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THE

48.
CANADA MEDICAL RECORD:

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EDITOR:

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Original Communications.

Cases of Cerebro-Spinal Fever. By WILLIAM GARDNER, M.A., M.D., C.M.; Professor of Medical Jurisprudence, University of Bishop's College.

I am induced to publish the two following cases of this disease, thinking that they may be of interest to the Profession, from the fact of their being typical cases of two different forms of the disease, the Simple and Purpuric, as described by Mr. J. Netten Radcliffe, in the second volume of Reynold's System of Medicine, and also from the fact of this having been, until within a few months, a rare disease in this city.

Case No. 1.—Frank C., a healthy little boy, *æt.* 10, was quite well on Sunday, 12th May last, when, having eaten a hearty dinner, he was seized with rigors, vomiting, headache, delirium, thirst, and other symptoms of high fever, which continued throughout the rest of the day and a part of the night following, when he commenced to perspire and then slept for some time. I first saw him at 11 a.m. of Monday, the 13th. He lay quiet; his skin damp, his clothing still wet from the perspiration, which had been profuse. The face presented a peculiar, vacant expression; when spoken to, he looked up and answered questions, but immediately relapsed to a semi-stupid state, in which the mind evidently wandered. The tongue was coated, and the bowels confined; the pulse 130; the temperature 101° . Ordered a dose of castor oil. I saw him again at 5 p.m. of the same day. The pulse as at last visit; the temperature is now $105\frac{2}{3}^{\circ}$. He is very restless, and in a condition of wild excited delirium. The vomiting, which had ceased with the subsidence of the fever, has returned, and now everything is rejected; has complained once of pains about his knees; there is, however, no swelling or redness of these joints, and they are not tender. Prescribed quinine in doses of 3 grains every three hours, with the view of reducing the high temperature; at 11 p.m. of the same day the pulse is 126; the temperature 100° ; the patient is quieter, but still delirious, and the vomiting continues. There are now present on the back and front of the chest, and on the abdomen, a number of petechial-looking spots; they are of small size, somewhat irregular in outline, purple in colour, and cannot be effaced by pressure.

Tuesday, 14th May, 10.30 a.m.—Has passed a restless, delirious night, and is in much the same

condition as at last report; 11.30 p.m., pulse 120; temperature $101\frac{1}{2}^{\circ}$, is apparently worse since morning, more delirious. The vomiting is less frequent. The head is forcibly retracted from spasmodic contraction of the muscles of the nape of the neck; there is rigidity of the hamstring muscles, the tendons standing out sharply against the skin, and a condition of semi-priapism exists.

Wednesday, 15th, 11 a.m.—Has passed a very bad night, having been very much excited with delirium of a wild character. The pulse is variable; from 96 to 120 during the visit, the beats are, however, of equal force; the temperature $101\frac{2}{3}^{\circ}$; vomiting has almost ceased; rigidity of the muscles of the nape and recti abdominis well marked; there is some squinting, the pupils are equal. Patient gives evidence of general hyperæsthesia.

Dr. Howard saw the patient with me in consultation this morning. The patient was ordered the following draught:

℞ pot. bromid grs. v.
Potass iodid gr iss.
Ext. ergot fluid miii.
Tinet. cinchon m xv.
Aquæ $\frac{3}{4}$ ss.

to be given every two hours, also an ointment consisting of equal parts biniodide of mercury and belladonna ointments, to be rubbed into the whole length of the spinal column every four hours. Special attention was also ordered to be directed to the feeding of the patient with milk, beef-tea, etc. 11.30 p.m. temperature, $100\frac{4}{5}^{\circ}$, pulse varies from 80 to 100. He is somewhat quieter, the delirium being of a less noisy character than this morning. His mental condition is somewhat peculiar; he lies quiet generally, but at intervals starts up, apparently under the influence of some delusion; the vomiting has ceased entirely, the bowels costive.

Thursday, 16th, 10.30 a.m. Temperature $100\frac{2}{3}^{\circ}$; pulse 82. Has passed a quiet night, but seems more lethargic than heretofore, although he can still be roused to consciousness; passes urine under him in bed; the petechial spots are disappearing, and no new ones are being formed. There is a copious eruption of herpes about the chin and lips; there is also livid, red, tender swelling of anterior and outer part of right ankle; condition otherwise as before; takes milk and beef-tee quite freely. 11.30 p.m., pulse 105; temperature $101\frac{1}{2}^{\circ}$. Ordered 5 grs. calomel to be followed at end of six hours by a teaspoonful of epsom salts.

Friday, 17th, 10.30 a.m.—Pulse 96; temperature $101\frac{2}{3}^{\circ}$, bowels moved; has passed the night fairly well. 11 p.m., pulse 118; temperature $102\frac{2}{3}^{\circ}$;

is somewhat more talkative and rambling than yesterday.

Saturday, 18th 10 a.m.—Pulse 125; temperature $101\frac{1}{2}^{\circ}$. Has passed a very restless night; pupils more than usually sensitive to light and somewhat contracted; the muscles of arms and legs not rigid; those of nape and abdomen as before; there is considerable swelling of right ankle joint. 10 p.m., pulse 120; temperature 102° ; is more conscious and rational than for a day or two; recognizes those around him; ordered a sedative draught of bromide of potassium at bed time to relieve restlessness.

20th, 10.30 a.m.—Pulse 122; temperature $103\frac{1}{2}^{\circ}$. Passed a quiet night, but complains of headache, for which ice is ordered to be applied to the head, also an injection to move the bowels.

21st, 10.30 a.m.—Pulse 130; temperature $104\frac{1}{2}^{\circ}$. The only new symptom to record to-day is the occurrence of starting of the whole body. Ordered the application of ice to spine. Also, in addition to other treatment, a dessertspoonful of claret every three hours.

22nd, 11 a.m.—Pulse 120; temperature $103\frac{1}{2}^{\circ}$. Has rested well, on one occasion sleeping for two hours together.

23rd, 11 a.m.—Pulse 126; temperature $103\frac{1}{2}^{\circ}$; was restless this morning, apparently at the time of the rise of the temperature. There is an accumulation of mucus about the eyes, producing that filmy appearance of the cornea, so commonly seen in the later stages of brain disease. 11 p.m., pulse 126; temperature $104\frac{1}{2}^{\circ}$. He has been more than usually talkative and rambling to-day.

24th, 11 a.m.—Pulse 108; temperature 101° . Slept well last night. The effusion into the ankle-joint is much reduced; no other change to report. 11 p.m., pulse 126; temperature $103\frac{1}{2}^{\circ}$.

25th.—Pulse 126; temperature $103\frac{1}{2}^{\circ}$; is quiet, apparently inclined to sleep almost constantly. The dose of bromide potass is in consequence to be lessened to 2 grs. every two hours, and that of the tinct. chinchonac to be increased to m. xx.

27th, 12 m.—Pulse 120; temperature $104\frac{1}{2}^{\circ}$. 11.30 p.m., pulse 118; temperature $104\frac{3}{4}^{\circ}$. The retraction of the head and rigidity of the hamstring muscles, which had been very much diminished for a few days past, is to-day somewhat increased.

30th.—Pulse 130; temperature $103\frac{1}{2}^{\circ}$. There is well marked risus sardonius; does not take food so well; other symptoms are unchanged.

June 1st. Is much worse to-day, having been nearly insensible since yesterday morning. There is rigidity of the whole trunk, very little action of

respiratory muscles, and very little food is taken; pupils somewhat dilated; pulse 144, weak; temperature 102° . Ordered head to be shaved, and biniodide of mercury ointment, 20 grs. to the ounce, to be rubbed into the scalp every four hours.

June 2nd.—Condition unchanged. No vesication has been produced by the ointment; consequently a fly blister is to be substituted. I received a message this p.m. to say that my services were no longer required, as Homœopathy had been called in.

From this date for about ten days, I did not see the patient, but at the expiration of that period, having been called to attend the child's father at his residence, I saw him occasionally until his death. The urgent symptoms present on the occasion of my last visit had of course passed away. The patient had become intensely emaciated, gave very little evidence of consciousness, and did not speak. He took nourishment fairly well when offered to him, and the evacuations were passed unconsciously. The pupils were natural; the rigidity of the muscles of the nape and trunk still persisted, so much so that, on attempting to turn him on his side, one was reminded of a dead body in rigor mortis. When thus moved the only evidence of consciousness he gave was to whine or moan. The abdomen was retracted, the bowels costive, never being moved except by injection. The effusion into the ankle joint had long ago entirely disappeared, as also the herpes about the face. In this condition he remained with comparatively little change until the last time I saw him, which was about a week before he died. Death took place during the eighth week of the disease.

Case No. 2.—L. C., a healthy, lively little girl, æt. 11, had always enjoyed good health up to the date of the illness about to be described, with the exception of an attack of scarlet fever five years previous, from which she recovered perfectly.

The patient was seized at midnight of the 25th June, 1872, with a very severe rigor. I was sent for almost immediately, and reached the house before the rigor had passed off. On inquiry I found that she had been quite as well as usual during the day, (appetite and spirits being good) except that she had complained of a little pain down the left side of the neck, and slight sore throat. The patient now complained of some headache, thirst, etc, and the pulse was rapid—144. I did not, at this early period of the illness, apprehend anything serious, and soon left the house, having prescribed a mixture containing small doses of Tincture of Aconite to be given at intervals during the night. I was again sent for

hurriedly at half-past seven the next morning. On reaching the patient's bed-side, which I did shortly after, being about 8 hours from the setting in of the symptoms, I was told by the friends that she had had two attacks of rigidity of the muscles, of the limbs and trunk, during which the head was somewhat retracted, and which had passed off in a few seconds. On inquiry I found that she had vomited several times during the night, had been very thirsty, had slept at intervals, occasionally for one hour together, and that, when awake, she had been somewhat incoherent and rambling. Her pulse now was still 144, temp. 105½. She is sufficiently intelligent to answer my questions correctly, and to put out her tongue when asked to do so, etc., but when left alone she is delirious. On looking at the skin I detected a number of spots, livid in color, irregular in size and shapes, some small, no larger than pin-heads; others in size equal to half the surface of a five-cent piece. They could not be made to disappear by pressure, and were not at all elevated. In short they possessed all the characters of petechiæ. The case was certainly serious enough now, in its characters. I ordered a sinapism to the epigastrium, beef tea in small quantities, ice, etc. The symptoms became aggravated during the day: the petechiæ becoming more numerous, the vomiting incessant, delirium more marked, and the paroxysms of rigidity recurring at shorter intervals. In addition to the previous symptoms diarrhœa now set in, not to any great extent, however.

Dr. Craik saw the patient with me this afternoon in consultation. In addition to the previous treatment Quinine was now prescribed in 2 grain doses in pill every three hours, and champagne in small quantities, etc. Everything was vomited, however; the vomited matters about 9 o'clock p.m. assuming the characters of coffee grounds, indicating hæmorrhage from the gastric mucous membrane. The patient became comatose, and gradually sank, dying at 4 o'clock on the 27th, having been ill about 28 hours only.

Montreal, July, 1872.

A short account of St. John's House and Sisterhood.

By JAS. PERRIGO, A.M., M.D., M.R.C.S.,
Eng., Demonstrator of Anatomy, University
of Bishop's College.

St. John's House and Sisterhood was founded in the year 1843, and owes its existence to a need very generally felt about that time for a better class of nurses for the sick. Few or no attempts had up to that time been made in England to give nurses an

efficient hospital training, or indeed a systematic education of any sort, still less to elevate and refine their motives, by leading them to regard their work as a religious one.

The design of the Institution is to improve the qualifications and to raise the character of nurses for the sick, by providing for them professional training, together with moral and religious discipline, under the care of a Lady Superior, and resident sisters, aided by a clergyman as Chaplain. The ladies who become resident sisters submit to no vows of poverty, no monastic obedience; there is no cloistered seclusion, no control exercised over the will or conscience.

The Institution derives its name from having had its residence in the district of St. John the Evangelist, in Pancras, London. In 1852, it removed to Queen's Square, Westminster, several of its nurses being admitted to the Westminster Hospital to be trained. In 1854, it provided some of the first nurses accompanying Miss Nightingale to the Crimea, and in the following year prepared and sent more than twenty lady nurses to the seat of war.

In 1856, having entered on the nursing of King's College Hospital, it was found advisable to move nearer to this fresh field of work. The house was therefore moved to Norfolk street, Strand.

During the year of cholera in London, several sisters and nurses were sent to give their help in necessitous districts. In 1865, the nursing of the Galignani English Hospital at Paris was undertaken, and in 1866, that of Charing-Cross Hospital, and since then, others.

In 1870, the large colliery village of Coalville, in Staffordshire, was visited by typhoid fever in an epidemic form, threatening at one time to involve the whole of the inhabitants. Two nurses were sent down, who, in commencing their work found more than 100 cases of fever: in several instances the father or mother, and four or five children were all ill at the same time.

The panic being great, no one could be found to attend the dying people. Cheered, however, by the presence of the nurses, the sick were in ten days reduced to 65, and in six weeks the fever was subdued. Other districts of England have been supplied with nurses in the same manner.

During all this time, notwithstanding the large number of nurses required for these successive undertakings, the staff of private nurses continued to be employed in all parts of the country, thus bringing the benefits of good and tender nursing to many homes of the upper and middle classes, as well as to large numbers of the sick and suffering poor.

The Institution consists of a President, Council, Chaplain, a Lady Superior, and Sisters. It is at the house in Norfolk street that all matters relating to the general concerns of St. John's House are conducted. Here the Lady Superior resides with such sisters as are required for the works carried on more immediately in the House. The staff of nurses for private families also reside here. Services for the nurses are held in the chapel of the House.

