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Original Communications.

*FOUR SUCCESSFUL CASES OF LAPAROTOMY.

By A. LAPHORN SMITH, B. A., M.D., M.R.C.S., Eng., Lecturer on Gynecology. Bishop's College, Montreal.

MR. PRESIDENT AND GENTLEMEN :

My object in reading this paper this evening is to perform a duty which is incumbent upon every surgeon, namely, to faithfully report every serious operation he performs, with the results, no matter how good or bad they may be ; and, secondly, to afford an opportunity for discussing some mooted points which are apt to present themselves any day in the practice of the general practitioner.

CASE I.—Mrs. D., æt. 26. Good family history. Began to menstruate at 13 ; was always regular till marriage, at 20 ; first child at 21 ; second child at 23. Both labors hard ; last instrumental. Began three years ago to complain of severe headaches, which prevented her from reading, and almost constant nausea and dizziness. She consulted several oculists about her eyes, and had glasses made to suit her, without relief ; and she felt very despondent.

She was then sent to me by Dr. Gaherty, on account of her general bad condition,

which he believed to depend on a laceration of the cervix. As this was moderate in degree, I hardly thought that it could be the cause of such marked disturbance of the digestive and nervous systems. In spite of my putting her on a very careful *regime*, and the trial, one after the other, of bromides, quinine and all the analgesics, as well as the application of both faradic and galvanic electricity, she was no better, and as the patient was very despondent and almost desperate about her condition, I decided to operate. I admitted her to a private ward at the Women's Hospital, with the intention of doing Emmet's operation, but when I was examining her I touched the ovary, and a violent attack of retching began. On examining her a couple of days later the same thing occurred, and as she described the pain caused by my touching the left ovary as of the most sickening character, I began to think that the ovary might be the cause of all her intractable symptoms. I had a consultation with Dr. Trenholme, who was attending with me during that term, who was of the opinion that the ovaries were the most at fault, and that if I had only one chance to cure her by operation, I should stake that chance on removing the ovaries and tubes. On placing the matter candidly before her and her physician, she bravely agreed to have

*Read before the Medico-Chirurgical Society of Montreal, 2nd May, 1890.

laparotomy done, but, as she told me afterwards, with the sincere hope that she would die under it. After a few days in the hospital she became so lonely that she insisted upon my attending her at her own house.

Preparations were made for the operation, with every aseptic precaution, the patient having taken a hot bath on several successive nights, and the instruments, silk and silk worm gut, all having been boiled in plain water. On the morning of the 16th January, assisted by Drs. Trenholme, Reddy, Spendlove and Gaherty, I removed the tubes and ovaries through a two inch incision, and without any difficulty. There was so little oozing that I did not deem it necessary to either irrigate or to insert a drainage tube, but in future I intend always to use the irrigator instead of sponging, which latter is apt to hurt the intestines. Shoemaker's thread was tried for ligatures, but, although very strong before being wet, it seemed to lose its strength afterwards, and broke, so that I had to fall back on silk, which held well. The incision was closed with four silk worm gut sutures, which I took care to pass through the peritoneum, fascia and skin only, and not including the recti muscles. The wound was dressed with dry boracic acid, and healed by first intention all through, and more than three months after the operation there was not the slightest sign of hernia. Nothing whatever passed her lips for the first twenty-four hours except hot water, and as little as possible of that. No morphia was used at any time after the operation. The bowels were moved on the third day with a saturated saline solution, and the vomiting was controlled by means of one-grain doses of calomel every hour, after everything else had failed.

Now, if I were to close this case by saying that the patient made an uninterrupted recovery, it would be telling the truth, but not the whole truth. The vomiting after

the operation was most distressing and continued for several days, preventing her from obtaining any sleep. Very hot water failed to relieve it during the first day, and milk and lime water, soda water, cocaine, and a mixture of pepsin, bismuth, hydrocyanic acid, and spirits of chloroform, all failed in turn the second day. It was not till I tried the calomel on the third day that it was controlled. Is there any way in which this difficulty can be prevented? If so, it would be well to know it; the vomiting is not only so distressing but also adds greatly to the pain of the incision. I have noticed several times that when the patient was carefully prepared by semi-starvation for at least three days before hand, there was absolutely no vomiting whatever. There is another advantage in having the intestines collapsed before the operation, and that is the saving of them from exposure and manipulation to which they are very liable, if distended with food or even with gas. One might think that because the bowels had been well moved previous to the operation, that the whole intestine would therefore be empty, but it is well known that a patient may have a very copious evacuation and yet have a large residue in the upper bowel.

