Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

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

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

☑ Additional comments / Commentaires supplémentaires: Continuous pagination.

THE

CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

U. OGDEN, M.D., R. ZIMMERMAN, M.D., L.R.C.P., Lond., } *Consulting Editors.* | A. H. WRIGHT, B.A., M.B. M.R.C.S., Eng., I. H. CAMERON, M.B., R. B. NEVITT, B.A., M D., } *Editors.*

SUBSCRIPTION, $3 PER ANNUM.

☞ All literary communications and exchanges should be addressed to DR. CAMERON, 273 Sherbourne St.

☞ All business communications and remittances should be addressed to the Publishers, Messrs. CARSWELL & CO., No. 28 Adelaide Street East.

TORONTO, MAY, 1884.

Original Communications.

A PECULIAR CASE OF SUPPURATIVE DISEASE.

J. E. GRAHAM, M. D.

The following case presents features which differ from those of any ordinary disease in our classification, and on that account it is worthy of special attention. Mrs. S., æt. 44, married, came under my observation January, 1882. She is the mother of six living children who are all in a fair state of health. Three have died, one a premature birth, a second of tabes mesenterica when three years of age, and a third of cholera infantum. Patient was strong and healthy up to eight years ago. She first noticed a pain in the side which her physician said proceeded from the spine. During that summer she had constant flooding. In September an abortion took place. From this she recovered and remained well for a year. She then gave birth to another child, making a good recovery after her confinement. In the following March, 1876, she suffered from congestion of the lungs from which she did not quickly rally. She then noticed swellings on each side of the neck. In a few weeks they were lanced and discharged a large quantity of pus. The discharge continued throughout the whole summer. In the autumn they healed up entirely, and she was free from disease during the winter. In June of the following year, 1877, another swelling appeared on the neck; it was superficial and rapidly disappeared. In January of 1878, an abscess formed quite rapidly under the left breast. In three or four weeks it was lanced and it healed up rapidly. The next appearance of trouble was in February, 1880, four or five months after the birth of the youngest child. Abscesses then commenced to form in the neck and in the subcutaneous connective tissue over the left breast. The latter was a very large one, eight ounces of pus having been evacuated from it at one time. The discharge continued for nearly a year.

During the past year, *i. e.*, 1881, the old scars in the neck have opened, and many new abscesses have formed in that region as well as in the arms and hands. They have commenced either in the lymphatic glands or in the connective tissue. They began first as hard tumours which would soften slowly when pus was formed of a yellow and "laudable" appearance.

Family History.—Her father died of consumption when he was forty years of age. Her mother died after confinement; she does not know the exact cause. Patient has five brothers and one sister all healthy. Consumption existed in her father's family, as his brother also died of it. As previously stated patient has six children, two born after the commencement of the present disease. These two are not strong but they do not suffer from any particular disease.

Present Condition.—The patient is a small and delicate looking woman, somewhat emaciated and scarcely able to walk.

She has a dark sallow complexion, and dark hair. The neck on both sides presents a number of scars. In some cases the cicatricial tissue is covered by scales. On the back of the left hand there is a large red surface having in its centre an elevated patch showing the position of a former abscess. On one of the fingers at the first joint is a swelling which is discharging pus.

I ordered at first cod liver oil and iron tonics.

During the following month, February, an abscess formed in the sole of the foot, which for five or six weeks gave rise to a great deal of pain and rendered walking impossible. It was lanced and discharged a large quantity of pus. It began in the deeper structures of the foot, and was very slow in coming to the surface.

At the first joint of the ring finger mentioned before, there now exists an ulcer presenting excessively irritable granulations.

In the early part of March, the cod liver oil and tonics were left off and calcium sulphide was given instead. The dose at the beginning was one-tenth grain which was increased to $\frac{1}{4}$ gr. three times a day.

No new abscesses formed after the administration of the drug. Some swellings which appeared to be the starting points of new abscesses disappeared rapidly. In six or eight weeks she became quite well and remained so during the summer.

The various abscesses ceased discharging, and there remained only cicatrices to mark their former situations.

The calcium sulphide was administered in gelatine capsules.

In November, 1882, the disease again returned. It began with some small swellings on the neck which gradually increased in size, coalesced and discharged small quantities of pus.

She then noticed a swelling in the connective tissue around the meta-carpo-phalangeal joint of the thumb of the right hand, and at the same time tenderness and swelling around the first phalanx of the index finger of left hand. These two swellings seemed to keep pace with one another in rapidity of growth. They were exceedingly painful and in a few weeks softening and suppuration took place. They were lanced when a large quantity of thick yellow pus was discharged. During this time her health ran down so that she was unable to leave the bed. There was slight febrile movement, quickened pulse and elevated temperature.

March 8th, 1883.—The abscesses above mentioned are still discharging a thin light coloured fluid. During the past week small superficial abscesses have formed at the seat of the old cicatrices in the neck. They have very thin walls and in many instances rupture spontaneously leaving ulcerating surfaces.

It has been frequently noticed that when a new crop of abscesses form, the scars where old ones have existed show a tendency to ulceration. The patient's general health has somewhat improved.

March 9th.—A microscopical examination of the blood showed the red corpuscles diminished in number, and the white somewhat increased. Of both kinds 3,500,000 were found in a cubic cent. and there was one white to sixty red. No change in the appearance of the red corpuscles. Examined also the pus from several different abscesses, found the following: Pus corpuscles, granular matter. Some large cells (round) twice or three times the size of ordinary pus corpuscles; the latter were few in number. Rod like bodies in all probability bacteria. Mass made up of an aggregation of pus corpuscles adherent together and undergoing granular degeneration.

April 9th.—Patient has been suffering for the past two weeks from intermittent diarrhœa accompanied by severe pain. Blood and matter has been found in the passages. There is a good deal of tender-

ness in the abdomen. Had to stop the sulphide of calcium pills on account of the nausea which they produced.

April 19th.—This evening Mrs. S., is not so well; temperature, 101°; pulse, 102; breathing, 30, not so regular, rapid and distressed; bowels of late have never been regular; the least change in diet excites diarrhœa.

April 20th.—Patient much better; fever, absent; pulse, 96. She complains of difficulty of breathing; diarrhœa has again returned. The passages contain pus and blood. On examination of chest, find what I had frequently noticed before, bronchial breathing at both apices. Noticed also to-day fine crepitation throughout the left lung.

June 1st.—Patient has been gradually becoming weaker; diarrhœa persistent; it is temporarily controlled by opium. The abscesses in the neck and hands have very much improved. The discharges from the bowels contain mucous and blood. There was constant cough with very free expectoration which was examined for bacilli of tuberculosis several times without success. The apices of both lungs presented symptoms of consolidation, on three or four occasions large quantities of matter were coughed up as if from an abscess.

June 5th.—Patient has lost strength rapidly. Abscesses have again formed in the neck, in the axilla of the right side and in both wrists. Those in the neck discharge large quantities of thin pus, which runs freely from the incision. The connective tissue betwcen the muscles of the neck is infiltrated with pus.

June 18th.—Opened a large abscess in the axilla; pus flowed freely from the incision; a hæmorrhagic condition has developed during the last two or three days. The sputa is mixed with blood and a sero-sanguinolent fluid is discharged from some of the abscesses.

June 19.—Patient gradually sank and died this afternoon. She retained consciousness until the last moment.

Post-mortem examination made twenty hours after death.—There was considerable emaciation, and the presence of scars showing the position of former abscesses. Pus ran out from several abscesses, which still remained open. On making an incision adipose tissue was found of a yellow colour.

Thorax.—Pleura adherent on both sides; heart very small, presenting fatty infiltration; valves healthy; blood fluid in character.

Lungs.—The lower lobe of right lung was congested, at the apex, on the same side there was consolidation, which appeared to be produced by extra amount of fibrous tissue. In the consolidated portion cavities existed. How these were found could not be satisfactorily explained On gross examination there did not appear to be any tubercle. The cavities were lined by a smooth membrane. In the left lung the same appearance existed at the apex. Several of the bronchial glands were enlarged, and in only one was any cheesy deposit found. In it there was also calcification.

Liver.—Was normal in size; but was fattily degenerated.

Spleen enlarged and soft, presented extravasation; kidney presented infarcts, particularly in the left. In both the capsule was not adherent. The parenchyma was distinctly fatty. In the right found an abscess with inspissated pus.

Intestines.—At the ileo-cæcal valve there was a good deal of induration and some destruction of tissue.

In the mucous membrane of the intestine above and below the ileo-cæcal valve ulcerations mostly round and varying in size were found. No peritonitis; very slight enlargement of the mesenteric glands.

Microscopical examination.—The kidneys presented a slight lardaceous deposit near the small arteries. There was also found in various parts dilated convoluted tubes.

We have here a case in which the illness extended over seven years. The principal

feature was the formation of abscesses, partly of the lymphatic glands, but chiefly in connective tissue in various parts of the body. The abscesses formed slowly; began first as small nodules, which gradually increased in size, softened and discharged pus of fluid character. Suppuration continued a long time—in some as long as a year. They all healed up except in the latter stages of the disease. Some of the cicatrices were bound down to bone, showing that the periosteum had been affected, but in no case was this caries or necrosis, except during the last eight or ten weeks in the meta-carpo-phalangeal joint of the thumb.

There was some slight caseation, but the pus was as a general rule healthy in appearance. The febrile disturbance was not very marked, but emaciation followed the formation of the larger abscesses. No general enlargement of the lymphatic glands existed. The spleen was normal in size, and the lungs were frequently examined, and except during the last two months were found healthy.

The question now arises by what name shall we call this disease. It resembles in many points pyæmia, and if there was such a condition as pyæmia so chronic as to last for years this case might be put under that head. In many points, however, this case differs from ordinary pyæmia. There were no rigors and the amount of fever was slight until the last few weeks. No local condition was found, such as dead bone, which could have given origin to septic poisoning.

A differential diagnosis must then be made between the following diseased conditions, Hodgkin's disease, syphilis, tuberculosis and scrofula.

It has been asserted that there are occasional cases of Hodgkin's disease accompanied by suppuration, but in them, there was a general enlargement of the glands or enlargement of the spleen; none of these conditions existed in this case. On microscopical examination no lymphoid deposits were found in any of the organs. Abscesses also were found in the connective tissue more frequently than in the gland. Syphilis is excluded as there is no history. Children born after commencement of disease showed no signs of hereditary syphilis. With regard to the two other diseased conditions, it would be necessary first to clearly define the difference between the two conditions, tubercle and scrofula before taking up the relationship which this case bears to either one. On this point the most opposite views have been entertained. Some consider scrofula to be a predisposing cause of tuberculosis and others, as for instance Mr. Treves, who has written a very valuable treatise on this subject claims that the two processes are identical, the one attacking particularly the lungs and the other the lymphatic glands.

By recent investigation however a sharp line may be drawn between the two diseases so far as the pathology is concerned. Although there may still be a wide difference of opinion as to the bacilli discovered by Koch being the cause of tuberculosis, most authorities are agreed that the presence of these bacteria is an indisputable evidence of tuberculosis. If by a proper microscopical examination of the discharge or the parts affected we discover bacilli, the case may be put under the head of tuberculosis whereas if they are not found the case is probably one of scrofula. Repeated examinations were made of the sputa and purulent discharges in this case and no bacteria were found. According to this view we must come to the conclusion that we have here scrofula in the adult to deal with. This is confirmed by the post-mortem as no tubercle was found in any part of the body.

What then is scrofula? Mr. Treves, to whose article I have previously referred, gives the following definition: "It is a tendency in the individual to inflammations of distinctive features, these are as follows: They are usually chronic and may be in-

duced by very slight irritation and persist after the irritation is removed. Such exudations show a remarkable tendency to resist absorption and to linger in the tissues, the affected areas becoming rapidly non-vascular. Among the common products of the inflammation are giant cells. The tendency of the process is to degenerate and not to organize and the degeneration usually takes the form of caseation. At the same time these inflammations have a tendency to extend locally and infect the adjacent parts, and their products present certain peculiar properties when inoculated upon animals. Lastly a great feature of all these processes is they tend to commence in and to most persistently involve lymphatic tissue."

Duhring in his work on skin diseases, says, "Of scrofulides as a rule the affection begins in one or more lymphatic glands, which become swollen and permanently enlarged, constituting firm roundish or oval tumours unattended at the beginning by redness or pain. They increase in size slowly, having attained certain dimensions they undergo softening. The skin covering them becomes hyperæmic, chronically inflamed, of a violaceous hue, thin and sensitive. In the course of time fluctuation is experienced and the tumour breaks down, discharging pus, bloody serum, and a whitish or yellowish flaky caseous matter. The discharge continues oozing for an indefinite period. The glands break down completely, terminating in ulcers. The tendency of the disease is to ulceration and cicatrization."

According to Billroth "scrofula is a disposition to chronic inflammation of the skin, bones and joints in which the inflammation may lead to the development of granulations, to pus and to caseous degeneration. Persons in whom swelling of the lymphatic glands, even if induced by temporary irritation long continued in the same state, or even increased without peripheral irritation." Perls, in his work on General Pathology, says (1) "scrofulous individuals are those in whom certain membranes, particularly mucous membranes, also, the skin and periosteum show a tendency to inflammation upon the slightest injury. (2) This inflammation does not terminate as in healthy individuals in rapid and complete absorption of the exudation, but is followed by chronic suppuration and infiltration of the neighbouring tissues. (3) After such inflammation lymphatic glands do not resume their former size but remain hard and large. (4) In the connective tissues, as well as in the lymphatic glands, there is a tendency in the exudation to cheesy degeneration."

It will be seen from these definitions that there is after all a fair consensus of opinion, as to the main features of the disease. Since the discovery of the bacillus tuberculosis, this condition can be more sharply defined, and all cheesy products containing the bacillis placed under the latter disease.

In the case which has been given, both clinical history and the post mortem examination would lead to the conclusion, that it was a case of scrofulous disease in the adult, and that it was quite distinct from tuberculosis.

The etiology of scrofula is a subject which has led to much discussion. There is little doubt but that it can be both hereditary and acquired. Phthisis in parents is a common cause of scrofula in children. In the case given there was a distinct history of consumption on the father's side. Scrofula in parents may also give rise to the same disease in the children. Instances of this are quite often met with.

