Urine: specific gravity 1010, acid; 44 ounces passed in the first twenty-four hours in hospital, 132 grains of urea per diem; about 20 per cent of albumen; slight mucous deposit. Microscopically there were found granular and epithelial casts. Micturition frequent.

The treatment consisted of daily hot-air baths, free purgation with compound jalap powder, and the administration of iron. He was discharged on June 28th. All the œdema had gradually disappeared; the albumen became less daily until none could be found. The urea did not increase, but remained at a low figure up to the time of his departure.

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## MONTREAL GENERAL HOSPITAL AND MONTREAL DISPENSARY.

### GYNÆCOLOGICAL CASES UNDER CARE OF DR. ALLOWAY.

CASE I.—*Large Uterine Myoma*.—A. B., aged 42, married fourteen years; six children, youngest 4 years old. Menstruation quite regular, occurring every four weeks and lasting four days; quantity very large, flowing rapidly, and in large clots. Profuse watery discharges between periods during last six months. No odor. There is no pain in sides, back or hypogastrium. No headache. In fact, feels in good health, with the exception of slight dyspnoea and general debility. Has noticed since May 1885 an abdominal enlargement, which has continued to increase up to present time.

*Examination*.—Tumor apparently occupies the whole of abdomen. Uterus is as large as at full-term pregnancy, reaching close to the ensiform cartilage. Solid note throughout from

pubis to above-named point. Tympanitic note in flanks. Tumor dense on palpation, and freely moveable; not nodular in any part of surface; does not contract or relax alternately, but an impulse pulsation is conveyed to the hand. On auscultation, a loud bruit is heard on both sides of tumor in flanks. This is synchronous with patient's pulse and with the impulse before mentioned; changes its intensity with pressure upon tumor. Per vaginam, cervix high up above pubis; Jenk's sound passed to the handle without reaching fundus, followed by a discharge of odorless watery fluid.

*Diagnosis*—Interstitial Myoma.

*Preparatory Treatment*—Low diet; saline cathartics; arsenic with nux vomica.

The subject of the above case is a very large woman, weighing over 200 pounds. She states that she has no pain nor inconvenience beyond slight dyspnœa when walking and a feeling of general debility. She is pale, however, and has the cachexia of other women suffering under a similar condition. The most interesting point in connection with the case consists in the very loud bruit heard at the lowest part of the tumor on each side. This bruit was more pronounced and louder than I have ever heard even at an advanced stage of pregnancy. It was particularly loud on the left side, but gradually diminished as the stethoscope approached the middle line of abdomen. When firm and increasing pressure was made upon the summit of the tumor, the bruit became less and less distinct until it seemed as if it could be altogether extinguished if pressure had been used of sufficient force. From this it would seem as if the phenomenon was due to pressure on the large artery trunks, probably the aorta or common iliacs, more probably the latter, and in this way account for the large difference in note-pitch and intensity on each side. The pressure on the artery must have been extremely slight, and not at all upon the veins, the lower extremities and external genitals being free from œdema. The bruit, however, may have emanated from the uterine arteries, as in cases of other enlargements of the uterus. A very interesting anomaly existed in the absence of both excessive hemorrhage

and pain. Hemorrhage was undoubtedly replaced by the constant and free discharge of thin watery fluid. This fluid was not a mucus from the glands; it was a pure hydrorrhœa, and it had almost the same blood-draining effect upon the system of the patient as a metrorrhagia.\* It acted as a constant drain to the vessels of the mucous membrane of the uterus which otherwise would have become hemorrhagic. The absence of pain is accounted for by the tumor occupying almost entirely the abdominal cavity, where it had plenty of space and freedom to enlarge without causing undue pressure upon nerve trunks. During the vaginal examination this condition was evident; the fingers could be passed with ease high up along the curve of the sacrum between it and the posterior limit of the growth. The sound also passed directly along the uterine cavity, close to and parallel with the sacral curve. All these data would show that the growth originally began in the fundus and extended down the anterior segment of the uterus, occupying almost entirely that wall, with extension to the sides.

The most painful forms of these neoplasms are those which begin in the lower zone of the posterior uterine wall, and extending downwards become firmly incarcerated in the cavity of the pelvis. I have assisted at cases of hysterectomy where it required the combined strength of the operator's two hands—one of them being aided by a cork-screw driven into the mass from above—to dislodge the growth from the pelvis.

It may be asked, what are the chances of a patient with so large a myoma as the one we have been considering, without surgical treatment? It is well known that such tumors may decline or become quiescent as the patient passes the limit of ovarian activity; but to say that these patients are not, every day they exist, in imminent danger of sudden death, is not true. Cases are recorded where those women have been attacked with dyspnoea and died suddenly of embolism. The blood of such women is in the most favorable condition to the formation of

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\* In cases of large myomata accompanied with hydrorrhœa, it may be suspected that the interior of the growth is the seat of fluid accumulations—so-called fibrocystic tumors. These tumors, however, are generally of the sub-peritoneal variety.

blood-clot, and this sudden and unexpected danger should not be lost sight of, or the patient misled in regard to it.

CASE II.—*Hemorrhagic Endometritis following Abortion.*—Aged 42; last child 2 years of age. States she had not menstruated for the period of one year and nine months, then became regular for three months, the last of which period was in May 1887. She missed June and July, and a few days afterwards had a severe hemorrhage, passing large masses. This bleeding became chronic, and continued to remain so for three weeks, when I was consulted. I found the uterus enlarged, freely moveable, retroflexed, and discharging freely of dark, venous blood. The cervix showed evidence of laceration and hypertrophy. I drew the uterus well down with volsella, and using the sharp curette removed a piece of decidua from fundus and hundreds of little vegetations. Patient during operation suffered no pain nor inconvenience. She had no blood discharge after the following day, and was up and well that day week.

CASE III.—*Hemorrhagic Endometritis following Abortion.*—This was a young married woman. She had given birth to one child eighteen months previously. Three months ago she became again pregnant, and had a most violent hemorrhage two days before I had been asked to see her. I found her blanched and bleeding pretty freely. On introducing the speculum, an extensive bilateral laceration of cervix became apparent. From the left corner of uterus a small piece of decidua was removed with the curette, and the rest of the interior of the uterus thoroughly brought under the influence of the instrument. This patient declared a week after the operation that she had not been so well for years.

The good effect of using the curette in these cases is attained by breaking up a vicious circle of endometritis and abortion following one another. A young woman aborts from some unforeseen cause; a small piece of decidua remains; hemorrhage and general debility ensue. The uterus, instead of involuting remains enlarged, tender, and becomes displaced. After a varied



and uncertain period of time the hemorrhage gives place to a leucorrhœa. Impregnation again takes place, and after the second month again abortion occurs, and so on repeating this vicious order of events until we have one of the most difficult morbid states it is possible for a woman to acquire, to break up. And I may say that after careful observation in the use of the curette, I am satisfied that the proper time to use the instrument in these cases is at the time of the casting off of the ovum. Under such circumstances we remove every vestige of adherent decidua, and also of swollen and thickened mucous membrane, forming what is known as the true decidua. After such an operation, the entire diseased endometrium—a lymphoid organ—has been removed. From the underlying muscularis a new endometrium is quickly formed; healthy in condition and capable of generating a sound placenta, what its predecessor could not have done.

To say that every uterus which aborts has a diseased lining, would not be scientifically true; but to say that the lining of a uterus after repeated abortions *becomes* diseased, and will fail to produce a healthy placenta in the future is, I think, unexceptionally true. Dr. Arthur W. Johnston's and Bland Sutton's writings upon the *menstrual organ* in this respect are well worth studying (*British Gynecological Journal*, September, 1886). I will even go further upon this question and state that women who are habitual miscarriers, are so, in many cases, from possessing a diseased endometrium, causing a blight of the ovum year after year.