Tympanitis or wind was another troublesome complication, which is met with more or less in every case, and which is probably due to paresis of the muscular fibres of the intestines. For this I tried assafoetida in pill form without much benefit, as also enemas of turpentine. What seemed to give most relief in this case was a tablet of soda mint every hour, and the application to the abdomen over the dressing of towels wrung out of hot water, hotter than the hand could stand. I also found that the patient experienced considerable relief from lying on her right side with her head low, so that the gas could float up into the sigmoid flexure and thus escape into the rectum. Another hint worth having is that Rochelle salt, as a saline purge, has the ad-

vantage over Epsom salt, in that the latter, after operating, leaves the intestine full of wind, which the Rochelle does not. I was indebted for these two last points to Dr. Jos. Price.

But the worst suffering of all is the dreadful pain. This is a thing which distinguished operators never even mention, and yet it is a thing which is rarely absent, as I have learned on inquiry from the nurses (which I hope I may be forgiven for doing) who told me that the laparotomy cases did suffer terribly for the first few days. It seems very cruel to allow them to suffer so and yet opiates and death are almost synonymous terms in abdominal surgery. In this case bromide of soda and antipyrine each gave some relief.

After going through all the anxieties and sufferings of the operation, the general idea among many is that the patient forever after enjoys robust health. In fact, we sometimes see the record of a case closed in the following words:—"Left the hospital in two weeks, feeling quite well." In my case I could not say this, for she was on my hands for three months afterwards, although if I had closed the report of her case at the end of three weeks I could have said:—"Patient up and walking about her room to-day, feeling better than she has done for years." But a week after that she was taken with very severe pain in the right iliac region and extending down to the thigh, accompanied by a temperature of 103, although during the first three weeks after the operation the temperature had never gone above a hundred. What it was due to I was unable to ascertain, as nothing whatever could be found in the pelvis to explain it. At the time of writing the patient is feeling a little better than she did before the operation, and is slowly gaining strength, being able to walk up town.

I omitted to mention that she menstruated once since the operation, commencing three days afterwards.

Dr. H. C. Coe, of New York, in a very candid paper in the *Record* for April 19, 1890, reports eight cases in which the patient was no better a year after the operation than she was before, and says: "I present the above facts without comment, and could easily double and treble the number of cases. If, with my limited experience, I have observed so considerable a proportion in which laparotomy is not followed by permanent benefit, at least so far as regards the relief of pain, those operators who number their cases by hundreds could, if they would, add much to our knowledge in this direction. Unfortunately, there is a singular reticence on the part of surgeons with regard to the ultimate results of their operations—provided that these are less successful than they expected."

"So far as I am concerned," he says, "whenever this subject is introduced I shall never cease to insist upon the truth, which I have repeatedly demonstrated to my own satisfaction in the examining room, at the operating table, and in the dead house, that recovery from laparotomy is not synonymous with cure." I have laid some stress on this phase of the question, because I think the *couleur de rose* reports of some of the great operators are apt to mislead very young and ambitious surgeons into having recourse to laparotomy without fully realizing the gravity of the operation and the uncertainty of its bringing relief.

This brings me to another phase of the question. Is any and every practitioner morally justified in performing laparotomy? This question was suggested to me by an incident which occurred while I was visiting Dr. Goodel, of Philadelphia. A lady and gentleman came out of his consulting room, and Dr. Goodel saw them out, but the gentleman had only gone a few steps when he returned to ask Dr. Goodel something which he had forgotten. On entering his sanctum again Dr. Goodel told me what had occurred. The lady had arrived that morning from a considerable distance by train to

go with her physician to consult Dr. Goodel about a very large ovarian tumor, which had been tapped several times, and which consequently was very adherent to the abdominal parietes. After confirming the diagnosis, Dr. Goodel recommended immediate removal. Her family physician then said that he always made a point of allowing his patients to choose the operator, and in this case the patient had chosen him, her family doctor, to perform it. Dr. Goodel wished him success, but what he came back for was to ask Dr. Goodel if they used the clamp now. As this was his first case, no wonder that Dr. Goodel was indignant. In a recent paper by Dr. Matthew D. Mann, of Buffalo, he gives his record, which alone is an answer to my question. In his first fifty cases he lost eleven, in his second fifty only five, and in his third fifty he only lost one. This is the experience of nearly all operators, and such being the case, I maintain that a man who in all probability would never have occasion to perform abdominal sections more than two or three times in his life is not justified in doing it at all. It cost eleven lives in Dr. Mann's first fifty, and five in his second fifty, in order to save forty-nine out of the third fifty.

