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Original Communications.

AN UNUSUAL CASE OF EPILEPSY.

By CASEY A WOOD C.M., M.S., Professor of Pathology, University of Bishop's College.

[Read before the Montreal Medico-Chirurgical Society.]

Some years ago Dr. Wm. Osler read a paper in this room in which he spoke of a case of Jacksonian Epilepsy. He was fortunate enough to be able to show the brain of the subject and the cortical growth (a small glioma) which gave rise to the epileptiform seizures. I am unable to demonstrate the actual existence of any disease within or about the motor zone of the patient about which I am going to speak, because he is still alive, but I thought it might be interesting to introduce for discussion here, by detailing such a case, the whole subject of false (now-hysterical) epilepsy. The subject of epileptic aurea and the modes of onset in epilepsy has always been an attractive one to me, and I would like to hear from members of this society in this connection.

Until 18 months ago, E. B., aged 70, was in fair health. Had never had syphilis but now suffers and has suffered at times for many years from rheumatic gout, the great toe of right foot being the chief seat of the trouble. Has occasionally had pains which were set down as rheumatism in several other joints of his body; but has never been laid up with them. Has never suffered from persistent headache; never had any injury to his head, and his intellectual faculties are well preserved. There is no history of family neuroses. His digestion is fair and his heart and kidneys are in normal condi-

tion. He had his first attack 18 months ago, and the half dozen attacks which he has had since then are similar to that one, only they seem to be getting worse. He first noticed twitching of the muscles of the left forearm and face. These twitchings increased its violence, and although he made efforts to control them they went on getting worse. He then began to experience feelings of fear as of impending danger, and in about a quarter of an hour after the first muscular contraction he thinks he became unconscious for a few moments, but is not certain of it. In half an hour the whole attack was over, and with the exception of a feeling of weakness in the arm he was all right again.

He has had since then, but at no regular interval, some half dozen attacks, varying little in character from the first one. Nearly every attack has been witnessed by his fellow workmen or his wife, and I have been able to get a pretty fair account of them. The loss of consciousness lasts but a few moments.

Sometimes he has had what he calls double attacks. That is, he will have a second attack a few minutes after the first, which is not as severe as the first and is not accompanied by unconsciousness. He knows when he is going to have an attack, and will grasp his left wrist in his right hand and do his best to prevent the spasm from getting worse or from attacking his face. I saw the latter half of one of these attacks which he declares he can bring on at will, or rather (because the man suffers much from the dread of approaching danger which accompanies the attack) he thinks that where he has a second attack it is due to putting the arm or his body in some uncomfortable position. I was talking to him one

day (having reached the house shortly after a seizure) when he said "There, I am going to have another attack." He grasped his left wrist firmly, but jerking began in the arm, the muscles of the upper arm being most affected. This was shortly followed by twitching in the other muscles of the arm, all growing worse, until the forearm became flexed upon the upper arm. Then the muscles of the face began to twitch and both sides seemed affected just as in true epilepsy. The man meantime made violent efforts to control the spasms, and called to his wife to prevent the flexion of the forearm. She succeeded in straightening it with some difficulty. In five minutes the attack was over and I am unable to say whether he was unconscious or not.

For several days afterwards he complained of weakness in the affected arm. The spasm in this instance and in every other attack was distinctly confined to the left arm and face, beginning first in the arm and extending to the facial muscles. Without the dynamometer test, the grasp of the left hand several days after an attack appears to be as firm as that of the right. I do not know why it should be so, but the patellar tendon reflex is wanting in the left leg and is faint in the right side. The only doubt it appears to me, in the diagnosis of this case as one of Jacksonian epilepsy, or in other words of disease affecting the face and arm centres about the fissure of Rolando is that matter of loss of consciousness. It seems to me however that the tonic muscular contractions confined to such related groups of muscles as those of the arm and face, the gradual onset, the loss of consciousness if at all but very slight and coming on near the end of the attack, after the patient has been able to make vain but intelligent efforts to prevent the involvement of the other arm and facial muscles, the absence of any history of his falling down, all these point to a local brain lesion and not to true epilepsy. There was no paralysis in this case not any tonic contractions of the muscles, although the patient complains of weakness in the arm for a day or two after an attack. One must conclude that there is no actual destruction of the cortex within the motor area, but that some growth or induration in a situation outside of it irritates, upon occasions, the centres that preside over the face and arm muscles.

In Dr. Osler's case there was a long standing contraction of the right foot.

Regarding the treatment of this case he has

been taking, for several months, 5 grs. of potassic iodide, 10 grs. of potassic bromide and 15 grs. of potassic bicarbonate, 3 times a day on alternate days, and so far he has been free from attacks. I am watching the case and awaiting developments. Thinking for obvious reasons, that it was advisable to have his eyes examined I sent him to Dr. Proudfoot, and I conclude with his report:

"I send you the following notes of E. B's case. I am sorry he could not come to see me again as I wish to examine his color perception and visual powers which I could not do before.

"At the time I examined him I found the humors of the eye perfectly transparent and nothing abnormal, with the exception of the "disc" which was somewhat greyish in color, and there were two or three small collections of pigment at the upper and outer margin; and a narrow atrophic ring extending round the lower and inner third, with a slight depression of the vessel in that region.

"There was no hyperoemia or other evidence of any very recent trouble, and the patient informed me that his sight was as good then as it had been for some time back."

A WORD OR TWO ON THE TREATMENT OF ACUTE PERITONITIS, WITH A COUPLE OF CASES IN ILLUSTRATION.

BY A. D. STEVENS, M.D., Dunham, Quebec.

It is not necessarily the rare and obscure in practice that possess the most interest to the class of men who read journals like your own. When a *point* can be emphasized—even a well known one—it is well to do so. With this end in view, I send a condensed account of treatment of a couple of cases of typical acute peritonitis.

G. W., aged about 40 years, of robust constitution, and carpenter by trade, fell ill on the 22nd of January last, from exposure to cold, while working upon the outside of a building. Two days later, symptoms of acute peritonitis developed. I gave him a few grains of hyd. c. creta and a saline cathartic, which emptied the bowels. The next day the increased tenderness of the abdomen, the tympanites, the elevated temperature and other well known indications more fully confirmed the diagnosis. From 20 to 30 drops of tinct. of opium (according as could be tolerated) were then ordered him every three hours, and turpentine stupes to be freely applied to the abdomen. Although the stomach was irritable, he managed to

keep down more or less iced milk and water. This, without interruption, constituted his treatment until the seventeenth day from the date of my attendance, and during the whole time, he had no movement of the bowels. On that day, the inflammation having to a certain extent subsided, I gave him an enema of lukewarm water, secured an evacuation of the intestinal tract, increased the quantity and quality of food, and again locked up the bowels with the tinct. opii for four days more. At the end of that time, the exceedingly tense, painful and tympanitic abdomen, having to a still larger extent given way, another enema was ordered,—but here my patient and I parted company, but not before I had left him a couple of ounces of laudanum to be used as he might require, and directions in general as to future management. It was midwinter, fearfully cold, and the home of the patient in a mountainous, snowy locality, and we did not meet again until he turned up at my place two months later, all right, with the exception of a swelled or oedematous leg, which I attributed to a phlebitis occurring subsequent to my leaving him.

In April last, O. S., aged thirteen years, of healthy parentage and himself likewise healthy, went, with several boys, to a neighboring sugar bush to get some warm sugar and enjoy themselves generally. After satisfying their appetites for new maple sugar, and to carry out the programme, they all took off their boots, and went home bare-footed through the snow. The next day the hero of my tale became sick, and luckily the parents gave him a cathartic—on the day following I had no trouble in diagnosing acute peritonitis. As the bowels had been previously well opened, I gave the little fellow a half dozen grains hyd. c. cretâ and fifteen drops tinct. opii, the latter to be given, more or less, according to the effect, every three hours. This (the laudanum), with turpentine stupes, was all the medication he received until the sixteenth day, when it was found that the inflammation had sufficiently given way to warrant an enema, which produced the first movement of the bowels he had had during the whole fifteen or sixteen days. The case went on well enough for a short time, when a sort of relapse set in, accompanied by typhoid or adynamic symptoms. These, however, after many “ups and downs” yielded to quinine, opium, brandy, milk and the like. Today he is as well as any boy in this Township. It will be observed, by the foregoing, that I kept the first patient's bowels continuously quiet and locked

up for seventeen days, and the last one for fifteen days. In my judgment, if, at any time during these anxious days, I had yielded to the urgent solicitations of friends and given even the mildest enema there would have been just two persons less now living in this community, and that is really all the point I wish to draw attention to.

If called early enough, empty the prima via. with a mercurial laxative, and then shut down *closely* and persistently with tinct. opii (not morphia) until the inflammation subsides. If the patient is not seen soon enough, don't give even the mildest laxative at first, but close up at once and *keep* unflinchingly closed up until that time arrives, no matter how long the subsidence may be in coming. The important fact intended to be made prominent herein may or not be an old story, but, according to my observations, the oftener it is repeated the better for all concerned. The patients will certainly not all die of this dangerous inflammation, if the extensive and roughened peritoneal surfaces are *not* disturbed by cathartics, or other means, from the very time the inflammation sets in, to the time of yielding.

Correspondence.

WINNIPEG, MAN., Aug. 15th, 1887.

To the Editor of the CANADA MEDICAL RECORD.

DEAR SIR,—In your July number, page 238, I observe an article from the St. Louis Medical Review, on “Fluid Extract of Ergot” as a local application in “*Spreading Erysipelas*.”

A few days ago I had a case in the Fort under my charge, which was Erysipelas of the foot and rapidly extending up the leg. I used Fluid “Extract of Ergot,” painting the foot and leg thoroughly and administered Tinct. Ferri. M x x ter die internally. In twenty-four hours after the application I was considerably surprised to find my patient's foot free from pain, swelling and arrest of the extending inflammation. He expressed great relief and desired to return to duty, this I declined to allow him. I repeated the application of Ergot four times, covering the leg with cotton wool. On the fourth day from the outset of the inflammation he returned to duty cured. It would be interesting to hear from others more of the results of this treatment in Erysipelas.

Yours, etc., ALFRED CODD, M.D., C.M.

Surgeon, R. S. M. Infantry, Winnipeg.

Progress of Science.

CONSTIPATION,

By J. MILNER FOTHERGILL, M. D., EDINBURGH,
Physician to the City of London Hospital for Diseases
of the Chest (Victoria Park).

In the constant round of daily practice the physician commonly encounters cases where the bowels are not properly open. Both sexes and all ages are liable to this undesirable condition. Frequently the constipation is very obstinate, and refuses to yield to the measures employed; or, in other cases, is only kept at bay by the constant resort to laxatives or even cathartics.

The bowel is not only the recipient of the waste and indigestible matters of our food, but has its own glands, which are not all absorbent. Whether the offensive odor of the fæces is due to mere fermentive or putrefactive change in the contents of the lower bowel, or the glands situated thereon lend some of the fœtor, it may not be easy to perfectly determine; but any one familiar with obstetrics knows how, when the foetal head is distending the perineum, the glands situated near the anus can be distinctly felt like so many small shot, and their secretion is as offensive as it is difficult to remove from the hands. The excreta possess an offensive odor which secures their disposal, and thus one good sanitary end is served by the unsavory secretions of these glands. These glands serve to lubricate the mucous lining of the intestine and thus expedite the passage over it of the contents of the bowel.

Any loss of activity in the muscular movements of the intestine will favor the tendency to a constipated condition. This is met with at all stages of life, but perhaps it is most markedly seen in the case of young females. A natural delicacy impels them to avoid the proximity of the closet, and gradually the bowels are taught to carry a greater and accumulating load. The pouches of the bowel become distended, and the fæces which pass them are alone voided, and are of more or less fluid consistency; so that a girl may believe her bowels open, or even think herself the subject of looseness of the bowels, when in reality her abdomen is filled with fæces. One ontoward result of such chronic constipation in young girls is displacement downwards of the ovaries, and these organs may become glued down to their new habitant by adhesive inflammation. Two unfortunate outcomes of this displacement of the ovaries are (1) sterility, and (2) irritable ovary. The most marked case of this kind which ever came under my notice was that of an American lady. For the sterility of course nothing could be done, the ova being hopelessly beyond the reach of the fertilizing zoöspersms. For the irritable tender ovaries something could be done, but the effects of treatment were so little satisfactory that the removal of the offending and useless organs was discussed.

Such a condition of chronic overloading of the bowels is furthered by the lack of bodily exercise during school-life. The school-girl is busy with her lessons and absorbed in her work; she scarcely gives a thought to her bowels, and perhaps is rather glad that they do not force themselves upon her attention. The resultant consequences are that the large bowel becomes distended, while the muscular fibres become attenuated, and the bowel becomes incapable of properly unloading itself when the opportunity is offered. The uterus is forced down upon the floor of the pelvis, and, as we have seen, the ovaries may be displaced. Until physiological aspirations arouse the idea of matrimony, and a marriageable age is reached, little attention is given to the physical state; and then a confirmed condition is discovered and one requiring considerable attention and trouble for its removal.