It has been asserted that parents in good health will beget scrofulous children; also that syphilis in parents is a predisposing cause.

Among the predisposing causes of scrofula is climate. It occurs most frequently in cold, damp climates, where there is poor ventilation, bad food, and bad hygienic surroundings. It is most frequently found in the densely populated districts of large cities.

It is especially a disease of early life. In the statistics given by Mr. Treves, the great majority of cases occurred between the ages of five and fifteen. He mentions only three cases out of a large number in which the disease began in adult life.

It has been stated by some pathologists that in scrofulous people there is a diminished quantity of blood in proportion to the weight of the body.

The exciting causes of scrofula are eruptive fever, slight irritation, decayed teeth, etc.

As to the pathology of scrofula, we might say that it consists in a tendency to chronic inflammation, followed by caseous degeneration. Although the inflammatory action is similar to that of tuberculosis, in the latter there is a distinct form of vegetable growth, the bacilli. It is quite possible that in the future, forms of bacilli or micrococci may be discovered which will explain the seemingly spontaneous origin of inflammations, such as existed in Mrs. S.'s case. Many cases of joint disease which have been put under the head of scrofula may really be found to be tubercular in character. In fact, bacilli have already been discovered in some of the cases examined.

It must be admitted that scrofula is a predisposing cause of tuberculosis. There is no doubt but that the caseous masses form a good soil for the growth of the bacteria.

Little need be said of the ordinary methods of treatment, as they are sufficiently familiar to you. It will be noticed that in the case related calc. sulph. for a time had an excellent effect in preventing the further formation of pus. I have used it with success in other cases. It ought to be given in 1/10 gr. doses. The larger doses do not appear to have as good effect as the smaller ones.

PHTHISIS WITH EMPYEMA.

G. E. DE WITT, M.D., CHESTER.

On the 2nd day of February, 1884, R. B., æt. 19, was brought to me from Lancook, a distance of seven miles by water, suffering much from dyspnœa, left side of thorax very much bulged from clavicle down to the last rib. Patient stated that about five weeks previous to my seeing him he had contracted a severe cold on the water while rowing, after which he was seized with a pain in the left side, and experienced chilly sensations. His father died of consumption at the age of 28, and his eldest brother has had hæmoptysis for several years past. On examination of chest I found vocal fremitus entirely absent on the left side, the heart was pushed above and to the right of its normal position, temperature 101°, pulse 120, respirations 36, a deep hectic flush upon each cheek. As the symptoms plainly denoted pleuritic effusion I immediately aspirated the chest through the seventh intercostal space when three quarts of semi-purulent fluid were evacuated, after which the patient became easier; he could lie down which he had not been able to do for the past fortnight. I could not see that the distension of the upper part of the chest had lessened any after the operation. Patient passed a tolerably comfortable night, next day found him somewhat easier than when I first saw him, but still suffering from dyspnœa, and cheeks much flushed. Finding fluctuation below and back of left nipple I lanced the integument sufficiently to insert a small probe-pointed canula which passed through the intercostal space into the pleural cavity with scarcely any effort, and gave vent to offensive pus until six quarts came away. I then washed out the cavity with a weak solution of carbolic acid and closed the wound with plaster. Next day patient's symptoms much improved, temperature 99°, pulse 100, respirations 24, the plaster had fallen away from the aperture made by the canula, owing to the discharge of pus. I again passed canula and evacuated a quantity of pus, syringed out cavity as before with an antiseptic wash. Owing to the discharge of offensive pus continuing I passed in a

rubber drainage tube four inches in length attached externally to a rubber-plate, covered the entrance with an antiseptic dressing, also the whole extent of the left chest with cotton batting saturated with an antiseptic; removed tube once in twenty-four hours, always taking away with the aspirator or through the canula a quantity of pus. At the end of a week I had drawn off 21 quarts of offensive pus and three quarts of semi-purulent fluid. During the next ten days about four quarts more were evacuated, making in all twenty-eight quarts drawn from this boy's chest in seventeen days. Owing to the almost constant discharge through the drainage tube much more passed into the dressing, the quantity of which I could not ascertain. During the twenty-four days that I treated the patient he did not have a sleepless night, nor did I have to give him an opiate, except once when he complained of pain in the side which I attributed to the entrance of air through the tube. Diet consisted chiefly of eggs and milk. On the 26th of February patient went home not well, but comfortable. The chest had regained its normal contour. Visited patient again the 4th of March, and evacuated with aspirator a quart of pus, washed out cavity with a solution of corrosive sublimate. I saw him again on the 15th, feet and lower part of legs considerably swollen, but after a few days subsided. Saw him again on the 24th and found him much improved. After treating the patient a few days I gave him daily nine grs. of Potass Iodid, which he has continued to take most of the time, also decoction of scoparius at times to produce a freer action of the kidneys. The patient and his friends are now sanguine that he will recover. The prognosis, however, is unfavourable. I do not report this case because of claiming any skill in its treatment, but to show the extraordinary accumulation of pus in the pleural cavity and the fact of the patient's surviving after its evacuation. Had the patient been seen and treated when attacked with pleurisy, much more could have been done for him, but had his chest not have been tapped when it was, he could have lived but a few hours longer.

The question arises, are not many allowed to suffer and often die for the want of aspiration in pleuritic effusion? We often meet with patients who complain of pain in the side, soreness and shortness of breath, whose trouble dates back to an attack of pleurisy; on account of the fluid never having been evacuated, absorption after a long time has taken place at the expense of the organs in the immediate vicinity. The first time I saw the operation of paracentesis thoracis performed was by the distinguished father of American aspiration, Dr. Bowditch, of Boston, thirteen years ago, who was very careful to take but a small quantity of fluid at a time, and never operate until the accumulation was so great as to produce dyspnœa and general distress to the patient. I think, however, that experience is teaching us every day that we should not wait too long, nor leave more than we can possibly help to be absorbed by the system. We know how desirable it is to perform the operation of paracentesis abdominis early in many cases, although we get only a small quantity of fluid at a time. Eight years ago a man, æt. 50 years, who had had organic disease of the heart for twenty-five years to his knowledge, contracted a severe cold, peritoneal dropsy immediately set in with extensive œdema of the lower extremities. During four weeks on eight different occasions I evacuated thirty quarts of fluid, averaging from three to six quarts at each tapping, with the aid of digitalis in small doses and iron, the patient recovered his usual health, and has ever since been able to follow his calling, using moderation. I might cite other similar cases, but my communication is already longer than I had intended.

The average death rate of Berlin during 1883 was 29.04.

MONSTROSITY.

J. H. GARDINER, M.D., LONDON EAST.

I have in my possession a remarkable specimen of monstrosity, consisting of a child with two heads complete, and well formed in every respect.

The mother was in the ninth month of gestation, when labor pains commenced, and labor did not last more than three hours. She is the mother of four children, all healthy and well formed; both father and mother are healthy. Pulsation continued in head last born, and in body, for more than twenty minutes after birth, and an attempt was made to set up respiration, but it was only partially successful. The head first delivered never showed any signs of life, after complete delivery, being very much congested at birth. One hour elapsed between delivery of first and second head.

There was one cord and one placenta.

The specimen weighed eleven pounds at birth.

There was a complete separation of necks down to shoulders, and separate spinal columns to termini.

The upper extremities are well formed, and two in number.

The lower extremities are deformed, talipes varus existing in all. There are three legs, two in the usual position, and one over right ilium. This third leg is most deformed of all, being smaller and more like a wing without feathers than a leg; there are six toes on it. Two anal canals exist, but the genital organs are of the usual appearance of those of a healthy male child.

The mother did not complain of any unusual sensations, impressions or longings during gestation, nor had she any fright. Now, the question is, how did such a monstrosity have an existence? Evidently twins were designed by nature, and from some peculiar placing of the double ova in early fœtal life, a blending of the parts resulted. The external blastodermic membranes have suffered less than the middle and internal; but I must leave to more skilled physiologists and embryologists to explain this medley on the part of nature. (It reminds me of Dr. Richardson's chicken without the feathers.)

Selections: Medicine.

SENATOR ON SELF-INFECTION BY THE PRODUCTS OF ABNORMAL PROCESSES OF DECOMPOSITION WITHIN THE BODY, AND THE RESULTING (DYSCRASIC) COMA (KUSSMAUL'S "DIABETIC COMA").

Senator says that dyscrasiæ are pathological states in which the blood or fluids of the body have undergone some qualitative or quantitative change, providing that this be not the result of some organized or unorganized poison introduced from without, in which case we speak of it as infection or intoxication.

These dyscrasiæ have long been recognized as the result of the retention of some normal excretion; and the history of medicine shows the importance formerly attached to such doctrines, all sorts of diseases being attributed to the suppression of perspiration, menstruation, lactation, and even the sperma virile, which was said to cause cachexia spermatica or seminalis.

The morbid influences of the retention of bile, urine, and carbonic acid gas are too well known to need dwelling upon; but in recent times the suggestion has been made that the body itself, or a particular organ, may become the source of a form of dyscrasia due to abnormal decomposition, which may be called autochthonous or autogenetic dyscrasia.

In former times, such doctrines were current in the guise of speculations about putrefaction or fermentation of the blood, lymph, etc.; but it is only recently that they have received any support from facts. When it was shown that septicæmia might result from collections of pus or putrefying fluids in the body, and it was established that this putrefaction might occur independently of external agencies, this doctrine of autochthonous dyscrasia was placed beyond doubt. But pyæmia and septicæmia are not quite what we ordinarily mean by dyscrasia, this term being generally restrict-

ed to chronic diseases; but the statement originally made by Petters in 1857, and confirmed by Kaulich, Betz, and Cantani, that acetone is developed in the blood and fluids in diabetes and other diseases, has been in recent times fully established; and, as is generally known, a particular group of nervous phenomena, "diabetic coma," has been ascribed to the presence of acetone or allied substances in the blood.

In 1868, Senator described a case of sulphuretted hydrogen poisoning resulting from an error of diet, and pointed out that the digestive organs are the origin of nearly all acute and chronic dyscrasiæ, and that self-infection may occur, and is followed by a series of nervous disturbances. Even during the normal digestive processes, putrefactive products of a poisonous nature—phenol, indol, and the aromatic series—are developed, and Brieger has lately obtained a poisonous alkaloid from peptone; while in abnormal digestion there are such products as butyric acid, sulphuretted hydrogen, marsh-gas, etc. All these substances have a more or less poisonous influence on men and animals, causing (in large doses) convulsions, paralysis, coma, and death; in small doses, dulness, vertigo, dimness of sight, tinnitus, etc. While the nervous system suffers most evidently, it is not alone affected; the kidneys being also frequently involved. Most of these substances are secreted by the kidneys, and irritate them. Changes in the digestive system have a direct influence in causing renal disease; and a certain chronic affection with albuminuria, still ordinarily regarded as a local disease, in Senator's opinion originates in the digestive system, and is of an autochthonous dyscrasic nature. [The author is apparently alluding to the chronic insidious form of granular kidney.—*Rep.*]

In diabetes the dyscrasia is undoubted, and is generally regarded as the cause of all the phenomena except the excretion of sugar. This last is probably due to some alteration of the digestive functions in the stomach, intestines, or liver; so that we may call diabetes an autochthonous entero-hepatogenous dyscrasia.

The uric acid diathesis, and gout, rickets, and many other conditions not so well defined, as, for example, oxaluria, also belong to this class.

But, besides the digestive organs, this self-infection may depend upon processes occurring in any of the normal or pathological cavities of the body; not only abscess-cavities, lung cavities, and purulent collections in the thorax and abdomen, but especially the urinary bladder and passages.

In chronic cystitis with ammoniacal decomposition of the urine, there gradually supervene dulness, depression, digestive disarrangements, "urinous" smell of the breath and sweat, drowsiness, and coma. These phenomena have been attributed to the absorption of ammonia, and this "ammoniæmia" has been more or less identified with "uræmia." This is not the place to discuss the identity of ammoniæmia and uræmia. Ammonia is probably not the only or even the principal cause of this dyscrasia, though it is the body which by its smell makes its presence most noticeable, and doubtless has its origin in the decomposition of urea. But the decomposition of urea gives rise to various other products, such as the sulphur-compounds, the ferments, etc., and in those cases where pus and mucous are undergoing decomposition, other putrefactive products are present in considerable quantities. The eminently poisonous nature of decomposed pus is well known, and is attributed to the presence of certain unstable fatty acids, *e.g.* butyric. Trimethylamine must also be mentioned as a product of the decomposition of purulent urine in the bladder, for the production of which the lecithin of the pus affords abundant material.

Finally, it seems not impossible that such decompositions may take place not only in the natural and pathological cavities of the bodies, but in the parenchyma and in the fluids of the tissues, even as primary conditions; that they can do so in consequence of infection from other parts, is no longer doubtful. But there are grounds for believing that imperfect oxidation causes decomposition in the tissues. Hoppe-Seyler has said that insufficient introduction of oxygen, either from obstruction in the air-passages or from excessive demand for it through great muscular exercise, causes, generally in the liver, perhaps in other organs, changes similar to those of phosphorus-poisoning, and in consequence an increased secretion of urea at the expense of the constituents of the organs. Leucin and tyrosin are found in the most different parts of the body where the blood-supply is insufficient and in this manner, when the blood-supply

is not altogether cut off, the decomposition products of the part find their way into the circulation. The influence of imperfect blood-supply is seen in those cases of acute or sub-acute intoxication which occur in certain examples of pernicious anæmia.

The effects of these dyscrasiæ are mostly manifested by alterations in the functions of the nervous system—pains in the head, apathy, drowsiness, passing into coma, or restlessness and delirium, convulsions, vertigo, tinnitus, nausea, and vomiting. Kussmaul was the first to describe under the name "Diabetic Coma" a peculiar mode of termination of diabetes, which he attributed to "a chemical decomposition of the blood," an "intoxication" which depended upon "chemical destruction of the economy in diabetes."