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### Reviews and Notices of Books.

**Experimental Researches in Artificial Respiration in Still-born Children.**—By F. H. CHAMPNEYS, M.B., F.R.C.P. London: H. K. Lewis, Gower St.

It is seldom that one finds so much valuable information compressed into such small compass (148 pages). The author has collected from the *Medico-Chirurgical Transactions* and the *International Journal of the Medical Sciences* seven papers, detailing his researches upon the comparative value of the dif-

ferent methods proposed for the resuscitation of still-born children. As the information obtainable from the ordinary text-books is meagre and incomplete, this book is particularly interesting. Dr. Champneys points out that attention should always be directed to the stage of asphyxia present, before treatment is begun. If in the first (livid) stage, reflex action can generally be relied upon, and almost any form of irritation will set up respiratory movement; but if in the second (pale) stage, reflex action is not to be relied upon, and all forms of irritation are useless and a waste of time. His experiments lead him to reject the methods of Marshall Hall, Howard and Schroeder as useless, and leaves the choice between those of Schultze and Silvester (with its modifications by Pacini, Bain and Schüeking). He decides in favor of Silvester's method, and concludes that, provided the feet are fixed and the body properly laid, the mode of seizure (by arm or shoulder) is of no moment. He strongly favors late tying of the cord, even in cases of livid asphyxia, where many authors advise that half an ounce of blood be allowed to flow from the cord before it is tied. This blood-letting treatment is based upon the full-blooded appearance of the child, and is objectionable, because the livid child has no more blood than the pale child, the difference being one of distribution rather than amount. Dr. Champneys' book deserves nothing but praise.

### **A Handbook of General and Operative Gynæcology.**

By HEGAR and KALTENBACH. In two volumes. Vol. I.

Edited by DR. E. H. GRANDIN. New York: Wm. Wood & Co. 1887.

The original German work is such a standard on the continent, that its appearance in English dress will be heartily welcomed by the profession. This volume is devoted to gynæcological examinations, minor therapeutic manipulations and elementary operations, and operations upon the ovaries. The chapter on Ovariectomy is by Kalténbach, the remainder is by Hegar. The book is full of valuable information, but the point of view is purely German. It is a pity that the name *castration*, so offensive to many, has been retained for operations upon the uterine

appendages. The terms *castration* and *spaying* are still the subject of so much prejudice and misapprehension, that it would be at least politic for advocates of these operations to adopt terms more euphonious and at the same time less irritating.

#### Diseases of the Female Urethra and Bladder.—

By PROF. WINKEL of Munich; and

#### Diseases of the Vagina.—By PROF. BREISKY of Vienna.

Edited by DR. E. H. GRANDIN. New York: Wm. Wood & Co. 1887.

This is volume X of Wood's Cyclopædia of Obstetrics and Gynæcology. It has been found inconvenient to issue the volumes in their regular order. Vols. 1, 2, 3, 4, 6 and 10 are now out; the others are promised in the following order: vols. 9, 7, 8, 11, 12 and 5. Winkel is well known to English readers, first by his work on the "Pathology of Childbed," translated in 1876 by Dr. Chadwick, and quite recently by his "Diseases of Women." Breisky is not as well known, except to those familiar with German literature. However, his appointment as successor to Spaeth in Vienna is a proof of the high regard in which he is held by his fellow-countrymen. We have nothing but praise for this work.

#### Elementary Microscopical Technology.—By FRANK

L. JAMES, Ph.D., M.D. St. Louis, Mo.: St. Louis Medical and Surgical Journal Co. 1887.

This is but one part of a work on General Microscopical Technology by Dr. James. As this part is simply the "technical history of a slide from the crude materials to the finished mount," it relates only to practical work. It does not pretend to give more than a very few of the principal and most useful methods in the various steps in the preparation of specimens. In thus avoiding the *embarrass de richesse* of methods, it of great help to anyone commencing microscopical work. It seems somewhat strange, however, that in speaking of the freezing methods of making sections, no reference whatever is made to the ether-freezing microtome, which is the simplest and quickest method

of making sections. Of course freezing has its disadvantages, but when that plan is adopted, the ether is far ahead of the various "freezing mixtures" referred to.

Some of the minor details referred to in various parts of this book are most valuable; it would help considerably if the same minuteness was applied to the description of the cuts. Fig. 11, for instance, which is a modification of Ranvier's photophore, requires explanation. Fig. 1 may represent the "Army Medical Museum Microtome," nevertheless it was first introduced by Dr. Rutherford of Edinburgh, and, consequently, in most works on microscopy is recognized as "Rutherford's Microtome," which is superseded by equally simple and much better instruments.

The book is a very useful one; it contains the most recent methods, and is especially suited for anyone commencing practical histology.

#### Transactions of the Michigan State Medical Society. Twenty-second Annual Session.

We have received the Transactions of the Michigan State Medical Society of the twenty-second annual meeting, held at Lansing, May 12th and 13th, 1887. In the section on Midwifery and Gynæcology there were some very valuable and instructive papers read. Amongst the most noticeable are—

"*When shall the Uterine Appendages be Removed?*" by Dr. Julius A. Post of Lansing. In this paper the writer relates the history of four cases, each of which is brought forward with a view of showing a class which should be operated upon in order that health be restored. The discussion on this paper by such gentlemen as Dr. Geo. E. Ranney, Manton and J. H. Carstene is of an able and interesting character.

"*What is Vaginismus?*" by Dr. W. P. Manton of Detroit. In a carefully prepared paper, the author adopts the view that this condition is owing to a spasm of the levator ani muscle.

"*Ovariectomy,*" by Dr. A. W. Nichols of Greenville; "*Is Gynæcology Fashionable?*" by Dr. J. A. Porter of Brooklyn; and "*Radical Cure of Displacements of the Uterus and Procidencia by Alexander's Operation and Median Colporrhaphy,*" by

Dr. J. H. Kellogg of Battle Creek, are all very interesting papers. The plates in Dr. Kellogg's paper however, we hope, are intended to be roughly diagrammatic, otherwise they are very terrible.

"*Child-Birth Lacerations*," by Dr. W. C. Walle of Holley, is an exceedingly interesting and practical essay. To notice here the many excellent practical observations on procedure would be more than space would admit of. But speaking of sutures for cervical lacerations, the author mentions horse-hair. We would say why not try silk-worm gut shotted, a suture of somewhat like nature, much more manageable and cleaner. We would also call the author's attention to the fact that few men who have once used the purse-string "one suture" operation for the immediate repair of the lacerated perineum will ever use more than one suture upon a future occasion. It is described in most of the recent text-books on Surgical Gynæcology, and "Buck's Handbook of Medical Sciences" has an article upon it.

**Anæmia.**—By F. P. HENRY, M.D., Professor of Clinical Medicine in the Philadelphia Polyclinic. (Reprinted from the Polyclinic.) Philadelphia: P. Blakiston, Son & Co.

In this small work we have a very full and accurate account of the different forms of anæmia, as they present themselves in practice. To any one wishing to be cognizant of the latest views on the nature and treatment of this important group of diseases, we would recommend them to read this work.

## Society Proceedings.

## TORONTO MEDICAL SOCIETY, -

*Stated Meeting, June 2, 1887.*

DR. MACHELL, 1ST VICE-PRESIDENT, IN THE CHAIR.

The following pathological specimens were shown :

*Cystitis ; adherent Pericardium.*—DR. W. H. B. AIKINS presented the bladder, ureters, kidneys, uterus and heart, removed at an autopsy in the General Hospital. The walls of the bladder were greatly thickened and there was evidence of an old cystitis ; the ureters also were hypertrophied, and the kidneys, which showed the cortical substance contracted, contained in their dilated pelves a quantity of pus mixed with urine ; the uterus from the same cause had a lateral flexion. The pericardium was so firmly attached to the heart throughout as to be separated with difficulty, and would closely correspond with what the ancients described as congenital absence of the pericardium.