In selecting remedial agents, the choice must be guided by the precise requirements of the morbid condition. To restore the muscular activity is as important as to excite the secretion of the intestinal glands. The ordinary catharsis does both, and so sweeps the contents of the bowels out by the anus. But every physician of experience knows well that the recurrent resort to active purgation gives about as unsatisfactory results as well could be attained. In the first place women of all ages bear active purgation very badly. The griping pains are ill borne and depress very acutely. When the bowels are cleared out by a violent action the process of loading up again sets in immediately, and another catharsis is soon required with all its attendant discomfort. In this respect women are closely approximated by men of feminine type. Active purgation is only well tolerated by robust persons. In others it should only be adopted when there is some distinct end to be served by it.

An occasional clearance of the bowels may be desirable; but the treatment should consist of a small amount of laxative materials, taken with perfect regularity, persistently and steadily. Two classes of laxative agents present themselves for notice: these are vegetable substances and mineral substances. Frequently they can be combined with advantage. For women the vegetable laxatives are best. As compared to men they do not bear well mineral purgatives, whether as natural waters or artificial solutions. Fortunately vegetable extracts readily lend themselves to pill form. The first laxative to come into general use was rhubarb. But unfortunately rhubarb has a secondary binding tendency following the primary purgative action. Thus, it is unsuitable for habitual use, though this action gives it a peculiar value when the bowels are to be unloaded previous to an operation on any of the contents of the pelvis. (In cases of diarrhœa set up by a railway journey, such use of rhubarb is most excellent.) The persons who adopt rhubarb for the relief of habitual constipation are not likely ever to be cured.

It has fallen to my lot to see such a case quickly relieved by substituting for the rhubarb some other laxative. Next in frequency of resort is aloes. Aloes acting upon the lower portion of the bowels is in great vogue in constipation linked with amenorrhœa (partial or complete). In consequence of this localized action aloes in full doses are not exhibited in pregnancy, except from ignorance or criminal intent. Fordyce Barker sees a certain utility in this localized action, and has from experience found that the stimulant action of aloes upon the area supplied by the hemorrhoidal arteries is good in the piles of pregnancy. Certainly the use of aloes in small doses, in combination with other laxatives, is rational practice. A certain amount of aloes should form a factor in the remedial agents employed in all forms of constipation in women, whether pregnant or not.

Then, beyond these two familiar laxatives, a host of others, which are more or less in use. Colocynth, gamboge, jalap, scammony, cascara sagrada, are perhaps those most in vogue. Castor-oil is rarely resorted to for constant use; while croton-oil might be more prescribed than is at present the case with advantage.

One matter, especially with female patients, must never be forgotten, and that is to diminish as far as possible the griping pains which activity in the muscular fibre of the intestine sets up. When the vermicular action is roused, violent contraction produces a griping pain very commonly; yet the muscular activity is essential to cure. To prevent this griping it is usual to add carminatives to the laxatives; black pepper, cayenne, and the essential oils all possess the property of taking away to a great extent these painful contractions, and so can be incorporated in the pill with advantage. One point must be borne in mind about the griping pains produced by the exhibition of laxative medicines, and it is this: griping may be due to violent contractions of the muscular fibre, which, however, may be ineffectual; and then the remedy is to increase the dose, when effectual efforts bring with them the desired relief. When the patient complains of griping pains it becomes necessary to ascertain whether the bowels are freely open or not; if not, a larger dose must be given. But if the bowels are freely open then the dose may probably be reduced with advantage.

In order to secure more energetic action in the muscular fibre of the intestine, it has become usual to add a little strychnia to the habitual laxative; and a very good practice it is. The steady use of such a compound pill will be found in time to put the bowels in a more desirable condition. But—in my experience at least—persons who suffer with habitual constipation lack perseverance. They either contrive to forget their medicine, or they give it up as soon as they are partially-relieved, and do not continue it (in lessened doses) until the new order of things is firmly established. And if the palate is offended by the medicine, abandonment of it prematurely is almost certain to happen.

Consequently humanity has declared for pills as the form of remedy *par excellence* in constipation.

A good combination would be provided by something of this kind for habitual use:

Strychniæ	gr. i.
Pulv. aloes	3 i
Pulv. piper, nig.	3 i.
Ext. cascara sagrag.	ʒi. j.

In pil. xxiv div. i bis, in die.

When the bowels have become more regular, then instead of a pill night and morning, one at bedtime alone would be sufficient; and after a time the pill might be given up entirely, having fulfilled its purpose. If something more potent is required, then half a drachm of croton-oil may be added to the pill mass.

Some practitioners are fond of giving hyoscyamus to relieve griping.

Where the condition is not very pronounced a laxative pill at bed time once or twice a week is sufficient. Where the patient is of a rheumatic nature, or there are deposits in the urine, it is well to add a mercurial to the laxative. Something of this kind would be found serviceable:

Calomel	ʒi
Ext. hyoscyami	ʒi ss
Pil. coloc. co.	ʒi

In pil. xii div. i p. r. n.

When such a pill is found not quite potent enough, it may be well to assist its action by a draught of cold water on getting out of bed next morning—often itself very efficacious. Or some form of purgative water may be preferred, or a seidlitz powder, or some effervescing preparation, of which the name is legion.

If one line of attack fails, then try another. Some victims to constipation try a variety of compounds before they find what they desire. In one case it is a proprietary medicine, in another an orthodox prescription. One old lady who for half a century had been in search of a remedy paid me the compliment of asking me what I could suggest. It was in my early days, and the range of my knowledge was limited, but I hazarded the suggestion that a draught of cold water on rising often proved a very good remedy. She adopted the suggestion with the most satisfactory results, and prophesied a career of usefulness for me.

When something is taken in the morning it is uncomfortable, and for business men in cities well nigh impossible to have the bowels acting during the day. To secure prompt action it is well to take the dose of purgative water (or its equivalent) with hot water, or tea or other warm vehicle. This will usually produce the desired effect; and, if taken on getting out of bed, secures the desired operation by the time breakfast is over. When a pill has been taken previously at bed time the bowels are usually ready to operate soon after the morning draught is taken; and then a motion before breakfast, followed by a second when that meal is over, fits the bilious business man for his day's work. Where a person is depressed and liverish, to sweep

all spare bile and all offensive matters out of the intestine is to give a mental cheerfulness which contrasts with the gloom which reigned before.

Where children are subject to constipation something palatable is required. Children, even more than adults, resent what has an objectionable taste. Castor-oil is detested in the nursery, and not without reason. Tincture of senna in a little tea is preferable. But of all forms of laxative a sweet ginger biscuit or cracker, containing a few grains of jalap, is the least repugnant to the childish palate. It should not be too hot, else the ginger offends. If such toothsome sweetmeat be granted as a reward for good behavior, the ruse will usually be successful; but if a shadow of a suspicion be excited that medicine lurks in the sweetmeat, a new line of attack at once becomes necessary. In other cases a little oatmeal or maize porridge to breakfast is enough. At other times a little stewed fruit, as figs, French plums, or even ordinary garden fruit, is found efficacious.

With many adults some treacle on whole-meal bread relieves the conditions which renders life a burden. The mechanical irritation set up by the particles of bran excites the vermicular action of the intestine, and all is well. Brown bread eaters are common everywhere. When travelling, such persons are liable to the presence of their bane, because brown bread is not always to be had. It will be well for these individuals to lay in a stock of pills in a travelling medicine chest, the now fashionable compound liquorice powder, or a bottle of some granular effervescent preparation.

When constipation is—as it very commonly is linked with inadequate action of the liver, the pure laxative should be linked with a hepatic stimulant. In the second edition of my *Practitioner's handbook of Treatment*, many of the prescriptions were altered, and the sulphate of soda substituted for sulphate of magnesia; the latter being a pure laxative, while the former possesses also a distinct action upon the liver. A certain very august personage is said to repose unlimited confidence in sulphate of soda, and certainly time has fully justified that confidence and demonstrated that it has not been misplaced. Others again find that phosphate of soda, familiarly known as "tasteless aperient salts," meets their requirements. Carlsbad salts also are in vogue.

The administration of an habitual laxative and the decision as to what agent or combination of agents, and what doses shall be employed, is one of the trials of prescribing. If the dose agrees at first in a week or a month it is either too potent or it loses its effect, and then an alteration of the dose, or the employment of some other agent or combination of agents, becomes imperative. Some persons have to keep "ringing the changes" and going a certain round, once more reverting to some compound that had lost its effect in past times. When a laxative has to be combined with tonics (or any drugs which have to be taken for some time) it is often well to give two prescriptions, one more

laxative than the other, and then let the patient arrange the doses as he or she requires. If this gives the patient a little trouble—well, the patient after all is the person who is benefited, and the trouble brings with it its own reward.—*Phil. Med. Register.*

SOME POINTS IN MINOR SURGERY AT THE PENNSYLVANIA HOSPITAL.

By THOMAS S. K. MORTON, M. D.,
Senior Resident Surgeon.

Shock is combated usually by warmth and stimulants. The former is applied by means of hot baths or water bags, generally the latter. The patient is surrounded by rubber bags filled with hot water. These we have had made for the purpose. They are round, from one and a half to two and a half feet long, from four to six inches in diameter, and have a filling-hole with a screw cap at one end, and a handle at the other. Atropia is freely used. Whiskey, ether, digitalis, aromatic spirits of ammonia, or, in desperate cases, aqua ammonia itself, are given. The injection of pure ammonia is, of course, always followed by local sloughing. Mustard, hot fomentations, large enemas, and drinks of warm fluids do good service. Previously warmed blankets are a great comfort as well as of benefit.

Ether is our standard anæsthetic, although the A.-C.-E. mixture is often employed; chloroform very seldom. A small amount of the latter is found useful to relax the muscular spasm which often remains in drunkards, even when ether is fully pushed. A few drops will often permanently stop it, when the ether can be continued. A.-C.-E. has given rise to no alarming symptoms in at least two hundred administrations from my hands, and I know of no untoward circumstance attending its use here. All general anæsthetics are administered from small, square-folded, very absorbent towels. Cone or apparatus are not used. The "rapid" and rectal methods have long since been abandoned as dangerous. The patent ink-bottle stopper is found convenient to pour ether from the bottle.

During the local anæsthetic action of cocaine, we have performed many minor amputations, circumcisions, and other small operations; but with us, at least, the field of the drug in this direction is becoming quite limited. Most eye operations, however, are performed under its influence.

Divided or torn muscles, tendons, and nerves, if their ends can be seen, are sutured with catgut. If not visible, they are freely cut for, and likewise sutured. Good function is the almost invariable result.

Subcutaneous operations, such as tenotomy, aspiration, and even exploration by needle, are performed with as much antiseptic precaution as if a large wound were made, for death has been known to occur from wound complication following each of

these procedures. Therefore, knowing that there is *some* risk, no matter how trivial, it becomes one's duty to avoid it.

In the amputation of fingers and toes below the metacarpo or tarso-phalangeal joints, rubber umbrella rings are used as tourniquets. The flaps are closely stitched, and, if there be any bleeding when the ring is taken off, a deep lateral stitch back of the line incision on one or both sides will always effectually control it. We never put a ligature upon these arteries, finding the above method amply secure, and, so far as our last few hundred such amputations show, unattended with disadvantage.

In exarticulations at the metacarpo or tarso-phalangeal joints, ligatures are applied if possible; but if the bleeding is obstinate, a deep stitch into the palm or sole can be made to control the appropriate vessel. These operations receive the usual house dressing and a palmar splint. They are, as a rule, not dressed from ten days to two weeks, when solid and complete union is expected and usually found.

Catgut sutures are passed through finger and toenails, without fear, if by so doing crushed or cut parts can better be brought into shape, and also in operations for ingrowing nails.

We have saved many fingers, ears, and noses, which came in hanging by mere shreds of tissue by promptly sewing them in place, and treating antiseptically. No opportunity has occurred by which to test the saving of those parts when entirely severed from the body.

Abrasions and brush burns are carefully cleansed and treated with either boracic acid ointment, or the standard house dressing.

The latter consists of: protective; Lister gauze, wrung out of 1:1000 HgCl₂ solution, and its skin surface thickly dusted with iodoform; a pad of dry 1:1000 cotton, and moist 1:1000 gauze bandages over all. We have found that Lister's boracic acid ointment makes up better if wax be substituted for the paraffine of his formula. Our receipt is: boracic acid and yellow wax, each 1 part, cosmoline 4 parts.

Ligatures are never applied except in the largest operative and accidental wounds.

Sutures run under or through the bleeding points effectually control them. No trouble is experienced in tying catgut sutures or ligatures, when the first tie of the knot is made as for a surgeon's knot. Catgut is invariably used for these purposes. In treating some hundreds of scalp wounds, no matter how extensive, I have never applied a ligature, always finding that carefully placed sutures will stop all hemorrhage.

Stitches are placed very close together in all wounds; this presupposes proper drainage if it is necessary. If so, it is secured by a few strands of finest catgut, placed along the bottom, and brought out at one end of the wound.