From the acetone-like odour of the breath, it seemed as if acetone was the toxic agent; but he pointed out how the cases differed from the acetonæmia described by Kaulich and Petters; and in experiments on animals he failed to produce, by acetone poisoning, symptoms very similar to those he had observed. Frerichs came to the same conclusion, and had no better results with ethyl diacetic acid; and hitherto all attempts have failed to determine the exact substances to which this intoxication is due. But Kussmaul's statements were amply confirmed, as such cases are by no means rare, especially in young subjects. It has been wrongly supposed that Kussmaul's description applies only to diabetes, and is always associated with urine giving a red reaction with ferric chloride. Both these positions are untenable, as the condition may be seen in other diseases than diabetes and apart from that reaction of the urine. Moreover, *coma* is not the most characteristic feature of Kussmaul's group of symptoms. It is the striking *dyspnœa with free respiratory movements and unobstructed air-passages*, and generally hurried respiration. Next to this, the most characteristic thing is the rapid pulse; then the excitement with groaning or sighing, jactitation, severe pains, and lastly coma. The temperature of the body is not notably increased, and in some cases has been below normal. No case of terminal coma, in which the peculiar breathing is not present, can be said to belong to this class.—R. Saundby, M.D., in *Lon. Med. Record.*

THE GERM THEORY OF DISEASE.—Dr. Henry F. Formad, gives in the *Medical Bulletin*, for March, an interesting review of the history of this theory. He gives also the present status of this theory as it applies to individual affections. Although from time immemorial it was believed that the body was infested with living organisms, which when increased beyond certain limits caused disease, the belief was first formulated into a scientific theory through the discovery by Schwann of the part played by living germs in the causation of fermentation and putrefaction. The discovery of the fungus causing disease in the silk-worm, by Bassis, and that giving rise to favus, by Schönlein, added to the strength of this theory. The experiments of Pasteur and F. Cohn placed the causative relation between fungi and putrefaction and fermentation, beyond the sphere of doubt. The first substantial support of the germ theory of disease, was, however, afforded by the discovery by Pollender, in 1849, of certain rodlets in the blood of animals suffering from splenic fever, variously known as anthrax, charbon, milz-brand and malignant pustule. These bacilli were subsequently isolated and developed in proper fluid, and were found to be capable of causing the disease in other animals. In 1873 Obermeyer discovered the spirillum of relapsing fever and Carter and others successfully inoculated monkeys with this disease. The greatest discovery in this connection, or at least that which has the greatest interest from its bearing on the human being, was that announced by Koch in March, 1882, viz., the bacillus tuberculosis:

He claimed that the tubercle bacilli are always present in tubercles, and often in the sputum of tuberculous subjects; that they can be isolated and cultivated, and that animals inoculated with them will be rendered tuberculous. Bacilli are also found in scrofulous lesions, lupus, in fæces of subjects suffering from tubercular enteritis, in secretion from laryngeal and pharyngeal ulcers, pearl disease, etc. There is strong evidence in favour of regarding Koch's bacillus as the cause of tuberculosis, and it is even accepted by some authorities as a settled fact; but so far Koch's observations stand alone, and cannot be accepted until confirmed by reliable, unbiased investigations of others. Therefore the question must still be considered *sub judice*.

Still the presence of the bacillus in tuberculous lesions is very generally confirmed, and its presence in the sputum of patients is regarded as strong evidence of tubercular disease.

The organisms most frequently found in connection with infectious diseases are the sphero-bacteria or micrococci. In erysipelas, Fehleisen discovered the *micrococcus erysipelatis* in the tissue at the periphery of lesions, and the same isolated, cultivated in gelatine soil and introduced into the ear of a rabbit, produced typical erysipelas after twelve to eighteen hours.

In leprous nodules the bacillus was demonstrated by Neisser, but no successful inoculations have been made.

Klebs and Crudelli claim to have succeeded in isolating the cause of malarial disease, the same being a bacterium, and called by them *Bacillus malariæi*. This bacterium was found in the blood of persons suffering from malaria by Cusoni and Marchiafava. Klebs and Crudelli claim to have produced malaria in animals, but it was regarded by other observers as a form of septicæmia. The experiments of Klebs and Crudelli have been repeated by Dr. Sternberg, U. S. A., with negative results.

In gonorrhœa a micrococcus was discovered by Neisser, and isolated, cultivated, and successfully inoculated in the urethra of man by Buckhardt. This was also disproven by Sternberg.

Micrococci are also found in pyæmia, septicæmia, puerperal peritonitis, scarlet fever, diphtheria, measles, small-pox, vaccinia, ulcerative endocarditis, purulent inflammations, etc. In typhoid fever peculiar bacilli were seen by Eberth, Friedlander, and Coats, and they were found in the lymphatic glands around the intestinal ulcers, also in the spleen.

In croupous pneumonia an organism has lately been described by Friedlander.

In syphilitic lesions, micrococci were found by Birch-Hirschfeld, Klebs, and others, but no reliable, positive inoculative experiments are recorded.

In the sputum of patients suffering with whooping-cough bacteria were detected by Burger.

Mention should be made of a new infectious disease of animals and mankind, called actinomycosis. The disease has long been known among stock-raisers as "swelled head," and was regarded pathologically as an osteo-sarcoma, affecting usually the jaws of herbivirous animals. A fungus, allied to the ordinary penicillium, but of a radiating structure, has been found in bone lesions in man, first by Langenbeck in 1843, and lately was discovered in the cattle disease mentioned above, by Bollinger, who called it actinomycosis. The fungus was subsequently rediscovered in man by Ponfick. But its etiological relation is not yet established.

A specific bacterium is also put forward for goitre by Klebs. Thus it is seen that the extreme germ theorists put forward a specific bacterium for each infectious disease, and even some non-infectious diseases are attributed to bacteria. Thus far, however, the causal relation of bacteria is established positively for only two diseases, malignant pustule (anthrax) and relapsing fever.—*Med. Age.*

CIDER AND ITS ANTI-CALCULOUS PROPERTIES.—A writer in the *Gaz. Med. de l'Algerie* calls attention to a recent publication by a pupil of Dr. Denis-Dumont, surgeon-in-chief of the Hotel-Dieu, of Caen, which professes to demonstrate that cider is the enemy of stone in all the varieties of calculi which, from one cause or another, affect the bladder. During a long experience in the hospitals of Caen, Dr. Denis-Dumont was struck with the almost complete absence of patients affected with stone—almost complete, because there were a few cases whose habitual beverage was wine. On treating these cases with cider, they were either considerably benefited, or entirely relieved of their malady. Struck with these facts, Dr. Denis-Dumont entered into correspondence with a large number of the medical practitioners of Normandy, principally those who practiced in localities where cider was the common and almost sole beverage. Of these practitioners, some of whom were of forty years' experience and longer, none had treated a case of stone. If they had treated any affection allied to stone, it was in cases where cider was not the ordinary drink, or it was due to some foreign cause. As a consequence, he has collected a mass of valuable observations which confirm his conjectures, and support him in formulating the proposition that cider is not only a prophylactic against the formation of stone and other affections of the bladder, but also that it is an energetic curative agent, when

in the condition to be absorbed, like any ordinary drink, and brewed in the best manner. Cider, even in Normandy, is frequently improperly made—but it would seem that bad cider is not worse than bad wine. The writer, using the precaution to declare that he is not of Normandy, goes on to say, with the effusion of a Frenchman, that, if the results of Dr. Denis-Dumont are admitted, they will furnish cause enough for the encouragement of plantations of apple-trees, and for the fabrication of a beverage which laughs at phylloxera, which has been served on the table of a Queen of France, to Saint Radegonde; which Charlemagne did not despise; which was celebrated after the epic mode in a Latin poem dedicated to the glory of Philippe-Augustus by Guillaume le Breton, and which François the First appreciated on his visit to Normandy.—*Md. Med. Jnl.*

The Mode of Production of the Tendon Reflex.—Jendrassik has made a number of experimental studies of the various conditions which are necessary for the presence or absence of tendon reflexes, particularly for the patellar reflex. The following conclusions express the most important of his results:

1. The "knee phenomenon" is a true reflex action, brought about by the mechanical irritation of the nerves situated in the patellar tendon. It is not necessary that the stimulus should be applied at the junction of muscle and tendon: stimulation of the part of the tendon lying farthest from the muscle is equally efficacious.

2. For the production of the reflex muscular contraction it is necessary that the muscle be passively extended: to a certain degree the contraction of the muscle is proportional to the stretching to which it is subjected.

3. Voluntary innervation of the crural nerve diminishes the patellar reflex, or may prevent its appearance altogether. Contraction of the muscles innervated by the sciatic nerve, however, instead of preventing rather favours the development of the patellar reflex.

4. The path of the reflexes lies in the spinal cord only in the gray matter. Lesion of the white columns cannot directly be a cause of the absence of the reflex.

5. Physiological increase of the tendon reflex is also produced by contraction of the other body-muscles: thus, simultaneous lifting of weights, or strong stretching of muscles, increases the reflex.

6. In the majority of cases pathological increase of the patellar reflex may be regarded as the result of an interruption of the conduction of inhibitory impulses from the brain to the spinal cord.

7. The author does not regard the "foot phenomenon" as a reflex, but rather as a tonic contraction, directly produced through the mechanical stimulus given in the sudden stretching of the soleus: the irritability of the muscle must therefore be increased.

In five instances severe stretching of the crural nerve in rabbits left the patellar reflex unaltered.—*Phil. Med. Times.*

Olive Oil and Gall-stones.—The *North Carolina Medical Journal*, commenting on the nature of the bodies discharged after a large dose of olive oil, reports a case of a man who was suspected of having gall-stones. A full dose of sweet oil was given and brought away about one ounce and a half of bodies of various shapes and sizes. Some were of a greenish colour, others brown, and others white. They were of the consistency of wax, were soluble in olive oil, in alcohol, and were inflammable. In a few days they melted down into a semi-fluid mass. With nitric acid and ammonia they gave the red reaction of cholesterin. Dissolved in ether and evaporated, white crystals resulted. Assuming that the chemical composition of these bodies is known, does the large amount of cholesterin indicate that these bodies are biliary calculi or enteroliths—will olive oil bring the same masses away from any one whether he has been suffering from biliary colic or not? If they are not biliary calculi what are they? Pure cholesterin is not known to exist in any other discharges from the bowels than the two bodies above mentioned. In olive oil there is scarcely more than a trace, and it is not known that there is any substance in the intestinal canal which, combining with olive oil, is capable of producing cholesterin. The editor trusts to make fuller investigations on the subject.

Ointment for Intercostal Neuralgia:—

℞ Veratrine ..... 10 Centigr.
Muriate of Morphia .... 10 Centigr.
Cold Cream..... 5 Grammes.

M. S. A.—Rub the part affected once daily with a piece as large as a pea.—*Lyon Méd.*

TESTS FOR CARBOLIC ACID. — 1. A small quantity of ferric chloride gives a fine violet coloration, and this test is so delicate that one part of phenol in 3000 parts of water can be detected.

2. If a drop of weak solution of carbolic acid be added to a few drops of a solution made by adding one part of molybdic acid to ten parts of strong sulphuric acid, a yellowish coloration is produced which rapidly changes to purple. If the mixture be gently warmed the reaction is hastened.

3. If a solution containing phenol is slightly warmed with some ammonia and a solution of sodium hypochlorite (prepared by adding carbonate of soda to a solution of bleaching powder, and filtering from the carbonate of lime) a permanent dark blue coloration is the result, which is changed to red on the addition of an acid. By this means one part of phenol in 5,000 parts of water can be recognized.

4. About the most delicate test for detecting minute quantities of phenol consists in the addition of bromine water, a crystalline precipitate being formed, known as *Tribromophenol*. A solution containing only one sixty-thousandth part of phenol gives this reaction after twenty-four hours.—*Pharm. Record.*

PURGATIVE LINIMENT.—The following preparation is recommended in *Zeitschrift der West. Allg. Apoth. Verein*, in cases where it is impossible to administer purgatives by the stomach:

℞ Tinc. colocynth., ... ʒ ix.
Ol. ricini., ... ʒ xx.
M.

Every morning and evening about one teaspoonful of this mixture may be rubbed in over the abdomen.

The tincture is prepared by the maceration of one part by weight of fresh colocynth seeds in ten parts of concentrated alcohol.—*The Analectic.*

MOLESCHOTT ON THE TREATMENT OF DIABETES BY IODOFORM.—The results of Dr. Moleschott's method of treatment are quoted in the *Paris Méd.*, Jan. 5, 1884, and are certainly promising. In five cases the sugar disappeared from the urine after a few days, and without special diet. The dose is at first ten to twenty centigrammes daily, but it must be increased gradually to 30 or 40 centigrammes.—*Lond. Med. Rec.*

EXAMINATION OF URINARY SEDIMENTS.—Certain urines, especially concentrated urines and those passed in febrile conditions, deposit upon standing a considerable sediment composed chiefly of alkaline urates, and often deeply coloured by uroerythrine. The detection of the organized sediments, such as blood globules, epithelium, casts, etc., in such cases is difficult and often impossible. To facilitate the examination in such cases Méhu (*Jl. de Pharmacie et de Chimie*, 1883, p. 228) adds to such sediments, after they have subsided and after most of the urine has been removed, a small quantity of a saturated aqueous solution of ordinary sodic phosphate. This dissolves completely the pigments and urates so that the subsequent examination of the sediment is comparatively easy. An excess of the sodic phosphate does no harm, but its addition frequently causes a precipitation of crystalline calcic phosphate. Méhu prefers this method of treatment to the common one in which the urates are dissolved with water. The latter delays the subsidence of the organized elements, and besides tends to soften and break them up.—*Md. Med. Journal.*

INFLUENCE OF IODOFORM ON THE BODY-WEIGHT IN PHTHISIS.—Dr. A. Ransome, in the *Brit. Med. Jour.*, Jan., 1884, p. 8, details notes on the use of iodoform in the treatment of phthisis. The drug was administered in the form of a pill, a grain and a half, combined with two grains of croton-chloral, three times a day. Twenty-one cases are recorded. Four of these were in the first stage of the disease, and three appear to have received benefit. Five were in the second stage of the disease; all of these increased in weight on commencing to take iodoform; but in three cases the increase did not continue, though they did not lose weight for several months. Of the twelve cases in the third stage, two distinctly gained in weight; six, after sundry variations, remained at the same weight after six or eight months of the treatment. The remaining four all diminished in weight. —*Lond. Med. Rec.*

CALABAR BEAN IN CONSTIPATION.—It has been observed as a result of the poisonous action of calabar bean on animals, that there is a tetanic spasm of the muscular coats of the intestines, which results in the

forcible expulsion of the contents. This physiological property of the drug suggested to Dr. Schaefer *(Berlin Klin. Wochenschrift)* the employment of the drug in cases of obstinate constipation (obstipation), dependent on weakness of the muscular coats of the intestines, such as may be frequently met with in women and old men. The results of his experiments have amply justified his anticipations, based on the physiological properties of the drug, severe cases having yielded to the treatment in less than twenty-four hours after its administration. His formula consists of a solution of 5/6 of a grain of extract of physostigma in 2½ drachms of glycerine. Of this six drops are given every three hours.—*Md. Med. Jnl.*

Specific for Migraine.—As an exceedingly practical fact, we should like to recommend the combination of the bromide of potassium and the deodorized tincture of opium (℥i to ♏xx), as almost a specific in the paroxysms of pain. We have seen this combination over and over again enable a patient to rise and go about her daily duties, relieved, without being apparently influenced in any other way. If the patient be impressed with the fact that the system gradually gets accustomed to this narcotic, and the remedy must be husbanded, great relief may be obtained for many years. We know of one lady who for twenty years has thus robbed an inherited migraine of its terrors, although now ninety grains of bromide and forty minims of the deodorized tincture constitute the least effective dose.—H. C. W. in *Phil. Med. Times.*

Salicylic Acid in Cerebro-Spinal Meningitis.—D. C. Ramsey, M.D., in the *St. Louis Courier of Med.*, regards cerebro-spinal meningitis as very analogous to acute articular rheumatism. Both being frequently ushered in by acute migratory joint pain, and both being acute inflammations of fibrous membranes. Cases being opportune he tried the rheumatic remedy in the spinal disease and with happy results. Four cases he treated with ergot, bromide of potash, morphia, quinia, etc., with three deaths and one recovery. Of seven cases treated by salicylic acid five recovered and two died. He gives fifteen grains every two hours until relief is obtained, then decreases the dose and lengthens the interval.