The Lady Superior is at the head of the community, and is intrusted with the supervision of all the works undertaken by St. John's House. Of sisters, there are more classes than one: they who are able to devote all their time to the Institution, and they who can only devote a certain portion of the year. There are also Lady Associates, who by their outside influence can further the interests of the Institution. With rare exceptions, no one can become a sister of any class without having first been trained as a lady pupil.

The Council of St. John's House undertake the nursing of certain hospitals under special agreements with the managing boards. The domestics of the hospital, as well as the cooking and washing departments, are also in certain cases placed by the authorities under St. John's House. The Lady Superior places one of the Sisterhood in the hospital as Sister in charge, who is at the head of the nursing establishment there. Associated with and subordinate to her, are other sisters, who share between them the several wards and the domestic management, superintending the work of nursing and of training nurses. All the members of St. John's House, engaged in the hospital, remain subject to the sole authority of the Sister in charge and of the Lady Superior. In all medical and nursing matters, the sisters and nurses carry out the instructions of the medical staff, and act in strict subordination to them.

The nurses in training at hospitals are called Probationer Nurses, and live at the Mother House, Norfolk street, during their year of training, working daily at the Hospitals and returning to St. John's in the evening.

Families desiring the services of these nurses are obliged to pay a guinea per week, as also the travelling expenses going and coming. In fevers and infectious cases, the charge is one and half a guineas; Small-Pox cases, two guineas.

After eight weeks attendance on the same patient, the nurse must return home or be exchanged for another. As far as circumstances permit, nurses are always supplied to the poor gratuitously.

All money for the services of nurses are paid to

the Institution. No nurse is permitted to receive any gratuity in money or clothing.

Every probationer nurse, after her year's training is finished, is engaged for a term of three years, receiving a salary of ten guineas for the first year, and twenty for each of the other two, in addition to board, lodging and washing. If the nurse should engage for a second term of three years, she receives a salary of twenty-two guineas; and the fourth term, twenty-six guineas. On the satisfactory completion of the twelfth year of service, a gratuity of £10 is given to every approved nurse. In addition to all this, there are some articles of dress furnished by the Institution.

In this manner, St. John's House performs a vast amount of good, not only in affording the proper attention to patients in families, and the poor, but frequently to villages and towns suffering from epidemics. It also affords a good field for numbers of respectable but poor females to earn a livelihood.

The ladies of Montreal have been very successful in forming an educational association, which evidently has a brilliant future in store for it. If a few ladies were to unite themselves for the purpose of the facilitating the training of destitute but intelligent females as nurses, we are almost certain the hospital authorities would give them all the aid they possibly could.

Montreal has a very few good nurses, and if this were done, it would be supplying a want long felt, and also afford means for some respectable females to support themselves.

Montreal, July, 1872.

A case of Poisoning by Opium. By SILAS EVERETT TABB, A.M., M.D., Professor of Botany and Zoology, University of Bishop's College.

On June 1st, 1872, 11.30 a.m., I was called to visit one J. H., who was supposed to have taken laudanum with the intention of committing suicide. On seeing the patient, which was half an hour after taking the poison, I found her quite reasonable and self-possessed. Pulse 110. I also detected the odour of opium in her breath. She called me aside and informed me she had taken half an ounce of laudanum; but for what purpose, however, she would not disclose. I examined the bottle that was said to have contained the drug, and easily recognized the odor of opium. The patient had obtained the laudanum from a druggist on the pretence of having a very severe ear-ache.

Immediately after getting the above information, I administered twenty grains of sulphate of zinc,

and followed it by copious draughts of warm water. Emesis was soon produced, and the ejected matter resembled closely in odor and appearance a quart of water to which had been added half an ounce of tincture of opii. By this time the young woman's friends became quite alarmed and desired me to call in another medical man in consultation; whereupon I suggested Dr. Perrigo's name. Dr. P. was forthwith summoned, and we watched the case together.

At 12.30 p.m., the drug began to produce its narcotic influence on the system. The pupils were somewhat contracted; pulse 120 and compressible, face flushed, eyelids red, patient restless and drowsy, and complained of numbness of the limbs, tightness of the chest, and a sense of constriction about the throat, and repeatedly affirmed that we wished to smother her.

Soon after Dr. P.'s arrival we administered an additional ten grains of sulphate of zinc. Now the vomited matter consisted almost wholly of the water administered, containing only a few particles, like bread crumbs, and emitting very faintly the odor of opium.

After the physiological effects of the drug began to manifest themselves we kept the patient moving about, allowing her at intervals to sit down for a few moments. During these intervals electricity was applied with apparently good effect, but as soon as she showed any inclination to sleep we had her on the move again, assisted by a friend. After 2 p.m. she had constantly to be kept walking about, and even then it was with difficulty that she could be kept awake.

About 2.30 p.m. she complained of abdominal pain, and half an hour later convulsive twitchings of the hands and arms were noticed. The objective condition of the patient at this time was as follows: face pale, surface cold and moist, lips and nails livid, pupils contracted and only slightly sensible to light, pulse 120. The patient also complained of a sense of fullness in her head.

We now put her feet into hot water and mustard, and applied cold effusions to her head, neck and shoulders. At this stage electricity was again applied. In a short time the patient began to improve, the narcotic (soporific) effects of the poison began to wear away, the expression of countenance became less stupid, eyes became brighter, pupils more dilated and sensible to light, but the sense of languor remained; pulse still 120; respiration rather slower than natural.

Shortly after midnight the patient fell asleep and slept for four hours. On waking she complained of

headache. In this condition I found her when I made my morning visit. I ordered her nourishing diet and a quinine mixture (gr. ss. ter die). Recovery was complete in a few days.

Montreal, July, 1872.

SIR HENRY HOLLAND, M. D.,

whose *Recollections*, lately published, is an entertaining record of a half century of professional life, says that very early in his practice he determined that he must never allow his work so to engross him as that he should not be able to give two months of each year to travel; and having made this resolution in the interest of health, long life, and the happy exercise of all the powers of his mind, some of which demanded regular travel into strange lands, he made the further resolution, in the interest of social enjoyment, that, during the ten months still remaining to him of his year, his earnings should never amount to more than a certain sum, and the whole of his time should never be mortgaged to his patients.

Progress of Medical Science.

ON PUERPERAL FEVER.

BY DR. EDWARD MARTIN, PROFESSOR OF CLINICAL MIDWIFERY IN THE UNIVERSITY OF BERLIN.

SINCE I had the honor of reading to this Society, in 1860, a Report on an Epidemic of Puerperal Fever, wherein I put forward the view that this disease depended upon a diphtheritic process set up in the female genital organs, I have omitted no opportunity of expanding and settling this doctrine; but if I venture to bring the subject again before you now, it is that I am impressed by the conviction that one reason why the views of this disease are still so divergent is, the confusion produced in the statistical reports by their comprising all the febrile diseases of lying-in women under the same rubric. Febrile conditions may be met with in lying-in women as well as in non-pregnant women, whether as a consequence of inflammation in almost any organ (but which has no connexion with the puerperal condition) or in connexion with various contagious diseases, as scarlatina, variola, etc. There may even be febrile affections consequent upon inflammatory action in the genitals of lying-in women, but which are essentially different from puerperal fever in the alarming sense of the word. Entirely unconnected with this, lying-in women may have very severe fever from inflammation of the breasts or nipples, after contusion or laceration of the uterus or vagina, as well as consequent on abscesses or ulceration which may ensue upon effusion of blood into the connective tissue. Such fever neither in its course, symptoms, or issue, resembles the conditions which arise from the diphtheritic process; and it is this which should be re-

garded as the essential characteristic of puerperal fever. Even the existence of thrombosis is not as a matter of course to be attributed to puerperal fever, as in many cases this remains entirely isolated, as contrasted with the thrombo-phlebitis which accompanies or follows the diphtheritic process.

Limiting in this way the conception of puerperal fever, the question naturally arises—What are we to understand by the “diphtheritic process”? You are aware that recent investigations have thrown most important light on the nature of diphtheria affecting other organs—especially the pharynx, where it has been shown to consist of a fungous formation, the spores of which are seen under the microscope to penetrate not only into the tissues, but within the bloodvessels—producing in this way a generalised disease. In diphtheria of the genital organs investigations have as yet not been extended thus far, and it remains a question calling for farther examination. Admitting, however, that the diphtheria is here due to a fungous formation, other questions arise. Is the fungus in question specifically different?—since we are familiar with various fungi which germinate in the vagina of both pregnant and non-pregnant women without giving rise to any dangerous affections;—is the fungus the mere carrier of the contagium? or is the puerperal fever produced in consequence of the special condition of lying-in women favoring the production of certain fungi, by reason of changes taking place in the organic substances and fluids?

Leaving these considerations, we may next advert to an examination of what the microscopico-anatomical basis of puerperal fever is. In the majority of cases we find on the external genitals and the vagina a diphtheritic deposit covering those wounded spots which, in the form of larger or smaller lacerations of the mucous membrane, so frequently occur during labor. The circumference of these spots is more or less considerably swollen. In many cases the diphtheritic deposit is thus confined to the external genitals, and the disease pursues its course by casting off the deposit without any or with very little general disturbance. But in the majority of cases coming under Medical recognition, the diphtheritis is not confined to the entrance of the vagina, but is found deep within the canal, covering the large or small lacerations of the os uteri, and within the cavity of the uterus itself. Here it occupies both the site of the placenta and the upper paries of the organ; and it is sometimes found exclusively here, and in no places accessible to the eye.

It may be objected that in many autopsies of women dying of puerperal fever no diphtheritic deposit has been found. This is a fact which I have myself verified in several instances, in which not only have the symptoms been present, but careful examination of the patient during life has shown the presence of the deposit. In explanation of this apparent contradiction, we must not forget that the diphtheritic deposit in many cases very quickly disappears, and especially when injections or caustics have been employed, while its consequences may persist and undergo farther development. That we

should not be able during life to see the diphtheritic deposit when within the uterus is conceivable enough, but the diphtheritic flocculi may be recognised in their expulsion with the returning uterine injections.

As a general rule, the diphtheritic process spreads rapidly from the genital organs, but it does so only rarely towards the skin of the thigh, nates, etc. These then exhibit an erythema (which has been well named puerperal scarlatina) or pass into ulceration. More frequently the diphtheria extends into the urethra and the rectum, if it have not already appeared there primarily; but its most common modes of spreading are either by means of the connective tissue surrounding the vagina and neck of the uterus, by the mucous membrane of the tubes to the peritoneum, or by the lymphatics and veins—these various modes of its extension being often combined with each other.

1. In the first of these modes, there is an infiltration of the pelvic cellular tissue, with a turbid serosity which extends to the peritoneal covering of the pelvic genital organs as far as the ovaries, there being usually also peritoneal effusion. This infiltration of the pelvic tissue may extend to the retro-peritoneal space, the kidneys, and the liver, and indeed even to the pleura and lungs; and after it has persisted for some time, it frequently gives rise to abscesses of the pelvic cellular tissue. By many authors this turbid-serous infiltration of the connective tissue is regarded as a primary occurrence, and a perivaginal or periuterine phlegmon is then represented to be the essential condition of the puerperal fever. This view I cannot accept, as it does not accord with the results I have obtained from observing cases from the first, since I have constantly seen traces of diphtheria preceding the turbid-serous infiltration. It is true that tumefactions in the vicinity of the cervix uteri may be present soon after birth, from other causes—as, *e.g.*, from contusion and effusion of blood into the connective tissue surrounding the cervix—and such swellings may also issue in abscesses. But we must distinguish these from those which are dependent upon the turbid-serous infiltration consequent on diphtheria, although in many cases the two conditions may be combined.

2. Another mode of spreading the diphtheritic process, which can scarcely be said to be of frequent occurrence, is along the mucous membrane of the internal genital organs to the peritoneum. In the cases of this kind which have fallen under my notice, I have often at the autopsies been able to follow the course of this usually rapid disease. In such cases, in which there was no other visible mode of propagation, the inner surface of the uterus was covered with a bloody-purulent matter, and the tubes (some times only one of these) were reddened, especially along their external third, dilated, and filled with a purulent mass, their funbræ being unusually swollen and reddened, and covered with or imbedded in fibro-purulent exudations. In these cases, usually a sudden attack of the pain peculiar to peritonitis (sometimes at first confined to one inguinal region) occurred on the second or third day after delivery.

3. The third mode of extension operates through

the vessels, and most frequently through the lymphatics. Many of the dilated lymphatic vessels, and especially those of the uterus, are found filled with masses of white crumbly or fibro-purulent matters. Sometimes, when life has been sufficiently prolonged, there are also circumscribed collections of pus, which it would be erroneous to regard as abscesses. This extension through the lymphatic vessels is usually complicated by the serous infiltration, the so-called phlegmon of the connective tissue; and, almost as a general rule, one or both of the ovaries is infiltrated with serum, and penetrated by dilated lymphatic vessels containing firm white coagula or purulent fluid. In some rare cases the ovary becomes completely loosened in tissue, as if from shredding away. In this form of extension exudation is seldom absent in the cavity of the abdomen, sometimes chiefly occupying the coverings of the genital organs, and sometimes having no defined limits. Finally, in some cases the diphtheria is propagated through the vaginal and uterine veins. This is especially shown in those prolonged cases in which the separation of the diphtheritic deposit from the genitals is followed by thrombosis of the veins, with its consecutive circumstances, such as breaking up, emboli, etc. Peritoneal exudations may also be met with, but not ordinarily. That the phlebo-thrombosis of lying-in women may, however, arise in other ways, quite independently of any diphtheritic process, needs only to be mentioned.