Small or superficial wounds as rarely require drainage as ligature. Scalp wounds are not drained

unless extensive. If the edges are much contused or torn, they are excised. Quite small wounds of the scalp or elsewhere, and sometimes larger ones, are, after antiseptic closure, covered in with a minute pad of bichloride cotton, and plastered down with either pure collodion or combinations of it with such drugs as evaporated tincture of benzoine (evap. fl. $\frac{3}{4}$ ij tr. benz. comp. to fl. 3 ij, and make to fl. $\frac{3}{4}$ ij with collodion), iodoform (10 per cent.), salicylic acid, etc. Wounds too small for stitches are similarly treated. Large wounds, of course, receive the house dressing and possibly drainage.

Very tense hematmata are freely incised, the clot or fluid blood curetted out, any bleeding vessel stitched or tied if it can easily be found, and the whole sewn up with or without a drain, according to size, and dressed with some compression.

Slowly resolving hematmata, or those in which suppuration is present or incipient, are manipulated in exactly the same way.

Punctured wounds are laid open, curetted, washed with 1:1000 HgCl₂ solution, and closed as above. If the bottom cannot be reached, a small drain should be carried as deep as possible, and the best hoped for.

Gunshot wounds are treated in much the same manner. If it can readily be done, the ball is extracted through the wound or by counter-opening. The entrance and exit (if there be one) wounds are excised, the tract of the ball curetted, thoroughly, a small gut drain carried all the way through, and the external wounds treated as simple incised ones.

Compound fractures, if the skin wound is small, are freely cut into, washed with 1:1000, curetted accurately stitched, and, if extensive, drained with catgut.

Some of them are dressed more frequently than the actual wounds require in order that good position of the bones may be secured.

Wounds of joints are treated in precisely the same manner, save that, unless they are dirty, we are satisfied with thorough washing with 1:1000, and omit the curette. Cure in one dressing is here attempted and good function expected.

Poisoned wounds are also treated somewhat similarly, but the utmost care is taken to get to the bottom of the wound itself and into all ramifications and sinuses with the curette and strong antiseptic solution (1:500). If the wound is very bad and cellulitis present or threatening, continuous antiseptic irrigation (1:2000) is started as soon as the cleaning out is effected.

Large glass percolating jars, with glass stop-cocks, or other regulating device, suspended over the part, give best satisfaction. Whilst thus employing irrigation any wounds should be well covered with protective, the whole part covered with lint, and the solution allowed to drip upon it.

Suppurating wounds might be classed as poison wounds, for the treatment is almost the same, namely: curette and antiseptic solution (1:1000

or 1 : 500), excision of wound edges and, usually, accurate approximation, with or without a drain, as circumstances indicate.

Punctured, gunshot, suppuration, poison, and compound bone and joint wounds, when thus dealt with, as a rule heal by primary intention and under but one dressing.

Felons, buboes, simple and suppurating cysts, inflamed bursæ, and large, small, and diffused eradicable abscesses are treated by exactly the same method and usually with like result.

Ineradicable abscesses, such as the psoas, are treated by this method as it can be made to go, and are then drained into an antiseptic dressing by means of a rubber drainage tube; through which they are from time to time washed out with antiseptic solution. Care must be taken in so doing, however, whether it be these or other cavities, not to let any of the solution remain in. It should be displaced by a weaker solution or distilled water.

In cutting into abscesses, old hematomata, etc., a better result is secured by opening them from one side through sound tissue.

Simple cellulitis is treated like the complicated form as described above.

Burns, if small in area, or confined to an extremity, are treated by the regular antiseptic dressing. All easily removed, dead skin, etc., is taken away; the parts washed with 1 : 1000 bichloride solution or iodoform sprinkled on (in part for its analgesic effect), then protective in narrow strips, and the dressing and cotton. Anæsthesia may be required to do this properly.

Extensive burns are covered in with boracic acid or oxide of zinc ointment, the surface of which is sprinkled with iodoform and, if there is much pain, smeared thinly with oleate of morphia. This dressing is covered in with cotton batting and a bandage or binder.

Just here it may be well to speak of sloughs, granulations, and skin-grafting, but what is said applies to all wounds as well as burns.

Under the antiseptic dressing sloughs are very slowly thrown off. It is our custom to excise them as soon as they become demarked. If properly done this causes scarcely any pain or bleeding and places the wound days, and, perhaps, weeks nearer closure. By picking up the edge of the slough with a pair of forceps, and cutting with knife or scissors through its readily apparent junction with healthy tissue, it is easily accomplished. By this same process I have successfully, and without pain or hemorrhage, amputated even fingers and toes which we had attempted to save.

All forms of exuberant granulations are usually shaved off with a sharp knife. The moist bichloride dressing, applied without the intervention of protective, is found to produce ample stimulation, if such is indicated.

If skin-grafting becomes necessary, a patch of thin skin is selected and made aseptic, as is also the granulating surface, if it is not so already. Almost microscopic pieces of the cleansed skin are

then cut out by means of a purified needle and a pair of scissors, and planted among the granulations. Narrow strips of protective are applied, and upon this is placed either the "house-dressing," or simply a pad of dry 1 : 1000 cotton. Any bichloride solution remaining about the parts should be washed off with distilled water before the grafts are cut and set, and strong solutions should not be used while the islets of epithelium are forming.

Leg ulcers, when small, are stimulated, if necessary by scoring with a sharp knife, nitrate of silver stick, etc.; dusted with iodoform; accurately fitted with a piece of protective, and a gauze dressing put on with a firm roller. If they are large, and have callous edges, these latter are trimmed off, the sore curetted, perhaps straps applied after the iodoform and protective, and then the same dressing. By this method they can always be kept perfectly sweet and clean; the discharge is but slight, and the pain still less. If the ulcers are very irritable, and will not bear the gauze dressing, boracic acid ointment is substituted for it.

Those painful, non-ulcerative conditions of the legs so often met with behave excellently under one or the other of the above dressings.

In such regions where it is impossible to apply or retain a regular dressing, great pains are taken in the cleansing before and after an operation, and iodoform in conjunction with frequent corrosive sublimate irrigations is freely used afterwards. Especially are these applications valuable about the genito-urinary organs and rectum. In females, after most operations thereabouts, the vagina is washed with 1 : 1000, and then filled with iodoform. Beyond an occasional irrigation of the external parts, nothing more need be done until the stitches—if they have not been of catgut—are ready for removal.

Chancroids heal wonderfully if kept buried in iodoform; sometimes they are previously brushed over with acid nitrate of mercury, etc. No treatment is directed to hard chancres unless complicated.

Body parasites are destroyed with 1 : 500 corrosive sublimate solution. No unpleasant effects have been known to follow even the freest use of the solution in this way. If the ear has been invaded, it is syringed with that solution, and then filled with oleate of morphia and a little wad of cotton put on top.—*Medical News.*

CATARRHAL PHTHISIS.

By THOS. J. MAYS, M.D.

There are three forms of pulmonary phthisis: the catarrhal, the tubercular and the fibrous. Of all these forms the catarrhal is by far the most frequent, and plays a most prominent rôle in the history of the other two. It is important, both from a prognostic and therapeutic point of view, to distinguish between these several varieties; hence, while catarrhal phthisis will principally and mainly engage our attention to-day, that much

of the tubercular and fibrous forms will enter into the discussion as is consistent with a complete understanding of the subject. A great deal of loose and indefinite material has been thrown around the subject of phthisis, which has very much interfered with a true conception of its relations, and, in order to avoid a similar difficulty, and to make an intelligent discrimination between the different varieties and their true etiology, we will, in the first place, devote a few thoughts to the elementary structure of the pulmonary organs. The parts of the respiratory organs which are principally affected in pulmonary phthisis are the alveoli or air cells. The walls of the air cells are composed of fibrous connective tissue, which is completely ramified by capillary blood vessels and lymphatics. On their external surface, or the surface which is in contact with the atmosphere, they are lined with a flat or pavement epithelium, and these are the elementary bodies which are principally involved in catarrhal phthisis. Between these epithelial cells there are stomata, or true orifices, which communicate freely with the lymphatic vessels in the alveolar wall, and it is through these openings that carbon particles and other foreign materials in a fine state of subdivision gain access into the lymphatic circulation, and produce the well-known discoloration of the lungs. The lymphatic vessels are distributed, in their course, around the blood vessels and the bronchi; those which wind around the blood vessels are called the peri-vascular, and those which wind around the bronchi are called the peri-bronchial lymphatics. These are the structures which play such a pronounced part in the production of true tuberculosis, and their importance must not be lost sight of. We have, then, presented for consideration, in this connection, the alveolar walls, covered on their outside with epithelium and ramified internally with blood vessels and lymphatics.

Now, catarrhal phthisis is generally an extension of chronic bronchitis into the alveoli, or is the product of acute catarrhal pneumonia. In either case it implies a catarrhal affection of the alveolar epithelium. The blood vessels become engorged, and the epithelial cells multiply and accumulate and clog up the alveoli with their products. The filling up of the alveoli with these catarrhal aggregates produces small bodies which partake of the shape of these cavities. In this way one alveolus fills up after another, until a whole group or cluster of them is involved, giving rise to roundish nodular bodies which are so frequently mistaken for true tubercles. They are not tubercles in the technical meaning of that term, but are merely *accumulated inflammatory or catarrhal products*. This train of pathological changes is due to a disturbance of the relationship existing between the production and expulsion of epithelial products, *i. e.*, the expectoration did not keep pace with the proliferation. If such a relationship were preserved, or could by any means be restored, it is evident that the disease would be at once called

into a state of abeyance. But the continued accumulation of excretory products exerts a pressure on the capillaries in the walls of the alveoli and in the interlobular septa, and in due course of time these infiltrated spots, thus cut off from their source of nourishment, will give rise to changes of a different pathological character, which will be discussed after we have disposed of another question which has an important bearing on our subject.

It has already been stated that catarrhal phthisis is evolved from catarrhal pneumonia, and the question arises here, why only from catarrhal, and not from croupous, pneumonia? As well as the other question, when does catarrhal pneumonia become catarrhal phthisis? In regard to the first question, it can be answered that croupous pneumonia seldom, if ever, passes into catarrhal phthisis, because its etiology and pathology rest on an entirely different basis from that of catarrhal pneumonia, as the following comparison of their chief characteristics will show: In croupous pneumonia the blood pressure is suddenly elevated, the blood vessels become intensely turgid and injected, the heart-beats become vigorous and powerful, fibrin leucocytes and red corpuscles exude from the more porous arterial walls into the alveolar cavities, where the whole assumes a semi-solid infiltration, undergoes a retrograde, fatty metamorphosis, becomes resolved and expunged in a short time, after which the disease comes to an abrupt termination. Catarrhal pneumonia pursues a different course. The disease comes on gradually and does not pass through the well-defined stages which mark the course of the croupous form; the tone of the circulation is reduced, and the whole constitution is in rather an adynamic condition; there is, as a rule, no exudation of fibrin, but instead the alveoli becomes filled with cast-off epithelium, leucocytes and some red corpuscles. These products have a strong tendency to undergo cheesy degeneration, and owing to its undecided progress and course it is very apt to become chronic, *i. e.*, to leave a vestige of disturbance here and there throughout the lungs, which, upon the slightest provocation, is fanned into freshness again. Again, it is important to observe the respective portions of the respiratory organs which are attacked by the two diseases. It is but rare that pure croupous pneumonia attacks an apex, unless it involves a whole lung, but it always shows a preference for the basic portions of the lungs, and involves either a whole or two lobes. On the other hand, catarrhal pneumonia shows a disposition to attack small portions of lung, such as one or two lobuli, and if it shows a decided preference for any locality, it is the middle or upper portions of the lung. This is particularly true of its chronic form.

Whether the difference in the nature of the pathological products in the two diseases—the one being a fibrinous exudation, and the other a catarrhal secretion—has any influence in determin-

ing the particular seat of attack, or not, it is very probable that one reason why the lower lobes throw off the catarrhal products more easily than the apices is that the moisture contained in the catarrhal secretion of the apices gravitates to the base, leaving that in the latter dry and unyielding, while that of the base possesses greater fluidity, and is therefore more readily expectorated. Then, again, it is evident, if other things are equal, that catarrhal deposits are thrown off more easily in localities where the lungs are active than where they are quiet, and it is well known that the apices have less respiratory motion than any other portion of the lungs, hence this weakness also contributes to the danger of the retention of infiltrated products, which become nuclei for still further accumulation. It thus appears why it is that croupous pneumonia, so seldom, if ever, terminates in phthisis, and, why, even in catarrhal pneumonia, the infiltrated products at the base are thrown out, and those in the apices are left behind, which makes the latter so vulnerable to phthisis in this disease.

I think, if what has been said is true, it follows that a catarrhal infiltration in an apex, in the vast majority of cases, if not in all of them, comes to stay, *i. e.*, it is a chronic affection, and tends towards disintegration and excavation from the very start. In other words, such a case is not one that belongs to the domain of catarrhal pneumonia, but is one of catarrhal phthisis from the very beginning. If, therefore, an infiltration, or even a prolonged expiration, occur in an apex without involving any other portion of the lung, we are undoubtedly justified in calling it a case of incipient pulmonary consumption, of the catarrhal form.