DR. A. H. WRIGHT had seen this patient *intra vitam* as an out-door patient at the General Hospital. She was said to have an abdominal tumor, but this proved to be a distended bladder ; 30 or 40 ounces of rather turbid urine were drawn off. Some days later he was called to see her at her own home. She was then suffering from incontinence, but there was no distention of the bladder ; had rather serious symptoms which he thought might be uræmic ; advised her to go into hospital ; did not see her again. Was surprised at appearance of bladder presented ; it looked like a bladder slightly contracted, with thickened walls ; would not suppose it could hold so much as 30 or 40 ounces.

*Sycosis Parasitica.*—DR. CRUICKSHANK (Ellesmere) presented a patient suffering from sycosis parasitica. The affection commenced about a month ago. A flattened tumor two by three inches in extent and presenting a dark red areola developed in the superior carotid region. It was pulsatile, but had not the expanding pulsation of aneurism. In several spots on the tumor were nodules topped by a discharging pustule. Similar spots were also present on other parts of the neck and on the face

and hands. Iodine seemed to aggravate the condition, but poulticing, followed by a dressing of corrosive sublimate (gr. ij ad ʒi), were found beneficial. The mycelium and spores of tinea were found under the microscope. Some cattle in the neighborhood had ringworm at the time, and it was supposed these were the source of contagion.

DR. FERGUSON had found chrysophanic acid useful in similar cases, and had also used the sublimate in collodion, gr. x ad ʒi, as advised by Taylor.

DR. AIKINS, speaking of the rarity of infections from cattle, quoted Neumann as having reported but seven cases in which the disease was derived from the lower animals.

*Ovaries and Tubes.*—DR. CAMERON presented the ovaries and tubes from three cases. (1) A woman aged 24 complained of severe pelvic pain for two years, and was incapacitated for work. She had had three attacks of peritonitis, and there was great and constant pain over the lower part of the abdomen. Tait's operation was performed. Small cysts were found in both broad ligaments; the ovaries were enlarged, inflamed, and adherent to the surrounding structures, especially the right.

(2) Patient aged 19 years. She had dysmenorrhœa with acute pelvic pain at and between the catamenial periods. She was bedridden, with repeated attacks of pelvic cellulitis. Dr. Ogden advised forcible dilatation of the cervix with the hope of allaying the constant vomiting from which the patient suffered. This was done, but without benefit. The operation was then performed, and patient has since entirely recovered from all these distressing symptoms.

(3) Ovaries and tubes from a case operated on by Dr. Bryce. The woman was aged 40, married, and had six children. She suffered from profuse hemorrhages, pains in the pelvis, and reflex symptoms. Both ovaries were prolapsed into Douglas's pouch and very tender. A uterine displacement was relieved for a time by a pessary, but the symptoms returned. The patient recovered from the effects of the operation without any bad symptoms, and is now practically well.

DR. A. H. WRIGHT is opposed to forcible dilation, although

it has been found useful in the hands of Goodell. It certainly never should be employed when there is any cellulitis. He is opposed to the removal of the uterine appendages of a young woman otherwise healthy, unless every known palliative measure has been found useless. Sir Spencer Wells will never give his consent to an operation unless the alternative is death or loss of reason.

*Fusiform Aneurism.*—DR. ATHERTON exhibited a specimen of fusiform aneurism of the popliteal artery with consecutive thrombosis of the vessel above and below, resulting in senile gangrene.

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—At the annual meeting of the Bathurst and Rideau Medical Association, held at Carleton Place, July 13th, the following officers were elected for the ensuing year :

*President*—Dr. Carnston, Arnprior.

*1st Vice-President*—Dr. R. W. Powell, Ottawa.

*2nd Vice-President*—Dr. D. Lynch, Almonte.

*Treasurer*—Dr. H. Hill, Ottawa.

*Secretary*—Dr. H. B. Small, Ottawa.

*Council*—Drs. Preston and McEwen, of Carleton Place ; Reeves and Burns, of Almonte ; Baird, Pakenham and Groves, of Carp ; Robillard, Prevost and Grant, jun., of Ottawa.



## Selections.

**Local Treatment of Scrofulous Glands.**

By Dr. H. C. Rogers, in *N. Y. Medical Journal*.—All surgeons are familiar with the class of cases to which I would draw attention, and probably there are few of them who have not wished such cases removed from their care. I allude to the large number of strumous children with slowly suppurating cervical and other lymphatic glands, tedious and insidious in their course, and generally, after months and, it may be, years of suffering, ending at the best in elevated or depressed cicatrices and unsightly scars. Under the most careful and judicious treatment the surgeon is most liable to bring disgust to his patient and friends and discredit on himself. The old practice by free incisions, blisters, valvular openings, and other means which were in use ten years ago, or have been introduced within that period, I have had recourse to with varying results, a few cases healing kindly, while others (the majority), in every respect favorable, have tried my skill and patience for weeks and even months. During the past two years I have pursued one of two lines of treatment: (1) Teal's method of dissecting out the enlarged and inflamed glands and scraping old sinuses. I have resorted to this method in three cases, with results which were all that could be desired. The one objection to it is that it is quite an operation and cannot be adopted without an anæsthetic. To this the parents and friends of the children frequently object, remarking that they would rather take a longer time than to have any operation performed on their little ones. (2) In the *Annals of Surgery* for December, 1885, p. 493, will be found an editorial by Dr. L. S. Pilcher reviewing an article in the *Revue de Chirurgie* for May, 1885, by Prof. Verneuil of Paris, on the treatment of cold abscess by drawing off the pus and injecting an ethereal solution of iodoform. I have treated by the method now mentioned nine cases in all. The swelling has gradually disappeared, taking from three weeks to two months. Professor Verneuil's plan is, first to evacuate the abscess by aspiration. To do this he makes use of a large-sized trocar, handling the

parts as little as possible. As soon as the liquid becomes slightly blood-stained he injects the cavity with the solution, which is one of five per cent. The largest quantity used is one hundred grammes; generally fifty or sixty grammes suffice. The amount of iodoform remaining in the abscess cavity to be absorbed rarely exceeds four to five grammes. He has never seen any bad effects from the absorption of ether. My experience has been that generally one injection will be sufficient. In only three cases have I found it necessary to repeat the injection into the same swelling. In four cases I injected glands where I could not find pus, but where the centre of the swelling was soft and in a condition to break down. In such cases my plan is to inject from ten to twenty minims of a two to three per cent. solution. In all cases the swelling is gradually reduced, so that in from four weeks to three months it has entirely disappeared. In all my cases I have employed internal treatment, as all the patients were more or less anæmic.—*The Epitome.*