I hope I will not be misunderstood; I do not wish to prevent anyone from becoming a laparotomist. I would only prevent those who have no intention of becoming laparotomists from doing laparotomy. This consideration has prevented me from doing at least a dozen operations, which consequently passed into other hands, because I had not decided to devote myself specially to this work.

To resume the report of my cases. My second was Mrs. M., æt. 28. First began to menstruate at 15, always regular till marriage at 20. No children. Contracted syphilis soon after marriage. One of the results of this was ulceration and stricture of the rectum. For this she was treated with constitutional remedies, and

on several occasions the stricture was dilated under an anæsthetic by Dr. Perrigo, who kindly sent her into the Western Hospital under my care Jan. 15. After one of these dilatations he told me that she imprudently exposed herself and caught cold, accompanied with pelvic peritonitis, which confined her to bed for several weeks. On examination I found a stricture which would not admit the tip of the finger, but besides that there was a swelling in the left broad ligament, which was painful on pressure, and there were daily evacuations of fetid pus from the rectum, and high temperature every night. She was unable to eat or sleep. She was unable to do her work, the slightest exertion causing her so much suffering that she was obliged to go to bed. I came to the conclusion that there was a pelvic abscess communicating with the rectum. Several interesting questions come up in such cases. Was the stricture of the rectum the cause of the abscess? or was the abscess the cause of the stricture? What is the best thing to do? Shall we try to find the opening into the rectum and enlarge it and drain and wash out with iodine and water? Is it any use washing out the rectum with solutions of iodised phenol? Shall we dilate the stricture first and attend to the pelvic abscess afterwards? Or shall we leave the stricture alone for the present and attend to the abscess? Then, again, how shall we treat the abscess? By drainage into the rectum? By drainage into the vagina? Or by drainage through the abdomen? These are questions I have been asked by former students now in practice, and my answer invariably is: Attack the abscess from the abdomen, because by that means we are best able to get at it. It is impossible to keep an abscess in communication with the bowels aseptic, so the sooner that connection is severed the better. It would seem at first as though the vagina offered good facilities for drainage, because it could possibly be

kept aseptic, and it can claim the advantages of gravity, but the objection to this means of drainage, is that we must go it blind when making the opening; although it must be said that this is the method employed by Martin of Berlin, who always drains through the vagina even after laparotomies, leaving a drainage tube in the abscess. If possible, of course, the abscess should be removed *en masse*, as is possible in abscess of the ovary. But when this is impossible, the abscess cavity should be emptied, its walls sewed to the abdominal incision and a drainage tube left in. I was strongly advised by my more experienced confreres, whom I consulted, to adopt this latter course.

The operation was undertaken on the 1st February, assisted by Drs. Trenholme, Reddy, Spendlove, Foley and Mr. (now Dr.) Vidal, but after opening the abdomen a large smooth round swelling could be felt on the left and continuous with the uterus at every point, so I was unable to find any spot at which I could insinuate my finger to commence enucleation. I invited Dr. Trenholme to try if he could do so, but without avail. Just as he was making a final attempt the abscess broke and the peritoneal cavity was deluged with the most horribly fetid pus. It was utterly impossible to sew the walls of the cavity to the abdominal incision, as it was so low in the pelvis, so I poured two gallons of water, which had been boiled and cooled to 110 Fahr., down into the very bottom of the cavity, and scrubbed the pyogenic membrane with my fingers until the water came out clean. While doing so my fingers came in contact with what felt very much like a varicocele in the male, and which I think was the pampiniform plexus of veins. I placed a perforated glass drainage tube in the very bottom of the abscess cavity and left it projecting from the lower angle of the incision, which was closed with five silk worm gut sutures, passed through the peritoneum, aponeurosis and skin. The tube was sucked out every

half hour at first, and afterwards at longer intervals. The vomiting in this case was unusually severe, either on account of the previous dyspeptic condition of the patient, or because she was hurriedly prepared for the operation as regards diet, she having been disappointed about the room becoming vacant several times, on each of which she had been properly starved. Calomel—one grain every hour—stopped this soon after resorting to it. The after treatment was similar to that described after the first case. There was slight suppuration at the top of the incision. The drainage tube was removed on the fourth day, longer than which it is not wise to leave them in, for fear of interfering with the closing of the wound. Some are opposed to the use of the drainage tube altogether; but I, for one, believe in the motto: "When in doubt, drain." The drainage tube saves all those patients who used to die of concealed hemorrhage without it, and in which it used to be called shock. And it saves nearly all those who used to die from purulent peritonitis, due to the retention of pus within the closed peritoneal cavity. The peritoneal cavity can take care of a good deal of lymph, of less blood, but it cannot dispose of very much pus. Care must be taken to keep the air of the room aseptic, or else to guard against the entrance of germs by means of the dressing.