In taking up the thread of our argument, when digressing to discuss the comparative pathology of croupous and catarrhal pneumonia and their relations to catarrhal phthisis, it must be remembered that we had not traced the pathological process of catarrhal phthisis any further than the stage of accumulation, and pressure of catarrhal elements upon the alveolar walls and interlobular septa. The infiltration very seldom involves a whole lung, or a whole lobe of a lung, but is generally scattered throughout an apex, and affects isolated groups of alveoli, or of lobuli. Thus far the process is principally limited to the alveolar walls, their epithelium and their blood vessels, and the interlobular septa, but the continued accumulation of the catarrhal secretions will, through their pressure on the surrounding circulation, cut off their blood supply, and hence become circumscribed foreign masses, which undergo a slow process of cheesy degeneration, soften from the centre to the periphery, are expelled, and leave behind cavities, large or small, in proportion to the amount of tissue destruction.

It is during this stage of excavation that the true tubercle is generated. Probably, in virtue of a specific element derived from the decaying catarrhal masses, a new poison originates here,

which is chiefly absorbed by the lymphatics in the surroundings of the affected parts. These vessels carry the poison along their ascending courses as they arise in the alveolar wall, and twine around the bronchioles and blood vessels; and it is here, in the beginnings and in the channels of the lymphatics, that this poison incites new nodular growths, which are genuine tubercles, but differ from those yellow aggregates, or nodules, which are found in catarrhal phthisis, both in genesis and structure. They are evolved from interstitial connective or lymphatic tissue, and are growths, or a hyperplasia, and not mere accretions, like the so-called yellow tubercles. These nodular growths first manifest their appearance in the alveolar wall, the surface of which they force into the cavity. By and by the continuity of the alveolar wall breaks, and the newly-formed interstitial connective tissue cells are forced into the cavity of the air cells. A number of nodules following such a course will very soon overcrowd and over-distend the vesicles, and, very naturally, those infiltrated areas will be cut off from their blood supply and disintegrate, in the same way as those of catarrhal infiltration. This is the stage in which the tubercular growth is so liable to be mistaken for the catarrhal infiltration, and *vice versa*. Both forms occupy the alveolar cavity, but on minute examination it will be found that one is composed of interstitial connective tissue growth, and the other chiefly of catarrhal products. Frequently, however, the two processes are so intermixed that their respective products are indistinguishable. Thus, then, after catarrhal infiltration has once brought on cavitation, and reinforces itself by tubercular infiltration and cavitation, it is evident that the destruction of lung tissue is very materially accelerated; and this explains why it is that a patient enjoys almost comparative immunity from the disease as long as the continuity of the lung is not broken, and why the disease advances more rapidly after this period has been reached.

This, then, is the tubercular form of pulmonary consumption, and differs from the catarrhal form, inasmuch as it usually is secondary to it. It is decidedly an affection of the lymphatic or connective tissue, while the catarrhal form is an affection principally of the epithelium of the alveoli.

Fibrous or interstitial phthisis, as it is sometimes called, differs, both in course and in duration, from the catarrhal and tubercular forms. It is essentially a hyperplasia of the fibrous connective tissue, or, in other words, an affection of the framework of the lung and the pleura. It is slow in its progress, and is usually preceded by bronchitis and bronchiectasy. It is thus often induced or preceded by a catarrhal inflammation of the bronchial tubes. Tubercles also form an integral element in fibrous phthisis, but the slowness of the disintegrating process allows time sufficient for its products to become better organized, and, hence, there is less danger of caseation and destruction of tissue.

Catarrhal phthisis is, therefore, not only the most frequent, but also, in many instances, the harbinger or the pioneer of the other two forms; hence we will, in conclusion, offer a few remarks in regard to its therapeutics. When we reflect that all portions of the lung are liable to catarrhal infiltration, and that resolution occurs more readily anywhere else than in the apex, the inference is at once forced upon us, that some close relationship must exist between infiltration and the apex. I think these products remain because there is less circulatory, lymphatic and respiratory activity in the apex than in any other portion of the lungs, and hence there is less facility for carrying them off. This assumption is further confirmed when coupled with the fact that in mitral disease, where there is an almost constant hyperæmia or fullness of blood in the pulmonary circulation in consequence, catarrhal infiltration—or tuberculization, for that matter—is almost entirely unknown. The continual hyperæmia does not allow an opportunity for the accumulation of these products, since they are constantly washed away by the serous transudation present in these cases. It is evident, therefore, that any agent which has the power of transfusing a greater degree of activity into the circulatory, lymphatic and respiratory function of the lungs will, just in that measure, clear up the infiltrated alveoli and restore the apex. Fulfilling these theoretical indications, I have, for a number of years, applied moist heat over the apex in these cases, and have certainly derived some very favorable results, as my former communications on this subject show. I believe that by stimulating the affected spot and its surroundings with a hot poultice, the blood and lymph flow become accelerated, and an increased interchange and absorption of the fluids and solids of the part follow.

—*Polyclinic.*

MINOR SURGERY AT THE CHAMBERS STREET BRANCH OF THE NEW YORK HOSPITAL.

By G. B. PHELPS, M.D.,

Surgeon To Out-Patients, Chambers Street Hospital.

The Out-Patient Department of the Chambers Street Hospital is for the treatment of surgical cases only. There is a class for pathological cases and fractures (except those of the bones of the hand and foot), under the care of Dr. Powers, in which about eighteen patients are treated daily; one for traumatic cases and the fractures above excepted, where about one hundred and thirty-six patients are treated daily under my supervision; and a class for venereal diseases, under Dr. Fuller's care, where about sixty-five patients are treated on Monday and Friday evenings.

As a rule, the patients pay very little regard to cleanliness, and many are almost tramps. The dispensary assistants are, besides two of the house-staff, either third-year students or recent graduates.

The work in the traumatic class is done almost wholly by gaslight. These conditions are mentioned to show under what circumstances the work is carried on.

Fresh cases have the surface about the wounded part washed with soap and water, and, if covered with oil, cleansed with ether. The wound is then thoroughly irrigated with a 1:1000 solution of bichloride of mercury. If there is hair about the part, this is removed with a clipping machine or a razor.

Incised and lacerated wounds of the scalp, after checking the hemorrhage by clamping and tying any bleeding points, or by pressure, are sutured with catgut, without drainage, unless the wound is very extensive. Contused wounds are similarly treated, unless there is much contusion of the edges, when the wound is packed loosely with wet bichloride gauze. Over the wound a compress of plain absorbent gauze, freshly wrung out of a 1:1000 bichloride solution, is placed, with a small amount of boracic acid ointment (twelve and a half per cent. boracic acid in cosmoline) spread on it just over the wound. Over this a thin layer of absorbent cotton is placed and bandaged on. Such cases report in twenty-four hours, but the dressing is not changed unless it is soiled or there is pain. These wounds usually do perfectly well, but a dressing can be rarely left on more than four days, because it becomes soiled, many patients reporting with bandages almost black. For three months there has not been a case of cellulitis of the scalp that has arisen while the patient was under treatment, though primary union is not always obtained, in some few cases there being slight suppuration. These wounds are then opened and allowed to granulate.

In wounds of the fingers, an effort is made to save as much of the member as possible, and surprising successes are often obtained. Wounds that admit of suture are drained with a few horsehairs or catgut strands. A dressing similar to that for scalp wounds is applied. The advantage of such a dressing over a dry dressing of either iodoform, iodoform gauze or bichloride gauze, is that it feels more comfortable, and that when it is removed it comes off without sticking or causing pain, while a dry dressing is usually so firmly held by the slight bloody discharge, that it requires some time and much trouble to remove it painlessly. In this dressing we depend upon the bichloride for antiseptis, the boric ointment being used to prevent sticking. Iodoform we do not use in this dressing, knowing that we have a reliable antiseptic in the bichloride of mercury, the only indication for the addition of iodoform powder being to relieve pain. But an aseptic wound causes little pain, hence the iodoform, which is expensive, is omitted.

From this dressing I have seen only one case of eczema, but the majority of our cases are wounds of the hand, in which the skin is tough. In wounds in which there is much laceration, we think it very important, either to make counter-openings for

drainage, if there is a large pocket, or simply to pack with moist gauze where this is small.

Divided tendons and nerves are sutured with fine catgut, and many excellent results follow. Ether is given in these cases, as a rule, for before operating it is often impossible to know how extensive a wound must be made. A heavy dressing is applied, and a splint to keep the parts at rest in extension or flexion, as the case requires.

Cellulitis has developed while the patient was under treatment very rarely, in only two cases in three months; but a small number apply for treatment with cellulitis already well marked. The history in these cases almost always is, "I didn't think it would amount to anything, and went to the druggist, who put this bit of plaster on." Too much cannot be said against applying strips of plaster to fresh wounds. If a bandage is not needed, we put a small compress of gauze over the wound, and hold this in place by means of plaster. If a cellulitis is just starting, and there is very little tension, or no particular point of pain, the original wound is opened, thoroughly washed with 1:1000 bichloride solution, and the parts then wrapped in a large compress wrung out in 1:40 carbolic acid, a piece of rubber tissue placed over this, and a bandage applied, leaving one end open so that the patient can, from time to time, pour on a small amount of the carbolic solution. The carbolic solution is preferred to bichloride, as the latter, applied as a wet compress over a large surface, is very apt to cause an eczema. From the carbolic acid solution I have seen three cases in three months in which large blebs formed, and the epidermis was loosened from a large part of the hand, but this accident is very rare. For women and children 1:60 carbolic solution is used. If the cellulitis has gone further, and there is evidence of pus, or there is much tension, incisions are freely made. Where possible, counter-openings are made, and a small rubber drain inserted. The treatment of cellulitis is considered of the greatest importance, and free and early incisions are demanded in the interest of the patients. We never wait for distinct fluctuation, or "pointing."

In the treatment of this trouble cocaine is of the greatest value, and, when properly used, always gives admirable results—that is, injected *into* the skin (*not* beneath it) at the point of incision, or beneath the skin on the proximal side of the point to be incised. For example, to open an abscess on the palmar surface of the distal phalanx, inject about ten or fifteen minims *deeply* into the middle of the palmar surface of the proximal phalanx; then wait two or three minutes before making the incision. These points in the use of cocaine were demonstrated to me by Dr. R. J. Hall.

In one case, five minutes after the injection of fifteen minims of cocaine about the elbow, the patient vomited freely, and three or four others have complained of nausea or faintness after the use of from fifteen to twenty minims. As many patients faint when they first come to the dispensary, either

from looking at their own wounds or those of others, it is not easy to know how much effect cocaine had in producing the faintness in these cases.

When wounds are granulating, balsam of Peru on strips of gauze is found to be very valuable in stimulating granulations. Nitrate of silver is sometimes, with advantage, alternated with this. If there is an offensive odor from a sloughing wound balsam will speedily destroy it.

Particular attention is required to prevent granulations from becoming excessive, and when they tend to grow above the cicatricial edge they are removed with a pair of curved scissors, which can be done without causing pain. This is much better than attempting to keep them down with caustics. The bleeding is stopped by pressure, and the ulcer then strapped, if the skin about it is healthy, or small pieces of rubber tissue are placed across the wound, and held in position by a dry compress and bandage. For this purpose rubber tissue is nearly as good as green protective, and much cheaper.

Burns are treated first with iodoform-ointment (twelve and a half per cent. of iodoform), if not too extensive (as on hand and wrist), later with an ointment of starch 25 parts, oxide of zinc 25 parts, salicylic acid 3 parts, and cosmoline 50 parts. Some cases do better under powdered subnitrate of bismuth.

Sprains are treated at first with iodoform-ointment, spread on gauze, which is covered with common cotton, firmly and smoothly applied. If at the wrist, a dorsal splint is used. Iodoform certainly relieves pain in these cases very much. The part is kept at rest about four days, and then, if pain persists, or there is much effusion, Paquelin's cautery is lightly applied, and the part bandaged after rubbing on a little vaseline. The cautery is used at a dull red heat, and applied so as produce a uniform redness over the joint, and should leave almost no scar. Iodine ointment (U. S. P.) is used sometimes, as a counter-irritant, and to hasten absorption. The tincture is rarely used, as it soon produces a hard, thick layer, so that the next application produces no effects on the parts beneath. We find the actual cautery, as used above, produces excellent results in strains of the back, old contusions, and, especially, in teno-synovitis crepitans of the extensors of the hand when combined with rest.

Of ulcers of the leg many are syphilitic, and in these constitutional treatment is the chief measure in producing a cure. In chronic, indolent, and varicose ulcers every effort is made to promptly place the ulcer in a healthy condition. If the granulations are pale, flabby, and above the surface, they are cut down with scissors and the ulcer strapped for a few days with yellow adhesive plaster. If the base of the ulcer is below the level of the surface of the skin, presenting the "mucous appearance," it is scraped with a sharp spoon and dressed with balsam of Peru. If the skin about the

ulcer is eczematous, an ointment of iodoform or boracic acid is applied. These last cases do better when given moderate doses of iron and quinine. At present the following treatment is being reintroduced, as a few years ago it was used here with success. The surface is washed with 1:40 carbolic acid solution and covered with narrow strips of rubber tissue which have been dipped in the same solution. Then a large compress wrung out in a saturated solution of boracic acid is applied; over this, rubber tissue and crinoline bandage are added, and the dressing is left on from four to eight days.