**The Proper Employment of Prepared Foods for Infants.**—By Dr. Victor C. Vaughan, in *Medical News*.—In the article referred to I urged that no milk should be given to the sick child with cholera infantum or other summer diarrhoeas. This prohibition applies to all prepared foods containing milk or to which milk must be added. Recently I obtained all the infant foods I could find in the market, prepared them according to the directions accompanying them, placed them in four-ounce bottles, making a duplicate test for each food, added some of the ferment which I had found would produce tyrotoxicon in milk, and kept the tightly stoppered bottles at a temperature of 38°C. for six hours, then tested the contents of each bottle for the poison, and found it present in every one of them. It should be clearly understood here that the poisonous ferment was added to the foods. This experiment fulfils the conditions which would exist were a child sick with cholera infantum to be fed with one of these foods; provided always, of course, that my theory as to the causation of this and kindred diseases in children is true. Some preparations of peptonoids

and peptones treated in the same manner as the infant foods failed to develop the poison, at least in quantities sufficient to be recognized by any chemical test. I may add here that a similar experiment was made with milk which had been boiled, and in this also the poison was developed. But in the boiled milk to which no ferment was added, as well as in the unboiled milk to which no ferment was added, the poison did not appear, at least within the six hours. Now, from these experiments I conclude that foods prepared from milk or to which milk must be added are not suitable for children who are suffering from the summer diarrhoeas. Just why the poison should appear in the milk preparations and not in the peptonoids, I cannot say. There are several possible explanations. The growth of the germ may simply be more rapid in one than in the other, and the difference in the development may be only one of time; but a difference of this kind is sufficient for all practical purposes. Then have the prepared milk foods no legitimate use? I think they have, and desire to point out what I consider to be their proper employment. Even under the most favorable conditions, milk can be kept unchanged only for a short time in summer. There is the same reason for the drying of milk and the preservation of its solids that there is for the curing of meat or the canning of fruit. The dried milk solids may be transported any distance and kept for any reasonable length of time, if properly prepared, without undergoing putrefactive changes. But they are to be used with children free from the summer diarrhoeas rather than with those suffering from those complaints. Where the source of the milk supply is doubtful, a properly prepared milk food would be much more reliable than the raw milk. Besides, with any dilution or addition that may be made, cow's milk cannot be rendered identical with the milk of women. Can the milk of the cow be rendered more nearly identical with that of woman than it is by the simple dilution with water and the addition of milk sugar? All chemists, I think, agree that woman's milk contains more peptone than does the milk of the cow. Kirchner, who has given much attention to this subject, and has experimented largely, believes that the difference in the digestibility of milk

from the cow and that from woman is wholly due to the larger amount of peptone in the latter. I cannot see, therefore, why the casein of the cow's milk should not be partially digested. That it should not be completely digested, I think there can be no question. It is certainly unscientific to feed any one for any length of time upon peptones altogether; especially is this true of children. To relieve the gastric juice altogether is to diminish its secretion. The muscle of the arm, the brain, and, indeed, every part of the body, is weakened by inactivity. The stomach can be no exception to this rule. It must have something to do, or it will soon be unable to do anything. There may be, and doubtlessly are, exceptional cases in which the temporary administration of peptones exclusively is desirable. But these are exceptional cases, and the administration of the completely digested food should be only temporary. Certainly these cases do not include healthy children. For these reasons I generally prefer the partially digested meat preparations to the peptones.

—*The Epitome.*

**Treatment of Erysipelas.**—By Robert Pollox, M.B., in *Glasgow Medical Journal*.—The treatment of erysipelas is most varied, nearly every practitioner who sees much of this affection having formulated a certain line of action for himself. I am of the opinion that the treatment must depend upon the type of the disease. In all the cases I have seen, the treatment demanded was a stimulating one. I refer to simple general erysipelas. But in localized erysipelas affecting the throat, ear and pharynx, aconite in small doses, frequently repeated, as recommended by Ringer, has been productive of the happiest effects when administered at the beginning of the attack. I will take as a typical example of simple cutaneous erysipelas that form which we so commonly see, commencing over the root of the nose and spreading over the face and forehead. In such cases I immediately begin the administration of 20 to 30 minims of tinct. ferri mur. (diluted of course with water) every two hours; and as a protective and palliative, I use: ℞ Gutta Percha, ʒii; Chlorof. Meth., ʒii solve; Zinc. Oleati, ʒii; Iodoformi, ʒss. M. Sig.—To be painted over the part affected.

The advantage of this preparation over the powdered starch, zinc or flour is its comeliness. Of course, previously to applying this preparation I have the parts carefully washed with tepid water, and often when there is much pain I use the decoction of poppy heads as a fomentation. This treatment usually effects an amelioration of the symptoms and the disease subsides. But in some cases the course of the disease does not stop here; it runs riot all over the head and neck, and the medicinal treatment then pursued is ammonia, bark, iron and quinine, with perhaps a grain of solid opium to obtain rest. I am happy to state that I have never lost a case of erysipelas, although the duration and severity of the complaint have varied much. The *rationale* of the local application above mentioned must be purely protective and palliative by excluding the irritating effects of the cold air, and not by excluding specific germs. The latest researches prove that the shizomycetes or streptococcus erysipelatosus is anærobic, or flourishes where air is excluded, living in and upon the tissues affected. I may note the many methods of treatment recommended, such as compression, or ligatures applied above the seat of the affection, advocated by Velpeau; the application of a solution of nitrate of silver in the form of a ring around the redness (Higginbotham's method); the application of tincture of iodine, white paint, solutions of tannin, silicate of soda, used by Alvarenga of Lisbon; the subcutaneous injection of carbolic acid or salicylic acid directly into the part, and the internal administration of quinine in large doses, or salicylate of ammonium, suggested by Dr. Barclay of St. George's Hospital. These may all be good, but so satisfactory have been the results by the iron and the antiseptic anodyne externally applied, that I have had no reason to depart from that treatment. I earnestly look after the hygienic surroundings of the patient, and give eggs, milk, beef-tea and other stimulating and light diet. The disease may, however, pass into a stage when surgical treatment must be adopted.—*The Epitome.*

**Precocious Children.**—The precocious child is constantly saying things so epigrammatic and brilliant as to call

out the wonder of admiring parents and relations; and oftentimes these strange unnatural utterances are made the subject of remark in the presence of the child, and some newspapers often devote a column to this bright and abnormal child-talk. Nothing could be more harmful than such encouragement of a condition that is out of all harmony with healthful mental and physical growth. As a rule, the precocious child is of a strumous or scrofulous diathesis, with a fair, brilliant complexion, blue eyes and golden hair, beautiful to look upon according to popular standards. He is delicately sensitive to mental impressions, and alive to the conversation of persons much older than he. He generally goes on in his unique career, outstripping his brothers and sisters, as well as his schoolmates, in the committing of tasks at school, as well as in the reading of books far beyond their comprehension. This generally goes on until the age of puberty, when he begins to falter. The hectic flush is seen upon the fair cheek, the eye becomes more brilliant, and the finer and the spiritual elements come out with almost supernatural intensity. By and by a slight cough arrests the attention; and, before the fond parent is aware, phthisis tuberculosis has laid the foundation for premature death.

Now, what shall be done to save such children, and make them develop into healthy men and women? First, we would say, *Let them severely alone.* By this we mean, do not encourage the precocious development by pushing the child ahead and showing the foolish weakness of exhibiting the child to visitors, or displaying him at the performances of Sunday-school concert or public-school exhibitions. We always pity the poor victims of such scenes, who come before audiences and recite standard poems or sing *cavatinas* to astonished crowds in heated rooms, amid the glare of gas-lights and dressed in tawdy finery, irrespective of the climate or weather. When we look upon their pale faces and attenuated legs, we wish we had the power to send them home and put them to bed. Second, be simple with such children; keep them young, and encourage them to talk child-talk, to read child-books, and to play with other children. Do not let them remain in the house in company with the older

folk, when the bright sun is shining, and the other children are romping upon the green with all the glorious freedom of childhood. Of paramount importance is the physical training of the precocious child. From the very nature of the case, all undue excitement must be avoided. The full quota of sleep must be insisted upon. No late hours should be allowed, full of the amusements that are such a strain upon the nervous system. The diet should be of the simplest character, consisting of food containing all the elements of nutrition, like milk, bread and soups. Confections, condiments and fancy dishes should never be set before children. Give fresh air in abundance, and insure the child to go out of doors in all kinds of weather.—*Popular Science Monthly*.

### **Abuses of Milk Diet in Therapeutics.**—

The therapeutical employment of milk not only has been popularized and the lay public made familiar with its various adaptations, but in the wake of the general apprehension has followed the usual exaggerations, and hence it is prescribed with little regard to the conditions properly requiring it. Under these circumstances it seems desirable to indicate the limitations of this therapeutical food, and to show wherein it may be hurtful rather than beneficial.