In these various but frequently combined modes of extension of the diphtheritic process of the genital organs, the great glandular organs of the abdomen, the kidneys, liver, and spleen are soon implicated, so that they are usually met with in a state of parenchymatous inflammation; and finally, the lungs, especially at their lower lobes, not infrequently exhibit the turbid-serous infiltration, pleuritic exudations being also associated with the peritoneal. A more infrequent result of the diphtheritic process, because in general a longer duration of the affection is required for its production, is inflammation of the peripheric cellular tissue, which may happen in different parts of the body. This most frequently occurs in and around the joints, around the muscles of the extremities (e.g., in the pernicious form of phlegmasia dolens), or around some of the superficially placed glands, as the breast or parotid.

It is precisely this great multiplicity of local affections, and their combination with each other, that constitute the peculiar characteristic of puerperal fever. As, however, sometimes one and sometimes another of these occupies the foreground, we are furnished with the explanation of why different authors have come to regard these different local affections, whether peritonitis, phlebitis, lymphangioitis, phlegmon, etc., as the essential feature of puerperal fever.

Although, in regard to our knowledge of the etiology of puerperal fever, decided progress has been made in recent times, yet many points remain obscure. Thus, in relation to the admission that the disease is autochthonous—i.e., that it may arise from the spontaneous decomposition of retained portions of the

placenta—we must not overlook the fact, that remains of the placenta or membranes are not infrequently retained for days, weeks, or months within the genitals, without any putrid decomposition taking place, or any symptoms of puerperal fever appearing, while their presence often gives rise to repeated attacks of hæmorrhage. If, then, in numerous other cases the retention of such remains is followed by septic decomposition and puerperal fever, it is evident that some other circumstance has to be sought for which has determined this unfortunate occurrence. From the known influence of the air in exciting putrefaction in fermentable bodies, it results that decomposition of the retained remains of the placenta would be especially expected when these protruded from the os uteri into the vagina, while they would be more protected from the influence of the air when enclosed within the cavity of the uterus. And, in fact, in this last case putrefaction does much more rarely occur; but it must not be overlooked that the remains of the placenta are then more intimately united with the wall of the uterus. However, there are plenty of examples of the occurrence of puerperal fever, notwithstanding complete expulsion of the placenta; and in such cases we must seek for other causes. Numerous cases have proved to me that women who are delivered while the subjects of recent gonorrhœa frequently become affected with puerperal fever, the diphtheritic process being immediately set up, and proving difficult of arrest. I must therefore admit that a preceding inflammatory condition of the mucous membrane of the genital organs stands in a certain relation to the occurrence of the diphtheritis. In the great majority of cases, however, the germ of puerperal fever gains access in other manners; and this is very positively shown by the well-known fact (confirmed by the numerous figures of the Vienna Lying-in Hospital, as also by the results observed in my own clinic, that the so-called street-births (*Gassegeburten*) are scarcely ever followed by puerperal fever. The transport of the diphtheritic germs takes place beyond all doubt very frequently during labor, more rarely after delivery, and sometimes shortly prior to parturition. In what the transported germ consists is less made out. Experience has taught us that cadaveric products and decomposed animal substances place puerperal women in danger, especially when an internal examination is made by fingers that have had to do with dead bodies without having been afterwards cleansed—although Practitioners may also convey the disease who have observed care in washing. The dead bodies in question have not always been those of the subjects of puerperal fever, although these entail a greater degree of danger. Again, certain secretions from suppurating wounds and ulcers conveyed to the genitals of a puerperal woman may give rise to diphtheritis. The epidemic prevalence of puerperal fever in Berlin during the winter of 1870-71 may with strong probability be attributed to the employment of so many of the civil Practitioners in the military Hospitals. Still more decidedly are diphtheritic products—which not infrequently are produced in scarlatina, typhus, cholera, suppurating cancer, etc.—dangerous to lying-in

women. The most usual mode of propagating the diphtheritic poison from the sick to the healthy is its direct conveyance by means of sponges, dirty towels, catheters, clyster-pipes, or the fingers of the accoucheurs; and in this way epidemics of puerperal fever are brought about most frequently in Hospitals; although they are also met with in private practice. What relation this origin bears to an incubation stage is uncertain; for although Veit has observed this to vary between twenty-seven and forty-eight hours, the number of cases adduced are as yet too few to allow of any general statement being made.

Diphtheritis of the genitals is not only met with in puerperal women, although they—on account of the denudation of the mucous membrane of its epithelium, and the numerous lacerations of tissue, as well as the ready decomposition of the lochial secretion—exhibit a special predisposition for contracting the disease, while the dilated vessels present a favorable condition for generalising the affection. Paul Dubois, forty years since, observed that the pupils at the Maternité, who, while menstruating, tended sick puerperal women, also became the subjects of an affection resembling puerperal fever. In Germany similar observations have been published, showing that, under certain favoring circumstances, a similar diseased process may be set up in non-pregnant women. I remember the case of a woman, 52 years of age, who was admitted into the gynæcological clinic of the Berlin Charité on account of repeated hæmorrhage. This arose from a large crumblng myoma, for the removal of which I used a forceps which probably had not been properly cleansed after a former employment. The woman died of diphtheritis of the internal genitals fifteen days after the operation. The autopsy disclosed the same lesions as are found in women who have died of puerperal fever—viz., diphtheritic deposit upon the wounded surface whence the tumour had been removed, lymphatic vessels filled with pus, and peritoneal exudation. It would seem to result, from other cases, that this diphtheritic process of the genital organs in non-pregnant women is but rarely followed by dangerous general disease.

Finally, it may also be mentioned that new-born children, and especially those of women who are the subjects of puerperal fever, sometimes are the subjects of a similar diseased condition, which in them proves fatal.

Little need be said concerning the symptoms of a disease well known to you all. The elevation of the temperature is characteristic—this rising, except in the cases in which the diphtheritis is limited locally to the genitals, to an abiding height of 39° or 40° C., or even yet higher. The rapidity of the pulse is also very persistent, frequently remaining much more than 100. The general condition appears usually, at the commencement of the affection, to have undergone but little change; yet in many patients there is soon observed a peculiar death-like aspect, although consciousness is generally retained to the last. In some cases there is delirium, and in some rare instances maniacal paroxysms, the autopsies usually revealing no morbid changes in the brain.

The diphtheritis itself is only visible to the eye within the uterus being discovered by the lochial fluid acquiring a peculiar smell, and by the discharge of diphtheritic masses on the re-issue of injections that have been thrown in. The features of the disease are in different cases essentially modified, according to the extension it has acquired. Very frequently the hypogastrium is painful on pressure in the region of the uterus, and tumefaction is here perceived both on external and internal examination. Such tumefaction, as already stated, may arise in puerperal women from other circumstances; and this is especially the case after laborious labors, effusion of blood having taken place into the cervix uteri or the cellular tissue surrounding the vagina. This hæmatoma may also, as well as the parametritis consequent on diphtheritis, pass into suppuration and give rise to pelvic abscess. The symptoms produced by the frequently ensuing affections of the intestine or bladder—peritonitis, pleuritis, phlegmon—call for no explanation.

With regard to the prognosis of puerperal fever in general, if we except the cases in which the diphtheritis remains localised, it is upon the whole unfavorable; for we must admit that one-third of the cases in which fever has ensued upon diphtheritis of the genitals terminate fatally. Death takes place most frequently up to the fifth day, and then up to the eleventh day. In some cases the disease may last even for months.

I have only a few words to say concerning treatment. The prophylaxis lays claim to our most earnest attention, and the etiology of the disease indicates many important points for the exercise of this. The extremest cleanliness of all having to render service to the lying-in woman, both as regards their persons and their clothes—especially their fingers and sleeves—and cleanliness in regard to all clothing, catheters, sponges, enema-pipes, etc., must be most stringently insisted upon. It is very much to be desired that all the utensils of labor should be new for each woman, and the same elastic catheters should never be employed for several lying-in women. As mere washing the hands which have become contaminated with infectious matter does not seem to afford sufficient security for internal exploration, I think it best under such circumstances to rest satisfied with external exploration. Especially does this rule apply to lying-in Hospitals when cases of diphtheritis have appeared; and my own experience on this point entirely confirms the propriety of the advice given by Halbertsma and Litzmann. How necessary, then, is that complete practice of external exploration which I have taught since I first held the Professor's chair, speaks for itself. Lastly, in regard to the curative treatment, I can only refer to what I have already stated in a detailed communication which I presented to this Society on "The Treatment of Puerperal Inflammations of the Female Sexual Organs." It must be pre-eminently symptomatic, and, as long as the temperature continues high before all things the fever should be diminished. Internally digitalis with nitre or acids, and externally tepid or cold applications, contribute to this end,

after due evacuation of the bowels has been secured. I cannot speak so well of quinine as do many authors. Local treatment has during the last ten years rightly been much tried. Cleansing out the vagina by syringing and injections of tar or creasote-water, with carbolic acid, chlorine, or solution of nitrate of silver, has without doubt proved of great utility, even although it has not often happened that the process has been out short by their agency. Injecting the same substances, suitably warmed, through a large catheter à double courant into the cavity of the uterus has sometimes been followed by a considerable diminution of temperature, as well as cleansing out the uterine cavity; but a decided general improvement has been by no means of such frequent occurrence as might have been hoped.

ECZEMA PALPEBRARUM.

Clinical lecture delivered at St. Mary's Hospital,

By HAYNES WALTON, F.R.C.S.,

Surgeon to the Hospital, and Surgeon in Charge of the Ophthalmic Department.

GENTLEMEN,—This is the most common affection of the eye. It is usually, but incorrectly, called *tinea tarsi* and *ophthalmia tarsi*.

The characteristics are the same as those of eczema of the trunk or of the limbs, a little modified by position, to which are added certain effects arising out of the conformation of the eyelid, the part of the lid in which the affection is most developed.

The whole thickness of the eyelid with its many textures are involved.

The skin is the texture most palpably implicated. It is inflamed, and there are marked changes in its structure, as well as derangement in its functions. Its sensibility is augmented. It is thickened by serous infiltration, and, as a consequence, is œdematous and some times fissured. It exudes at times a serous lymph. Sometimes papules, sometimes vesicles, sometimes pustules, form on it. The commonness of the last entitles the disease to be placed under the pustular form. There is nothing peculiar in this from an ophthalmic point of view, because the pustules prevail in hairy situations. Cuticle, which, thus raised, may be entirely thrown off and replaced by a soft, lardaceous-looking material, which is merely unhealthy cuticle attended by muco-purulent secretion, or by a thick crust formed by the drying of the morbid secretions which are poured out from the skin itself, the Meibomian glands, the cilia follicles, and the conjunctiva—most, or all, of these eruptions may co-exist.

The usual appearance of the disease when we are consulted is that of crusts on the edge of the eyelid by which the cilia are glued together in groups. In children there is usually an overflow of tears, and the cheek is excoriated or roughened.

The subjective symptoms are itching or tingling, but neither of these is well marked in this region, and the patient escapes much torment; or soreness; or stiffness of the eyelid; or a sensation of roughness

in the eyeball, or of grit in the eye, which necessitates the eye being kept partially closed; and nearly always agglutination of the eyelids during sleep.

The usual variation in eczema are met with here. The inflammation, or the pimples, or the pustule, or the exudation, or the infiltration may predominate. This includes mildness or severity of such symptoms. Thus, there may be present but the least redness or swelling, with only a little scurf between the cilia; or most of the eczematous features in the fullest intensity.

The upper eyelid suffers more than the under.

The disease may be partial, affecting only a portion of the edge of the lid, or completely occupy it, and involve besides a considerable portion of the rest of the palpebra.

Both eyelids are usually diseased, and of both the eyes.

Effects of Eczema.—Beneath incrustations which adhere to the cuticle, there is always excoriation from which serum and thin pus exude. The ulceration may be sufficiently deep to destroy much of the skin, and even some of the tarsal cartilage.

The cilia follicles seldom escape damage, from which the cilia grow abortively (and trichiasis is induced) or are lost from suppuration in their follicles.

The fibro-cellular tissue of this situation becomes thickened and dense. This is the chief source of the thickening of the ciliary region, which may be very marked.

The tarsal cartilage becomes thickened and hardened, and contracted from side to side.

The Meibomian glands become altered in function, pour forth a viscid secretion (the chief source of the agglutination of the eyelids), and are ultimately destroyed, and their outlets closed by cicatrization. Some of them may suppurate.

The conjunctiva undergoes the morbid changes usually produced in it by inflammation.

Entropium may ensue.

Slight ectropium is more common. This is associated with damage to the punctum lacrymale, together with displacement of it and loss of the inner and part of the outer edge of the eyelid, with cuticular degeneration of the surface, by which a glazed red margin is left, constituting what is called *lippitudo*.

The whole of the palpebral and most of the ocular conjunctiva may inflame.

Intolerance of light may be produced, irrespective of cilia irritating the eyeball.

Eczema is essentially, in the eyelid, a chronic affection, without any specific course, although there are stages or periods of irregularity of the several morbid phenomena. It may last for years, and even for life, with intermission to the more prominent symptoms, all the while spoiling the eyelid more and more. It generally lessens in severity, and may even cease, when the cilia follicles and the Meibomian glands are destroyed.

Cause of Eczema Palpebrarum.—Struma, or poor nutrition, is so frequently an accompaniment of the eczema, that it must be regarded as the remote or predisposing cause. There is frequency of the disease

among the children of very poor people. In nearly every case there are evidences of an inherited or an acquired scrofulous constitution. There are enlarged lymphatic glands, or a swollen upper lip, or sore ears, or a tumid belly, or derangement of digestion or strumous conjunctivitis, or paleness, with looseness of the skin. There are immediate or exciting causes, such as small-pox, measles, scarlet fever, smoke and filth in bad dwellings, impure air.

General Treatment.—I regard the constitutional remedies as the most essential. If the eczematous diathesis be subdued—that is, if the poor nutrition, or the debility from whatever origin, which is the predisposing cause of the affection be removed—the local manifestation of the disease will soon vanish; yet sooner, if assisted by local measures.