This patient suffered more from wind than from any other effect of the operation, and the only thing which relieved her was tincture of assafetida; but it worked like a charm. In five minutes she would bring up large quantities of wind, with entire relief. On February 21 she was removed to the public ward, and on the 24th of February she was discharged.

25th April, 1890.—Patient called to-day at my request and said that she never felt better in her life; eats well, sleeps well, and is entirely free from pain, which had been almost constant since five years. She is now able to walk long distances and

wash and scrub without inconvenience, and she has gained greatly in flesh. On the other hand, her stricture of the rectum is no better, and, on examination, proves to be very much contracted, not allowing the finger tip to be introduced. There is, however, very little discharge from it, and no pain on defecation, as there was before. Another slight inconvenience is that every few weeks a little pimple forms at the site of the drainage tube hole, at the lower angle of the incision, which she opens with a needle, allowing to escape a few drops of yellow, watery fluid and a few bubbles of gas. There is no sign of anything like hernia, the wound being very small and firmly closed.

CASE III.—A full-blooded Caughnawaga squaw, sent to me by a former pupil, Dr. Patton. As the patient spoke neither English nor French, it was difficult to obtain a very clear history. But her condition spoke for itself; there was her womb hanging out of her body between her legs, ulcerated by contact with clothing, and we could make out that pessaries and every other device had been tried in vain to keep it in. She was sent in to be operated on. With the consent of my colleagues I performed hysteroraphy, or ventro-fixation of the uterus, on the 19th March, with the assistance of Drs. Trenholme, Reddy and McConnell. Dr. Reddy had no difficulty in pushing the uterus up through the abdominal incision as soon as I had made it, with a sound in the vagina, and it was easy to seize it with a pair of bullet forceps, which my assistant held while I scarified the anterior surface of the fundus, and included it in three of the five silk worm gut sutures with which the abdominal incision was closed. She did remarkably well after the operation, suffering very little from either tympanitis or pain. Rochelle salts were given on the second day. The highest temperature was $99\frac{1}{2}$ on the morning of the third day, after which it fell to $98\frac{1}{2}$ and remained so until she left the hospital.

On the 29th March she was removed to the public ward, and on the 11th April, 23 days after the operation, she left for Caughnawaga, her husband insisting on her walking to the station, nearly a mile distant. On the 24th April Dr. Patton wrote, at my request, to inform me that he had examined her that day and found the uterus high up and fixed.

CASE IV.—Miss V., æt. 38, dressmaker. Began to menstruate at 14, and was always regular until the age of 17, when it stopped for six months. At eighteen she began to suffer from dysmenorrhœa and vomiting, with almost constant pain in her left side and back, and she soon became so weak that she was unable to walk. For the last five years she has been a chronic invalid, never being able to work more than a few hours a day. She was admitted into the Women's Hospital under my care, on the 12th of March, presenting the appearance of having gone through much suffering. On examination the fundus uteri was found to be lying in the hollow of the sacrum and apparently pressing on the left ovary. The sound entered to the normal depth, but the uterus was retroverted and retroflexed. After consultation it was decided that the pain was due to the abnormal position of the uterus pressing on the ovaries, and that the left ovary was probably diseased. It was also decided that removal of the ovaries, with fixation of the uterus to the abdominal wall, would give her good prospects of relief.