Calcium Sulphide in Diabetes Mellitus.—Dr. C. M. Cauldwell relates the histories (*N. Y. Medical Journal*) of two cases of saccharine diabetes in which calcium sulphide was administered with apparent benefit. A moderately strict diabetic diet and hygienic measures were used in conjunction with the calcium. In one case improvement began in two weeks and the sugar entirely disappeared from the urine six weeks after the treatment was instituted. The second case received unquestionable benefit at the end of three weeks and no sugar was detected after one month's treatment. A third case took the calcium faithfully for one month without benefit.

Action of Strychnine on Cardiac Dilatation.—M. Maragliano states that he has used strychnine in cases of cardiac dilatation with very good results. At the first examination he carefully found out the dimensions of the heart, and after the internal use of this medicine for a day or two, he discovered the dilatation was greatly reduced in size, and when he had continued the treatment for a week, the diminution was very marked indeed. If the strychnine is not continued for some time the beneficial results disappear, but when given in the form of sulphate in doses of two or three milligrammes three times daily it gives great relief.—*The Analectic.*

New Test for Lead in Water.—Mr. A. W. Blyth has announced that cochineal is one of the most delicate tests he has found for the presence of lead. The test is a one-per-cent. solution of cochineal in proof-spirit. Ten drops of this is added to a fluid ounce of the water contained in a white porcelain dish.

If the water is free from lead the colour is simply a dilution of the pink tint; but if it contain but one seven-hundred-thousandth part of lead the tint will be a purplish pink, and if it be as much as one seventy-thousandth part it will become a purple blue.—*Pharm. Rec.*

Electrical Reaction of the Sensitive Nerves of the Skin in Ataxics.—M. Mendelssohn's researches demonstrate the existence of an abnormal electrical reaction of the sensitive nerves of the skin in ataxics, analogous to the reaction of degeneration

of the motor nerves found by Erb. Later researches will allow the period of the disease to be stated in which this anomaly of electric reaction supervenes, as well as its relations with the alterations of the cutaneous nerves in ataxy lately described by Westphal and Déjerine.—*Le Prog. Méd.*

Calcification of the Pleura Costalis.—In a man who died of cancer of the stomach M. Gilbert found a thick plate of bonelike material covering the internal surfaces of the ribs on the right side, from the sternum to the vertebral column. Its internal surface was smooth, and separated from the ribs by connective tissue, while the internal was rough and adherent in some places to the lung. Chemically, the plate had nearly the same composition as bone, but microscopical examination showed that it was only fibrous tissue loaded with lime salts.—*Brit. Med. Jnl.*

Cod Liver Oil with the Muriates of Ammonium and Sodium.—J. P. Curley, M.D., in the *Med. News*, recommends an emulsion of pure cod liver oil with gum acacia, each ounce of the preparation containing sixty-six per cent. of cod liver oil and sixteen grains of the muriates of ammonium and sodium. The ordinary dose to be taken in sweetened water or milk. He has found the combination to be well borne by the stomach, and to act well in those cases in which the oil is indicated.

A Pleasant Disinfectant for Rooms.—From an Italian journal we note that a few drops of the following mixture on a plate will pleasantly disinfect a bed room: camphor, twenty parts; hypochlorite of lime, alcohol, water, each fifty parts; oil of eucalyptus and oil of clove, each one part. Dissolve the oils and camphor in the alcohol. Mix the hypochlorite of lime with the water, and add this to the alcoholic solution in a capacious vessel, and keep it cool until the mixture is complete.—*Pharm. Record.*

Arterial Pressure.—Dr. C. S. Roy's conclusions are that there exist in the vagus nerve, fibres decreasing the force of cardiac contraction distinct from the fibres that diminish the frequency of the beat, and, similarly, that there exist in the accelerans cordis fibres augmentative of force distinct from fibres increasing the heart's frequency.—*Am. Med. Ass. Jnl.*

The Coagulation of the Blood.—Mr. L. C. Woolridge ("Journal of Physiology," August, 1883) remarks that blood plasma, after it has left the vessels, converts the white cell into fibrin and liberates a certain substance, called fibrin ferment, which is able to bring about the coagulation of the fibrinogen in the plasma. This fibrin ferment owes its power of coagulation tc the presence of a substance called lecithin, a body omnipresent in protoplasm. Lecithin is prepared by making an alcoholic extract of the lymph cells.—*N. Y. Med. Jnl.*

Surgery.

CICATRICIAL STRICTURES OF THE ŒSOPHAGUS.

CLINIC BY M. TERRILLON.

(Translated from *Le Prog. Méd.*)

To explore the œsophagus there are two methods: When the stricture is situated very high, in certain persons it may be explored by the finger, but it is better to use an instrument. The searcher consists of a whalebone stem, on which bulbs of various sizes may be screwed. When a narrow stricture is suspected, a small bulb may be used, but cautiously for the larynx may be penetrated, or on account of the spasm produced, the upper part of the œsophagus may not be passed, and a stricture be found which in reality has no existence.

Cough will notify you that you are in the larynx; though sometimes with a trachea of moderate susceptibility the trachea may for many days be catheterised, and food even may be introduced into it without suspicion until terrible evidences reveal the fault committed.

It sometimes happens that the extremity of the sound butts upon the sides of the laryngeal portion of the œsophagus, where there is a fold which allows the sound to become engaged and arrested in a kind of *cul-de-sac.*

A third obstacle is spasm of the œsophagus which effectually arrests the sound, but by lightly persisting the spasm is soon overcome.

It is always necessary to use the left index finger as a guide to lower the base of the tongue, on arriving at the epiglottis the sound has only to follow the finger to penetrate into the œsophagus.

Suppose that having passed these obstacles we enter the œsophagus. The bulb will inform us of the seat of the stricture, still inferior spasm must be mistrusted, it is evidenced by knots of contraction; by gentle insistance and maintaining the pressure the stomach is reached. The manœuvre is analogous to that employed in catheterization of the urethra. Unfortunately this spasm is very difficult to overcome, especially in women, and may for months and years simulate a true stricture.

Spasm plays a prominent rôle in œsophageal stricture. It is an element upon which we must always count; it exaggerates the degrees of stricture, it may mislead us to their number; it is due to pain. The seat of stricture is often difficult to appreciate. For this it is necessary to recollect the distance which separates the incisor teeth from the upper extremity of the œsophagus. The following measurements must always be borne in mind. The œsophagus has a length variable between 22 and 25 cm., and there are 15 cm. between the incisors and the upper part of the œsophagus. It is necessary then to penetrate from 38 to 39 cm. in order to surely enter the stomach.

Suppose the seat of the stricture is known, and we now wish to learn its calibre. Here also I must appeal to your knowledge of normal anatomy. What is the normal calibre of the œsophagus? It also is variable, but remember that its maximum diameter is 0.02 cm. A less diameter is compatible with excellent health. The symptoms of stricture begin when it is not more than 12 mm. When we wish to practice exploration a bulb 14 mm. in diameter is introduced, it ought to pass; if it experiences an obstruction there is a stricture, a smaller bulb is then tried until one succeeds in passing, the size of this bulb indicates the degree of stricture.

The notion of the length of the stricture is more difficult to acquire, it is an affair of sensation, and requires a skilled hand. The number of strictures will be marked by the number of jumps of the bulb, but you know already that spasms must be taken into account; multiple strictures are rare. The searchers were at first full bulbs screwed upon a flexible stem; they were introduced easily, but in withdrawing them the heel of the bulb always encountered the chanton of the cricoid arched against it and occasioned difficulty in withdrawal. So their form was modified, instead of olivary, the bulbs were flattened on their anterior face.

The great amelioration consists in rendering these bulbs capable of following a conductor; for this purpose the olivary bulbs were perforated in their long axes, and after having passed a whalebone, furnished at its extremity with a small flexible gum bougie (Verneuil-Colin's modification) the bulb is screwed upon a flexible handle with two eyelets; then the bulb was introduced on the bougie, which is in position, and which passes into the central hole of the olive, and in the eyelets of the handle on which it is screwed. Thanks to this artifice; very narrow strictures may be passed.

The treatment of these cicatricial strictures may be:—1. Dilatation, sudden or rapid. 2. Slow or progressive.

The first method is seldom employed except for the upper extremity, and when the stricture is of large calibre. It is a brutal operation. One acts blindly, and may give rise to peri-œsophagitis, and in certain cases produce death.

The second method is carried out with olivary instruments and bougies. In case of a stricture of four mm. we will pass an olive; the next day we increase its diameter; and so on little by little until the stricture is dilated.

These olivary bulbs have immense inconveniences; by their form they drag upon the mucous membrane, often causing it to bleed. On entering and returning they pass and repass with the same inconveniences; these repeated traumatisms may induce those ulcerations so frequently found at the level of the strictures. The olivary also augment the *culs-de-sac* in the neighbourhood. If one is not patient, and has not a skilled hand, one may even perforate the œsophagus in one of the dilatations where the wall is thinned by inflammation and softening of the tunics. So we have arrived after many trials at treating these strictures like those of the urethra, that is to say with bougies.

These bougies are of black gum, smooth and terminated by an olive as those of the urethra. They may be screwed to the extremity of a handle or of a whalebone stem, which serves to maintain them. Prof. Bouchard has especially advocated this method of treatment. The diameters of

these bougies differ by one mm.; there are twenty bougies—the largest diameter being two cm. They are heavy; containing a bit of lead in their interior, which greatly aids in their introduction, with the requisite care, these bougies, are let fall, so to speak, into the œsophagus; it is necessary to push them very little.

This bougie, in passing into the stricture, repels the walls excentrically like a coin. There is the same advantage in not pushing the bougie into the stomach; the bougie resting on the stricture weighs upon its walls; little by little it dilates them, and this dilatation continuing the whole time of the sojourn of the bougie, you will exercise a continuous and durable action. The bulb on the contrary acts momentarily and instantaneously. It is necessary to augment the diameter of these bougies very slowly; with this scale of one mm. of difference it is well to change the bougie every ten or fifteen days only. This instrument has also an inconvenience, if there is a *cul-de-sac;* if there is a dilatation, the bougie will have also the tendency to lodge itself in this *cul-de-sac,* and may cause perforation.

By proceeding slowly and gently these accidents may be avoided, otherwise you will be sure that you are in the stricture when after having introduced the bougie, you endeavour to withdraw it, if you are in the stricture, the instrument is grasped, and the hand which withdraws feels a resistance.

It sometimes happens that these strictures are dilated in a few weeks. But when fibroid peri-œsophagitis is present a certain degree of dilatation is reached which cannot be exceeded. This is what has happened to our patient. I cannot succeed in passing a larger sound than the one I have employed this long time, and which is not very large, being only nine mm. in diameter: however, as we pass it every day during the week she has been in hospital, deglutition has become much easier.

It is then not so much the narrowness as the resistance of the walls of the stricture which influences the prognosis.

Some cases resist every attempt at dilatation, so surgeons have asked if an operation could not be made here as in the urethra, and have devised œsophagotomy, internal and external, analogous to urethrotomy.

1. *Internal Œsophagotomy.*—First of all the stricture must be permeable. Maisonneuve, Trélat and others have made trials, have had good results; but also bad ones for sometimes grave accidents happen. To perform internal œsophagotomy first introduce a whalebone sound and on this sound guide the instrument, which cuts either on entering or on returning. Instruments are used with concealed blades, two small sections are made and one may afterwards dilate; but it is necessary to dread consecutive phlegmonous inflammation, I would not voluntarily employ it.

2. *External Œsophagotomy.*—is quite another operation but which can be employed only in strictures of the upper portion situated in the cervical portion of the œsophagus.

This operation having in view the nourishment of the patient, we must go below the stricture. It also is a dangerous operation, which has given rise to phlegmons, which have killed the patients. It is now-a-days frequently practised amongst foreigners, but is inapplicable to our patient.

Finally I come to a very modern operation, gastrostomy. In the stomachal region is made an orifice by which the patient will be nourished.

Every surgeon who has seen a patient die of inanition has had to consider attempts of urgency, but the first patient operated upon in these conditions with this end in view, and who recovered, was operated upon by M. Verneuil.