Patients with varicose veins are advised to wear Martin's bandage.

Chancroids with an active erosive tendency are treated by cauterization with nitric acid and 95 per cent. carbolic acid. The latter causes only slight pain and anesthetizes the part, but is often too superficial in its action, and nitric acid is then applied to the sore, which is dried and dusted over with iodoform powder, and a piece of absorbent cotton packed into the ulcer. The patient is instructed to wash the parts about the sore daily with water, and then dry them thoroughly before applying iodoform and compress. Chancroids which are simply indolent are touched with cupric sulphate and then dressed, as before mentioned, with iodoform.

Chancres are not cauterized or excised. An "expectant treatment" is followed until the eruption appears, when mercury is given by inunction, the ointment or oleate being used. The stomach is thus undisturbed, and tonics, usually indicated, are readily taken and well borne. When the inunctions are commenced the patient is made to use a tooth-brush and castile soap to keep the teeth clean. In addition a gargle of chlorate of potash is given. Unless the precaution of cleanliness is observed the gums soon become tender and bleed readily, but with it, these symptoms rarely develop.

The majority of patients being forced to keep at hard work no attempt is usually made to abort a bubo. In some few cases when rest can be obtained pressure is applied, and in a majority of cases suppuration is avoided. As soon as there is redness and much pain in the bubo, an incision is made without waiting for signs of fluid to appear. The incision is made after the injection into the skin of cocaine, and very little pain is felt. The incision is a free one, parallel to Poupart's ligament, and opens the whole of the tissues involved. The finger is then introduced into the incision, and the spongy mass thoroughly broken down and enucleated, a steel curette being frequently needed when the mass is firm. To open freely the pockets on either side of this cut several others are made at angles to the primary incision. The bubo is then packed with iodoform-gauze and heals by granulation.—*Philadelphia Medical News.*

THE TREATMENT OF COLDS.

(J. H. Whelan, M. D., R. N., in *The Practitioner*.) Of all disagreeable constitutional tenden-

cies, the tendency to "catch colds" is the most disagreeable to the individual, and besides its unpleasantness there is always the danger that a catarrh may outstep its usual limits and develop into some grave inflammation.

Is the nature of common catarrhs generally understood? To a certain extent I think it is, but not fully. Let me enunciate broad characteristics of colds. Catarrhs are excited *de novo* by exposure to wet, colds and draughts. This is a truism. Most frequently they develop in delicate and highly neurotic individuals, in fact in the classes which furnish martyrs to common neuralgia. I believe, moreover, that when once a catarrh is properly established the affected person's breath is infectious, in the acute stage of the disease at least. What then is the nature of the affections? (1) Is it a specific poison comparable to that of the infectious fevers? (2) Does the affection start as an idiopathic inflammation and develop a specific poison which is given off by the breath? (3) Is it of nervous reflex origin purely?

Burger has discovered micrococci in catarrhal secretions, and they are possibly factors in the affection. Let us suppose that these micrococci or these spores are distributed nearly universally in the atmosphere, and are carried in fomites. Let us suppose them in their usual state to be unable to attack the healthy buccal, nasal, or mucous membranes. Let us presume that there is a condition in which the trophic nerves of those membranes become depressed and lose their tonic action by the action of poor blood, or from the periodical neurasthenia of hereditary neurotics. Here the result of section of the trigeminus on the eye is recalled to one's mind, and the fact pointed out by Snellen that ophthalmia did not ensue if the eye was carefully covered with cotton-wool, thereby to a great extent excluding micro-organisms, before the nerve section was made. Let us suppose that by feeling in such pastures the progeny of the attacking micrococci become so virulent as to be able to attack successfully the healthy membranes. We know by Pasteur's experiments the intensive effects of culture on some microorganisms. On these not unreasonable suppositions then all the peculiarities of catarrhs are explainable.

Influenza epidemics would be explained by supposing that within large tracts of country all catarrhal micrococci became suddenly virulent, owing to some climatic or telluric fostering cause, or to some law of heredity or evolution of the organisms themselves. This would account for the extensive and sudden outbreaks which, on first view, seem so surprising.

The usual "codding" treatment of colds, except in the very old, very young, or very delicate, is a mistake. A person suffering from a catarrh should certainly be warmly clothed and avoid draughts; but by shutting himself up in a warm room, by taking warm air baths and lowering medicines, he only promotes the development of the exciting cause of the affection.

"Feed a cold, starve a fever." There is a deal of wisdom in the first part of this advice. A person with a catarrh should take an abundance of light, nutritious food, and some light wine, but avoid spirits, and above all tobacco.

Now as to medicines. All depressants should be avoided. For some time I was in the habit of taking a mixture recommended by Dr. Jules Styrap, composed of minute doses of morphine, antimonial wine, and potassium citrate. This beyond doubt always subdued the acute inflammatory stage, but I have no hesitation in saying I was depressed by its action, and rendered liable to relapses and renewals. Personally I have found the large dose of an opiate in the early stages, as extolled by Sir Thomas Watson and Dr. George Johnson, very unpleasant and of but little use.

Trying to avert an attack by a large dose of potassium iodide failed in my hands. The bromides were useless through all stages. Antiseptic inhalations and spraying afforded temporary relief from the distressing symptoms, but failed to cure.

Belladonna, quinine, arsenic I have found useful when given separately—not so much in large as in small doses. When combined I believe them to be nearly specific—prophylactically and therapeutically, if I may so speak.

The formula I invariably use is as follows:—

℞. Quininæ sulphatis,.....gr. xviii ;
Liquoris arsenicalis,.....mxiij ;
Liquoris atropinæ,.....mj ;
Extracti gentianæ,.....gr. xx.
Pulveris gummi acaciæ, q. s. ut fiant pilulæ
xii.

Sig. One every three, four, or six hours, according to circumstances. If these pills be commenced in the early stage of a common cold, *i. e.*, when the affection is as yet confined to the nose and pharynx, the effect on will be nipped in the bud. At starting one pill should be taken every three or four hours, and later on every six. If a catarrhal subject has a box of these pills always at hand, he has, I believe a weapon wherewith to meet and defeat his enemy. The longest I have seen a cold last whilst the patient was fairly taking these pills was three days. How the remedy acts I do not know, except it be as a powerful nervine and general tonic, bracing the patient's tissues up to resist the attacks of the exciting cause of the affection.

TREATMENT OF ERYSIPELAS,

ROBERT POLLOK, M. B.

The treatment of erysipelas is most varied, nearly every practitioner who sees much of this affection having formulated a certain line of action for himself. This arises to some extent. I think, from the fact that simple erysipelas has a tendency to subside spontaneously in about 5 or 6 days, and often the treatment adopted obtains the credit while nature does the work. I am of opinion that

the treatment must depend upon the type of the disease. In all the cases I have seen, the treatment demanded was a stimulating one. I refer to simple general erysipelas. But in localized erysipelas affecting the throat, ear, and pharynx, aconite in small doses, frequently repeated as recommended by Ringer, has been productive of the happiest effects when administered at the beginning of the attack. I will take as a typical example of simple cutaneous erysipelas that form which we so commonly see, commencing over the root of the nose, and spreading over the face and forehead. In such cases, I immediately begin the administration of 20 to 30 minims of tinct. ferri mur. (diluted of course with water) every two hours; and as a protective and palliative, I use: ℞. Gutta Percha, 3 ii : Chlorof. Meth., 3 ii solve; Zine. Olcati, 3 ii; Iodoformi, 3 ss. M. Sig.—To be painted over the part affected. The advantage of this preparation over the powdered starch, zinc, or flour, is its comeliness. Of course, previously to applying this preparation. I have the parts carefully washed with tepid water, and often when there is much pain I use the decoction of poppy heads as a fomentation. This treatment usually effects an amelioration of the symptoms, and the disease subsides. But in some cases the course of the disease does not stop here, it runs riot all over the head and neck, and the medicinal treatment then pursued is ammonia, bark, iron and quinine, with perhaps a grain of solid opium to obtain rest. I am happy to state that I have never lost a case of erysipelas, although the duration and severity of the complaint have varied much. The *rational* of the local application above mentioned must be purely protective and palliative by excluding the irritating effects of the cold air, and not by excluding specific germs. The latest researches prove that the schizomycetes or streptococcus erysipelatosus is anaerobic, or flourishes where air is excluded, living in and upon the tissues affected. I may note the many methods of treatment recommended, such as compression, or ligatures applied above the seat of the affection, advocated by Velpeau; the application of a solution of nitrate of silver in the form of a ring around the redness (Higginbotham's method); the application of tincture of iodine, white paint, solutions of tannin, silicate of soda, used by Alvarenga of Lisbon; the subcutaneous injection of carbolic acid or salicylic acid directly into the part, and the internal administration of quinine in large doses, or salicylate of ammonium, suggested by Dr. Barclay of St. George's Hospital. These may all be good, but so satisfactory have been the results by the iron and the antiseptic anodyne externally applied, that I have had no reason to depart from that treatment. I earnestly look after the hygienic surroundings of the patient, and give eggs, milk, beef tea, and other stimulating and light diet. The disease may, however, pass into a stage when surgical treatment must be adopted. If simple bullæ or vesicles form, I relieve the tension

by evacuating them, and dress the surface with tartrate of potash and iron lotion in the strength of 10 grains to the ounce of water. When sloughing and suppuration take place I make free incisions; the pus and sloughs thus obtain a free exit; the separation of the mortified parts may be accelerated by the scissors. I then apply an antiseptic solution by means of the syringe or douche, dry the parts thoroughly, and dress with sublimated wood wool. The best antiseptic lotion is corrosive sublimate one grain in five ounces of water, or nearly in the proportion of 1 to 2,000. Koch's solution, as it is now called, is the same as the old "M'Kenzie's" collyrium. An important point which should not be overlooked in the treatment of erysipelas as well as in so many other affections, is the effectual clearance of the *primæ via* by a good purge, administered at the commencement of the attack. If erysipelas assume a typhoid form, alcoholic stimulants are strongly indicated. Infantile erysipelas I treat on the general lines laid down, although the tincture of iron is not so admissible owing to its griping tendency; acetate of iron is less irritating. When erysipelas commences in the throat, inhalation, or the steam atomizer, with some antiseptic, should be used. I watch carefully for cedema of glottidis. If it does occur, tracheotomy is the only resource.—*Glasgow Medical Journal.*

ON THE TREATMENT OF PLEURISY WITH EFFUSION BY HAY'S METHOD.

Abstract of a Clinical Lecture, delivered at the Hospital of the University of Pennsylvania,

BY WILLIAM OSLER, M.D.,

Professor of Clinical Medicine in the University of Pennsylvania.

GENTLEMEN: You have had in the ward classes during the past month, several interesting cases of pleurisy, which have familiarized you with the clinical history and physical signs of the disease, and I shall, to-day, first direct your attention to certain points in the plan of treatment which we have followed. Let me briefly summarize the history of the cases.

CASE I.—A. B., aged twenty-three; admitted on the 21st. He had been a healthy man. Three days before admission he was caught in a rain-storm and remained all day in his wet clothes. The following morning he had pain in the head, neck, and right side; in the latter situation the pain was of a sharp, stabbing character, and increased by drawing a deep breath. He had fever, lost appetite, had also a sore throat and diarrhoea. When admitted the face was flushed, the respirations 34 in the minute, pulse 100, and temperature 101°. He lay on the left side. Examination showed deficient expansion on the right side, with jerky, inspiratory movements. There was a distinct friction fremitus to be felt and heard below

the right nipple, and there was slight dulness in lower axillary and infrascapular regions. On the fourth day the temperature was normal, and there were signs of effusion to the level of the fifth rib.

CASE II.—J. M., aged twenty-four, a well-nourished young man, was admitted on November 12. In 1883 he was poisoned with arsenic, and is now ataxic, the result, apparently, of a peripheral neuritis. His present trouble began three weeks before admission. Four or five days after exposure to cold and wet, he felt a pain in the right side and had a cough, with fever and occasional sweats. He did not go to bed, but gradually got short of breath, and for this symptom he sought relief at the hospital. Shortly after his admission I called your attention to the characteristic physical signs in this case. The effusion was in the left side and reached as high as the lower border of the second rib. The heart was displaced and there was an impulse near the right nipple. You saw him in clinic two weeks ago to-day.

CASE III.—William G., aged twenty-three, admitted to the Philadelphia Hospital October 12th with shortness of breath. He had been ailing for seven weeks. Had never had a chill or pain in the side. Had been feverish at times, had sweated and had been gradually getting short of breath. Though not able to work, he kept about and had not been in bed. There was left pleural effusion with absolute dullness reaching to the clavicle and displacement of the heart to the right; with the hypodermic needle the fluid was determined to be serous. He had been drinking before admission, and for nearly ten days there was mild delirium tremens.