In certain disorders of the digestive functions, milk causes a sense of discomfort, decided uneasiness, oppression—sometimes even pain, and it prolongs the morbid condition. The cases of this kind may be grouped into two classes: those in whom the caseine is the offending material; those who cannot properly digest the cream or butter. We find examples of the first class more frequently amongst children, but they are by no means uncommon in adults. They are detected the more readily in early life, because the curds are rejected by vomiting, or appear undigested in the stools. Adults unable to digest caseine, or who digest it slowly or painfully, have epigastric distress, heaviness and oppression for several hours after meals, stupor and disinclination for exertion coming on after an hour or two and continuing until the offending material has passed well down the intestines.

An excellent substitute for the milk when the caseine disagrees is barley-water with cream. The barley-water should be carefully strained and have the density of good skimmed milk, and one-sixth or one-fourth cream added, so that the mixture has the consistency of rich milk.

The second class of subjects to whom milk is unadapted are the cases of duodenal, hepatic and pancreatic diseases, because of the deficiency in the secretions necessary to the process of emulsionizing fats, and preparing them for entrance into the lymph vessels. Fats decomposing form very irritating fat acids, and the change in the reaction of the intestinal juices is the cause of serious secondary troubles in the biliary functions and elsewhere. To fit milk for use under such circumstances, it must be skimmed, and about the time the stomach digestion is completed, aids to the intestinal digestion should be administered. Such aids are a soda alkali, and it may be, some pancreatic solution to effect complete digestion of the fatty constituents.

The mere bulk of the cream is an objection to its use in certain diseases. In dilatation of the stomach, the space occupied by the necessary quantity perpetuates the disease. The reflex effects of distension of the stomach in cases of weak heart, and in angina pectoris, may not only cause distressing symptoms, but may even prove fatal. It cannot be too strongly stated that milk is a highly objectionable aliment in heart disease, whenever the motor apparatus of the organ is diseased, and whenever its movements are readily influenced by morbid states of the stomach through the reflex channels.

In no malady, as I conceive, is milk more abused than in acute rheumatism. It is very often the chief—sometimes the only aliment employed during the whole course of this disease. Besides the objection inherent in its mere bulk, certain theoretical considerations of its nature should have considerable weight in deciding the question of use. The very obvious objection that milk furnishes lactic acid as a product of its fermentation, should not be ignored. All the world knows the intimate relation between lactic acid and the rheumatic poison. By the introduction of lactic acid, a form of endocarditis, not distinguishable from the



rheumatic, is set up, and of those diabetics treated by lactic acid, a considerable proportion suffered from attacks of rheumatic fever (acute rheumatism). It is difficult, of course, to determine this point with certainty, but I have reason to believe that patients with rheumatic fever do not get well so quickly, and are much more apt to have relapses when they consume much milk during the course of the disease. Surely, sufficient reasons exist for undertaking a thorough investigation of the question. My own practice, in the cases in which I am consulted, is to advise against the use of milk as an aliment in acute rheumatism.

In typhoid fever, milk is the one food now given, irrespective of the character of the cases. Of late this almost universal practice has come to be challenged. It has been depended on, without investigating the state of the digestive functions, and quite unmindful of the effect it may have on heat production. It is often given in too great quantity at a time, or so frequently that the stomach has not disposed of one quota before another is thrust upon it. Unless the gastric juice has preserved to a considerable extent its power of converting the albuminoids into peptones—which we have no right to expect—the caseine resists its action; hence it follows that the materials of digestion should be administered soon after the milk is taken, and to prescribe it without reference to the ability of the stomach to dispose of it is to insure increased fever and delirium, and more frequent stools. Besides supplying the means for proper digestion of the milk, attention should be given to its administration at such intervals that every portion given may be disposed of before another is permitted to enter the stomach. It is a trite observation, which is not therefore the less true, that it is more important to the nutrition if some food be well digested rather than a large amount be merely swallowed.

Notwithstanding, since Donkin's first reports, milk has entered largely into the dietary of diabetics, its utility has recently come to be seriously questioned. If conversion of milk sugar into grape sugar does not take place, there can be no doubt of the value of milk in this disease, since it possesses so great a number of alimentary constituents. If, as now asserted, this con-

version does take place, the free administration of milk in diabetes must be regarded as an abuse.—ROBERTS BARTHOLOW, M.D., LL.D., in the *Journal of Reconstructives*, July 13, 1887.

**Hemorrhoids.**—By Dr. A. G. Gerster, in *Philadelphia Medical Times*.—I believe that a moderate degree of hemorrhoidal trouble can be treated successfully by carbolic acid injection. The objection raised to this method is that it sometimes causes extensive sloughing, not only of the hemorrhoidal node, but of a large portion of the mucous membrane of the rectum. A case occurring in New York was reported, I believe, in the *Medical Record*, in which four inches of the rectal mucous membrane came away after a single injection of a hemorrhoidal node with carbolic acid. In some cases phlebitis, etc., have resulted, placing the patient in great danger. But my personal experience with this method is limited to only one case. I have not employed it oftener, because most of the cases which come under my care are either light cases, not calling for any operation, or grave cases in which I prefer to give positive and permanent relief by resorting to the operation which you have seen me repeatedly perform at the hospital. I mean the use of either the ligature or the actual cautery and clamp.

Mild cases of hemorrhoids, or those in the incipient stage, I frequently see get well without any operation at all. I have my share of such cases and I rarely operate upon them. But I take the trouble to examine the patient carefully from head to foot to learn all that I can about his internal economy. First, I examine for large masses of faecal matter hoarded up in the gut. This is a very ordinary condition of things in a man of sedentary habits who is overfed and does not take sufficient exercise. Nearly all persons who suffer from hemorrhoids belong to this class. On examining them carefully you will find the large gut filled with faecal matter. But they may assure you that they are as regular as clock-work; they have a motion of the bowels every morning, and sufficient they think. Apparently it is sufficient. The evacuations which these patients have take place only through the middle of the gut, and more and more

of the fæcal matter becomes deposited on the walls. Imagine an old sewer being filled up in that manner, and you can form some idea of the interior of these people.

Now, give this patient a good dose of calomel and salts, causing his bowels to move freely, and then examine him, and you will often still find a large quantity of fæces distending the intestine. But after once thoroughly cleansing out your patient he will not need an operation for the hemorrhoids. You will have done what a learned, sensible physician should do. You will not have treated the hemorrhoids as the pile-doctor does, whose vision does not extend beyond the internal sphincter, but you will have treated them as does the modern intelligent physician, whose vision takes in the entire patient. You will have cleaned out the Augean stables and have done the man a real service.

Look upon another patient, a fat man, one whose skin is pale, and who appears to have no blood. Examine him, and you find that he has an enlarged liver. You question him, and you find that he has been drinking more beer than is good for him. Now, if such a man has internal hemorrhoids, would it be rational simply to treat those hemorrhoids? He looks like a vigorous man, but you find that after ascending a few steps to enter your office he is out of breath and is glad to sit down and rest himself. He has come to be treated for hemorrhoids, but on further examination you find not only enlargement of the liver, but also disease of the heart. There is obstruction of the whole portal circulation. Of course, the hemorrhoidal veins are over-filled. Would it be rational for the physician to treat such a patient simply for hemorrhoids? Of course not. If he did so treat him his diploma should be taken from him. The heart disease ought to be treated, and, if successfully, the hemorrhoids will disappear. I have given these examples to show that hemorrhoids in the incipient stage do not require surgical treatment. Topical treatment will, of course make it easier for you to effect a cure, and it will satisfy the patient. He will feel that something is being done for his piles. He could not understand that you were benefiting a diseased condition in his rectum by treating his heart

alone. He is a layman ; he cannot see through the whole case. A good many doctors cannot. Therefore, give him some application for the anus. Let him put an ice-bag there, or a salve, or use an astringent injection.