The secret of the cure consists, then, essentially in discovering the nature of the debility—whether it be assimilative, nutritive, or nervous—and subduing it. This includes attention to the disordered function of any internal organ. I have known of several severe examples of the affection which have been completely cured by change of residence—and nothing else—from this to a warmer country.

Local Treatment.—In every instance the cilia should be closely cut. Any of them that are irregular or abortive should be plucked from their follicles. For the eczema itself, the remedy must be shaped according to the condition of the eyelid when the patient is seen, subject to the principles of reducing the inflammation, stimulating to a more healthy action the exuding surface, removing accumulated secretions or crusts, and healing excoriations or ulcerations.

When the inflammation is acute rather than chronic, the use of an evaporating lotion to reduce any unnatural heat is advantageous. When it is chronic, warm applications, as fomentations, are preferable. With the reduction of inflammation, the case is materially better.

When the disease is in an early stage, and the surface-accumulation is scanty and of the lighter form (chiefly from serum), and the inflammation is subdued, or where it is so slight as not to be a prominent symptom, stimulation is called for.

Lotions are not applicable, on account of their liability to irritate the conjunctiva and the cornea. Ointments answer better, and they serve the double purpose of enabling the drug to be definitely and persistently applied, while they prevent the eyelids from adhering. They are demanded of varying strengths, according as irritability or sluggishness of the skin prevails; the stronger being for the latter state. They should be applied twice or thrice daily, with a sable brush, after the part has been cleaned with warm water and Castile soap, and any secretion washed off. The merest smearing of the surface will suffice. After trying various substances, I have settled down to the use of the hydrargyri oxidum rubrum. My weakest formula is one grain of this to a drachm of the unguentum cetacei; my strongest, two grains to the same.

The greater the strength of the ointment, the more sparingly and neatly must it be used, lest it should get within the eyelids and inflame the eye.

Should either seen to irritate, it must be used less strong or less often.

When the disease is of old standing, and the incrustations are dense and adherent, being made up of dried pus, epithelium scales, sebaceous matter, carbon and dust from the atmosphere, beneath which there is sure to be excoriation and ulceration, other treatment is needed. The incrustations must be removed without damaging the eyelid. My plan is to keep them oiled with almond oil for a couple of days, and then to sop them for a long time with hot water and a rag until they are sufficiently softened to be wiped off or picked off; oil the lids, and on the following day wash them and dry them thoroughly, and touch all the excoriated or ulcerated parts with nitrate of silver. For years I used strong solutions of this drug, but now I apply it solid, scraping the stick to a point, and touch the parts lightly and definitely, taking the greatest care not to let any of it enter the eye. I keep a piece of blotting-paper at hand to soak up any moisture which may be about the edge of the lid. Should any of the caustic accidentally enter the eye, in spite of all caution, the eye should be very freely washed at once in a basin of tepid water, to relieve the burning. This plan may require to be repeated. An interval of a week at least should be allowed, during which the eyelids should be washed and oiled twice or thrice daily.

From time to time the cilia should be re-cut, or re-plucked.

Or, again the application of the nitrate of silver is required when there are pustules on the lid, with little or no incrustation.

Any excoriation or roughness of the cheek should be attended to. Eczema palpebrarum will readily yield to the methods which I practise and recommend. Certain damage which may have been inflicted on the cilia follicles is capable of much repair, and tolerably healthy cilia may grow in the place of abortive ones, or of many which have dropped. But many, or all of them, may be destroyed. The Meibomian glands are always more or less destroyed in all prolonged or severe cases of the affection. When treatment is undertaken before the glandular apparatus of the lid suffers, every trace of the disease may be removed.

The injury which the disease inflicts, and which is so apparent, must not be mistaken for the disease itself, or else treatment will be continued when it is unnecessary, and often undertaken when the eczema is cured.

The trichiasis, the entropium, or the ectropium which may be induced demands special treatment, of which I shall not speak to-day. *Medical Times and Gazette.*

FIBROUS DISEASE OF THE UTERUS.

There are cases in which surgical aid is declined, or cannot be recommended, and apart from them the possibility of relief by medical treatment is still a moot-point. With the idea of ascertaining what really are the opinions and practice of that branch of the professions under whose notice these cases, more

frequently come, the *British Medical Journal* has collected a number of notes, which, if they show that the "therapeutics of the disease are uncertain and tentative," are by no means devoid of interest. From the report, extending over several weeks, we select the salient points:—

The medical treatment of fibrous tumours may be divided into:—The promotion of absorption; the restraint of the growth; the promotion of expulsion; and the restraint of the bleeding, which they cause—says Dr. Braxton Hicks. He confesses that he has never seen anything which could encourage one in the expectation of *absorption*. He has given iodine, bromine, and bichloride of mercury numberless times, without diminution in the size of the tumour. He thinks he has observed *restraint* of growth from the employment of iodides and bromides given over a considerable period. When the effect of these drugs on the testis and ovary is considered, it is not difficult to understand how they tend to lessen the engorgement and activity of the sexual organs. To this treatment should be added the recumbent posture part of each day, and the avoidance of external pressure. Expulsion may be promoted by ergot, given in ten-grain to half-drachm doses twice daily, for two or three days during the monthly epoch. He has seen more than twice an intermural fibroid converted into a polypus and rendered capable of removal. To restrain loss of blood, the recumbent posture, gallic acid, and ergot are most reliable, the former in twenty-grain doses two or three times daily, the latter in ten or eighteen-grain doses two or three times daily. Gallic acid, combined with quinine, cinchona, or other good tonics, during the intervals of bleeding, he has found serviceable. Where much anæmia is present, he has given iron, alum, and gallic acid combined, and changed it during the "period" to ergot, or full doses of gallic acid. The formula is one grain sulphate of iron, ten grains of sulphate of alumina, ten grains of gallic acid, five minims of dilute sulphuric acid, and five minims of chloric ether, in one ounce of peppermint water. Dr. Hicks has not seen much benefit derived in those cases from the employment of *cannabis indica*s.

Dr. Matthews Duncan prescribes iodine and bromine for this affection. They sometimes appear to be of use in diminishing the bulk of the fibroids. When hæmorrhage is severe, a solution of per chloride of iron, pharmacopœia strength, may be applied by means of the hollow probe and syringe, to the bleeding surface; this treatment he considers invaluable, and it sometimes even saves life.

The term *fibrous* is objected to by Mr. Spencer Wells as leading to error. They are simply excessive developments of unstriped muscular fibres of the uterus, with connective cellular tissue. They contain little or no fibrous tissue, and from their appearance may not be improperly termed *fibroid*, but not *fibrous*. He is astonished to find doubts expressed as to the fact of the disappearance of these "growths and can only explain these "by the juvenility, or limited experience of the observer" and has seen enough to convince him that medicines have a very considerable influence, provided the remedy be

adapted to the case, for cases diagnosed by Farre, West, Priestley, Oldham, etc., have either disappeared or reduced in size to insignificance. This may not be seen in young women, is rare during active uterine life, but not unfrequent after the cessation of the catamenia. In cases where the tumour is elastic—probably more cellular than fibroid—with fluid infiltrating the cellular interspaces, Mr. Wells considers bichloride of mercury, with bark, is often followed by a remarkable diminution in the size of the growth. Where there is much irregular bleeding he agrees with Dr. McClintock in regarding chloride of calcium as of great value. When bleeding has the character of menorrhagia, he has more confidence in *vineæ major*, (the great periwinkle of our shrubberies)—than in lime, gallic acid, or ergot—as recommended to him by Mr. Squire, he prescribes it as laid down in Squire's version of the pharmacopœia.

Dr. W. R. Rogers is of opinion the medical treatment of fibrous tumours of the uterus must be palliative, but it is true that after the climacteric period has been passed, they occasionally become absorbed. The flow of blood to the uterus is diminished by the cessation of ovarian excitation, the process being aided by the use of iodine and mercury. Anasarca and ascites accompanying fibrous enlargement of the uterus should be treated in the usual way by purgatives, diuretics, stopping hæmorrhage, when not severe, by astringents, sulphuric and gallic acid, acetate of lead, etc. Should these means fail, he plugs the vagina. Bichloride of mercury and decoction of ergot he has found useful in some cases, and the persevering use of chloride of calcium in others. Injection of iodine or solutions of iron (after dilatation of cervix) have often checked hæmorrhage. Free incision of the cervix, as advised by the late Sir J. Simpson, he has found to arrest, for a while, and diminish hæmorrhagic losses.

Omitting all local measures, Dr. Routh speaks of the purely therapeutical treatment of these cases as being very effective. Bromide of potassium, bichloride of mercury, solution of chloride of calcium, compound tincture of ergot, strychnine, compound jalap powder, and purgatives generally, also, electricity, the external application of iodine, and blisters. These remedies, long continued, produce good results. In his treatment, Dr. Routh does not restrict himself to any one plan, but adopts two or three, together with local measures. He has seen a large fibroid, blue from congestion, and causing copious floodings periodically, diminish greatly in volume by the ordinary *mistura alba purgative*, after one week's use. The continuous current of high intensity he believes to be most effective in some cases. It seems to coagulate the fluids in the tumours, and to disturb their situation so that they become absorbed. In the space of one year he has seen a tumour the size of a man's head become small as an orange by this treatment, but wounds are formed by the poles, difficult to heal. Dr. Routh places one pole at the spine, and the other within the vagina and os uteri, and guards with gutta-percha all of it except the extreme ends.

The removal of uterine growths by drugs being, in

the present state of medical science, out of the question, we have to consider, says Dr. Wiltshire, how to relieve hæmorrhage, and also the troubles arising from pressure on the surrounding parts, dysuria, congestion, pain in defæcation, hæmorrhoids, etc. For hæmorrhage he relies upon bromide of potassium and gallic acid, and is rarely disappointed. Opium, perchloride of iron, sulphuric and gallic acids, etc., he gives in other cases. To relieve pain resulting from pressure he uses morphia, hypodermically or by the mouth, opium enemata, chloral, suppositories of belladonna, etc. In dysuria, he administers with excellent results occasionally bicarbonate of potash and hebanane and belladonna, and spirit ether nit.

The sooner we abandon the idea of curing or of lessening the size of fibrous tumours of the uterus—that do not admit of surgical relief—by mere drug treatment, administered by mouth, skin, or vagina, Dr. Alfred Meadows considers the better will it be for our patients' health and comfort, and for our professional reputation. To reduce by any system of medication, a fibrous tumour of the uterus he considers hopeless, and he is satisfied that we are not in possession of a drug able to influence the nutritional changes of the uterus, and its morbid companion, so as to check the growth of the latter, or to promote its absorption; yet much good may be accomplished by judicious medical treatment, and, in the main, we aim at either the relief of pain or the arrest of hæmorrhage; as a rule, these are in inverse proportions to each other. He has found that the more sub-peritoneal the tumour is, the greater the pain and the less the hæmorrhage; and the more sub-mucous it is, the greater the hæmorrhage and the less the pain. For the relief of pain he prefers medicated vaginal pessaries carrying a third or half a grain of morphia with a sixth or a twelfth of a grain of atropine. Where there is slight discharge, a few leeches to the cervix uteri will afford relief. To arrest hæmorrhage, few drugs he has found so efficacious as a combination of peracetate of iron and ergot. Nitrate of silver in quarter-grain doses, and acetate of lead with dilute nitric acid came next in efficacy.

Dr. Andrew Inglis, of Aberdeen, has no faith in mercury for fibroids of the uterus given internally or applied externally, nor in bromides nor iodides. He considers ergot to produce mechanical results, either by bringing on absorption or in carrying enucleation and expulsion. He has a case of a large fibroid which, eight or nine months ago, suddenly began to shrink, and has not produced since then any unpleasant symptoms. To stop bleeding, the patient was given for several days large doses of ergot. He has likewise a patient with a small tumour hanging out of the uterus, and under similar treatment it is daily becoming smaller.

In one case a very large mass was considerably reduced in less than a month by electricity applied by means of several rods introduced, says Dr. Murray, of Newcastle-on-Tyne.—*Abridged from the Doctor.*

CASE OF SUPPURATING BUBOES WITH DIFFERENT PLANS OF TREATMENT.

BY ALFRED S. BOSTOCK, M.R.C.S.

Suppurating buboes being of so common occurrence, I thought the notes of the following case might be interesting to the readers of the *Medical Times and Gazette*:—

A coolie woman was admitted by me into the Colonial Hospital, Trinidad—when I had charge—with a suppurating bubo in each groin.

On May 16, I opened one of the buboes with a curved bistoury, and as I knew by that process buboes were a long time in healing, I determined to try another plan on the other side, therefore, on May 19, I opened the other bubo with a trochar and canula, and by that means evacuated the contents; then I injected a solution of sulphate of zinc, gr. iv. ad. ʒj., and put on pressure with some lint in the form of a pad covered with a bandage. On the following morning there was occasion for an aperient, and the ordinary black draught was administered.

May 21.—I removed the dressing, and found some very thin purulent secretion, which I pressed from the bubo by the aperture made when removing the canula. I then replaced the bandage over a fresh pad of lint. There was no complaint of pain during this treatment.

24th.—The bubo opened with the trochar was quite healed up. The other bubo was looking very healthy.

26th.—On pressing the bubo a thin serous-looking fluid came out at the opening left by the canula.

28th.—The bubo was quite healed. So that this bubo healed in nine days; whereas the bubo which I had laid open with the bistoury was not healed until July 4, taking in all fifty days. *Medical Times and Gazette.*

SUNSTROKE.

The report of an important discussion on this subject, which took place at the Louisville College of Physicians and Surgeons, reaches us very opportunely, and we proceed to give our readers some account of it.