The effusion in these cases varied from the slight amount in Case I., which would probably have disappeared in time without medication, to the large exudation in Case III. filling the side of the chest. In treating pleuritic effusion we have to choose between medicinal and operative measures, and these cases illustrate the rules which I have already laid down for your guidance. In the first two cases the symptoms were not urgent, the condition of the patients good and the duration of the disease not prolonged. In Case II. we were in doubt whether or not to aspirate, as the line of dulness reached to the second rib; but I am glad we decided to try first the effect of medicines.

Now the usual routine in treating pleural effusion is to give purgatives, diuretics, and diaphoretics, but the plan to which I wish specially to call your attention this morning is the use of concentrated solution of saline cathartics introduced by Professor Mathew Hay, of Aberdeen. We have employed his method extensively in dropsies from various causes and with very satisfactory results.

Dr. Hay found, when investigating the physiological action of saline cathartics, that if the salt was given in a very concentrated form, when the intestines of the animal contained very little fluid, it produced a very rapid concentration of the blood owing to the abstraction of water to form

the intestinal secretion excited by the salt. If the saline was not given in concentrated form or was administered at a time when the bowel contained much liquid, the action upon the blood was very slight. The effect is very rapidly produced; in one instance, in a man after giving six drachms of sulphate of soda, the number of blood corpuscles per cubic millimetre rose from 5,000,000 to nearly 7,000,000, owing to the great loss of liquid in the free purgation. A few hours later this increase was no longer apparent, as the blood had rapidly abstracted the tissue fluids and so replaced the amount lost. You know that the pinched, shrivelled aspect of a person who has had a severe choleraic attack is due in large part to the absorption of the tissue lymph to supply the rapid waste caused by the liquid stools.

It is on this principle that the use of cathartics in dropsical effusions is based, and Hay's method is new only in the application. In the administration of the salt, the solution must be concentrated, and taken at a time when there is very little fluid in the intestines. Our usual plan is to order the patient to take nothing after the evening meal, and then, an hour or so before breakfast, the salt is given dissolved in as little water as possible. The sulphate of magnesia is preferable to the sulphate of soda, as it is more soluble. Four or six drachms in an ounce of water is the usual dose, but two ounces, or even more, may be given. The patient must not drink after it. This usually produces from four to eight watery stools, without pain or discomfort of any sort. It very rarely disagrees, though you remember in the case of Mrs. C., the patient with extensive anasarca from Bright's disease, we had to give up this plan on account of the vomiting it induced. Dr. Hay calls attention also to another point which we have repeatedly verified, namely, that the salt acts also as a diuretic. He found experimentally that the blood underwent a second concentration, not so marked, but lasting for the greater part of the day, and this he rightly attributed to the diuretic action of the absorbed salt.

Case II. is a striking instance of the value of this plan of treatment. Two weeks ago I demonstrated to you that the fluid reached as high as the third rib, and was rapidly subsiding. He has been given every second morning, since his admission on the 12th, half an ounce of sulphate of magnesia in an ounce of water, and, as you can see by the chart, this has produced from three to nine watery stools. His diet has been restricted somewhat in liquids, but he has had no other medicine. We find now, on examination, good expansion on the left side; the heart has returned to its normal situation; on palpation a distinct friction can be felt in the axillary region; tactile fremitus is present; on percussion the note is clear in the antero-lateral regions, and posteriorly it is resonant almost to the base; the breath sounds are heard well over the whole side, with the exception of the extreme base, where they are still

feeble. The patient was discharged the day before yesterday to go on duty as night watchman on the surgical side. We may regard this as an exceptionally good result. It is the third instance in which I have seen a large effusion disappear rapidly treated by Hay's method.

Exudations of less extent will sometimes disappear in a few days. Case I. we saw early in the acute stage, and, to relieve the distress, he was wet-cupped with marked benefit. This is a measure which I do not often employ, as I find that morphia subcutaneously fulfils the indication; but here the pain was rapidly relieved and the breathing became much quieter. The effusion in this case reached only to the fifth rib. He had four or five doses of the concentrated saline solution, and was freely purged. To-day there is scarcely a trace of fluid, and you notice that, on percussion, the lung is clear almost to the extreme base.

In Case III. saline cathartics were also employed, but other and more prompt measures were indicated. The left chest was full, the percussion note on the clavical was absolutely flat, and the fluid had been accumulating for at least seven weeks. Under such circumstances the withdrawal of some of the fluid was imperative. It is a good rule to aspirate when the fluid reaches the second or third rib. The removal of from twenty to thirty ounces will often suffice, and you can trust to medicines to remove the balance. When you find the fluid at the level of the clavicle, aspirate at once, as connected with this condition there are certain dangers which we cannot ignore. Such patients are liable to sudden and alarming attacks of dyspnoea. This occurred in Case III., and my house physician, Dr. Donohue, wisely withdrew at once between two and three pints of fluid. There are instances, also, of sudden and fatal collapse under these circumstances. Such a case occurred last spring in the Philadelphia Hospital, when I was on duty for my colleague, Dr. Tyson. A woman was admitted, stated to be suffering with pneumonia. I saw her for a few minutes at the conclusion of my visit, and made a rather hasty examination, and determined the existence of dulness on the left side. She died suddenly and unexpectedly the next day, and, to our mortification, we found the left chest full of fluid, the lung greatly compressed, and the heart pushed far over. We could not determine the cause of the sudden collapse, but I feel certain it might have been averted by timely aspiration.

In Case III. we would not trust to the saline cathartic alone as the patient's general condition was not good. He was aspirated twice subsequently, and had an occasional morning purge. At present he is convalescent, has gained in weight and strength, and although there is still dulness at the left base, I believe it is due chiefly to thickened pleura and not to fluid.

My experience with this method is sufficient to justify a strong recommendation of its merits. In the general dropsies—renal or cardiac—the results

have been equally good. There have been failures, to one of which I have already referred, and I have on several occasions heard complaints of nausea following the strong and bitter solution. In another case last summer, the patient, a young man, thought the daily purgation and a rather dry diet terrible hardships, and he escaped from the hospital.

The essence of the method lies in getting the strong salt into the intestine at a time when the fluid contents are scanty. The concentrated bitter solution excites a copious secretion from the intestinal glands, which distends the intestine and induces rapid peristalsis. Saline, as well as other purgatives, have long been employed in the treatment of dropsies, but this plan of Hay's is so simple, produces so little irritation, and at the same time acts powerfully, and as you have seen, effectually, that with us it has superseded other methods in cases in which we wish the action of a powerful and prompt cathartic.—*Medical News*.

THE DIURETIC ACTION OF MERCURIAL PREPARATIONS.

The diuretic action of calomel, known to the older physicians, has been, as the readers of the GAZETTE are familiar, again brought to the attention of practitioners, and we have published testimony from a number of different observers which indicates that under certain circumstances calomel is one of the most active diuretics that we possess.

That this diuretic action is not peculiar to calomel, as has been claimed by a number of writers, but is also, though perhaps to a less degree, possessed by other mercurial preparations, has been brought into prominence by Dr. Rosenheim in a paper read before a recent meeting of the Verein für Innere Medicin of Berlin (*Therapeutische Monatshefte*, April, 1887).

The author employed corrosive sublimate, yellow iodide of mercury, and the amidato bichloride in amounts of from $1\frac{1}{2}$ to 2 grains given daily. These preparations of mercury also proved themselves active diuretics in these large doses, but they produced more irritation in the intestinal canal than calomel, and also fell behind calomel in the degree of diuresis. On the other hand, the stomatitis produced by these mercurial preparations was but slight. Diuresis only follows when large doses of some mercurial preparation are rapidly absorbed, seemingly indicating that the production of diuresis is due to the acute mercurialization of the organism. The correctness of this view is rendered more probable by the large amounts of mercury which are excreted through the urine.

Dr. Rosenheim's experiments with calomel still further strengthen its position as a diuretic. He employed it in sixteen cases of heart-disease complicated by dropsies, in several of which kidney complications were also present. In nine of these cases a prompt diuresis and disappearance of the oedema followed the use of calomel. In four its

action was but moderately successful, and in three it entirely failed. It is worthy of notice that in all these cases before calomel was administered digitalis had been tried and proved inefficacious. Since it has been found that calomel has no direct action either on the heart or kidneys, kidney-disease offers no contraindication to the use of calomel for the purpose of producing diuresis. In fact, Dr. Rosenheim has employed calomel for this purpose in purely nephritic dropsy. It is true that the results, however, were unfavorable. In the greater number of patients to whom calomel was administered a more or less severe stomatitis was produced, and in nearly all cases diarrhoea.

In the discussion which followed the reading of Dr. Rosenheim's paper, Dr. Leyden reported that he had treated three cases of cirrhosis of the liver with calomel. In one failure had resulted, in one marked but temporary relief, and in one a permanent amelioration.

In the treatment of dropsy from heart disease, he regarded calomel as a valuable contribution to our therapeutic measures.

Füßinger, on the other hand, claimed that the diuresis produced by calomel, although perhaps occurring in a high degree, was invariably ephemeral, and he regarded its mode of production to dependent upon a direct action on the glandular epithelium of the kidney, since calomel never acted as a diuretic in oedema dependent upon previous parenchymatous nephritis.

Dr. E. Biró, of Budapest, has also confirmed the general experience of others as to the marked diuresis which follows use of calomel, and although in his practice stomatitis, colic, and diarrhoea were frequently produced, he regards these complications of but little moment in view of the powerful action of the remedy. He has found that the degree of diuresis depends upon the intensity of the oedema, and he relates one case of mitral insufficiency in which the amount of urine was increased on the fifth day from eight hundred to six thousand eight hundred cubic centimetres. For the stomatitis, which is at the worst merely transient, he recommends a mouth-wash of potassium chlorate, and small doses of opium powder for the diarrhoea and colic.

Terray (*Pest med. chir. Press.*, 1886) and Weinstein (*Wien. med. Blatt.*, 1887, No. 7, p. 206), whilst affirming the diuretic effects of calomel, as reported in the *Medical Chronicle*, May, 1887, draw attention to the evils which may follow its administration. Terray states stomatitis occurred in all his cases, and its intensity seemed directly proportional to the diuresis.

Weinstein records a marked increase in the excretion of urine in four cases of pleural effusion, two cases of cirrhosis of the liver, and one case of Bright's disease. But he found great evils arise from the administration of calomel as a diuretic, profuse diarrhoea, stomatitis, and salivation sometimes occurring after even small doses. The diuretic influence of the drug, he says, is not of long

duration and he recommends it chiefly in ailments which have run their acute course, leaving oedema behind them, and in those where the mercurial itself is likely to exercise a beneficial effect, *e. g.*, in pleural exudations.

NUTRIENT ENEMATA

EWALD, of Berlin, writes to the *Therapeutische Monatshefte* for April, 1887, his usual methods of preparing such enemata as follows:

In hospital practice an enema may be made most simply by beating up three or five eggs with four or five ounces of a fifteen or twenty per cent. solution of grape-sugar, and this mixture may be carefully injected, as most convenient. If needed, starch solution, or a mucilage-water, may be added, or, if there exists much irritation, a few drops of tincture of opium. An injection of about eight ounces of tepid water, or solution of common salt, should precede the nutrient enema, and the latter should not be given until the bowel is thoroughly emptied; otherwise the nutrient matter may be at once rejected. Enemata should not be larger than eight or nine ounces, and it is better when this amount is given in two or three doses during the day.

When more elaborate methods can be followed, two or three eggs should be beaten with a spoonful of cold water. As much powdered starch as the point of an ordinary kitchen-knife will take should then be added, and a small cup, or half a large glass, of twenty per cent. solution of grape-sugar, which may be purchased at any chemist's. The whole should be gently heated, and a wineglassful of common red wine added.

The mixture should then be gently stirred or beaten, and the caution should be observed not to heat it so hot as to coagulate the egg albumen. When ready for injection the quantity of fluid should not exceed a half-pint.

If peptones can be easily procured, a teaspoonful of the peptone may be added to the solution of sugar; while advantageous, it is not absolutely needed, for eggs prepared without peptones are easily absorbed.

The enema should be given with a syringe whose terminal tube is long and flexible, or an irrigator, whose rectal is large and flexible, may be used. After taking enemata the patient should be kept quietly upon the back, or on the side, for some time.

HYDROCYANATE OF IRON IN THE TREATMENT OF EPILEPSY AND NEURALGIAS.

BY G. W. BAYLOR, M. D.

Like many other preparations of the ferruginous type, hydrocyanate of iron appears capable to subserve quite a number of indications, though its predominant value is exhibited in the treatment of

eilepsy. My attention was first called to this remedy in the treatment of epilepsy by Prof. D. S. McGugin, of the Iowa Medical College, in the supplement of the *Journal of Materia Medica*, in the year 1872, in which he speaks of it as the remedy *par excellence*, and cites a number of cases that were permanently cured by this drug alone. Having at that time under my care and treatment a young man aged eighteen years, who had been a sufferer from that terrible disease, "epilepsy," since early childhood, and which had resisted the action of all remedies then known to the medical profession, I determined upon a trial of the hydrocyanate of iron, as it was a case which seemed to demand such a combination or such a remedy—as his general system was in a bad condition, which is usually the case after a protracted course of treatment with the bromides.