But when you have to deal with a hemorrhoidal condition of an aggravated character, where considerable pathological change has taken place, where there is considerable infiltration and hypertrophy and prolapsus of the mucous membrane surrounding the hemorrhoidal nodes, where they have become ulcerated and reached that stage when they cannot shrink and return to a normal state, then a surgical operation will be necessary.

**The Bergeon Treatment and Pneumatic Differentiation.**—The enthusiasm aroused by the claims of the advocates of rectal injections of sulphuretted hydrogen gas as a remedy for phthisis has sufficiently subsided to permit a dispassionate estimate of the value of the remedy. In popular parlance, the treatment was boomed with great vigor for a time, but it has now settled down to its legitimate value. It is to be feared that the hopes which consumptives based on it have not been realized, and that these unfortunates must suffer and die as before, although, doubtless, some may find relief from the newer method as some have received and will continue to receive relief from the method of treatment employed in the beginning. The one fact which has been developed out of the recent excitement in connection with the Bergeon treatment is that the specific for phthisis has not yet been unearthed.

Pneumatic differentiation which preceded Bergeon's method in the consideration which it received at the hands of the profession, while not attracting so much attention, owing, probably, to the cost of the necessary apparatus, nevertheless presented big hopes in certain quarters. It, too, has found its level, and we have been quite interested in a statement of the comparative value of these two later additions to the physician's armamentarium for consumption, as prepared by Dr. John A. Robison, of Chicago :—

“ Since the discovery by Koch of the bacillus tuberculosis,

the leading minds of the profession have been actively at work trying to formulate some mode of attack by means of which this foe to health may be routed. The presence of this bacillus has been acknowledged by nearly all pathologists to be positive proof of phthisis. Of course there has been a difference of opinion as to whether the bacillus is the cause of tuberculosis, or whether it is simply a bacterium which only thrives in tubercular soil. In accordance with these two theories, there have been formulated two methods of treatment: first, to introduce directly into the air cells an antiseptic and germicide, with the double object of killing the bacillus and rendering the native soil unfit for habitation; second, a method of treatment has been inaugurated in which the sole purpose is to cause the habitat of the bacillus to be so changed that it cannot thrive. The first method is called pneumatic differentiation, the second gaseous enemata or Bergeon's treatment.

Both methods of treatment are highly endorsed by leading members of our profession. Remarkable results, according to the reports of the observers, have followed the use of each treatment.

Of the cases treated by pneumatic differentiation 23 per cent. die, 35 per cent. are improved, and 30 per cent. are not improved, while ten per cent. recover. Of the cases treated by gaseous enemata 9 per cent. die, 71 per cent. are improved, 15 per cent. are not improved, while only 1 per cent. recover. A glance at these figures would lead one to render a verdict in favor of gaseous enemata. And it is probable that if the present craze for Bergeon's treatment prevails longer, the statistics will show a much larger percentage of recoveries. But it would be manifestly unjust for us to render a verdict on the above figures. It will be noticed that the percentage of improvements by gaseous enemata is 71 per cent., and by pneumatic differentiation 35 per cent. But the fact must be remembered that the improvement under the gaseous treatment is often temporary. Dr. Fitch writes:—"In every case the improvement, though rapid at first, has been partially or entirely arrested after a time." Dr. William Pepper, of Philadelphia, says:—"This method of

treatment is seldom of real benefit, although it is occasionally of benefit by relieving certain symptoms." Therefore, we must conclude that very faulty deductions may be made from statistics. My object in thus going into detail is to enter a protest against the fashionable method of reasoning now so prevalent among physicians. They keep records of a certain number of cases for a limited period, and observe that certain results follow, and straightway jump to the conclusion that these results are due to the treatment instituted. I insist that, to be of any value, statistics must be carefully kept for a number of years; then they may be reviewed, corrected, and an unbiased judgment passed on them. Conclusion:—Statistics in regard to pneumatic differentiation and gaseous enemata are at the present time worthless.

Then how shall we judge of the value of these treatments? Simply by the action that is obtained on each individual patient. We must follow the same rule in the administration of these agents as in others. We must take into consideration the age, sex, social condition, mode of life, occupation, etc., of the patient; the stage of the disease and its symptoms, and the results which follow the treatment in each case, irrespective of those in other cases. In this way we soon learn to discriminate between the cases, and can to a degree of positiveness tabulate the cases in which these methods of treatment are useful. In my experience the respective treatments have been useful in certain classes of cases. The pneumatic cabinet in my hands has proven a very valuable adjunct to the treatment of catarrhal affections of the naso-pharyngeal and bronchial passages, and has proven excellent for calisthenic purposes in cases of deficient expansion of the chest, chronic pleurisy without effusion, and cases of emphysema. But, unfortunately for me, I have never obtained permanent benefit in cases of phthisis pulmonalis, except in a young woman who had incipient phthisis. For this reason I have discarded the use of the cabinet in the treatment of phthisis pulmonalis.

The cases in which gaseous enemata have proven of benefit have been those in which the disease was in an advanced stage,

and the symptoms were anorexia, profuse expectoration, fever, night sweats, emaciation, and in some cases diarrhoea. In nearly every case there has been a slight improvement for a few hours, but in only five cases has there been a prolonged benefit. In one of these cases, on admission to the hospital, his temperature was 104° F. He was placed on the gaseous treatment and no antipyretics were given. From March 12 to April 10 his temperature ranged from 101° F. to 104° F. Since April 10 he has been 99° F. or below. This may be a coincidence. The treatment has resulted in these cases in increased appetite and weight, cessation of night sweats, oftentimes disappearance of the diarrhoea, and lessening of the expectoration. In many cases the action of the gas was hypnotic. Alas! these results have proven temporary in nearly every case. But when we were successful in obtaining these results, the patient expressed such a sense of relief, and especially was delighted at the thought of not taking *so much medicine*, that we became firmly convinced it is the duty of the physician to resort to the treatment in these cases even when he can offer no hope of a permanent cure."—*Medical Age*.

### **Enlargement of Prostate and Cystitis.**

Dr. Vercoe writes to the *Medical Age* as follows:—"I think I have found out something new in enlargement of the prostate and cystitis. It is to irrigate the prostate and base of the bladder with a double-eyed catheter per anum with simple hot water. It works well. Like similar applications to the uterus, it requires to be well done. For cystitis also I have found turpentine stupes of decided benefit, applied until a substitutive irritation of the bladder was produced by absorption of the turpentine, then change to flaxseed poultices. It acted well in my last case. I also ordered absolute rest and a strict milk diet."

CANADA

# Medical and Surgical Journal.

MONTREAL, SEPTEMBER, 1887.

## ICHTHYOSIS CONJUNCTIVÆ.

At the present day, when ophthalmologists are increasing so rapidly in numbers and when all appear eager to rush into print, there is and must of necessity be a great deal of trash written and re-written, the result of short experience and hasty observation. Amid all this, it is refreshing to come across something new and original from men of extended experience and shrewd observation.

We wish to draw the attention of our readers to the subject of a paper recently read by Dr. Buller of Montreal, before the American Ophthalmological Society, at New London, in July last, on the occurrence of a "rare form of granular ophthalmia associated with ichthyosis of the skin." The granules occur on the palpebral conjunctiva, most conspicuously just in front of the retrotarsal fold, where this membrane most nearly resembles the integument in its structure. The "granules" are flattened, irregular in shape, about one to two millimetres in diameter, intensely hard; pale, semi-gelatinous appearance, of a faint red color. The color is due to the presence on their surface of numerous minute rusty dots, each of which consists of a capillary loop. The secretion was pale, extremely tenacious mucus.