I will not describe this operation, which consists in making a fistulous opening into the stomach. With the successes which we have had in abdominal surgery it is this operation for which I would have the greatest preference. For the moment our patient is well nourished by liquids. But will this continue? For a long while we have not succeeded in passing a larger diameter. We now intend to try to dilate still further, and it is only when if decidedly we are unable to maintain our patient in good health, that I would propose gastrostomy to her.

Treatment of Chronic Urethritis and Cystitis.—Dr. Guyon lays much stress upon the constitutional treatment with cod-liver oil, arsenic, iodide of iron, the sulphides externally and internally, balsams, douches, etc., according to the diathesis. The local

treatment by injections, instillations, and catheterization, is also of great value. Injections are only useful when judiciously employed; although most frequently used, they often fail on this account. They are either too strong or not strong enough; they either do injury or they are not efficient. Instillations made with an olive-pointed catheter, in which an opening exists at the side of the olive, are more valuable. A syringe is adjusted to the other extremity of the catheter, and the instrument is gradually introduced into the urethra until it meets a slight sense of resistance, when five or six drops of the solution are thrown in; after waiting a few minutes, the instrument is introduced farther, and, when it reaches the posterior extremity of the urethra, twenty to twenty-five drops are injected. The medicament usually employed by M. Guyon is the nitrate of silver (1/20 to 1/50); he also uses the sulphate of copper (1/10 to 1/50). Catheterism is not to be practiced early, for fear of complications, orchitis, cystitis, etc., but in obstinate cases it may be cautiously used every second day; the metallic bougies are the best for the purpose. Medicated bougies seem to be without utility. Should blennorrhagic cystitis with hemorrhages occur, it is best treated by instillations of nitrate of silver, which rapidly stop the bleeding. This treatment is also effective in chronic cystitis, which is particularly liable to be persistent and have relapses.—*Atlant. Jnl. Med.*

Tenotomy of the Tensor Tympani.—When the writer was in Vienna eighteen months ago, having heard Weber-Liel speak in extravagant terms about the advantages to be derived from the tenotomy of the tensor tympani, he sought the opinion of Gruber on the same subject. With a significant look of want of confidence, he suggested the leaving of the section of the tensor tympani to others. We find, however, from the *Annales des Maladies de l'Oreille, du Larynx*, etc., that Gruber is now performing the same operation. He claims that it is indicated in cases of permanent contracture of the muscle, and claims that the success is almost certain when the inflation of air gives temporary relief. Dr. Weber-Liel claims that this operation will put an end to attacks of vertigo associated with affections of the ear, and acting on his suggestion, Gruber operated on a case of fourteen years' standing, which had passed through various practitioners' hands. The patient, a woman, aged twenty-six, had suffered from impairment of hearing for fourteen years; associated with this difficulty was a frequent noise in the ears, accompanied with severe headache. All these symptoms were worse in damp weather. For several months past there was added to the above troubles violent attacks of vertigo, the patient fearing she is about to fall down forward. Section of the tensor tympani was effected and the noises ceased, the hearing improved; the vertigo was at first worse, but it improved gradually and was at length—the time is not given—completely relieved.—*The Analectic.*

Rule for Reducing Dislocations of the Hip-Joint.—Having flexed the leg on the thigh, and the thigh on the pelvis, slowly rotate the limb as far as possible, inward or outward, according as the toes pointed in or out before beginning the manipulation; then rapidly and forcibly rotate the limb in the opposite direction, and the head of the femur will usually slip into the acetabulum.

For example: In the iliac and sciatic dislocations, the toes point inward; therefore, rotate inward as far as possible, and afterward rotate outward. In the pubic and thyroid dislocation the toes point outward, hence rotate the limb outward still more, and then inward.—*The Analectic.*

Hypophosphites of Lime in Cancer.—The following is Dr. Hunter McGuire's formula for the use of hypophosphites of *lime* and *soda* in cancer of the breast:

℞ Hypophosphite of lime and soda, ℥ ss.
Diluted phosphoric acid..... ℥ ss.
Distilled water..... ℥ viij.

M. Sig.—Teaspoonful in water three times a day, and when indicated, he sometimes uses in addition *arsenic* and *iron* in the forms of chlorides of *arsenic* and *iron*.

There can be no doubt the progress of the cancer can be delayed by the use of this combination.—*The Analectic.*

Catheterizing the Eustachian Tube at the Ear-Clinic in Rome.—The difficulty of the introduction of the catheter into the Eustachian tube lies in the fact, that the posterior pharyngeal wall is taken as the

adjusting point to turn the back of the catheter into the mouth of the tube, and thus the instrument is pushed too far back. Prof. Rossi carries the catheter over the osseous floor of the nasal cavity, and as soon as the beak reaches the velum pendulum, it oscillates visibly, brought about by its contractors. The beak is then directed to the corresponding side, and slips at once into the ostium tubæ.—*The Analectic.*

OPEN WIRE BOUGIES IN THE TREATMENT OF GONORRHŒA.—D. C. McVail, M. B. states (*Brit. Med. Jnl.*) that gonorrhœa is a specific catarrh of the mucous lining of the urethra. He points out the desirability of keeping the inflamed surfaces apart, just as in the treatment of a moist eczema intertrigo. To accomplish this end he has had made open wire bougies. These are of two forms. The first is for the effective administration of injections, and is composed of a short length of catheter tube; to one end of which are soldered the wires of the open bougie, and to the other is attached a short piece of india rubber tubing. The instrument being introduced until the catheter portion is well within the meatus, the injection is introduced by a syringe until the passage is quite full, the india rubber tube is then compressed to prevent the escape of the fluid. In from twenty to thirty minutes the injection will be almost entirely absorbed, and the bougie may be withdrawn. The second form is an open wire arrangement throughout and is constantly worn by the patient, so that the discharge may drain freely away. These instruments are well borne by the urethra, and the patient pursues his usual avocations while wearing the second form. The length of the wire bougies is in proportion to the distance up the canal to which the catarrhal affection has travelled. In recent cases an inch and a half may suffice; in older cases it may be necessary to have it much longer.

DEATH FROM ETHER.—T. Holmes, M.A., F. R. C. S. (*Brit. Med. Jnl.*), reports a case of ether death occurring at St. George's Hospital in a woman who was about to be operated upon for a sloughing fibroid of the uterus. Death was by apnœa. Artificial respiration by Silvester's method was at once applied, the trachea opened, and a large tube introduced. The femoral pulse was felt for a long time. Death was attributed to respiratory spasm.

CANCER OF THE RECTUM. — Prof. Trélat *Rev. de Therap.*, Jan. 16, 1884), formulates the following propositions in reference to treatment:—

1. Cancers of the rectum which do not cause accidents should be left alone.

2. Cancers of the very extremity of the rectum, or of the margin of the anus, should be extirpated.

3. Accidents should be treated as they arise, but palliative measures are to be avoided. In this respect, he is in accord with Prof. Verneuil, but opposed to many English surgeons.

4. When the finger can be passed beyond the cancerous mass, rectotomy should be performed, otherwise not; but a way of derivation should be made by lumbar colotomy or by forming an inguinal anus.—*Med. and Surg. Rep.*

PATHOGNOMONIC SIGN OF SYPHILIS.—Dr. Detmold, remarking on the difficulty in deciding whether certain symptoms were of syphilitic origin, points out a sign which he considers as pathognomonic, viz., permanent œdema over the anterior surface of the tibia. Not that œdema in this region was always of specific origin, but when it was found on both tibiæ, and when no local cause could be discovered for it, there could be no reasonable doubt that it was due to syphilis.—*Med. News.*

THE TREATMENT OF RINGWORM.—Dr. R. W. Taylor, in the Journal of Cutaneous and Venereal Diseases, recommends a solution of bichloride of mercury in tincture of myrrh, four grains to the ounce, to be applied twice a day, in the various forms of ringworm.

Midwifery.

HÆMORRHAGE AFTER ABORTION. — Why should there be bleeding after a criminal abortion and not after a natural one? This may be illustrated by fruit growing on a tree. When the fruit is mature, it drops off from a slight shake, and no injury is done either to the tree or to the fruit. But, if you pluck the fruit while it is immature, you will probably break the twig from which it grows. Again, and this illustration is a happier one, if the fruit is blighted from any cause, it will drop off readily without any injury to the tree. So,

when a woman has a natural miscarriage, it is analogous to the falling off of the blighted fruit. The ovum is dislodged from its attachments, usually by the escape of blood behind it, and is thrown off as a whole, viz., the sac, with a little fœtus inside; no membranes are left behind, and no injury happens to the womb. But when, by criminal means, miscarriage is induced, it is like plucking the fruit while it still has sap-communication with the tree, and mischief results. The method most frequently employed to induce abortion is by puncturing the membranes. When this is done, the waters and embryo escape, but the adherent membranes remain behind. The secundines may remain after a natural abortion, but this is not the rule. In this woman the bleeding continued for four months, showing that the membranes remained attached to the womb, and acted like a polypus. This loss of blood was sufficient to produce a condition of anæmia. Menstruation then ceased. She has now partial amenorrhœa. She has been treated in the dispensary, and has been much benefitted. Before coming to the hospital the menses were very irregular. This is the history that often follows serious hæmorrhage at confinement. There is a strange peculiarity connected with loss of blood. It is frequently observed that where a person is losing blood in driblets she will grow fat. This fact is taken advantage of in æsthetic countries by butchers, who bleed the calves in order to have white and at the same time fat meat.

In the treatment of these cases we give iron in large doses. We also give cinnamon, which causes a flow of blood to the womb. The uterus should be irritated by making applications to the fundus. The diet should be good, the digestive apparatus should be kept in order, and the bowels regulated. When the woman has grown fat from the loss of blood, it is not easy to restore the menses.

I have often seen women from thirty to thirty-five years old begin to grow fat, and soon the menses would cease. These women are frequently excessively anxious to have children. There is nothing more difficult than to establish menstruation in such patients. I have tried all forms of treatment. I have used the galvanic stem pessary, in some instances with success, and in other instances with failure.

I explain this condition in the following manner: At the change of life there is atrophy of the reproductive apparatus, and especially of the ovaries. At that time women, as a rule, either grow stout or else they grow thin. Now, although I have no post-mortem results to offer in support of my opinion, I believe that in women of the age I mentioned, and who cease to menstruate, there is atrophy of the ovarian structures. Such a supposition readily explains the reason why it is so difficult to establish the flow in these women.—*N. Y. Med. Jnl.*

The Combined Method of Turning in Placenta Prævia.—Dr. C. Behm refers to the method which was described by Braxton Hicks in 1861, and to the literature of the subject, in addition to giving a somewhat extended notice of his own experience, involving fifty-three cases with this complication, in the clinic of Professor Gusserow, at Berlin. These cases are divided into two series, the first numbering thirteen, the second forty. Those in the first series were treated by the old method of version; thirty of those in the second by the combined method; the remaining ten required other procedures. The thirteen mothers gave birth to fourteen children, and the mortality was four for the mothers and ten for the children. As to the insertion of the placenta, in three cases it was marginal, in five lateral, and in five total or central. Of the forty cases in the second series, there were no deaths on the part of the mothers, but eight were the subjects of fever, and one suffered with hæmorrhage on the seventh day of the puerperium. Of the forty children, nine were born alive, five of whom were mature, two premature, and two with vital defects. Of the thirty-one dead children, six were mature, eleven were premature, and fourteen had vital defects. Notwithstanding the small percentage of survivals on the part of the children, the author considers the results excellent, and would so consider them even had all the children been lost, when the peculiar conditions attending this complication are born in mind.

The advantages of the combined method of turning are summed up in the avoidance of sepsis, which it insures, and also the limitation of the loss of blood, by means of the tamponade which is effected by the breech of the child. Turning having been

accomplished, the author differs with Spiegelberg, Fritsch, and others in their view that extraction should be as rapid as possible. In twenty-four of his cases in which he noted the interval between turning and extraction it varied between one-half hour and eleven hours, birth taking place in the largest number between two hours and two hours and a half after turning. In the interval the strength of the patient should be reenforced, and stimulants are regarded with more favor for this purpose than any method of transfusion. As a means of preventing atonic post-partum hæmorrhages, this method of turning has answered perfectly in the author's experience, and no accidents of this nature occurred to him. The aphorism which he proposes for the treatment of placenta prævia cases is *haste, with delay*—haste in performing combined turning, delay in extraction.—*N. Y. Med. Jnl.*

THE APPLICATION OF THE FORCEPS TO THE BREECH.—Truzzi relates his experience in this method of using the forceps, a method which has been proscribed by most obstetricians in a series of fourteen experiments upon the cadaver. The conclusions are as follows: 1. in a case in which the buttocks are wedged in the superior or middle portion of the pelvis, and the indication is for rapid extraction, the application of the forceps is preferable to traction in the groin with the finger, crotchet, or fillet, an operation which is likely to be attended with fracture of the femur or laceration of the soft parts in Scarpa's triangle. 2. Ollivier's proposal to apply the forceps upon the thighs, and not upon the pelvis of the fœtus, is plausible in theory, but not warrantable in practice. If his directions were carried out, the abdominal walls, and especially the region of the liver, might be compressed in a dangerous manner. 3. The application of the forceps upon the sides of the fœtal pelvis is easier, more certain, and less perilous than Ollivier's method. The soft tissues which cover the iliac bones form a suitable protection for them, and an unusual compressive force would be requisite to injure the bony structure. In all the author's experiments there was neither fracture of the iliac bones nor injury to the sacro-iliac or pubic articulation. 4. In order to obtain a good grip, the bite of the blades should reach the level of the iliac crest. The *point d'appui* should be taken at the iliac crest; the convexity of the fœtal hips will adapt itself to the concavity of the blades of the forceps, and the abdominal viscera will escape injury. 5. Porro's forceps thus applied has an excellent grip, especially in the anterior presentations. In the intervals between the efforts at traction it is desirable to maintain a certain compressive force with the instrument, lest the resiliency of the iliac bones cause the instrument to lose its grip. 6. Porro's forceps will answer all the requirements for application to the breech. The author thinks that most of the forceps which are now in use are too large, and have departed far from the simple plan of the original instrument.—*N. Y. Med. Jnl.*

THE ANATOMY OF THE HYMEN.—Dr. S. Pozzi has recently made a double series of anatomical investigations on this subject. First, on the embryo, in order to determine by sections the independence of the formation of the hymen, and the terminal parts of the ducts of Müller; and, second, on infants and adults, in order to dissect the masculine band *(bride masculine)* of the vestibule, and show its relations to the hymen. The conclusions which he draws from these investigations are as follows:—

1. The hymen is an appendage of the vulva and not of the vagina; it is formed at the expense of the urogenital sinus, which also forms a short vestibular canal, this last being the entrance to the vaginal canal.