I wrote to Messrs. Tilden & Co., New York, who kindly sent me a sample of the iron. I then put my patient upon the following:

℞ Iron hydrocyanate

Pul. valerian a gr. cxx

M.—Ft.—Pil. No. 120. S.—One pill three times daily after meals.

Each pill contains a grain of iron and one grain of valerian. The dose was gradually and cautiously increased, so that at the end of three months my patient was taking eight grains of the drug daily. At the expiration of this time (three months from date of first treatment) I had the pleasure to see my patient greatly improved; his appetite and digestion which had been bad, now good; general health improved; he was no longer irritable and gloomy, but was sprightly and hopeful, and looked forward with confidence to an ultimate and permanent cure. The paroxysms, which had been frequent and severe, had entirely ceased. Treatment continued. Patient died about six months afterward, or nine months from date of treatment, from an intercurrent disease. I believe if patient had lived or been put upon the hydrocyanate of iron treatment sooner, that a permanent cure would have been effective. There is one thing sure in this case, that it controlled the paroxysms better and more effectually than any remedy that had been administered before. It possesses this advantage over the bromides, that it not only controls the paroxysms better but it does not impair the general health of patient like the latter. Since that time I have administered this remedy to some eight or ten cases with decided success—about half of this number being cured, others being old and chronic cases—were more or less benefited. Now I do not claim that hydrocyanate of iron is a specific for epilepsy, but I do claim, that, if judiciously administered and continued for a sufficient length of time, "say one year," that it will cure more cases than any remedy or remedies known to the medical profession. It is an excellent remedy in the treatment of the various forms of neuralgias. It can be combined with sulph. of quinine, sulph.

of morphia, or the extract of henbane, as each individual case may require. It exerts a powerful influence over the functions of the uterus, and when combined with the extract of belladonna I know of no remedy better to relieve congestive dysmenorrhœa or irritation of the ovaries when of a neuralgic character.—*S. W. Med. Gazette.*

MILLTOWN, IND.

RINGWORM.

(Dr. Henry Brown, Manchester.—*British Medical Journal.*) The subjoined formula for the local treatment of ringworm is suggested by Dr. Payne's lecture on the treatment of that epithytic disease. In sending it I am simply handing down a form received from others, and used in the out-patient practice of the Manchester infirmary, many years before the publication of the British Pharmacopeia. When the acidum sulphurosum was made official, it was used for a time instead, but we had to revert to the old form made up of materials fully recognized and explained in Squire's Companion. The form is: ℞. Sodæ hyposulphitis dr. j; solve in aquæ fl. oz. viij; et adde acidi hydrochlorici fl. dr. j; for outward use only. The use of this lotion, as water-dressing covered with oiled silk, and accompanied by daily washing in soft soap and water, has proved as perfectly satisfactory, as Dr. Payne says the principle of the treatment of ringworm is perfectly simple. It fulfills Dr. Payne's conditions, and kills fungus. I presume the sulphurous acid gas acts beyond the limits of the aqueous solution.

NEW REMEDY FOR CYSTITIS.

Having seen nothing concerning the new remedy for cystitis and hyperæsthesia of the genito-urinary tract, Pichi (Fabiana imbricata), and being very much pleased with it, I will report, briefly, its action in a few cases. The first case was one of cancer of the uterus, where the whole anterior part of the vagina was indurated and contracted—the patient having to urinate every half hour all night, and the pain would start the tears every time. I gave the following prescription: ℞ extract pichi ʒvj, liquor potass., ʒss. elixir aromat. q. s. ʒiij; a teaspoonful once every three hours. In less than two days—in fact, the first night—she had to get up but once. She took the medicine irregularly, as required, until she returned home, which was three weeks after, and it controlled the painful urination completely. Neither did she have the backache, which had been a constant accompaniment heretofore.

Case 2.—A lady, with frequent and painful urination; having to get up four times at night. She had been overtreated by one of the two numerous class who see a cause for every ill that woman is heir to through a vaginal speculum. In this case the medicine acted equally kind and promptly, remedying the backache as well.

Case 3.—Man with a *mild* gonorrhœa. Stopped all scalding of the urine at once.

Case 4.—An old lady, aged eighty-three, who said it appeared very strange none of the doctors could do her any good. She had to get up several times at night to urinate, but she had an idea that there were no doctors except old men. I promised the medicine should relieve her in forty-eight hours. Because a neighbor had got along so well with the fever, she became reckless enough to trust a young doctor's word, and was all right in twenty-four hours, and has continued so since.

I have tried local applications in two cases of vaginitis, and they were greatly benefited, and ceased using it. Am now anxiously watching for an old man, with prostatitis and cystitis, to come along. I owe so much to eclecticism, in the short time I have been investigating it, that I wish to inform the brethren of that school, concerning a new weapon of "specific" tendencies, and increased consumption will lessen the cost. I believe P., D & Co. alone handle it now.

P. S.—Have considerably lessened the first-named dose; now give ten drops once in three hours.—*California Med. Journal.*

TREATMENT OF PROLAPSUS ANI IN INFANTS.

Dr. Betz, of Heilbronn, relates in the *Memorabilia*, 1886, Heft 4, the case of an infant five months old which had been afflicted with prolapsus ani for five weeks. Cold water enemata, ice suppositories, dusting with pulverized alum, tannin locally and internally opium, bromide potassium, and even injections of ergotine had been employed without benefit. The little patient was in a deplorable condition, greatly emaciated, covered with large and small boils, and intertrigo; it was incessantly straining and crying. The prolapsed bowel was a livid, conical plug, 5½ cm. in length; it was readily reduced, but pressure being removed it was shot out again by the straining of the child. Profiting by a knowledge of the treatment previously used, he at once determined to resort to nitrate of silver applications, but as the application of stick caustic always acts unequally on the mucous membrane, and may result in ulceration, he made a solution of argent. nitr. 1. o, sulphuric ether 5 o, alcohol 25. o. This solution, though it gives rise to some smarting, can be evenly and equally applied and enters the tissues to a considerable depth. The prolapsus was thoroughly painted with the above solution, and even after a few minutes it became paler, began to shrink, and could be reduced more readily. To act on the upper portion of the mucous membrane a small piece of alum was introduced high up into the rectum. To prevent the bowel from slipping down, and to exert continued pressure on the anus, the nates were firmly pressed together and held in this condition by three broad strips of adhesive plaster, which were applied on either side, running from the anterior surface of a

thigh across the seat to the opposite anterior surface of the abdomen. The next object was to stop the tenesmus and to prevent defecation, which was accomplished by keeping the child slightly under the narcotic influence of opium, and restricting its diet to small quantities of milk and water. The tenesmus stopped at once, and flatus was freely passed in twenty-four hours. The dressing was reapplied after two days. No prolapse occurred. The anus was cleansed with a wad of cotton steeped in carbolized oil, five per cent., and a piece of alum was again inserted. The anus was found drawn into folds and contracted. After three days, a new dressing was necessary. The gut being slightly prolapsed was treated with the stick caustic. Two days later the dressing was permanently removed. Stools came on without tenesmus. In order to insure contraction of the anus, he ordered it touched with alcohol for a few days. The cure was completed in eight days. Betz, though he is inclined to attribute much of the rapid success to the application of nitrate of silver, claims that the combined treatment carried out by him is entitled to the credit for the same, and would in a similar severe case not do without the adhesive dressing, the opium, the restricted diet and the alum suppository, in addition to the nitrate of silver application, while in the milder case nitrate of silver, opium and restricted diet would be sufficient for a cure. No relapse occurred.

ABSORPTION FROM THE MUCOUS MEMBRANE OF THE URINARY BLADDER.

The question as to the occurrence of absorption through the mucous membrane of the urinary bladder has often been considered both at the bedside and in the laboratory, but the results have hitherto been sufficiently discrepant to leave room for more exact work on the subject. The latest contribution towards a solution of the problem bears the mark of exact scientific observation, and seems to us largely to settle the matter. In the current number of the *Journal of Anatomy and Physiology*, there is a paper on "Absorption from the Mucous Membrane of the Urinary Bladder," by Dr. Herbert H. Ashdown, late senior demonstrator of physiology in the University of Edinburgh, in which a critical summary of the work already done is given, and a series of carefully-conducted experiments is reported. The observations were made on rabbits and dogs, and consisted essentially in the analysis of results obtained by the intravesical injection through the urethra of substances possessed of known physiological properties or readily estimated chemical reactions. The author divides his experiments into three groups: (1) Those in which the drugs administered have a sufficiently distinct physiological action of their own to indicate their presence when absorbed into the system. (2) Those in which the renal elimination of the drugs given can be readily demonstrated. (3) Those in which the quantitative

analysis of a solution of known chemical composition can be conducted after it has remained for several hours in the bladder. The results of the triple series are strikingly similar, and appear to justify Dr. Ashdown's conclusions. These are: (1) That absorption of a very large series of chemical substances does take place from the mucous membrane of the urinary bladder when in a perfectly healthy condition. (2) That the urinary constituents themselves—those substances eliminated by the kidney as effete products of the system—are absorbed from the bladder in varying proportions, this applying more especially to the water and urea, but also, though to a less extent, to the inorganic solids. (3) That the degree of distention of the bladder plays a most important part in increasing or diminishing the rapidity of such absorption. (4) That regular rhythmical contractions take place in the muscular wall of the bladder; that these contractions are largely influenced by the degree of distention of the bladder, being most marked with a moderate amount of distention of the viscus, and but feebly marked in slightly distended or in over-distended conditions; and that the character of these contractions is largely affected by the nature of the fluid contained in the bladder.—*The British Medical Journal*, February 12, 1887.

TREATMENT OF NOCTURNAL ENURESIS.

Dr. Alexander Harkin in a paper on this subject says:

I have long since discarded belladonna and bromide potash as insufficient remedies, and have adopted the use of the derivatives, and revulsives, such as dry and wet cupping, or blisters to the nape of the neck, applied as high as possible and as close as circumstances will permit to the neighborhood of the foramen magnum occipitale and the region of the medulla oblongata.

I have had but seldom to apply to the cupping; one full vesication being generally sufficient; a blister three inches in length by two in breadth, either by emplastrum lyttæ, or the linimentum cantharidis of the Pharmacopœia, applied vertically, suffices. It is very seldom that a second application is required; occasionally, especially in females, after some months of respite, there may be a call for the renewal of the remedy; in obstinate cases and in grown up patients, dry or wet cupping may be requisite to complete the cure.—*Provincial Med. Journal*.

VENESECTON IN PUERPERAL ECLAMPSIA.

Of the twenty-five cases which have come under my observation during the past thirty-five years, in all there existed more or less arterial tension, and increased blood pressure, which constituted a factor of importance in the progress and termination of the disease. With a view of averting the evil

consequences of this influence on the circulation of the brain, I am convinced that venesection is a remedy which cannot be dispensed with in the treatment of eclampsia. I can say with truth that all my cases in which it was resorted to early, freely, and judiciously, have recovered with a single exception. In this case, after modern depletion, anaesthetics were used too freely, to the exclusion of other remedies. One of the earliest and most manifest effects of venesection is that of unloading the engorged venous system, the lungs, the right cavities of the heart, and the cerebral circulation. If the combined influence of inordinate action of the heart and excessive engorgement of the venous sinuses of the brain, be permitted to continue, the delicate structures of that organ must suffer irreparable injury from pressure, and profound coma result. In these cases of profound coma with stertorous breathing, frequent and bounding pulse, increased temperature, when the scene is varied by repeated paroxysms of spasms, let us not be misled in our treatment by any false theories in the pursuit of a vacillating policy. There is absolute safety in the lancet judiciously and timely applied under these circumstances. The state of pregnancy, above all other conditions, is the most tolerant of depletion. The enormous quantity of blood often lost during labor without serious results sustains this opinion. The measure must not only be resorted to early to avert impending danger to the cerebral structures, but copiously, to break down permanently arterial pressure. From sixteen to twenty four ounces will probably suffice to cause a decided amelioration of the symptoms. As a usual result, the action of the heart will be slowed, the pulse will become soft. The impulse of the organ will be diminished, temperature will decline, coma will be partially relieved, consciousness will return temporarily, and cyanosis will diminish. But depletion cannot accomplish everything. There may be a return of trouble. But when these desirable objects have been obtained even temporarily, we have a favorable basis for the application of our eliminative, anaesthetic, and sedative remedies.—BEDFORD BROWN, M. D., *Journal of American Medical Association*.

Phosphate of lime is strongly recommended by Dr. Rebery for the night-sweats of phthisis. M. Potain, and after him Dr. Rebery, employ the tricalcic phosphate in doses of four grammes, often necessarily increased to eight and fifteen grammes. The excellent results obtained are attributed by Dr. Rebery to some special action of the medicine upon the perspiratory apparatus. It would seem more likely that the general improvement in the condition of the patient brought about by the phosphate should be the reason for the diminution of the night-sweats, one of the symptoms most indicative of the great debility of persons subject to phthisis.—*Phil. Med. Times*.