Another very important peculiarity is the great stubbornness with which they resist all the usual lines of treatment for granular ophthalmia. The conjunctiva, as a whole, presented a glazed, pinkish appearance.

In the cases observed by Dr. Buller, there was present well-marked ichthyosis of the skin, and taking this association into



consideration, together with the anatomical similarity of the tissues and the probability that both eruptions depend on the same error of general nutrition, he leans to the theory that the ocular trouble is really an ichthyosis of the conjunctiva.

We will shortly enumerate the characteristics which distinguish this eruption from the ordinary trachomata :—

1. Form, size, color and hardness.
2. No tendency to inflammatory exacerbations.
3. Absolutely passive behaviour under ordinary treatment.
4. Character of secretion, which is mucus.
5. Non-contagiousness—the patients being children living with their families, and none of the other members being affected.

These very interesting observations have their parallel in other affections, *e.g.*, lupus, lepra, eczema, epithelioma, pemphigus, &c.

Again, we might remember that the conjunctiva and integument are developmentally of the same origin, *viz.*, epiblastic, which would yield some support to Dr. Buller's theory.

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## THE SIGNIFICANCE OF THE ABSENCE OF HYDROCHLORIC ACID IN THE GASTRIC JUICE.

Lately much significance has been attached to the absence of hydrochloric acid from the gastric juice. Von den Welden, Debove, Dujardin-Beaumetz, Riegel and others have published observations which tended to show that in many cases of carcinoma of the stomach there is an entire absence of hydrochloric acid from the gastric juice. So confident were those observers of this constant loss, that they considered it a valuable diagnostic symptom.

From some recent researches made by Wolff, of Gothenburg, and Ewald, of Berlin (*Berliner Klin. Wochenschrift*, No. 30, 1887), it is plain that no such significance or value can be attached to the absence of hydrochloric acid. In seventeen patients who were under treatment for various troubles, the contents of the stomach were repeatedly examined, and in eight the gastric juice was always free from hydrochloric acid. Six

of these eight patients were certainly free from carcinoma or any other gastric trouble. Of the remaining two, one had dyspepsia and the other cancer of the uterus. In the uterine cancer case, the stomach after death was found to be free from cancer.

The conclusions derivable from their researches are thus formulated by Wolff and Ewald :

1. That there can be an absence of hydrochloric acid from the contents of the stomach even when administered medicinally, without there being any manifest disease of the stomach.

2. That hydrochloric acid is often not to be detected in diseases of the stomach which are certainly not of a malignant nature.

3. That there are cases (not malignant) also where even the peptone-forming powers of the stomach fail.

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#### EFFECT OF ENTOZOA UPON THE BLOOD.

The *Zeitschrift für Thiermedizin* publishes an account by Dr. R. Wernicke of Buenos Ayres of a local outbreak of severe anæmia among sheep, proving fatal in every instance. In making an autopsy upon two immediately after death, he found nothing beyond great bloodlessness of the organs and a large number of anematoid worms (*strongylus contortus*) in the stomach. Examination of the blood showed that almost all the corpuscles were greatly altered in shape (poikilocytosis) ; thinking that it might be a post-mortem change, a number of diseased and healthy animals were examined, with the result that in the diseased animals this change was always present, while the blood from healthy sheep showed normally formed corpuscles arranged in rouleaux. That the change was due to the parasite was proved by the fact that on treating the patients with turpentine they all recovered, except a few upon the point of death, while some purposely left without treatment died of the disease.

The above is specially interesting, considered in relation to the recent reports of cases of pernicious anæmia due to *Bothri-cocephalus Latus*. It is to be regretted that the report of the blood is not more thoroughly made, no count of the blood corpuscles or estimation of the hæmoglobin being given.

## THE MEETING OF THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.

This, the largest scientific association on the continent, held its meeting for the current year from the 10th to the 17th of August, in New York. Though this was the thirty-sixth meeting, New York has entertained the association for the first time, and also possibly for the last, for a good many years at least. It seemed to be the opinion of many that socially the meeting was not up to the average, and was in no way worthy of the metropolis of America. The local committee, the authorities of Columbia College, in whose buildings the meetings were held, and certain local scientific societies deserve great praise in making up to a large extent for the indifference of the Gothamites in general.

One of the newspapers says, commenting on the trip around the harbor, which terminated at nearly eight o'clock in the evening, and during which the only refreshment was cold water:—"The people of New York have not regarded the association with the awe bestowed upon it by smaller cities." So much the worse for New York. Probably no city in America, in proportion to its size, has done so little for science as New York; and an analysis of those things for which the metropolis feels "awe" might not tend to raise it in the eyes of the world. There were a good many subjects discussed at the meeting which were of vital importance to great cities, New York included. Poverty on the one hand, and reckless extravagance on the other, are evident in the metropolis to the eye of every visitor. Now, there were some papers and discussions with very direct bearings on these subjects presented, and in a scientific way, with figures of an exact character, that cannot be despised. The New York medical profession, as a whole, ignored the association, though it is to be remembered that many of the best men are away on vacation trips.

A somewhat new feature of the meeting was the joint discussion by members of different sections of questions of great vital importance to the nation. Thus, one entire day was given up to the reading and discussion of two papers by Prof. Atwater,

on "The Physiological and Pecuniary Economy of Food," and "The Food of Workingmen and its Relation to Work Done." Comparison, the writer maintained, showed that the American consumed considerably above the standard of necessity, and *wasted* a great deal more, while the European seldom excelled the standard, and frequently fell below it. In America, all classes of working people consumed far more than was necessary to the maintenance of health and strength. Taking the world through, the mass of people select foods which analysis shows to furnish actual nutrients at the lowest cost. But the people of the United States evince a marked exception. They endeavor to make their diet attractive by paying high prices, rather than by skillfully cooking and tastefully serving. "An inexplicable sensitiveness exists upon this point among American workmen. The best the market affords alone is good enough for them."

Prof. Ordway of New Orleans thought Americans did not consume so much more than Europeans. Waste mostly explained the apparent difference.

French Canadians, continued Professor Atwater, at home consume  $3\frac{1}{2}$  lbs of food per day each. On going to Massachusetts factories their quantity of food per day is increased to 5 lbs. The dietaries also of Americans were richer in proteids than foreign ones. As one result, the American can and does turn out more work.

Mrs. Richards, of the Boston Institute of Technology, showed the bearing of cookery on the problem, and complained of the difficulty experienced in inducing the poor to use oatmeal porridge.

In a paper by Prof. James of the University of Pennsylvania, Mr. Atkinson's opinions so widely promulgated were criticized. The former thought Mr. Atkinson's views as to American wealth, etc., altogether too optimistic and without sure foundation in fact.

Before the Anthropological section, Dr. Hart showed, by the statistics of several hundreds of cases, that the mental attitude of the patient was dependent on the site of his disease. He concludes that optimistic views result from diseases above the diaphragm; pessimistic ones from those below it; while maladies

of a constitutional character, as rheumatism, malaria, etc., might incline to either the one or the other. No explanation as to the causation of these psychological tendencies was given.

Canada was not largely represented. Prof. Wesley Mills of McGill University read a paper before the Anthropological section entitled "Study of a small and isolated Community in the Bahama Islands." It illustrated the influence of environment in modifying races. Also a paper before the section of Biology, "On the Physiology of the Heart of the Snake."

Over 730 members attended the meeting, and 200 papers were read.

President Morse delivered a telling address on the accumulating evidence in America for organic evolution.

The next meeting is to be held in Cleveland under the presidency of J. W. Powell, Director of the U. S. Geological Survey. We believe Cleveland, like most cities, will consider it an honor to entertain this great scientific association.

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### BRITISH MEDICAL ASSOCIATION.