2. The name *bulb of the vagina* has been unwisely given to the lower part of the vascular plexus, which occupies a prominent position in that canal. There is no ground for distinguishing a distinct organ here, and it should not be compared to the bulb of the urethra in man. It may as well be said that the corpora spongiosa are the analogues of the labia minora.

3. An attentive examination of the vestibular region in woman will show a small band or frænum *(bride)* between the clitoris and the meatus, about two-tenths of an inch long in the adult, easily recognized by the rectilinear outline of its borders, marked by a median furrow, and divided inferiorly so as to encircle the meatus. When the hymen exists, it appears to be continuous with this frænum. Pozzi proposes to call this small band, now described for the first time, the male frænum of the vestibule *(bride masculine du vestibule).*

4. The study of the balano-urethral frænum—so noticeable in cases of hypospadias—shows the identical connections between that large band and the atrophied frænum *(bride)* of the female vestibule.

The bifid condition at the meatus and its continuity with the hymen are easily shown. But in hypospadias it is clear that the frænum is a vestige of the corpus spongiosum arrested in the embryonic stage. The hymen of the hypospadias then, proceeding from the frænum, is an appendage of the corpus spongiosum, and is the terminal part or bulb. This conclusion may be applied to the female organ, and it may be said that *the hymen in the female is the analogue of the bulb of the urethra in man; it is the bulb arrested in the fœtal state, non-erectile, and membraniform.* [Henle has noted the frequent presence of cavernous or erectile tissue in the hymen.]

5. The connections of the gland of Bartholin to those of Cowper may be also easily made out. The considerable length of the excretory canal for the male glands, compared with their shortness in the female, should be especially considered. This admits of the opening of the canal considerably in front of the membranous region, at a certain distance in front of the posterior part of the bulb; that is to say, at a point exactly corresponding to the opening of the duct of Bartholin, in front of the hymen, at a certain distance from the fourchette. The opening of Bartholin's gland in the prehymeneal portion of the vulva is the origin of that singular lengthening of Cowper's duct.

6. The male frænum of the vestibule in woman is the vestige of the anterior or cylindroid portion of the corpora spongiosa, just as the hymen is the vestige of their posterior or ovoid portion.—*Gazette Méd. de Paris*, February 23, 1884.—*Med. News.*

Hydrastis Canadensis in Painful Menstruation.—In one of the recent numbers of the *Archiv. fur Gynakologie*, Prof. Schatz calls the attention of his colleagues to the value of tincture of hydrastis in many cases of painful menstruation, which hitherto have been supposed to need operative interference. The hydrastis contracts the vessels and lessens the genital congestion. Often by its use the pain attending the menstrual epoch is diminished or wholly removed.—*Med. and Surg. Rep.*

Dodging Period.—Dr. Goodell thought the dangers of the menopause much overrated. Cancer and fibroids of the uterus occurred more frequently at that age than any other, and had caused the popular dread. Although hæmorrhage was always pathological, its cause could not always be discovered, and in this "dodging period" serious hæmorrhage might occur and no dangerous condition exist. He would like to believe that cancerous growths had a benign incipiency, but could not go so far. The microscopists made many mistakes in ascribing malignancy to growths removed from the uterus. Dr. Goodell then gave a number of cases in which experienced microscopists had given prognoses of early fatal termination, based upon the cell-formation of growths removed from the uterus; but these patients had recovered, and now showed no evidence of any diseased condition. With regard to the small proportion of cancerous growths following laceration of the cervix uteri, he called attention to the large number of Irishmen using clay pipes, and the small number of lip cancers; and yet it was universally acknowledged that the use of a clay pipe was the principle cause of such growths.

Blood-letting is practised very freely in Turkey and the East, and women, as a consequence, got very stout; such women were more liable to profuse hæmorrhage at the "dodging period."—*N. Y. Med. Jnl.*

The Uterine Mucous Membrane During Menstruation.—A recent number of the *Zeitschrift fiir Geburtshuelfe und Gynæ-kologie* contains a paper on this subject by Dr. Theodor Wyder, of Zurich. He commences with a criticism of the observations of others on the point, and takes exception to most of them on the ground that sufficient care has not been taken to discriminate the effects of disease and of *post-mortem* alterations from physiological changes. He admits some few former descriptions as valid, and has made observations on nine women himself. His own were made in the following manner. He chose women in health and menstruating regularly. During menstruation a speculum, not oiled, was passed, and the blood and mucous oozing from the cervical canal were collected with a glass rod or a syringe, neither instrument being oiled, and care being taken not to let it enter the cervical

canal lest any cervical structure should be accidentally detached. The blood and mucous thus procured were examined microscopically. He comes to the following conclusions:

1. During menstruation a part of the superficial layer of the mucous membrane is destroyed, while the rest persists. This removal of the superficial layer of mucous membrane takes place to a different degree in different cases, sometimes being complete, sometimes "minimal." The separated layer in part retains its structures, in part is broken up into detritus, in some cases small bits of mucous membrane, in structure like the membranes of dysmenorrhœa membranacea, but causing no pain on account of their smallness, being found in the menstrual discharge.

2. The separation is a consequence of the menstrual hæmorrhage, and not of primary fatty degeneration. The latter is rather a consequence of the detachment and breaking up of the mucous membrane effected by the bleeding.

3. The superficial and middle layers of the remaining mucosa are composed of small cells, and have no resemblance to the decidua of pregnancy; while in the deeper layers there is a cellular hyperplasia of the interglandular tissue plainly intended to reproduce the tissue cast off during menstruation.

4. The regeneration of superficial epithelium takes place both from the glandular epithelium, and from the larger or smaller islets of superficial epithelium.—*Maryland Medical Journal.*

Pseudo-Cyst of the Ovary.—At the Pathological Society of Nantes, M. H Heurtaux exhibited the specimens of a pseudocyst which had given rise to all the clinical signs of a true ovarian cyst. The patient, aged 45 or 50, had for months observed her belly increasing in volume, becoming globular and fluctuating. She had had no particular previous history, no anterior phlegmasic phenomena, and the distress resulting from the development of the belly alone caused her to seek surgical aid. A median abdominal incision disclosed a thick smooth resistant surface, similar to that of a cyst. Numerous adhesions existed between this surface and the abdominal wall especially at the sides. Puncture gave exit to many litres of citrine liquid, similar to cystic fluid, the discharge frequently stopped and began again when the canula was displaced in different directions. The dissection of the adhesion was laboriously accomplished with the thermo-cautery, scissors and fingers. Much trouble was experienced in destroying a very close adhesion at the periphery of the pouch, uniting it with the colon ascending, descending and transverse. This adhesion once divided, the small intestine appeared perfectly free. The pouch which had been taken for a cyst had no posterior wall, and was found applied like a watch glass to the arc of the colon. It was a kind of apron covering the mass of the small intestine.

The cavity was constituted in front by a wall convex anteriorly, fibrous, thick, and resistant; behind by the meso-colons and the small intestine. There was no trace of the great omentum. The patient survived the operation only a few hours. The incomplete pouch which was presented, represented a segment of a sphere about 25 cm. in diameter at its base. Its external surface smooth, of fibrous appearance. Its internal face is areolar. These characters added to the absence of the omentum lead to the presumption that the internal face is constituted by the omentum degenerated by a partial peritonitis. The external face is supposed to be formed of new membranes fixing it to the large intestine.—*Gaz. Med. de Nantes.*

Rupture of the Aorta During Labour; Post-Mortem Delivery.—The following case is reported from the Obstetrical Clinic at Helsingfors. A woman, æt. 38 years, pregnant with her third child, after taking a bath, came to the clinic complaining of cold. Her previous health had been good. Vaginal examination showed that the os was completely dilated. The head was in the first position. The uterine contractions were energetic. Ten minutes afterward the patient suddenly had a violent convulsion, went into a state of collapse, and ceased to breathe. It being evident that the woman was dead, the forceps were quickly applied and the child delivered.

An autopsy of the woman showed that the pericardium was distended with a large quantity of blood. The heart was fatty, and strongly contracted. A little above the sigmoid valves, was found a rupture of the aorta, involving the internal and middle

coats. The aortic coat was very thin at the seat of rupture, and there was a small spot of atheroma on the ascending portion of the vessel. Heinricius, the reporter, thinks that the rupture was due to the increased blood-pressure caused by the energetic contractions of the uterus and the abdominal walls. He has not been able to find another case in literature of the rupture of the aorta during labour.—*Med. News.*

VAGINAL HYSTERECTOMY.—Professor Mueller of Bern, performs this operation (*Med. News.*) for carcinoma uteri by a method differing from those usually employed. To prevent hæmorrhage he first compresses the abdominal aorta with the fist, and by limiting his incisions to the anterior and posterior walls of the vaginal vault he avoids bleeding from the large vessels which ramify in the lateral walls. The uterus is retroverted through the posterior incision (a difficult operation), provisional threads are thrown around the broad ligaments and undivided vaginal walls, and the uterus is split vertically in two symmetrical parts. The resulting pedicles are now tied with strong double ligatures and divided near the uterus which is then removed. The vessels of the stumps are tied, and the aorta freed from compression and any other bleeding vessels secured. The stumps are allowed to retract and the ligatures cut off on a level with the vulva, and the vagina tamponed. The parts are thoroughly douched with sublimate solution. The ligatures should come away in the third week.

A NEW METHOD of Partial Extirpation of the cancerous uterus is reported by Dr. Ely Van De Warker. He amputates the cervix uteri up to the vaginal junction. Excising it as high as the os internum making an irregular triangle with the base at the vaginal junction, but little hæmorrhage follows. The uterus is packed with masses of absorbent cotton dry from an iron solution of one part of subsulphate of iron to three of water. The dressing is removed on the second day, then the opening is packed with caustic cotton, using a solution of chloride of zinc, protecting the vagina with vaseline pomade made by adding one part soda bicarbonate to three parts of vaseline.—*Med. Review.*

THE
Canadian Practitioner,
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, MAY, 1884.

PROPOSED CHANGES IN THE COUNCIL'S CURRICULUM.

In our last issue we referred to the proposed changes in the standard required for matriculation at the Intermediate Examinations. It will be remembered that one of the proposals was to make sixty per cent. the minimum in each of the following six subjects: English Grammar, English Literature, Composition, Dictation, History, and Geography. We hope the members of the Council will consider the question very carefully before adopting any such proposals. Such a standard for ordinary passmen is not required (so far as we know) by any Teaching Institution in the world. In fact such a requirement is simply a farce, because not one out of ten would be likely to obtain such marks if the examination was conducted with ordinary efficiency.

In order to test this question in connection with the case in point, we consulted Mr. Marling, and by his kindness and courtesy were allowed to inspect the marks obtained by three hundred successive candidates at the Intermediate Examination of 1883. The result showed that only one solitary individual out of the three hundred obtained sufficient marks for a *pass*, according to the standard proposed by the Council's Committee.

It may be that the standard at present is rather low, as the minimum ranges from twenty-five to about thirty-eight per cent., but at the same time it should not be forgotten that fifty per cent. is required on

the aggregate. It might be well to adopt a higher grade, but the change should not be sufficient to reject the great bulk of the candidates who present themselves. The result would be to force the students to take the Arts Matriculations in the different Universities, as they are at present accepted. To such a result we offer no strong objections, but we fancy such was not the intention of the Council.

It was also proposed to require Graduates in Arts to take the full course of four years as prescribed for others. We would certainly like to see all our students engaged in the study of medicine for a period of four years before commencing practice, but at the same time we think the Profession would not suffer by allowing these Graduates one year in consideration of the great advantages obtained by them in four extra years of study, especially when their course includes subjects contained in the ordinary medical curriculum. It is well to remember, at the same time, that the Council in its honest endeavours to raise the standard of medical education is sadly handicapped by the procedures of a certain Examining Board, an Institution which is a disgrace to the Classic City of Edinburgh as well as the whole United Kingdom, which is apparently willing to accept and pass anything from this continent, when the sufficient number of guineas is at the same time forthcoming.

We would prefer to see Botany retained in the Primary Examination, unless the candidates had passed on this subject when matriculating. Pharmacy might well be substituted for Therapeutics in the Primary, and Therapeutics included in the Final. We quite approve of the proposals to compel the candidates to present certificates of proficiency in mounting microscopic specimens, also certificates of attendance on six post-mortem examinations with ability to draw up reports of same, and certificates showing that they have worked satisfactorily as clinical clerks and surgical dressers.

SENATE ELECTION FOR TORONTO UNIVERSITY.

We hope the Graduates in Medicine of Toronto University will remember that the voting papers should be sent to the Registrar between the 1st and 6th of May, in time to be delivered before noon, May 7th. Although there were two Medical Men among the retiring members, we regret to say that Dr. Graham has declined re-election. Dr. Thorburn is therefore the only Medical Candidate in the field. It is certainly desirable that there should be a fair Medical representation in the Senate, and we earnestly hope that Dr. Thorburn will not be defeated through the carelessness and indifference of the Medical Graduates. Don't fail then to fill out your papers at once, and send them in. With reference to the other Candidates, Mr. Louden is too well known to need any eulogies from us. He is one of our most distinguished Graduates, of whom we are all proud, and one of the most efficient members in the Senate. Mr. Coyne, of St. Thomas, is one of the ablest of our younger Graduates. He is very active and zealous in University matters, and will get a large vote, both in and outside of Toronto. To the other candidates we have no objections to offer, excepting this, that every vote cast for any one of them will diminish Dr. Thorburn's chances of re-election. We want no *plumping*, as such a course is unfair, and would alienate the *Arts Men* from us.

We ask our friends therefore to vote *at once* for

James Louden, M.A.
James Thorburn, M.D.
James Henry Coyne, B.A.