Dr. L. P. Yandell, having passed in review the many experiments that have been made as to the effect of heat on the human body, and stated that health is comprised within the very limits of degrees of Fahrenheit's thermometer, expressed his opinion that sunstroke is produced by heating the body above its natural temperature. It occurs in rooms artificially heated, or rendered oppressive by solar heat and crowding, as well as in the direct rays of the sun. It is a casualty of hot weather. Attacks are more frequent during the hour of the day when the heat is at its maximum and men are engaged in laborious exercise. But the casualties are by no means confined to the day or the hours when men are active. In a French ship at Rio Janeiro one hundred cases were afforded by a crew of six hundred, and most of them occurred at night when the men were breathing a hot suffocating, impure air. Attacks at night are also

common in the crowded barracks of India, a vitiated atmosphere conspiring with heat to bring on the affection by rendering the blood impure, as well as by raising its temperature. Clothing unsuited to the climate and season may be mentioned as another circumstance which favours the occurrence of sunstroke. Whatever retains the heat of the body or impedes the circulation of the blood must act injuriously upon men on the verge of a fatal temperature.

Another circumstance co-operating with heat is the want of acclimatisation. All observers agree that the accident occurs much more frequently with those who are not inured to the climate. The attack may come on suddenly, without warning; or, on the other hand, may afford ample warning. In some cases the first symptom has been a burst of laughter, or the starting up and struggling of the patient to escape from some imaginary danger. Often he falls insensible and unconscious when at work, having given no indication of distress; but more frequently it will be found that he has complained for hours, or it may be for days, of heat and dryness of his skin, embarrassed breathing, and a general sense of uneasiness or distress. The skin in all cases has ceased to perform its function. The surface is not only hot and dry, but rough and scaly. The lungs are oppressed, and exhalation from their surface is diminished. The temperature of the blood thus rises constantly, at the same time that the waste tissues render it impure, and the heat of the surface becomes intense. The treatment of sunstroke must vary with the various morbid conditions. In some cases nothing can be done. The patient is moribund from the beginning, and dies in a few minutes. In cases of syncope, if death is not instantaneous, the treatment is the same as for concussion of the brain. In a majority of cases the douche is the most promising remedy. The patient is to be kept as quiet as possible, and if under the use of the cold water his pulse sinks, the application must be discontinued.

If Dr. Yandell's views be correct it follows, that sunstroke ought to be prevented by taking care that the sources of supply of heat do not exceed the waste. It is accordingly laid down that exercise, which is a heating process, should if possible be moderate; clothing should be of the thinnest materials and loose, cold water should be drunk freely, as affording matter for cutaneous transpiration. It must be seen that the skin is moistened with perspiration. The moment a man at work in the hot sun ceases to sweat he is in danger of sunstroke, and should at once quit work and supply the deficient moisture of his skin with water. This is indispensable to the reduction of the accumulated heat of his body. Water is the resource when the body is subjected to an inordinate temperature. After too long a draught upon the system perspiration fails, and nothing will then avert sunstroke but the timely use of water to the surface. A man may work long in a hot sun, or labour or sleep in a heated room with impunity, provided he keeps his skin and clothing wet with water. Can it be doubted that in all the cases where men have dry, harsh, hot skins for hours together, and with it a sense of oppression and anxiety, the impending danger might be

turned away by these cooling measures? These principles are equally applicable to the management of horses in hot weather.

Dr. D. T. Smith remarked that the statement that very high temperature is necessary to the production of sunstroke is undoubtedly true; but also that this high temperature must be continued a long time, which had not been mentioned. Excessive heat for a short time will not produce it. The nervous exhaustion attending the attacks is shown by the cessation of perspiration and the contraction of the pupils. Some cases supposed to be sunstroke lack this symptom, and are thereby known to be spurious. Among the prodromic symptoms is frequency of micturition. One feature in the cold water treatment is worthy of notice: if the pulse becomes weaker while it is applied, it should not be persevered in.

Dr. Hornor stated that he used to spend the summer in the country in Pennsylvania, where he frequently assisted in the rye-harvest, which is in July, the hottest time of the year. In this all the circumstances seemed to combine which usually produce sunstroke—great heat long continued, obstruction of the air by the tall rye, no shade, but the direct rays of the sun beating down on their heads; and yet they enjoyed perfect immunity from sunstroke, never having a single case among thirty or forty reapers. He attributed this to the fact that at each end of the field, and sometimes in the middle, they had an abundance of water, frequently iced, of which they drank copiously every time they came within reach of it, and also washed their hands and faces. He regarded the free use of water, externally and internally, an excellent prophylactic.

Dr. Milhoe stated that he had been stationed for some time on the Colorado River, where the mean temperature in the shade was 105 degrees, but frequently rose to 112, 114, and even 120 degrees. He corroborated Dr. Yandell's statement as to the necessity of loose clothing and the free use of cold water. The soldiers usually wore straw hats, with a hole in the top, and filled the crown with leaves or wet sponge. They wore flannel shirts, in order not to check perspiration. When cut off from water sunstroke was frequent among them. They drank enormous quantities, often two or three gallons a day. Having no springs, they were obliged to use river water, which was very warm. Their method of cooling it was to keep wet blankets around the vessels containing it, by which means they could reduce the temperature of the water to about 80 degrees, which tasted cool to them in their heated atmosphere. They also took the *cup-bath*, which consisted in pouring cupfuls of water over their heads and letting it run down their bodies. In order to sleep comfortably, they would wet the ground and lay mats over it. The evaporation from this kept them cool while sleeping on the mats. By the employment of these means sunstroke was rare among them. He used to regard sunstroke as congestion of the brain, but he had seen cases in which the surface was cold and the pupils contracted. In such cases the stimulating treatment was employed.

CANCIUM ORIS.

"I have never found any application so useful or so effectual as hydrochloric acid," as a local remedy in cases of cancium oris, says Mr. McGreevy (*British Medical Journal*). Chlorate of potass and borax is not sufficient to check the severe nature of the gangrenous ulcer in those cases. Nor has Mr. McGreevy found nitrate of silver, nitric acid, nor any other remedy, except hydrochloric acid to be of the least value. Hydrochloric acid he has never found to fail in checking the progress of the disease, and promoting healthy action. The acid is easily applied by means of a feather or small brush, and the pain caused by it is less than we might suppose, and is accounted for by the partial nervous insensibility of the gangrenous spot.

SPOTTED FEVER AND ITS TREATMENT.

That this is a rheumatic affection is made manifest from the following symptoms: twelve hours preceding the attack, when physicians are called, the patient complains of flashes of heat, with slight chilliness, and a sense of "leg weariness," or sharp pains darting through the extremities; he retires, and between the hour of midnight and four in the morning he is aroused from a sleep which has been disturbed by frightful dreams, by a chill which last from twenty minutes to one or two hours, succeeded by great febrile excitement, accompanied with severe lancinating pains within the cranium, extending down the back and in the limbs. The countenance, often flushed, expresses surprise or wildness and terror. The eyes are rolled upward and inward, with half-closed lids, the pupils are of a vibratory character, dilating and contracting at almost every respiration, which peculiarity is maintained until the brain is freed from all of the "materies morbi."

The above enumerated symptoms do not correspond with those attendant upon congestion or inflammation of the brain, but point directly to a neuralgic or rheumatic disorder. There is great restlessness, moaning or uttering plaintive cries. The pulse is soft, slightly increased in frequency, and decidedly irregular, losing one beat in nine or ten. The breathing is irregular, and is not controlled by the action of the heart; the pulse has been as high as 140 and respirations nine, within a minute. This is never present in inflammation of the brain proper, or at least I have never observed it. The speech is thick, and articulation very imperfect. Constipation is present, and obstinate, but much easier affected by purgatives than in cases of inflammation of the brain. The tongue is generally coated with a white granular fur, which changes first to a brown and then to a black, which peels off in flakes or rolls of the thickness of brown paper, after which it is liable to go through the same changes again. The lips and gums are affected in the same manner, with collection of sordes on the teeth. There is general soreness of the whole body—hyperæsthesia—which continues from the commencement of the attack until convalescence is fully established.

Sudden changes in the weather very materially

affect the condition of the patient; after a change from a warm to a cold, damp atmosphere, all the symptoms are worse, and from a cold to a warm period, the symptoms are improved. Not one case has occurred in this place, but what has been preceded from twenty-four to forty-eight hours by a sudden change in the weather. Physicians of good repute in this county have treated cases for two and three weeks for inflammatory rheumatism of the lower extremities, and on their return visit, after a sudden change in the weather, have found their patients laboring under an attack of "cerebro-spinal meningitis" so-called, and have been more firmly convinced than ever that all diseases are very liable to partake of the epidemic influence, not supposing that it was the same thing, only that it had changed its base of operations.

Death may take place in from twelve to seventy-two hours from compression of the brain, which is produced by a thickening of the membranes and a deposition of effused fluid between the pia mater and arachnoid; the usual symptoms indicative of this condition being exhibited by the patients; a thickening of the membranes of the spinal cord would produce paralysis below the compressed portion, which has been noticed in a number of instances. That rheumatism will produce this condition of things, I think there are none who will deny, and as it is plausible and reasonable to suppose from the evidences that I have seen, and from the testimony of other physicians, I am convinced that cerebro-spinal meningitis should be known as cerebro-spinal rheumatosis.

The treatment should be prompt and active during the first three days. When coma is impending topical depletion should be resorted to by cups applied to the temples, back of the neck, and down the spine, followed by hot fomentations, which will afford great relief. The application of ice to the head and spine is positively injurious. The patient should be brought under the influence of calomel as speedily as possible, with free purgation. Dover's powder, with the addition of morphine, if necessary, to relieve the acute pain and procure rest. Quinine in large doses from the commencement should be exhibited and steadily pursued. Diuretics, as acetate of potassa, sweet spirits of nitre, or neutral mixture should be given at intervals. After the relief of the brain symptoms, it should be treated as any ordinary case of sub-acute rheumatism. I use the following mixtures:

- ℞ Tinct. prickly ash, tinct. cimicifuga rac,
 - Tinct. g. guaiacum, aa..... ʒ ij.
 - Tinct. colchicum rad..... i.
 - Acetate of potassa..... ʒ ij.
 - Syr. simplex,
 - Spts. vin. gallici..... ʒ ij. M.
 - Sig.—A dessertspoonful every four hours.
 - ℞ Quin. sulph..... gr. xl.
 - Tinct. ferri chlor..... ʒ ij.
 - Sir. simplex,
 - Aquæ menth. pip., aa..... ʒ i M.
 - Sig.—A dessertspoonful three times a day, with Dover's powders at night if necessary.
- I have had under my care thirty-two cases of this

disease; three proved fatal within forty-eight hours—all of the remainder have recovered; the treatment has not been materially different from what has been just stated.—J. MACLAY ARMSTRONG, M.D., of Edwardsville, Ill., in the *Med. and Surg. Reporter*.

ABSTRACT OF A CLINICAL LECTURE ON
ERYTHEMATOUS LUPUS.

By ROBERT LIVEING, M.D., PHYSICIAN TO THE
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GENTLEMEN,—I propose to direct your attention this afternoon to an interesting case of erythematous lupus now in our Hospital; but before doing so I shall take this opportunity of making a few introductory remarks on lupus generally, in order to point out with greater clearness the distinctive characters of the erythematous form.

Lupus may be defined to be a local disease, chiefly attacking the skin, and especially the skin of the face. It consists essentially in an infiltration of the cutis, with a peculiar cell formation, which undergoes degeneration, and leads subsequently to the destruction of the invaded tissue and the production of a permanent cicatrix. Of the exciting causes of lupus we know little or nothing—it is never contagious, and very seldom hereditary, though we may admit that a scrofulous diathesis is a predisposing cause of its development.

There are several modes of classifying or distinguishing the different varieties of this malady. The commonest, simplest, and perhaps the most scientific is to recognise only two classes—(1) Lupus vulgaris and (2) Lupus erythematous. Historically, also, this division is interesting, inasmuch as Lupus vulgaris was accurately described long ago by Willan, while the true nature of Lupus erythematous was first recognised in our own time by Cazenove.

Now, although this division has the merit of simplicity, it is not quite sufficient for descriptive purposes. A disease which assumes such varied forms as Lupus vulgaris requires some further subdivision to aid and give method to our descriptions. Hence we may conveniently adopt the following nomenclature, and classify the different forms of lupus under the following heads:—(1) Lupus tuberculosus; (2) Lupus vulgaris exedens; (3) Lupus vulgaris non-exedens; (4) Lupus syphiliticus; (5) Lupus erythematous.

I am well aware of many defects in this mode of classification; but, on the whole, I believe it to be the most convenient that we can at present adopt. Under one or other of these heads it is quite possible to arrange all the varieties of lupus commonly met with. I must warn you, however, against the mistake of supposing that there is any essential difference between these varieties. They one and all possess in common the distinctive characters of true lupus.

Now let me say a few words in explanation of the names I have adopted.

Tubercular lupus is the *lupus of childhood*, though not strictly confined to the very young. It shows itself in the form of small nodules or tuber-

cles, appearing on the face, about the size of a split pea or larger. These little elevations are elastic, and painless, often of a bluish hue, rather vascular, and with little tendency to spread or ulcerate unless the disease be injudiciously treated. Many of you may remember a little girl who was for some time under my care with this variety of lupus, and who gradually improved under cod-liver oil and mild local treatment. Hebra, I believe, uses the term “tubercular lupus” in a less restricted sense.

Lupus exedens is the *lupus of young adult life*, and is, unfortunately, the most common kind. It has the well-known characteristic feature of ulcerating deeply into the cutaneous and neighbouring tissues, and produces the most frightful disfigurement, while it heals with thick scars, like those of a burn. This form is most common between puberty and 25.