PERMANGANATE OF POTASSIUM IN THE TREATMENT OF ECZEMA.

The first case was that of a child, two years of age, who was covered with eczema and impetigo. Various treatments had been tried in vain, and he was ordered a daily bath of permanganate of potassium, of the strength of 15 grains to the bath of water, the child to remain in it till the water turned brown. Since then Dr. Hullman has used the remedy both in adults and children, and mostly with good effect. When the skin is much covered with scales or scabs it should first be well brushed with soap and water. In another case of very chronic eczema of the back of the hand, where the usual remedies had been tried without success, a solution of 10 grains of the salt to an ounce of water was applied freely with a brush. The disease disappeared in about ten days. A third case of eczema of the face in a young lady also yielded to the treatment in fifteen.—*London Medical Record*.

ON NOTCHES IN THE UPPER CENTRAL INCISOR TEETH WHICH RESEMBLE THOSE OF SYPHILIS.

There is a state of notching of the upper incisor teeth which affects the two central ones of the permanent set, and produces a condition very deceptively like that of syphilis. The notches are central, and very conspicuous. A chief point of difference from the syphilitic tooth is that the tooth is usually wide instead of narrow at its free edge. Syphilitic teeth almost always show narrowing, like a screw-driver, as well as notching. Another point of difference is that the teeth, when looked at carefully, are seen to be craggy and very hard, not worn as the syphilitic tooth. In a very marked example of the pseudo-syphilitic notching, the father of the patient told me that the condition was hereditary, and the youth's mother had teeth of the same kind. In this instance, there was no history of fits in infancy or of the use of mercury or teething powders. Nor, indeed, were the conditions those of stomatitis, or mercurial teeth. The defects occurred in pairs of teeth, and did not damage the whole row. Nor were the first permanent molars—the test teeth of the mercurial set—involved. I have in several other examples of craggy teeth been assured that the peculiarity was in the family. I feel certain, therefore, that we must admit inheritance as an occasional explanation of peculiarities in the form of the teeth. I was once shown, in one of the Paris hospitals, a pair of teeth such as those which I have above described, and great surprise was expressed that I could not admit that the were characteristically syphilitic.—*Jonathan Hutchinson, in the British Medical Journal*.

TREATMENT OF NIGHT-SWEETS WITH PHOSPHATE OF LIME.

Doctor Rebery has added his observations to those made some time ago by Prof. Potain and Guyot, and comes to the conclusion that the phosphate of lime is the most efficacious remedy against the night-sweats of tuberculous patients, not only because it allows of an almost indefinite continuance of administration without bad results, but because in the largest number of cases it has given the most favorable results. Prof. Potain finds that when doses of from four to six grams remain without effect, increased doses up to 15 grams attain the desired results. Sometimes also the absorption of the medicament does not take place and hence its inactivity. One must always administer it in a soluble form, either as acid phosphate or lacto-phosphate of lime or even adding to its administration it in form of powder, some acid mixture.—*Weekly Medical Review*

A CASE OF EXTRAORDINARY FECUNDITY.

On Sunday last a woman, aged about 35 years, was delivered at the Toulouse *Maternité* of three children at full term (two boys and a girl), all three, being perfectly formed and full of life.

The same woman, within four years, has had two other twin pregnancies, with the above, she has given birth to seven children in three confinements and within an interval of four years.

The seven children are alive.—Translated for the *Record* from *Le Journal de Geneve*—SEUSSE.

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CHRONIC LARYNGITIS AND ITS SEQUELÆ.

The *N.Y. Medical Record* of August 20th says : That Dr. Hunter Mackenzie publishes a lecture on chronic laryngitis and its sequelæ. Simple chronic laryngitis and thickening of the laryngeal structures

may occur as a consequence of acute laryngitis, or from repeated attacks of the subacute variety ; occasionally its mode of development is protracted and insidious. It may be partial—that is, only one-half of the larynx may be thickened permanently—it may be general, affecting more or less all the intrinsic structures. The question of degree or locality of the inflammation bears an important relation to prognosis. Chronic laryngitis may be primary or consecutive. Primary chronic laryngitis indicates that the laryngeal affection has not been preceded by any local or general affection ; the term consecutive may be applied to that variety which precedes or supervenes during or after the course of the zymotic diseases, malignant disease, or pulmonary phthisis, or which is the result of extension from the nares or pharynx. In simple chronic laryngitis there is very seldom any true ulceration or loss of substance, unless there is evidence of struma, tuberculosis, or syphilis. The character of the voice almost entirely depends upon the vocal cords. Complete aphonia (whispering voice) is, in the absence of nervous or mental causes, indicative of severe laryngeal changes, and shows destruction of the vocal cords, or of the cords and ventricular bands ; it is a point to be remembered that a fairly effective voice can be produced by the ventricular bands, should the vocal cords be destroyed. Chronic laryngitis, in addition to the symptoms produced on the voice, respiration, cough, etc., may sometimes be the cause of gastric disorders ; when pharyngitis is present, and the saliva is in excess, or when frequent movements of swallowing are made, owing to the sense of tickling at the back of the throat, an excessive amount of air is swallowed, giving rise to gastric flatulence. The following are some of the sequelæ of chronic laryngitis. In the insidious form, the possibility of tubercular degeneration is always present ; in those cases it is only by the examination of the sputum or laryngeal secretion, and the presence of the bacilli of tubercle being detected, that one can be certain the case is one of tubercular disease. Another sequela of chronic laryngitis is the formation of new-growths ; these may be papillomatous, mucous, fibrous, or cartilaginous, according to their seat of origin. The more chronic a case is, the more likely is the supervention of the most serious of all sequelæ, the tubercular degeneration. In the case of malignant disease of the larynx no definite conclusion should be arrived at without examining microscopi-

cally the sputum or pieces of the growth, as in its early stages, and even in its later stages, malignant disease possesses no distinguishing characters to the naked eye. With regard to the treatment, it must be essentially of a local character to be of any use, by means of inhalations, sprays, powders or pigments. In well-marked cases recourse should be had at once to pigments, and of these nitrate of silver is the best. Commencing with a solution of thirty grains to the ounce, the strength should be gradually increased every ten to fourteen minutes, until one hundred and twenty grains to the ounce or even more are used. These pigments ought to be applied locally by means of a laryngeal brush, under the guidance of the laryngoscope, at first three times and after twice a week, over a period of several months; this energetic treatment is necessary only in well-marked cases of thickened vocal cords, or of the intra-laryngeal mucous membrane. In chronic laryngitis dependent upon chronic nasal catarrh, attention should be directed to the nose; the nasal passages ought to be frequently cleansed by means of a solvent spray (one drachm of bicarbonate of soda to a pint of water), and immediately after an astringent solution ought to be applied, such as sulphate of zinc or acetate of lead, one or two grains to the ounce of water. At the same time the pharynx should be occasionally stimulated by the application of a solution of chloride of zinc, twenty or thirty grains to the ounce. In granular pharyngitis the application of London paste, or of the galvano-cautery, to the prominent follicles is usually necessary. When chronic laryngitis has ended in the formation of distinct growths, they must be removed by intra- or extra-laryngeal surgical measures. Certain of the sequelæ of chronic laryngitis may necessitate the opening of the wind-pipe, and the operation of tracheotomy is to be preferred to thyrotomy, if the same objects can be obtained by it. The rest and freedom from irritation that is obtained after tracheotomy often cure a chronic laryngitis which may have become serious, and in cases of tubercular disease much comfort can often be given to the patient by the early performance of this operation. The author concludes his lecture by urging on all medical men the importance of treating cases of chronic laryngitis with promptness in the early stages, so many cases being neglected at first, when some active measures might be taken, which become useless if deferred.

STOOPING FORWARD.

Under this caption, the *Lancet* says: Every one knows that stooping forward, particularly after rising quickly from bed in the morning, when the stomach is empty and the heart has less than ordinary support from the viscera below the diaphragm, is very apt to occasion a form of faintness with vertigo, not unlike that which occurs in sea-sickness. We do not at the moment speak of the faintness and giddiness from cerebral anæmia, which are directly consequent upon suddenly assuming the erect, after long continuing in the recumbent posture, but of the more alarming sensation of being in the centre of objects which are rapidly passing away, usually from left to right, with loss of power to stand or even sit, and an almost "nightmare" feeling of inability to call for help or do anything to avert catastrophe, while throughout the experience the sufferer retains painfully acute consciousness. This, we say, is familiar as one at least of the effects not uncommonly produced by stooping forward under the special conditions indicated. With many other varieties of the vertigo consequent upon heart weakness or cerebral anæmia, observation or experience has made us all acquainted. We can not, however, help thinking that the consequences of even partial compression of the veins of the neck, offering an obstacle to the return of blood from the head, with its important organs, are not so well recognized. The peculiar form—or, more accurately the several forms—of headache distinctly caused in this way when the head is long bowed forward on the chest, bending the neck on itself, can not fail to occur to every one; nor will the high tension of the eyeball, the turgid and heavy eyelids, the snuffling note, the deafness, with buzzing or throbbing in the ears, the heavy breathing, and the puffed and perhaps flushed or darkened color of the face, resulting from the obstructed venous circulation through the bended neck, be forgotten. There are other and more perilous, though secondary, effects of leaning forward when the heart is weak, or the blood-vessels are not so strong as they ought to be, which should not be overlooked. Beyond question the extra strain thrown upon the apparatus of the circulation by anything that impedes the free passage of blood through almost any part of the venous system is more severe and dangerous than a *physically* equal strain thrown on the arteries. At least, this is so in adult life, and, without going further into details in connec-

tion with the *modus operandi* of the mischief to which we point, it may be permissible to urge that the subject is one to which attention may be usefully directed. The weakly, and those who are not unlikely to have hearts readily overburdened, and blood-vessels easily stretched beyond recovery, or even ruptured, should be warned quite as earnestly against suddenly assuming, or too long retaining, postures which do—however slightly and partially—impede the return of blood through the veins. We know how prolonged sitting may cause the veins of the legs to become distended, and either give way or permit the extravasation of their contents. When this sort of thing happens, even though in comparatively trifling degree, in the case of vessels directly connected with such delicate organs as the eye, the ear, and the brain, it is easy to see that the results may be very serious in their character; and, probably; few postures commonly taken up by persons who lead somewhat sedentary lives are so prone to do mischief unnoticed as that of 'leaning forward' as at work at a table which is not sufficiently high to insure the head being so raised that the veins of the neck may not be in any way compressed or the return of blood from the head embarrassed or delayed. We see reason to believe that if this apparently small matter were more generally understood, there would be fewer head and heart troubles, and we will go so far as to say that some lives now lost would be saved."

AN UNHAPPY MISTAKE.

The *Dublin Medical Press* of August 18th says: An occurrence is reported from Paris as deplorable in its way as any of which we have heard of late. Two children were sent to a hospital suffering from variola, both of whom were called Georges. For obvious reasons the parents were forbidden to see them pending treatment and convalescence. One of the children died soon after admission, and the decease having been duly notified to the parents, the interment was proceeded with. After the lapse of some weeks the parents of the survivor were informed that they could fetch their child, but on a messenger being dispatched for this purpose, the identity was disputed, and after some delay it was discovered that the bed-cards had, by some mishap, been changed, and that the child really belonged to the other parents who had

been informed that their infant was dead. It is needless to dwell upon the gravity of such a mistake, which could not fail to have caused great and needless pain to both parents. It is greatly to the credit of the hospital administration that this is really the first time that such a case has presented itself, for the system lays itself open to such errors. It has been suggested that in view of the disfigurement caused by diseases such as variola, it would be eminently desirable to provide each patient with a bracelet duly numbered by means of which the identity might be assured. An unworthy attempt has been made to throw the discredit of this regrettable accident on the institution of lay nurses, but it is evidently the fault of the system rather than that of individuals.

WASHING OUT THE STOMACH.

This operation, such a novelty a few years ago, is coming quite in vogue in the treatment of certain forms of dyspepsia. The following is the way in which it is carried out: A soft red rubber tube is passed gently down into the stomach, quite to the pylorus; with this tube is connected about a yard of flexible tubing and a glass funnel, which is held on a level with the patient's breast. Tepid water is poured slowly into the funnel until a sensation of fulness is experienced. The funnel is then lowered to the level of the waist, and the fluid allowed to siphon out. The process is repeated until the water returns quite clear.

LITERARY NOTE.

An unusually important work is announced by Cassell & Company. It is "Martin Luther; The Man and His Work," by Peter Bayne, LL. D. Dr. Bayne's sympathy is as great as his literary skill. The men and women of whom he writes are alive. The reader will not only be made acquainted with the facts of Luther's life, but he will follow the events of his career with the vivid realization of a spectator of a powerful drama. One who has seen the early pages, says of this remarkable work that: "it is undoubtedly one of the most comprehensive and accurate personal histories of that great promoter of the general democratic movement of modern times, and also a capital record of the notable chapter in spiritual evolution."