THE THIRTY-EIGHTH ANNUAL MEETING of the Association of Medical Superintendents of American Institutions for the Insane, will be held at the Continental Hotel, in the City of Philadelphia, on Tuesday, May 13th, 1884, at 10 a.m.

UNIVERSITY OF TRINITY COLLEGE.

At the Convocation of the University of Trinity College, held on Thursday, April 17th, the following degrees were conferred:

M.D., C.M. — H. Robertson, A. M. Baines, T. C. Cowan, A. Davidson, S. W. Lamonaux, H. Meikle, T. McK. Milroy, J. C. Mitchell, J. B. Gullen, E. M. Hoople, E. B. O'Reilly, J. T. Sutherland, E. R. Wood, W. McE. Brown*, J. L. Davison*, G. A. Bingham*, E. H. Williams*, G. Fierheller, E. A. Hall, G. L. Airth, James Johnston, J. Standish McCullough, S. A. McKeague, F. H. Johnston, D. Gow, A. Gillespie, S. M. Dorland, W. S. Harrison, E. J. Eade, J. M. Cochrane, A. D. Lake, A. McKillop, W. E. Sprague, Jas. S. McCullough, R. Ovens, T. Ovens, G. L. Johnston, W. J. Chambers, P. N. Davey, T. H. Mott, T. McCullough, O. M. Belfry, J. C. Bell, E. Furrier, A. V. Delaporte, J. E. Brown, J. E. W. Anderson, J. Park, E. A. Fillmore, J. H. Kilgour, A. V. Sturgeon, J. C. McIntyre, T. M. Lawton, D. N. Carmichael, W. H. Hamilton, W. O. Scott, A. Farncomb.

M.D.—W. H. Macdonald.

C.M.—Dr. F. D. Canfield, Dr. J. A. Gaviller, Dr. W. W. Geikie, Dr. W. T. Harris, Dr. D. McLeod.

Gold Medallist.—The University Gold Medal was conferred upon E. H. Williams.

* Certificate of Honour.

VICTORIA COLLEGE.

The following gentlemen having passed their examinations have been recommended for the degree:—

M.D., C.M.—A. C. Smith, G. H. Carveth, H. Bascom, C. M. Foster, T. W. Simpson, G. A. Cherry, J. E. Elliott, H. S. Martin, D. Campbell, E. F. Hixon, L. G. Langstaff, A. Sangster, S. E. C. McDowell, A. T. Rice, C. W. Hunt, G. S. Wattam, J. H. Jolliffe, J. O. Orr, W. A. Robertson, J. W. Campbell, A. Broadfoot, F. Beemer, J. R. Phillips, C. W. Chaffee, J. H. C. Willoughby.

Primary Examination.—W. J. Parry, J. E. Pichard, W. C. Heggie, H. A. Wright, W. C. McKinnon, W. J. Teasdale, J. A. Rutherford, J. R. Dales, D. M. Williams, W. H. Wright, G. Simenton, C. E. Lawrence, L. L. Hooper, C. J. Smith, J. M. Forster, P. P. Park, G. Sanson, C. A. Hodgetts, E. E. King, G. A. McDiarmid, L. G. Smith, A. McGillivray, T. J. McDonald, S. West, R. J. Wood, A. B. Riddell, W. R. Baker, C. J. Hastings.

TRINITY MEDICAL SCHOOL.

The medals, scholarships and certificates of honour were awarded to the successful contestants at the school building, on the 16th ult.

CERTIFICATES OF HONOUR.

First Year.—John McLurg, James McLurg, J. Hamilton.

Primary.—S. Scott, A. Graham, R. Lucy, W. H. McKeague, O. M. Belfry.

Third Year.—J. Rannie Logan.

Final.—W. M. Brown, E. H. Williams, G. Fierheller, S. A. McKeague, G. A. Bingham, G. L. Airth, R. Ovens, A. D. Lake.

SCHOLARSHIPS.

First Year.—1st. John McLurg, $50; 2nd. James McLurg, $30.

Second Year.—S. Scott, $50.

Third Year.—J. Rannie Logan.

MEDALS.

1st. Silver, E. H. Williams; 2nd. Silver, G. Fierheller.

Gold Medallist, W. M. Brown.

COLLEGE OF PHYSICIANS AND SURGEONS

PRIMARY, 1884.

Anderson, J. E. W.; Bigelow, A. W.; Bateman, R. M. Britton, C. H.; Birkett, H. S.; Brock, L.; Barber, John; Canfield, F. D.; Cook, E. M.; Cassidy, J. J.; Cunningham, H. C.; Cutten, L. F.; Cleminson, J. M.; Charlesworth, W. H.; Davis, W. N.; Doolittle, P. E.; Dales, J. R.; Dwyer, A. W.; Dickson, G. J.; Edmison, A. H.; Earl, E. H.; English, W. M.; Eadie, A. B.; Ellis, D. D.; Ford, H. B.; Fielde, E. C.; Foster, C. M.; Ferguson, James; Grant, J. H. Y.; Graham, A.; Hall, W. R.; Hamilton, W. H.; Hamilton, H. J.; Heggie, W. C.; Hughes, P. H.; Hay, W. W.; Jones, John A.; Johnston, D. R.; Kyle, W. A.; Lynch, W. V.; Lapp, C.; Little, A. T.; Lucy, Robt.; Logie, Wm.; Mather, M.; Mothersill,

L. J.; Marty, J.; Mellow, S. J.; Mott, T. H.; McKeague, W. H.; McKenzie, G.; McCormack, N.; Noecker, C. T.; Osborne, A. B.; Parke, J.; Peaker, —.; Pichard, J. E.; Peters, G. A.; Parry, W. T.; Russell, D. G.; Rutherford, J. A.; Reynolds, Helen, E.; Routhier, L. G.; Rice, A. T.; Shaver, A. M.; Simenton, G.; Sanson, Geo; Snelgrove, C. F.; Sandford, C. M.; Stacey, C. E.; Stirling, J. A.; Scott, Stuart; Smith, C. J.; Simmons, J. W.; Scott, W. O.; Shoults, Geo.; Smith, R. A.; Sprague, W. E.; Staebler, D. M.; Thompson, L. W.; Totten, O.; Veitch, Geo.; Willson, W. A.; Wright, W. H.; Wishart, D. J. G.; Weekes, W. J.; Winnett, F.; Young, W. J.

FINAL, 1884.

Addison, J. L.; Anderson, J. E. W.; Bingham, G. A.; Beatty, Elizabeth; Canfield, F. D.; Carveth, G. H.; Clerke, J. W.; Campbell, D.; Cochrane, J. M.; Cook, E. M.; Coughlan, R.; Davis, W. N.; Duff, H. R.; Draper, J. S.; Elliott, J. E.; Fierheller, G.; Foster, C.; M.; Fraser, R. N.; Ferguson, James; Fielde, E. C.; Hall, W. R.; Hixon E. F. Hamilton, W. H.; Hunt, C. W.; Herald, Jno.; Hall, E. A.; Johnston, G. L.; Jones, John A.; Johnston, F. H.; Kent, F. D.; Langstaff, L. G.; Lake, A. D.; Martin, H. S.; Mott, T. H.; McKenzie, A. F.; McGillivray, Alice; Orr, J. O.; Ovens, T.; Park, J.; Patterson, J. W.; Pringle, A. F.; Routhier, L. G.; Robertson, W. N.; Rice, A. T.; Ruttan, R. F.; Scott, W. O.; Shoults, Geo.; Sangster, A.; Smith, R. A. Sprague, W. E.; Stewart, S.; Spence, J.; Staebler, D. M.; Stewart, R. L.; Stirling, J. E., Smith, Elizabeth; Webster, H. E.; Young, W. J.

WOMAN'S MEDICAL COLLEGE.

The closing exercises of the Woman's Medical College, of Toronto, were held on the afternoon of Saturday, April 19th, in the theatre of the Normal School. A very large and interested audience were present. Dr. Barrett, M.A., President of the College, ably presided over the meeting. On the platform, beside the Chairman, were His Honour the Lieutenant-Governor and Mrs. Robinson, Mrs. McEwen, Dr. Geo. Wright, and Dr. Stowe-Gullen. Dr. Geo. Wright delivered the closing address. In well chosen words he gave a succinct account of the inception and progress of the College, touched upon the obvious necessities of female medical education, and referred to the generous support this College had received from the public, and detailed the advantages offered by Toronto for an institution for the teaching of medicine.

Dr. Barrett then stated that, through the kindness of a lady who took a great interest in the Woman's College, a scholarship had been given to the most successful candidate in the annual examination. The value of the scholarship amounted to $60. He asked Mrs. J. B. Robinson, to present to Miss Gavinia Gowans the cheque for that amount.

Mrs. McEwen, one of the warmest, most energetic and devoted friends of the College then addressed the meeting, congratulating Miss Gowans upon her success and hoping for a continuance of it in her course through life. She then proceeded to give a short statement of the financial condition of the College, and handing the subscription book to the President regretted to announce the sorrowful fact that this closed her connection with the College.

Dr. King, of Manitoba College, made a few remarks. The proceedings were then brought to a close by the announcement that the lectures would begin on the 1st of October next, when from present indications there would be a large class in attendance.

The subscription book was then asked for by some of the audience, and was returned with the addition of many handsome donations.

SOME of our readers have, doubtless, been called upon to pay their dues to the College of Physicians and Surgeons, and all have, doubtless, intended to settle up their indebtedness. But owing to the hurry of life, the pressure of business, inadvertence, or forgetfulness, the matter has slipped from the minds of some. Their memory may have been rudely jostled by the reception of a lawyer's letter, or sad to relate, the courts may have had to settle a claim by, in some cases, adding costs, which were greater than the indebtedness which was sought to be recovered.

To those who may, in the future, receive a legal intimation that they owe the Col-

lege the dues for a year or two, we give the advice to pay up at once, and save the additional expense and trouble entailed upon all parties by delay or forgetfulness. The matter is out of the jurisdiction of our genial friend, the Registrar, Dr. Pyne, who was ordered by the Council to put the accounts into the solicitors' hands for collection. And the solicitors are acting with that promptitude which is a characteristic of the legal body in all cases in which money has to be paid—by other people.

The American Surgical Association is now meeting in the Lecture Room of the National Museum, Washington. The meeting extends from 30th April to 3rd May, and a most interesting list of papers is announced.

Correspondence.

To the Editors of the Canadian Practitioner:

Will you kindly allow us space in your journal to make an explanation with regard to our names having appeared as subscribers to a work on "Domestic Medicine." The book was left at our residences under the pretext, in nearly every case, for examination, and a slip was presented for signature. The person, who left it, in each case ,said he desired the signature merely to show that the book had been received, and for no other purpose. Not wishing to act discourteously we signed the slip, which was a simple receipt for the work, and the agent has no authority to use in his advertisement our names as subscribers for the "Practical Home Physician."

Wm. Oldright, M.D.
J. A. Temple, "
J. E. Graham, "
Wm. T. Aikins, "
George Wright, "
W. B. Geikie, "

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

Canadian Institute, March 13th, 1884.

The President, Dr. Graham, in the chair. The minutes were read and confirmed. Dr. W. H. Macdonald was proposed for membership.

Dr. Ross presented a cancer of stomach.

Dr. McPhedran showed a placenta from a woman æt. 21, primipara, delivered at full term of dead fœtus, which, from its immature macerated state, had evidently been dead for some weeks. Fœtal movements were last felt six weeks before birth; she had been working hard, scrubbing, etc., on moving into a new house. A few days afterwards she had a return of morning sickness, which was relieved by drop doses of chloroform. The placenta is small, quite firm and thin in parts; contains two clots, a recent one about the size of an almond nut, another smaller, much older, and apparently partly organized at the margins. In two or three places the placenta is thick, soft, and on section seems fibrous in structure. Microscopic examination of the part around the recent clot shows fibroid structure for the most part, but partially organized, intermingled with extravasated blood. The villi, in some parts, appear to be thickened; in others, they are more or less destroyed by extravasation. Many places show well marked fatty degeneration. The trouble was probably due to placentitis, the extravasation being secondary. There was no history of syphilis.

Dr. Cameron asked what were the distinguishing features microscopically between a blood clot, inflammatory, and gummatous deposits.

Dr. Graham thought that in syphilitic deposit there would be a more concentric arrangement of the fibrous material than in a simple clot.

Dr. Ross said the cellular element predominated in syphilis, the fibrinous in an organized clot.

Dr. Wallace presented a case of knee-joint disease. A boy æt. ten years, last July, in getting into bed, struck the knee against the bedstead; not suffering much pain he did not apply for treatment until four months had elapsed. The joint was then enlarged, especially on its inner aspect; no pain complained of; a slight limp when walking. The family history is good, although their lungs are supposed to be weak.

The case was examined by the members.

Dr. Cameron considered it a case of tubercular osteitis and recommended rest, pure air and good food, cod liver oil and iron.

Dr. Ross had had under his care a case which had pursued its course entirely without pain until contraction of the muscles set in. Tenotomy was then performed and good results ensued.

Dr. Ross presented for examination a little girl who had had diphtheria, followed

by paralysis of the tensor and levator palati muscles, myopia was also present due he thought to the effects of the diphtheria.

Also an elderly lady affected with Bell's paralysis of the right side. The trouble had supervened three years ago and had been gradual; it was primary not hemiplegic.

Dr. Reeve said that the myopia in the first case might be a condition of simulated myopia in which the defect of sight was overcome by approaching the object.

Dr. Cameron thought the paralysis following diphtheria was due to an ascending neuritis, or to atrophy and fatty infiltration of muscle fibre due to inflammatory trouble.

Dr. McPhedran exhibited the œsophagus of a small dog in which the neck bone of a fish had become impacted just above the cardiac orifice of stomach. The bone was about 1½ inches long and lay transversely, having perforated the œsophagus and entered the left pleural cavity in which was found various fluids that had been taken during the four or five days the dog lived after the bone was swallowed.