The name lupus non-exedens is a very inappropriate one as applied to any particular variety, and yet it is one that we can hardly entirely dispense with. It is generally used to indicate certain forms of lupus vulgaris which do not tend to produce open sores or ulcerate deeply into the tissues invaded. It may be said to occupy a position intermediate in its anatomical characters between lupus exedens and lupus erythematous.

By syphilitic lupus I do not mean a syphilitic ulceration resembling lupus, but a true lupus which is modified in its characters and appearance by a *constitutional syphilitic taint*. It is generally, though not always severe, and spreads deeply into the subcutaneous tissues. It is important to distinguish this form of lupus from the more common syphilitic ulceration of the nose, inasmuch as the latter is more rapid in its progress; and far more amenable to treatment. Besides these four principal names that I have used for the purpose of classification, there are many other terms applied to the disease under discussion—terms all more or less useful for the purposes of description, but which, for the sake of perspicuity, I have avoided—such, for example, as “serpiginosus,” “hypertrophicus.” Again; we have the impetiginous lupus of Mr. Startin, and the lupus psoriasis of Mr. Hutchinson—the latter a non-exedent form of the disease, which appears in scattered patches about the body, and has a close superficial resemblance to psoriasis. All these and the other forms to which I have referred may be considered as varieties of lupus vulgaris.

In typical erythematous lupus we recognise some very distinctive features, of which the most important are the following:—In the first place it is the *lupus of Middle age*; (2) it is much more common in women than in men; (3) in begins it the sebaceous glands and hair follicles; (4) it spreads slowly, and has little tendency to form open ulcers; (5) it attacks chiefly the papillary layer of the skin, and leaves smooth white scars, which are covered with cuticle, and are neither hard nor puckered.

I will now read you a brief history of the case before us (taken by Mr. Charlesworth);—C. N., aged 54, unmarried, of a consumptive family. When aged about 16 some of the early symptoms of phthisis developed; and she was sent to the Isle of Wight,

where she recovered. Since that time she has enjoyed pretty good general health, with the exception of a severe attack of ague while living in a fen district. There is no history of syphilis, hæmorrhoids, or uterine disorders. The skin disease from which she now suffers began about ten years ago by the formation of a small reddish dry patch on the back of the right hand, of about the size of a florin; subsequently two similar patches formed on the left upper arm, and one on the right thigh; all these patches gave rise to considerable itching. The disease on the head began about six or seven years ago, and at the present time it affects the scalp, forehead, and face; on the latter it is arranged in a symmetrical manner somewhat resembling a butterfly in shape. The lower margins of both orbits, the fore part of the nose, the upper lip and mouth, are free. The skin over the scalp is freely movable, and the eruption in this situation is of a glistening appearance, and has a red base covered with thin white scales; scattered here and there are white, smooth, even scars. Over the forehead are some dry superficial scales. The hair over the part affected is almost destroyed, but nowhere is the sensibility of the skin impaired. The facial eruption, which is the most recent, is of a much brighter colour, with irregular, well-defined margins, studded with small tubercles, some of which are isolated; it seems in a more active condition. The right upper eyelid is healthy, while the skin of the left is affected and a little contracted at the inner side, so as to prevent the eyeball being properly covered by the lid. The whole surface of the eruption is dry, attended with little pain, but is very irritable.

Allow me now to call your attention to the leading features of this case, and the characters by which we arrive at a diagnosis.

Firstly, then, our patient is of the female sex, and I may remind you that erythematous lupus is far more common in women than in men. Mr. Naylor, indeed, estimates the proportion as about eight or ten to one. Again, you will remember that this variety is essentially the *lupus of middle age*; and in accordance with this view we find in the case before us that the age of 40 was attained before the disease made its appearance. It is true that Dr. T. Fox states (at page 206 of his work on "Skin Diseases") that erythematous lupus "mostly attacks children, and especially those of the lower orders." It is, however, more than possible that Dr. Fox would at the present time modify this statement; you must not, therefore, attach too much importance to it. Neumann justly remarks that the disease "is rare under the age of 20."

Last, but not least, we have the history and character of the eruption. It is of about ten years' standing, and began by the formation of a red erythematous patch on the back of the hand, and another, a little later, on the forehead. The former of these has remained almost stationary since its first appearance, and contrasts remarkably with the latter, which has gradually spread with perfect symmetry over the central part of the scalp, producing baldness, and leaving perfectly smooth white scars, which are neither raised, puckered, nor depressed; the skin

retains its elasticity, and the scalp is movable. The disease has spread downwards as well as upward; it has invaded the bridge of the nose, and then spread laterally over both cheeks, always keeping a perfectly symmetrical course, so that the two sides of the face are equally affected, and thus a butterfly-shaped patch is formed, leaving the skin under the eyes, on the forepart of the nose, and around the mouth perfectly healthy.

This gradual and *symmetrical* spreading of the disease is very characteristic of this variety. Again, note especially the well-defined and slightly raised margin of the patch, the colours of which contrast remarkably with the healthy skin around, while here and there a tiny tubercle springs up just beyond it, showing distinctly the direction in which the disease is progressing—namely, at its circumference.

The whole patch has a red base, and is sparingly covered with thin white and dry scales. Nowhere has there been open ulceration except on the right cheek, which shows a few white lines of scars, evidently caused by the healing of small ulcers, the possible result of too vigorous local treatment.

These patches are nearly painless, but are at times attended with severe itching, which has been noticed as a frequent symptom erythematous lupus. The sense of touch, as far as we can determine, remains as perfect as ever. All this in accordance with our usual experience of the malady. The exceptional feature, however, in this instance, in the large extent of surface involved in the course of ten years. We may, indeed, look upon the case as intermediate between *lupus vulgaris non-exedens* and *lupus erythematous*, but approaching more nearly to the latter, though, like the inhabitant of a border-land, partaking of the characters of both races.

We may ask, Is the disease in this instance modified by any syphilitic taint? In reply, I would merely remark that the patient lost her teeth at an early age, and that we have no history of congenital syphilis to assist us in arriving at a positive conclusion on this point.

I will now direct your attention to the morbid anatomy of this disease. The earliest indication of a pathological process going on in the skin is the appearance of a patch of erythema, which is not at first very persistent. After a time we find that the walls of the sebaceous glands of the skin affected become thickened with fibrous tissue and cells, and their ducts plugged with altered sebum of dark-greenish colour, producing a peculiar and characteristic dotted appearance.

Similar changes occur in the hair follicles, and, as a consequence, baldness is produced. The papillæ are also invaded, and are said by Neumann to be immensely enlarged. The new cell-growth does not generally extend into the deeper layers of the corium. As a subsequent change, the sebaceous glands and the pigmentary layer of the skin are entirely destroyed, and we have produced the well-known smooth white scars which are plainly seen on the scalp of our patient. In some very mild cases the scar left is so slight as to be quite imperceptible; these cases are, however, exceptional.

The diagnosis of erythematous lupus, except in its earliest stage, is not generally difficult, though if hastily examined it might be mistaken for a patch of dry scaly eczema or psoriasis, especially if, as sometimes happens, it is thickly covered with white scales. To assist our diagnosis we must bear in mind the appearance of the erythematous patch, with its well-defined margin and red base, the comparatively small extent and slow progress of the disease, the history of the case, the part affected, and, above all, the fact that neither eczema nor psoriasis leave scars or produce the peculiar alterations in the function and structure of the sebaceous glands which are characteristic of erythematous lupus.

Prognosis.—The prognosis is in the case before us, I need hardly say, unfavourable, as the disease is of long standing, and has made great progress.

Treatment.—With regard to the treatment of this most obstinate malady I have little that is satisfactory to tell you. Nevertheless, it is quite certain that under judicious management the progress of many cases is arrested which would otherwise only pass from bad to worse. Our first care must always be not to do harm; for it is a very easy matter, when strong caustics are used, to leave our mark, and produce a severe scar where nature would have left but a smooth and slight one. In addition, we should always bear in mind that erythematous, in common with most other kinds of lupus, is always influenced unfavourably by exposure.

Of the many remedies that have been recommended, not one can be said to produce with certainty a marked effect on the progress of the disease. Amongst the most useful may be mentioned cod-liver oil, arsenic, and small doses of perchloride of mercury, and perhaps the most generally useful of all—viz., combinations of iodine and bromine salts. Our patient is at the present time taking by Mr. Nunn's advice, the Woodhall bromo-iodine water, from the well-known Lincolnshire spring, which has proved in his hands a successful remedy in more than one case of lupus.

In choosing local applications you must beware of strong caustics. If they are used at all, they should be supplied with great care, and only along the border of the lupus patch. Of milder remedies, blistering is one of the most useful, especially if it is combined with other treatment, such as the use of a weak nitric acid lotion, or the application of some form of tar. Hebra strongly recommends a plan by friction with soft soap, and the occasional use of soft soap plasters. The application of mercurial plasters is, perhaps, more generally useful than any other local remedy. You must, however, be prepared to find that the treatment which succeeds in one case may be unsuccessful in another, and that in many cases you can only hope to palliate or relieve the disease without producing a permanent cure. *Medical Times and Gazette.*

TREATMENT OF SPERMATORRHEA.

Mr. G. G. Gascoyne gives the following reconsiderations in the *British Medical Journal*:

The occasional introduction of a catheter as large as the urethra will take, is often of the greatest service; it should be passed into the bladder and allowed to remain for five or ten minutes, according to the tolerance of the patient; its mechanical pressure helps to unload the congested capillaries and small vessels of the urethra; its contact deadens and destroys the extreme sensibility of the urethral nerves, and renders them less susceptible to the influence of slight excitants; whilst, by stimulating the muscles, it provokes their contraction, and so renders material assistance in emptying the larger veins. A silver catheter is the best instrument for the purpose, as it exerts firmer pressure than an elastic bougie; and as the urine can be drawn off through it, the patient will not require to micturate for several hours, which is a point of some importance, as the urethra is often very tender, after the passage of an instrument for the first few times. The frequency with which it should be employed depends upon the amount of discomfort its presence occasions; and, if the pain be great, it should not be left in more than a few seconds, lest rigors, swelled testicle, etc., be occasioned. Sometimes the urethra is *extremely* sensitive, and much pain attends the use of the catheter; but this is an additional reason for persisting with it, though a smaller one may be employed at first, so as to cause less pain. I have sometimes found that smearing the catheter with blue or calomel ointment or with half a grain to a grain of nitrate of silver rubbed down in an ounce of lard, to be of use in obstinate cases; but I prefer the blue ointment to anything I have yet tried. Some camphor, extract of opium, belladonna, etc., may be combined with these ointments if thought desirable. Care should be taken that these applications do not reach much beyond the curve of the instrument, and it should be thoroughly well oiled before using it. The oversecretion of mucus is always checked by the use of the catheter, whether armed with ointment or not.

Cold bathing, cold douches, etc., should not be employed on going to bed. The ordinary bath in the morning does good; but cold applications at night should be forbidden, as the reaction which follows them will increase the local circulation, and so cause congestion and erection of the penis, and thus increase the probability of emissions.

Not only must the position assumed in sleep be attended to, but undue warmth in bed avoided, whether by using very soft beds or too large an amount of clothing. The bowels should be carefully regulated to prevent any accumulation within the rectum; and the urine examined from time to time so as to detect an excess of uric acid, the presence of oxalates, etc., which may render its passage irritating to the hypersensitive urethra. Over distension of the bladder must at all times be guarded against, and the patient warned to pass urine on waking in the morning lest he doze off again with a full bladder, which is one of the most certain provocations of erection and emissions.

Before commencing to treat this affection constitutionally, it is generally necessary to allay the digestive disturbances which are so common and often so severe by giving such remedies as may be applicable to the condition of the patient, either with or without the more special medicines. By neglecting to do so, we may not only add to the dyspeptic troubles and obtain no benefit from the drugs given, but a valuable medicine may do harm and be brought into disrepute, in consequence of its being administered at a time when the stomach cannot tolerate it.

Internally, I have found astringents of more use in this disorder than tonics; or they may be combined. Gallic acid, the dilute mineral acids, especially the sulphuric, may be given. Tincture of matico will often be of service, and more so, in my experience, than any other plant rich in tannin, as it appears to act upon the genito-urinary tract, rather than upon the bowels, as is often the case with the others.

Ergot is one of the most valuable remedies for this affection, and the liquid extracts of the *Pharmacopœia* is a very efficient and convenient form for giving it; whilst the dilute sulphuric acid can be added, if thought advisable.

When the urethra is very sensitive, and the passage of urine painful, small doses of copaiba are often most comforting; or the other oleoresins may be tried if it disagree; but none of them, in my opinion, is equal in value to copaiba, when it can be borne.

I am not disposed to regard strychnine in these cases with very great favor; when there is much irritability of the nerves I believe it often adds to this; but when this is subsiding it may be of use as a tonic; so may quinine or iron, but in no other way. I have never given the tincture of iron in the enormous doses (from one to three drachms three times daily) recommended by some, and so I cannot speak personally of its value in such large quantity.

Cantharides, phosphorus (except the dilute phosphoric acid), and the so-called aphrodisiacs, do harm by acting as stimulants to the nervous system generally, and therefore to the local nerves. Cantharides also, by its action upon the bladder is, especially when given in large doses, a very injurious drug in these cases. For the same reasons I disapprove of local blistering; while the sore left by the blister acts, moreover, as a source of irritation, and adds to the liability of emissions.

Belladonna, in my hands, has proved to be an uncertain remedy; in some cases it has appeared to do good by allaying irritation, whilst in others there were no beneficial results from it. The dryness of throat, disturbance of vision and diarrhœa, which are often caused by it, constitute an objection to its employment in full doses, and without them its value is very questionable.