The recent meeting of the British Medical Association in Dublin was one of the most successful ever held. The President, Dr. Banks of Dublin, gave an address on "The History of Medicine in Dublin." Dublin has indeed reason to be proud of the illustrious physicians who have done so much for scientific medicine. Stokes, Graves and Corrigan have written for all time.

The address on Medicine was delivered by Prof. Gairdner, of Glasgow. It was a scholarly and philosophical review of the progress of medicine since the days of Cullen.

The address in Surgery was delivered by Dr. Hamilton, Professor of Surgery in the Royal College of Surgeons of Ireland, "Tissue Resistance and Antisepticism."

The address on "Pharmacology and Therapeutics" was delivered by Dr. Whitla of Belfast. He gave cogent reasons why the general profession should be better represented on the committee whose duty it is to prepare the British Pharmacopeia. The number of useless preparations that encumber this work

exceed the useful, and there will be no change until such time as the voice of the active practitioner will be heard in the committee.

The addresses in the other sections were each and all of great merit.

### CANADIAN MEDICAL ASSOCIATION.

The twentieth annual meeting of the Canadian Medical Association, which takes place in Hamilton on the 31st of August and the 1st of September, promises to be one of more than ordinary interest. The following gentlemen will lead the discussions in the various subjects:—

Dr. Grasett of Toronto will open the discussion on Surgery. Subject, "Obstructed Urinary Outflow."

The Hon. Dr. Sullivan of Kingston and Dr. Groves of Fergus will take part in this discussion.

Dr. McPhedran of Toronto will open the discussion on Medicine. Subject, "Empyema." Dr. McPhedran will deal chiefly with the pathological conditions, the behaviour of the fluid, and the principles of treatment.

Drs. Mullin of Hamilton and Oldright of Toronto will refer principally to the diagnosis and treatment.

Dr. Eccles of London, who opens the discussion on Gynæcology, will discuss the nature and treatment of "Subinvolution of the Uterus." He will be followed by Drs. Temple of Toronto and Powell of Ottawa.

Dr. Stewart of Montreal, who opens the discussion on Therapeutics, will give a sketch of "The Present State of Cardiac Therapeutics."

Dr. Davidson of Toronto will read a paper on "The Use of Stimulants."

Dr. Cassidy of Toronto will read the report of the Committee on Hygiene.

The following papers are promised up to the present time:—

1. Dr. Wm. Osler, Philadelphia—  
"The Cardiac Relations of Chorea."
2. Dr. T. Wesley Mills, Montreal—  
"A Physiological Basis for an Improved Cardiac Pathology."

3. Dr. Archibald Malloch, Hamilton—  
“Report on Twenty Cases of Tracheotomy in Diphtheritic Croup.”
4. Dr. William Gardner, Montreal—  
“A Year’s Work in Abdominal Surgery.”
5. Dr. Ryerson, Toronto—  
“Thalamic Epilepsy.”
6. Dr. F. Buller, Montreal—  
“Headaches in connection with certain Ocular Defects.”
7. Dr. Stirling, Montreal—  
“A few points in the Etiology and Treatment of Conjunctivitis.”
8. Dr. W. H. B. Aikins, Toronto—  
“Detection of Typhoid Bacilli in Drinking Water.”
9. Dr. R. L. MacDonnell, Montreal—  
“Loss of Knee-jerk in Diphtheria.”  
“Aortic Aneurism—(a) Hitherto Unobserved Symptom.  
(b) The Results of the Treatment by Iodide of Potassium.”
10. Dr. J. C. Cameron, Montreal—  
“Some Practical Points in Aseptic Midwifery.”
11. Dr. Campbell, Seaforth—  
“Albuminuria of Pregnancy.”
12. Dr. Sweetnam, Toronto—  
“Stricture of the Rectum—A New Form of Treatment.”
13. Dr. Daniel Clarke, Toronto—  
“Neurasthenia.”
14. Dr. Laphorn Smith, Montreal—  
“A New Theory and Treatment of Diseases and Displacements of the Uterus.”
15. Dr. Bruce Smith, Seaforth—  
“The Treatment of Pneumonia.”
16. Dr. F. W. Strange, Toronto—  
“Malignant Disease of the Bladder.”
17. Dr. Hingston, Montreal—  
“On the Removal of Naso-Pharyngeal Tumors.”
18. Sir James Grant, Ottawa—  
“Renal Calculus and Cheyne Stokes’ Respiration.”
19. Dr. James Bell, Montreal—  
“Demonstration with the Cystoscope.”
20. Dr. Dupuis, Kingston—  
“Removal of the Astragalus.”
21. Dr. Wyatt Johnston, Montreal—  
“Puerperal Peritonitis.”

## THE INTERNATIONAL MEDICAL CONGRESS.

The Congress will be opened on Monday morning, Sept. 5th, in the presence of the President of the United States, when an address of welcome will be delivered by the Secretary of State, the Hon. Thomas F. Bayard. Addresses will also be delivered by Austin Flint of New York, M. Semmala of Naples, Unna of Hamburg, Fielding Blanford of London, Lutand of Paris, and Neudorfer of Vienna.

During the sessions of the International Congress at Washington, the *Medical Register* of Philadelphia will issue daily editions containing full reports of the general sessions and all the sections. The six editions will be mailed to any address for the small sum of 50 cents.

The following circular has been issued by the New York Bureau of Information :—

“ The Ninth International Medical Congress will convene in Washington on Monday, September 5th. Washington is 200 miles from New York, six hours by railroad.

“ Foreign steamers to New York land at New York or at Jersey City or Hoboken, opposite New York. The New York Bureau of Information have engaged a reception parlor in the Hoffman House, corner of Broadway and 25th Street. The Broadway car line, which is crossed by the car lines from the steamer landings, passes in front of the hotel.

“ Rooms at the Hoffman House, which is conducted on the European plan, can be obtained through the Committee at a reduction of 25 per cent. One or more of the Reception Committee will be in attendance between 2 P.M. and 4 P.M. each day on and after August 20th. At other hours the clerk of the hotel will act for the Committee. Members intending to attend the Congress are requested to send their names in advance to the Reception Committee, Hoffman House, New York, so that the Committee can secure for them reduced hotel and railroad rates.



## Medical Items.

—Sir James A. Grant, M.D., of Ottawa, will, we are pleased to learn, deliver the introductory lecture at the opening of the fifty-fifth session of the Medical Faculty of McGill University, on Monday, the 3rd of October, 1887.

—The hundred and fiftieth anniversary of the foundation of the University of Göttingen was celebrated during the second week in August. Numerous delegates from many European Universities were present.

—It has at last been decided to have a Board of Health for this Province. The following gentlemen constitute it:—Drs. Garneau, Lemieux, Rinfret and Pelletier. It is to be hoped that health matters will now receive that attention which they deserve.

—Prof. Hermann Munk, the distinguished physiologist in the Berlin Veterinary School, has recently received congratulations from all quarters on the completion of the twenty-fifth year of his work in that institution. Prof. Munk's work in connection with the localization of the cortical special centres is of great importance, and it is to be hoped that he may still live to work and to clear up one of the most difficult problems of physiology.

**BROMIDIA.**—Dr. W. H. May, of New York city, writes as follows: "I have had very successful results in the administration of bromidia in cases having their origin in disorders of the nervous system, such as cholera infantum, paralysis, insomnia, etc. *But I find it to be of special value in treatment of delirium tremens and the results of debauch*; it being retained upon the stomach and speedily controlling the most dangerous symptoms, and producing the desired calmness and sleep necessary when morphia and other soporifics have failed to do so, and thus rendering the disorder amenable to further treatment. I have also prescribed it successfully in the terrible state of nervous exhaustion due to opium habitues endeavoring to relinquish the habit. And, finally, as the result of experience, I pronounce it the hypnotic *par excellence*."