In connection with this specimen Dr. McPhedran reported the case of a gentleman, who, while eating a dinner of beef steak, suddenly felt something stick in the throat. It caused great dyspnœa and inability to swallow anything but fluid and even that with much difficulty and discomfort. He was seen immediately afterwards but nothing could be discovered either by the finger or the laryngoscopic mirror. The difficulty was referred to the part behind the larynx. A small probang was passed gently without meeting any obstruction; a horse hair *umbrella* probang was then passed but without finding anything. During the following two weeks there was scarcely any change in the symptoms; nothing but fluids could be taken. External pressure revealed tenderness or rather consciousness of touching the site of the trouble when the finger was pressed on the right side behind the cricoid cartilage. General health suffered from improper nourishment and anxiety. After a couple of weeks the symptoms began to improve somewhat and fluids could be taken with less discomfort. The examination was repeated on two or three occasions but without effect. Emesis did no good. The last examination was made on January 7th last, five weeks after the occurrence of the accident. By this time he could swallow semi-solid substances though with some discomfort. On this occasion a large piece of compressed sponge was first introduced into the œsophagus through a tube and after some time withdrawn. There was no pus on it to indicate ulceration. A horse hair probang was then passed and withdrawn fully expanded but brought up nothing. Finally a large œsophageal sound was passed into the stomach; it had been passed on a previous occasion. The next day the symptoms were much better, and on the day following they had completely disappeared. It appears probable that a small spicula of bone or some similar foreign body which had been lodged in the wall of the œsophagus had become loosened by ulceration and was removed by this last exploration. The gentleman, though of a nervous temperament, was not in the least inclined to hysteria.

Dr. Nevitt mentioned a case which he had reported to the Society of a woman who after swallowing a piece of the crisp skin of a roasted goose felt something stick in her throat Nothing was found by examination, but shortly afterwards she had repeated and alarming hæmorrhages and died. Post-mortem showed the trachea and bronchi filled with blood and an ulcer of the œsophagus leading to a perforation of the superior thyroid artery.

Dr. Cameron had met with several cases which he considered of nervous origin.

Dr. Graham mentioned the case of a woman who entered the Hospital with symptoms of paralysis of larynx and pharynx or aphasia. She was treated for the latter for nine days when she died, and post-mortem a plate containing false teeth was found in the larynx, but no brain lesion.

Dr. Graham presented a case of colloid cancer of the great omentum, the primary lesion he thought was upon the anterior wall of the stomach; the liver was invaded throughout with secondary nodules. The mucous membrane of the stomach was but slightly affected.

2. C. F., æt. 23, sub-diaphragmatic abscess opening into the pleura and lung, (See *Practitioner*, April, '84, p. 102).

3. Epithelioma of rectum with an opening into the bladder. There were secondary deposits in the glands of the pelvis and mesentery. Mucous membrane of bowels

was much congested. The liver was not affected.

4. R. D., æt. 60, right lung was adherent to walls of chest to about the level of the fifth rib. On the posterior surface of the anterior wall was found a tumour which projected into the lung substance, and on the anterior surface of the posterior wall there was also a tumour about the size of a man's hand, cartilaginous in appearance, broken down in the central parts and filled with pus and coarse granular debris. Projecting from the posterior tumour was a calcified spiculum about three inches long directed towards if not actually connected with the anterior tumour.

5. Uterus of a woman who had died of eclampsia twelve hours after delivery.

6. Kidneys from an Italian who had had both feet frozen. The kidneys were much enlarged, white, weighed eight ounces each. Interstitial and parenchymatous nephritis existed together.

Dr. Cameron thought that the second case reported might be classed under the head of perinephritic abscesses, occurring in the upper plane described by Roberts and Gibney. In regard to the peculiar growth found in case four, he inquired whether it was considered congenital. He had seen a somewhat similar case which he had thought was a new growth.

Dr. Ferguson reported a case of hereditary polydactylism. The child had six fingers upon each hand. The child's mother and a sister of the mother had been born with six fingers; while a second sister had had six fingers and six toes, and their mother had also six fingers.

2. The case of A. B., a young man of good health had indulged in violent exercise at football, on Saturday, the next day while at church he felt chilly, but had no distinct rigor. On Monday the left knee was swollen; was first seen on Tuesday at 9 a. m. It was regarded as a case of synovitis. The thigh rapidly swelled, and on Thursday the right lung was consolidated, and on Friday a large amount of fluid had accumulated in the pleural cavity of that side. The pericardium also rapidly became distended with fluid, and patient died on Saturday evening. The right pleural cavity, the left knee and thigh, and the pericardium contained large quantities of pus. He considered the violent exercise on Saturday gave rise to an excessive waste of tissue more than the system could eliminate and consequently rapidly fatal pyæmia set in.

3. Syphilitic pyrexia in a young man twenty-eight years of age. The sore appeared on the 25th day from the first exposure, and 6th from the second. The glands became distinctly enlarged by the twelfth day. This was followed by a macular eruption. There was great loss of weight, severe headache, sleeplessness and profound cachexia. For three weeks the temperature ranged from 102° to 105°, which was the highest point reached. There was some delirium. Specific treatment was badly borne by the mouth and hypodermics were resorted to. The temperature fluctuated greatly. There was a distinct vesicular eruption along with the macular.

Dr. Macdonald asked why, after empyema was diagnosed, the pus was not evacuated by aspiration or otherwise?

Dr. McPhedran inquired how Dr. Ferguson accounted for the complete consolidation of the lung.

Dr. Ferguson could not account for the lung consolidation. He did not aspirate for in the patient's condition, it would have been useless. Pus formed first at the knee, then in the thigh and pleura. The heart was apparently invaded last.

Dr. Cameron thought it probable that it was a case of ulcerative endocarditis; the knee trouble being consecutive to the heart affection.

Dr. Duncan said that at the last inquest he had held at the gaol, the subject had died of pyæmia with no apparent cause for it except a trivial burn upon the finger. Pus was found in the knee and in the elbow joints.

Book Notices.

Le Citoyen Americain. Minneapolis, Minn.

Transactions of the N. Y. Medico-Chirurgical Society, 1883. Vol. III.

Weekly Health Bulletins for March. Ont. Board of Health. P. H. Bryce, M.A., M.D., Secretary.

Michigan State Board of Health. Abstract of Meeting, April 8th, 1884. H. B. Baker, M.D., Secretary.

Aneurism of the Femoral Artery and a Knife Wound of the Intestines. By W. O. Roberts, M.D. (Reprint from *American Practitioner.*)

Transactions of the Medical Association of the State of Missouri at its 26th Annual Session, held at Jefferson City, Mo., May 15, 16, and 17, 1883.

Weekly Health Bulletins and Meteorological Reports for State of Michigan, and Monthly Mortuary Report for the City of Lansing. O. Marshall, M.D., Health Officer. Issued by Michigan State Board of Health. Henry B. Baker, M.D., Secretary.

Electrization of the Sympathetic and Pneumogastric Nerves. With Simultaneous Bilateral Compression of the Carotids. By J. Leonard Corning, M.D. (Reprint from *N. Y. Med. Jnl.*)

Surgical Applied Anatomy. By Frederick Treves, F.R.C.S., Assistant Surgeon and Demonstrator of Anatomy, London Hospital, etc. Philadelphia: Henry C. Lea's Son & Co.; Toronto: Vannevar & Co.

This is a comparatively small book, but contains within its 500 pages a wonderful amount of interesting and valuable information, useful alike to the advanced student and the practitioner, be he Surgeon or Physician. As signified by the title, it treats of Anatomy as applied especially to Surgery, but to a considerable extent also to Medicine. It is likely to prove one of the most popular and useful works in the series.

Illustrated Medicine and Surgery. Edited by Profs. Geo. H. Fox and Frederic R. Sturgis of New York, with the co-operation of Profs. Willard Parker, A. C. Post, J. L. Little, T. G. Thomas, A. L. Loomis, F. Delafield, D. B. St. J. Roosa, C. R. Agnew and Austin Flint. Vol. II, No. IV. Quarterly. New York: E. B. Treat, No. 757 Broadway.

The contents of this No. are as follows:—Herpes Facialis, (1 Illustration) by G. F. Jackson; Removal of a Capillary Nævus, (2 Illustrations) by Jarvis S. Wight; Hypospadius Hermaphroditisium, (2 Illustrations) by James L. Little; A Case of Hereditary Deformity, (2 Illustrations) by E. P. Williams; Mucous Patches of Os Uteri and Vagina, (1 Illustration) by Fessenden N. Otis; Venereal Warts, (1 Illustration) by Walter L. Ranney; Three Cases of Fracture of Spine, (8 Illustrations) by J. Emmett Holt; Downward Displacement of Transverse Colon, (2 Illustrations) by C. H. Thomas; and a Case of Syphilitic Dactylitis (2 Illustrations) by H. P. Lyttle.

Drugs and Medicines of North America. A Quarterly devoted to the Historical and Scientific discussion of Botany, Pharmacy, Chemistry and Therapeutics of the Medicinal plants of North America, their Constituents, Products and Sophistications. J. U. Lloyd, C. G. Lloyd, 180 Elm Street, Cincinnati, Ohio.

The first number of the first volume of this Quarterly has reached us. It contains articles upon some of the Ranunculaceæ, Clematis Virginiana, Thalictrum Dioicum, Thalictrum Anemonoides, Anemone Nemorosa, Anemone Patens. The work has many illustrations, both of the macroscopic and microscopic appearances drawn by J. A. Knapp and Louisa R. Stowell, and also taken from various authorized botanical works. The authors have undertaken a great task, one that requires an immense amount of energy, research, tact and judgment to carry it to a successful issue.

Shakespeare as a Physician. Comprising every word which in any way relates to Medicine, Surgery or Obstetrics, found in the complete works of that writer, with criticisms and comparison of the same with the medical thoughts of to-day. By J. Portman Chesney, M.D., Prof. Gynæcology, N. W. Medical College, St. Joseph, Mo. J. H. Chambers & Co., Publishers, Chicago, Ill,, St. Louis, Mo., Atlanta, Ga.

The scope and intention of this work are well set forth in the title, and the only comment called for is on the manner of the execution. It is divided into nine chapters, comprising Obstetrics, Psychology, Neurology, Pharmacologia, Etiology, Dermatology, Organology, Chirurgery and Miscellaneous Topics; has evidently been compiled with much labour and carefulness, and presented with as much of continuity as could reasonably be expected. We have all, doubtless, observed and noted for ourselves with wonder and amusement the extent of Shakespeare's acquaintance with "the ills that flesh is heir to," but nowhere else than in this book have we met with an attempt to fully collate such instances and present them in a connected form. We owe the author a debt of gratitude for the zeal and assiduity with which he has performed the task; and feel that members of the profession will at once attest this fact, and provide themselves with a source of profitable delectation by the purchase of this book. On its perusal we are sure each will be little disposed to say, "I am nothing if not critical."

The Pathology and Treatment of Gonorrhœa. By J. L. Milton. New York: Wm. Wood & Co.

Wood's Library for 1884 reproduces the fifth edition of this well-known English work. It is certainly one of the most interesting and instructive books upon the subject in the language, the author's uncompromising iconoclasm with regard to the pet theories of others, his faculty of terse criticism and large practical wisdom lending at once zest and utility to his production. In this last edition, the gonorrhœal affections of the heart, pericardium, peritoneum, pleura, dura mater and sheath of the Spinal Cord, pyæmia, and pyelitis are for the first time treated of; Neisser's gonococcus discussed, and most, if not all, of the modern much vaunted remedies investigated and justly, if not considerately, consigned to that "limbo vast and round, since called the Paradise of fools."

Personal.

Dr. John S. King has been South for a few weeks holiday trip to recuperate his health.

Dr. Reeve was unanimously elected President of the Toronto Medical Society at its last meeting.

Dr. Frank Buller, of Montreal, was married on the 16th ult. to Miss Lily Langlois, of Quebec.

Drs. Geo. A. Graham, of Hamilton; W. A. Ferguson, N. B.; Wyatt Johnson, Que., have been appointed medical assistants to the Montreal General Hospital staff.

Dr. Lachapelle, of Laval University, Montreal, accuses the Examiners of Victoria University of communicating the nature of the examination questions to the students previous to the examination.

Dr. McConnell has been elected Alderman for St. Mark's Ward, and Dr. Carroll for St. Matthew's. They are the first representatives of the medical profession in the City Council since 1871, when Dr. Howson and Dr. Riddel sat at the Board.

Dr. Rolph Lesslie has been appointed Surgeon-General of the Lower Congo. Dr. Lesslie had only lately returned from the Congo, when he acted as physician to Sir Frederick Goldsmid's expedition, and now he accompanies Sir Francis de Winton, who is Governor of the district.

The editor of the Hanover *Post* has a $5,000 libel suit on hand, because he charged a patent medicine firm, who ignored his repeated calls to pay their indebtedness for advertising, with being cheats and swindlers.

Miscellaneous.

Shall I Locate? and Where?—Dr. George B. H. Swayze, of Philadelphia, makes the following sensible remarks:—"But *does* the city doctor have the easier life? No, one hundred dollars in the country will reach as far as three hundred to six hundred in large cities, according to location. With fees nearly the same among the general rank and file of the profession, it is self-evident that the city doctor must do extra work, must sustain extra wear and tear of body and mind to come out even. The perplexing uncertainties of a city establishment harass the lives of city physicians by day and by night. Hence, also, that so many city practitioners feel impelled to round out limited receipts by engaging every spare hour, needed for rest and recuperation, in the severe toils of authorship in some form. It is the pressure of current expenses, rather than the pleasure of overwork, that keeps so many pens busy turning out reports, reviews, essays and books; and hence the publication of so much that is speculative, artificial, unreliable, and unsatisfying to the mass of practitioners." * * * * * "And it need not be imagined by physicians in the country that eminent college professors acquire fortunes by practice; many of the greatest and the best have died insolvent. In the accessible calm and relaxation that physicians find in country locations without detriment to pocket and prospects, there is a luxury of comfort unknown to the profession amid the almost pauseless din and hurry of city life. *There* may he always find equivalent substitutes for money, when money there is none—but such is not the case in cities; *there* he may be greeted by refreshing landscapes, expansion of scene, quiet for weariness, reflection and sociality, but not so in cities, where all is contracted, walled-in, hustle and tussle, with no rest to eye or ear, or nervous system, or head or heart, from year to year. Is it any wonder so many long to get away for even a little while to enjoy the needful peace of Nature's quiet in God's country?"—*Md. Med. Jnl.*