Camphor is a most useful drug; three or four grains made up into two pills, with half a grain or a grain of opium and one or two of aloes, have more frequently allayed irritability and prevented emissions, than anything I have yet tried. Opium alone does not succeed as well, and a larger dose is necessary, so that the untoward symptoms sometimes produced by it are more likely to be incurred.

I have tried chloral in a few cases, and with very great advantage: in doses of fifteen or twenty grains at bed-time, it has answered its purpose admirably.

Bromide of potassium, in thirty or forty grain doses, will sometimes be of service; but it seems to me a less certain remedy than chloral, which I am disposed to regard as one of the valuable agents we possess for these cases, though as yet my experience of it is limited.

Suppositories vary much in their action whatever drugs they may contain. Occasionally they answer well, but often they do not lessen, and I am not sure they do not sometimes increase, the irritability of the parts.

Galvanism I have not employed myself; but in the few instances where I have known it tried by others, it has seemed to me to do more harm than good, by adding to the nervous irritation.

Lastly, as to cauterization by the *porte-caustique*, I need scarcely say that I am strongly opposed to this method of treatment; for, if my view of this disorder be correct, this instrument can relieve it in no other way than as the passage of the catheter does. I do not believe that ulceration or other morbid conditions of the ejaculatory ducts are the causes of seminal losses. We have no evidence that these pathological conditions exist except, it may be, in very rare instances; and, if so, the application of nitrate of silver to the prostatic mucous membrane in every case of nocturnal emission must be unnecessary; and in spite of its alleged harmlessness, I consider it to be a dangerous treatment. I have known two persons die from the effects of the *porte-caustique*, and I have seen others suffer severely from its employment. This may not be the usual result; but I do say that the application of nitrate of silver to the urethra, whether in stick or in strong solution, is at least a very sharp remedy, and will often produce violent inflammation, and sometimes lay the foundation of a stricture or of a chronic irritation of the bladder. If, then, caustic be applied on an incorrect surmise as to the condition of, and its effects upon, the prostatic mucous membrane and ejaculatory ducts it is not only an unnecessary, but, in my opinion, an unsafe method of treatment.

EARLY DIAGNOSIS OF TYPHOID.

In an abstract of a clinical lecture at Cambridge, published in the *Lancet*, Dr. P. W. Latham insists on the value of the thermometer, observing that during the first four or five days the general symptoms which may then accompany the disease—viz., the rigor, the languor and feebleness, headache, epistaxis, giddiness, pain in the back and aching of the limbs, the appearance of the tongue, the state of the bowels, the condition of the urine, &c.—may not be very distinct, or any one of these morbid symptoms may be entirely absent. In a considerable number of cases, in fact, it would be impossible to say, without using the thermometer, whether the patient were suffering from typhoid fever or not. But the thermometric course of the disease at this time, unless it supervenes on some other malady, is very regular;

and by taking the temperature at 8 a.m. and 6 p.m. for three days the presence of typhoid fever may be decided. On the other hand, one single observation may, with very great probability, negative the existence of the disease.

The following is the formula (from Wunderlich) of this initial stage:—

	Morning.	Evening.
1st day	98.6° F.	100.4° F.
2nd "	99.4°	101.4°
3rd "	100.4°	102.6°
4th "	101.6°	104°

If, then, a person, previously quite well, feels uneasy, perhaps has a rigor, and in the evening we find his temperature about 100.4° or 101 F., falling the next morning about a degree, rising again in the evening, and approximately following the above course the disease may be diagnosed with tolerable certainty.

On the other hand, the disease is not typhoid fever if (1) on the second, third, or fourth evenings the temperature approximates even to normal (98.6° F.); (2) if during the first two days the temperature rises to 104° F.; (3) if between the fourth and sixth days the evening temperature of a person under middle age does not reach 103°; (4) if the temperature on two of the first three evenings is the same; or (5) if it is the same on the second and third mornings. From the fourth to the tenth day the evening temperatures are tolerably uniform, the highest being most generally on the evenings of the fourth, fifth, or six days, and reaching from 104° to 105.5° F. or even higher. The morning temperatures are from 1° to 2.6° F. lower than the evening ones; on the fifth, sixth and seventh days, the variations between the morning and evening temperatures being less than take place from the sixth or seventh to the ninth or tenth days. During this period (from the fourth to the tenth or twelfth day), if the general symptoms are obscure, an absolute diagnosis may not be readily made, and the disease may be confounded with several others, unless thermometric observations extend over several days.

LAMINARIA TENTS.

Dr. J. C. Nott, of New York (*Am. Jour. of Obstetrics*), presents the following conclusions in regard to the use of laminaria tents:

1st. Where moderate dilatation is required, the laminaria is preferable to the sponge tents.

2d. If placed in warm water, just before introduction, for a few minutes, they become flexible, coated with mucilage, are easily curved to suit the cervical canal, and may be inserted with the utmost facility.

3d. From their smoothness and softness they are removed without force, and produce no abrasion or irritation.

4th. They may be medicated with morphia, iodine, or anything soluble in water, but do not absorb alcoholic solutions or glycerine. After being so charged, they may be dried and kept for use an indefinite time.

5th. They do not become putrid, and therefore poisonous, as do sponge tents, and may therefore be retained twenty-four hours or more with impunity.

6th. The black, ovoid laminaria, from the Bay of Fundy, is much preferable to the other varieties yet brought to our markets, and free from the objections he has seen made to laminaria by some writers.

7th. The laminaria will be found of great benefit in obstructive dysmenorrhœa, if introduced a few days before the menstrual period, and also in cases of uterine catarrh connected with contracted cervix; they prepare the way well, too, for all intra-uterine medication. In either case, if softened in hot water before introduction, they rarely produce any pain or irritation.

8th. He thinks it better to insert several small tents than one, as the small ones expand more rapidly than the large ones.

HEART SOUNDS.

The following table of indications of sounds of the heart is taken from "L'Aide Memoire de Medicine, de Chirurgie et d'Accouchement, by Dr. Corlieu," published by Baillière et Fils, Paris:—

A PATHOGNOMIC TABLE OF SOUNDS OF THE HEART (*Bruits de Soufflé*.)

I.—PRE-SYSTOLIC.

Auriculo-ventricular constriction.

II.—SYSTOLIC.

- | | |
|---|--|
| 1. At the base and apex. | Chloro-anæmia. |
| 2. At the base, with propagation in the large arteries. | Lesions of the Aortic valves, with or without constriction. |
| 3. At the apex. | Lesion of the auriculo-ventricular valve, with or without insufficiency. |

III.—DIASTOLIC.

- | | |
|---|------------------------------------|
| 1. At the base. | Aortic insufficiency. |
| 2. At the apex, confounded with the presystolic murmur. | Auriculo-ventricular constriction. |

IV.—TWO BRUITS DE SOUFFLE.

- | | | | |
|----------------|---|-----------|---|
| 1. At the base | { | 1st time. | Aortic constriction, with |
| | | 2nd time. | Aortic insufficiency. |
| 2. At the apex | { | 1st time. | Auriculo-ventricular insufficiency with |
| | | 2nd time. | Auriculo-ventricular constriction. |

1. In auriculo-ventricular constriction the maximum *bruit* is at the apex.

2. In aortic constriction the maximum is at the base, propagating itself along the aorta and carotids.

3. In aortic insufficiency the *bruit* with the second time with maximum at the base.

4. In anæmia, slight *soufflé* with the first and second time, always at the base, and sometimes at the apex.

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A Monthly Journal of Medicine and Surgery.

EDITOR:

FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P., LOND.
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In presenting to the Profession the first number of the *Canada Medical Record*, we desire to offer a few words of explanation, which, although to some extent of a personal character, are yet not without interest and importance to the Profession at large. In doing so we will be as brief as is possible, and while we will state facts plainly, we can but express our very deep regret, that circumstances compel our doing so. As most of our readers are aware, for the past eight years we have, in conjunction with Dr. Fenwick, conducted the *Canada Medical Journal*, published by Messrs. Dawson Brothers. In 1864, when the *Journal* was started, Dr. Fenwick was connected with McGill College, while we were simply a plain member of the Profession. This position of affairs continued till January, 1871, when we accepted a chair in the New Medical School, which was then formed in Montreal, and which was afterwards accepted by the University of Bishop's College, as their Medical Faculty. At this time Dr. Fenwick explained to the publishers, that our having joined the new School rendered it impossible for him to continue longer associated with us in the editorial management of the *Journal*, and suggested our withdrawal. After some consideration the publishers affirmed that, as the *Canada Medical Journal* was published by them at the joint request of Dr. Fenwick and ourselves, it was impossible for them to request us to retire, but that if Dr. Fenwick found it impossible to continue associated with us in the editorship of the *Journal*, they would either suspend its publication or continue it under entirely new editorial management. In this state we approached the close of the volume in 1871, when, just before the last number of the volume was issued, we were waited upon by Dr. Fenwick, who for the first time informed us of what had been transpiring between himself and the publishers. He, however, expressed his desire, arrived at after much deliberation, that our editorial association should continue, and as we were perfectly willing, we together waited upon the Messrs. Dawson, and informed them of the fact. Thus the eighth volume of the *Canada Medical Journal* was entered upon. During its course no questions of a controversial character were discussed between the editors.

Indeed, owing to circumstances, which it is needless to mention, it was beyond our power to engage actively in its management, and Dr. Fenwick had all but its entire control. As the eighth volume drew to a close, we were informed by the publishers that a lock similar to what existed the previous year was again threatening, when we insisted that it should be settled definitely one way or another, without delay. We were shortly after seen by Dr. Fenwick, who informed us that after much deliberation he had decided not to continue longer associated with us, in conducting the *Journal*, our being connected with the New Medical School being the only reason assignable. We used every argument we could think of to induce him to change his mind, but without avail, and, entirely powerless to prevent it, the publishers determined to suspend the publication of the *Canada Medical Journal*. Under these circumstances, we appealed to a few friends outside of the School with which we are connected for advice. We went to them first because we have invariably felt that those who are the main support of a Medical Journal are they who care least about matters, which to most School men appear of momentous consequence. This being our conviction, ever since we have been connected with Canadian Medical Journalism we have avoided treading upon ground which we felt was dangerous, and till the *Journal* ceased to exist such was the course it followed. This being the case—not only willing, but anxious, to even go out of the way to avoid school questions, our friends saw no good reason for the action of the "Senior Editor of the *Canada Medical Journal*;" and their advice was to start a new medical periodical, which would carry out the principles we have just enunciated, especially as Dr. Fenwick had determined to issue another journal, which, from the course he had taken, they felt must partake at all events, in great measure, of the feelings which must have prompted him to the action we have with much regret and pain just detailed. We next sought the advice of a few of our confrères of the New School, and as it coincided with that already tendered us, we determined at once to launch the *Canada Medical Record* upon the sea of Canadian journalism. It is now before the Profession, to whom we with confidence appeal. We wish it to be distinctly understood that, although connected with a Medical School, we will in the future, as we have in the past, keep that fact as far from our mind as possible, while working for the *Record*, and that our platform pure and simple will be, elevation of the standard of Professional Education, fair play

to the Profession in all public appointments, and opposition to monopolies which unfortunately exist in the Professional as well as in the Mercantile world. We look to the general profession of this rapidly growing and extending Dominion to aid us in the establishment of the *Record*, and, to place it within the reach of all, we have put the subscription at the low rate of two dollars a year. We hope that many at least of those whom it has been our pleasure to reach through the columns of the old *Journal* will still extend to us their patronage, and we promise them a live *Journal*, well up to the times, and thoroughly independent in its character. The shape we have adopted has much to commend it, being that of the most successful Medical Journals both in Europe and the United States. Although only twenty-four pages, the amount of matter it contains is quite equal to a forty-eight page *Journal* of the old *Canada Medical Journal* size.

From our friends we solicit contributions of cases, and indeed any items of medical news. We intend to keep the Canadian Profession informed as to what is going on in the Medical world.

THE CANADIAN MEDICAL ASSOCIATION.

On the 11th of September next, the Canadian Medical Association will assemble in the City of Montreal, for the fifth annual time in Convention, when we trust to see gathered from every part of our now extensive Dominion many at least of those who have the honor and the welfare of our Profession at heart. Although at the time we write no active preparations have been made for the entertainment of those who will so soon be our guests, we know that on this score those who may attend will not leave our fair city without carrying away with them a good opinion of the hospitality of its physicians. But, although we are looking forward to much pleasant social intercourse at the approaching meeting, it is well that we should bear prominently in mind, that a very serious duty awaits the members of the Association, and that upon the action of this meeting, to a very great extent, will depend its future success. Started at Quebec in 1867, with an enthusiasm which surprised even its most enthusiastic supporters, the meetings which followed at Montreal, Toronto, and then Ottawa came fully up to expectation. But last year at Quebec, although the more than princely hospitality of the Medical men of that city in 1867 must have left upon the minds of those who were present the most pleasant recollections, still the attendance was

not what it should have been, nor was the same interest shown by those who were present as was observable in former years. After the organization of the meeting, members seemed to have lost all interest in the proceedings, and the Medical Bill was discussed by a few, while the great body of the Association felt that the proceedings were not only tiresome, but that some of the scenes enacted were not worthy of a Convention composed of members of the Medical Profession. Of the vast importance of the Bill itself, no one who has closely studied the position of our Profession in all the Provinces of the Dominion, will deny. The grand feature of the scheme, the Central Examining Board, would at once give a rank and standing to our Profession, which cannot be attained by any other means. The determined hostility, however, which has beset this measure, first at Ottawa and subsequently at Quebec, caused almost the entire time of the Association to be occupied in its discussion, and, as a consequence, the purely scientific, and, to the great majority of its members, the really interesting part of the proceedings were so curtailed, as practically to render useless such papers as were produced. So strong was the feeling upon this point at Quebec last year that, by consent almost unanimous, it was agreed that for the last time the Medical Bill should be produced at Montreal for discussion, and whatever fate should attend it, henceforth the Canadian Medical Association would devote its energies in a channel more congenial to the tastes of the great majority of those who have with regularity attended every meeting. Such being the decision which was arrived at, we trust that every member will study the details of the Bill, which has been scattered broadcast, we might say, over the country, before coming to Montreal, and be prepared to deal fairly and honestly with the measure, when its discussion is again renewed. If the feeling is that its ideas are too advanced for the age in which we live, let us lock it away in a casket, and in years hence, when it is unlocked and the Bill taken from thence and adopted, as in time we believe it will, our children will wonder that their parents were so foolish as to push from them that which promised so much for their welfare..

Whatever action is intended to be taken upon the Bill will we hope be attended to in the early meetings of the Association, for if members leave Montreal as thoroughly dissatisfied with the work done as they did at Quebec, we fear that it will not be long before we would have to write an epitaph for the Canadian Medical Association. If, on the other hand, time be given for the reading and proper dis-

discussion of the papers, which we are informed are in course of preparation, a new interest will attach to the meetings, and all will feel that the time thus passed has been well and profitably spent.

We would also suggest that members should arrange to pass three days in convention, instead of only two days as formerly.

WILLIAM FRASER, M.D., M.F.P. & S., GLASGOW.

It is with feelings of the deepest regret that we have to announce the death of William Fraser, M.D., of this city, which melancholy event took place somewhat suddenly, on Wednesday morning, the 24th of July, at five o'clock. It appears that, although almost unknown to his professional brethren, for more than a year past he suffered from enlargement of the prostate gland, with occasional attacks of retention of urine. One of these seems to have occurred on Sunday, the 21st. On the Monday he was far from well, and against the strong remonstrances of his family, he made his professional calls, being out the greater part of the day. Several of his professional friends, who saw him, remarked how ill he looked. On the Tuesday morning he sent for his former pupil, Dr. Craik, who at once took him in charge. In the afternoon symptoms of urinary infiltration set in, and a consultation of the McGill Medical Faculty was called for the evening, by which time the infiltration was extensive. The scrotum was freely incised, and a quantity of ammoniacal urine escaped, and although this gave great apparent relief, by ten o'clock in the evening he became comatose, and, as already said, breathed his last about five o'clock on Wednesday morning.

Dr. Fraser first entered as a medical student at the University of McGill College, in the session of 1834-5. He also attended the following session, and took his M.D. in 1836 from the same University. He was also the possessor of the diploma of the Faculty of Physicians and Surgeons of Glasgow, but when it was obtained we have not been able to gather. In June, 1845, he was appointed Lecturer on Medical Jurisprudence in McGill College, and he continued to hold that chair till the year 1849 or 1850, when he succeeded to the Professorship of Institutes of Medicine, which he continued to fill up to his death with satisfaction to his colleagues and with profit to those whose good fortune it was to pass under his care. As a lecturer, if not brilliant, he was clear and concise, comprehended his subject thoroughly, and was able to convey his information so as to be understood by the junior members of the class. In

this last particular we, think, was his greatest charm as a lecturer. Occupying so long, as he did, the same chair, his lectures contained an immense mass of information, and that too of a valuable and practical character, which he had apparently, year by year, culled from the current literature of the day. Dr. Fraser was also one of the attending physicians of the Montreal General Hospital, being elected to that office on the 11th May, 1847, and continued actively to perform its duties up to the period of his last illness. During the almost forty years he was in practice, he was scarcely ever absent from his post, the only serious holiday he ever took being a European trip of several months in 1870. As a physician he was most favorably known, and enjoyed an extensive and lucrative practice. His juniors in his profession constantly sought his advice in consultation, and all felt that his judgment was thoroughly reliable. His sudden demise leaves a blank, which will be felt in Montreal for many a long day. Dr. Fraser was a native of Perth, Scotland, and had attained his fifty-eighth year.

THE LATE DR. FRASER.

A special meeting of the Medico-Chirurgical Society of Montreal was held on Saturday evening, the 27th July, when a very large number of members were present. The following resolutions were unanimously passed; the mover and seconder of each, in a few remarks, giving expression to the general feelings of the Society to the great loss which it had sustained in the death of Dr. Fraser.

Moved by Dr. Peltier, seconded by Dr. Reddy:

That the members of the Medico-Chirurgical Society deeply regret the loss of their late friend and associate Dr. William Fraser, whose high qualities as a physician and professor had justly endeared him to his colleagues and fellow-citizens, and whose self-sacrifice and devotion to duty shed lustre on our Profession.

Moved by Dr. David, seconded by Dr. Francis W. Campbell:

That this Society desires to place on record the interest in its meetings shown by Dr. Fraser, whose active assistance helped so much to render them interesting and instructive.

Moved by Dr. Thompson, seconded by Dr. Dugdale:

That this Society extends to the family of the deceased their heartfelt sympathy in the great bereavement which has befallen them.

Moved by Dr. Fenwick, seconded by Dr. Godfrey:

That a copy of the above resolutions be published in the Medical Journals and city papers.

PERSONAL.

We notice that Dr. E. F. Slack, son of the respected Rural Deal of Bedford, has returned to Canada, after spending several years in the old country, studying his profession. He was twice elected House Surgeon of Charing-Cross Hospital, as a reward for his assiduity. This, we understand, is the first time that such an event ever occurred in that Institution.

Dr. Muir, C.B., who some few years ago was head of the Army Medical Department in Canada, has just returned to England from service in India. The *Lawyer* says he is to assume the duties of head of the Sanitary branch of the Army Medical Department. Dr. Muir's many friends in Canada will hear with pleasure of his promotion.

Dr. George Ross resigned the House Surgeoncy of the Montreal General Hospital last March, and his resignation took effect on the 1st of May. The Board of Governors of the Hospital passed most complimentary resolutions, regretting his departure. Every word was well deserved, for a more conscientious and painstaking House Surgeon the Montreal General Hospital never had, and it has had many good ones. Dr. Ross has commenced private practice in Montreal, and has our warmest wishes for his success. Dr. Roddick, Assistant House Surgeon, has been appointed to the vacancy. Dr. Clarence Chipman has been appointed Assistant House Surgeon.

Dr. Wolfred Nelson, a graduate of McGill and of Bishop's College, went to Europe some weeks ago, as Surgeon of the *Emperor*. Dr. Maurice H. Buck, an old McGill graduate, has just returned from *London*, by the Steamship *Medway*. He was in poor health but is better, and talks of settling in Montreal.

Dr. Trenholme, professor of Midwifery of Bishop's College, has been in London since the middle of May. He returns in time to resume his professional duties.

Dr. Lucas, Gold Medalist of McGill College, is in London.

Dr. McLaren and Dr. Morrison graduates of McGill College of last spring, have commenced practice, the former in Ormstown, Q., and the latter in Huntingdon.

Dr. Latour, graduate of Bishop's College, has commenced practice in Biddeford, Maine, and Dr. Lanouette of the same school in Ceriloy.

Dr. J. Baker Brown, the celebrated gynecologist, has become paralysed, and is in great pecuniary distress. A fund is being collected for him in London, of which Dr. Forbes Winslow is the Treasurer.

ANNUAL CONVOCATION OF VICTORIA COLLEGE, COBOURG.

The Annual Convocation of Victoria College was held in Victoria Hall, Cobourg, on the 28th of May. There was a large gathering of the friends of the Institution from all parts of the Provinces of Ontario and Quebec, quite a number of the old graduates being present to show their continued interest in their *Alma Mater*. The immense hall was crowded with a brilliant audience.

There were conferred twenty-five degrees in Arts, four in Law, and forty-four in Medicine.

President Nelles, in an eloquent speech, expressed his strong confidence in the growing usefulness and future prosperity of the College. The attendance of students during the year had been large, and the present graduating class would reflect credit upon any University. They had, in proof of their affection for their *Alma Mater*, established, in perpetuity, a scholarship of \$72 for the first in English Literature and Modern Languages. The Toronto Branch Medical Faculty had established a Gold and Silver Medal, and the school was in a promising condition, although they had suffered a severe loss in the death of Dr. Rolph, who, as a Professor and Lecturer, had achieved a reputation wide as the continent. The new buildings in process of erection would greatly help the school, as they were in proximity to the Toronto Hospital. The Montreal Branch was in a flourishing state.

We have lately received an American paper containing an account of the cross-examination of Dr. E. Warren in the trial of Mrs. Wharton, who was accused of poisoning General Ketchum. The Doctor supported the theory of the defence, which was that the General had died from cerebro-spinal meningitis. The following sharp retort was made by Dr. Warren in his cross-examination by Attorney-General Sylvester:—

"Attorney-General: A doctor ought to be able to give an opinion of a disease without making mistakes.

"Dr. Warren: They are as capable as a lawyer.

"Attorney-General: Doctor's mistakes are buried six feet under the ground. A lawyer's are not.

"Dr. Warren: But they are sometimes hung as many feet above ground."

TO PROCURE A DAILY STOOL.

A correspondent of the Philadelphia Medical Reporter recommends the following novel procedure

"At a regular hour every day, all things being in readiness, tap gently and repeatedly on the anus with a bit of wood or any substance hard enough to produce irritation, and the sphincter will almost certainly relax after a while."

The Chicago Microscopical Society recently held a public meeting at which there was an attendance of fifteen hundred persons. One hundred instruments were exhibited, valued in the aggregate at \$30,000 dollars. There were in the hall twenty-two tables where the owners of the instruments stood ready to exhibit their preparations.

Medical Items and News.

NITRATE OF SILVER IN BED SORES.

Betz regards nitrate of silver as the best remedy for bed-sores. Instead of making use, however, of lint dipped in the solution of lunar caustic, he prescribes an ointment composed of five decigrammes of the nitrate of silver, fifteen grammes of lard, and thirty of wax, which he spreads on linen, and applies to the sores, taking care that the piece is rather larger than the sore. This is repeated morning and evening.—*The Doctor*.

BLOOD-LETTING.

Dr. Byrd, Professor of Obstetrics in Washington University, once more raises the banner of bleeding, and says the practice is more satisfactory than any other. Indeed, he asserts in the *Medical and Surgical Reporter*, that in all inflammatory diseases it is the most scientific and efficient agent, and that the necessity for it is as great at the present time as ever it was in the past.

In certain conditions of the brain found in most cerebral diseases it is, we think, not only indispensable, but the only remedy necessary.—*The Doctor*.

REMEDY FOR PAINFUL WOUNDS.

Take a pan or shovel with burning coals, and sprinkle upon them common brown sugar, and hold the wounded part in the smoke. In a few minutes the pain will be allayed and recovery proceeds rapidly.

CASTOR-OIL MADE PALATABLE.

The *Boston Medical Journal* says that castor oil may be rendered as "sweet as honey" to take by combining it with an equal amount of glycerine, in which a few drops of oil of cinnamon has been rubbed up.

THE BATH IN SMALL-POX.

DR. STOKES, Regius Professor, of Dublin, says:—"We cannot doubt that the mortality in small-pox hospitals would be greatly diminished by the use of the bath. After describing a very severe case of confluent small-pox in which the patient was kept alive only by stimulants, he says the trial of the

warm bath was suggested to him by Mr. Smyly. The effect was instantaneous and marvellous. The delirium ceased as if by magic. It was the delirium of pain; and the patient exclaimed, 'Thank God! thank God! I am in heaven! I am in heaven! Why didn't you do this before?' The fetor immediately and completely disappeared, so that, on entering the ward, no one could suppose that there was a case of small-pox in it. He was kept at least seven hours in the bath."

LOCAL APPLICATION OF HYDRATE OF CHLORAL.

Dr. Strother states that thus employed it is of excellent service in "neuralgia, pleurodynia, rheumatism, gastralgia, nausea, and vomiting." A saturated aqueous solution is applied over the seat of pain with slight friction, and glycerine, olive oil, or cream is used as a subsequent dressing. There will in most instances be enough of the chloral absorbed to produce a considerable anodyne effect, in addition to its rubefacient action.—*Boston Medical Journal*.

A VACCINATION MARTYR.

"EXAMPLE is better than precept." Acting upon this wholesome maxim, a Medical Practitioner stated during the progress of a case in the Court of Queen's Bench the other day, that he had been vaccinated 477 times. It was his practice to vaccinate himself when parents objected, to prove that there was no harm in it.

WASH FOR CHILBLAINS.—Sulphurous acid, three parts; glycerine, one part; and water, one part. The acid will be found particularly useful in the irritating stage of chilblains.—*Cincinnati Medical Reporter*.

CHRONIC DIARRHŒA.—Dr. E. L. Shurley, of Manistee, Michigan, has had good success in the use of the compound solution of iodine (Lugol's.) He gives five drops in half a tumblerful of water four times daily.—*Buffalo Med. and Surg. Jour.*

The external application of iodine, applied with sweet oil, has seemed to have a marked effect in many cases of chronic diarrhœa that had for a long time resisted internal treatment.

A case of fracture of the clavicle from muscular exertion is reported in the *Pacific Medical and Surgical Journal*. The man was attempting to raise himself up by his hands.

MARRIED.

In Montreal, the 18th July, at the residence of the bride's uncle, Alexander Hart, Berthelet street, by the Rev. Charles Chapman, M.A., Thomas A. Rodger, Esq., M.D., C.M., to Grace, daughter of the late Charles Dow, Esq., of Grangemouth, Scotland.

DIED.

FRASER.—On Wednesday morning, the 24th July, William Fraser, M.D., Professor of Institutes of Medicine, McGill University, aged 58 years.

BLANCHET.—At Quebec, on Sunday, 21st inst., Jean Baptiste Blanchet, M.D., aged 32 years.