The operation of hysteroraphy was performed on the 18th March, an incision being made about two inches in length and the tubes and ovaries removed on both sides. Both tubes and the right ovary were much congested, and the left ovary was decidedly cystic. The uterus was then pushed up to the abdominal incision by an assistant, with a sound in the vagina, when the fundus was easily grasped with bullet forceps. The ordinary silk worm gut sutures were then passed through the uterus, peritoneum,

fascia and skin, so that when they were tied the uterus was held firmly against the incision. I, did not, however, scratch the anterior surface of the uterus in this case, which I regret not having done. The patient made a very slow recovery, and I cannot say that so far she is very much improved by the operation. She suffered more from tympanitis than from anything else, although the bowels were kept constantly on the move with Rochelle Salts. What relieved her most was fifteen-drop doses of tr. assafoetida and ten-drop doses of tr. valerian. The temperature kept at 99½ for the first week, and then there began to be morning remissions to normal, with a rise on one evening to 101. The sutures were removed, one every day, beginning at the tenth day. There was a good deal of tension on the last suture, which consequently cut somewhat deeply into the skin. The abdominal incision healed by first intention, the powdered boracic acid never having become moist. I think that covering the wound with dry boracic acid is about the best way to treat it, as it renders it almost impossible to become septic. If there is any moisture it dissolves the boracic acid, but leaves always at least a saturated solution of that acid, in which no germs can live. The patient left the hospital on the 22nd of April, still very weak. A day or two before leaving her temperature suddenly went up to 103, but fell again next day to normal. I examined her on the 25th April, and was sorry to find a large exudation so completely filling the pelvic floor that I was unable to feel the uterus exactly. This exudation was the probable cause of the rise of temperature, but I cannot explain why the exudation took place. Notwithstanding this, the patient is sitting up in a chair and can walk about her room.

2nd May.—On examining her again to-day the exudation is mostly re-absorbed, and I was able to make out the uterus back

again on the sacrum. Fortunately the ovaries are not there to be pressed upon.

These two cases of hysteroraphy are, as far as I can learn, the first that have been done in Canada; if anyone here knows of any other on record, I should be glad to be corrected. The first one on the Indian woman has been a perfect success. But in the second case, which was complicated with removal of the appendages and the leaving of silk ligatures in the peritoneal cavity, the result has not been satisfactory, although in such a chronic case, as was pointed out by Dr. Mills a few weeks ago here, when nerves have been transmitting unhealthy impressions for so long a time we may expect that a considerable period must elapse before they get out of their bad habits.

The operation on the Indian woman was remarkable from the very slight evidence of suffering she evinced after the operation, although no opiates of any kind were employed. In marked contrast to the three white women, who all complained bitterly of the pain. I believe that this high susceptibility to pain is the direct result of stimulation of the nervous system by education and civilization.

I intended to make this paper very short, merely in fact to place the two hysteroraphies on record, but the Secretary requested me to make my paper a little longish, as there was not a very heavy programme for the evening; so I hope you will accept this excuse for perhaps having tired you a little.

Attacks of Urticaria occurring at night may be successfully aborted (says Dr. Ohmann-Dumesnil in *Med. Chips*, January, 1889) by the administration, at the time of the onset, of a pill containing one-sixtieth of a grain of atropine. Of course, the patient's general condition should receive subsequent care.

Three or four grains of chloral hydrate, dissolved in an ounce of glycerine, is recommended as a gargle in quinsy. It is efficient by being locally antiseptic, astringent and sedative.

Society Proceedings

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Regular Meeting, April 18th, 1890.

DR. ARMSTRONG, PRESIDENT, IN THE CHAIR.

Present: Drs. Shepherd, F. W. Campbell, Alloway, Jas. Stewart, Hutchison, Schmidt, DeCow, Harry Bell, Finley, K. Campbell, Spendlove, Johnson, England, Jas. Bell, Trenholme, Laphorn Smith, Gurd, Birkett, England, Jr., McCarthy, Allan, Blackader, Jr., Reed, J. A. McDonald, Williams, Jack, Booth, and Y. L. Brown, of Melbourne, as a visitor.

After routine, Dr. Prager, of Nanaimo was elected an ordinary member.

Dr. Wyatt Johnson exhibited a specimen of aneurism of the arch of the aorta, in which not only the whole vessel was dilated, but also the large vessels given off from it. In spite of its size it was not diagnosed during life, the only symptoms being due to aortic regurgitation. There had been no tugging at the trachea, the reason being that the trachea was very loosely attached to the aorta, this sign was therefore not always present in aneurism.

Dr. Finley said the patient had been under his care; never had any dyspnoea or pain or paralysis. He also showed a specimen for Dr. Fenwick of obstruction of the intestines, the symptoms having come on two days after birth. There was no occlusion of the rectum, and the diagnosis was made of stricture of the duodenum, but at the operation it was found to be situated in the jejunum, near the duodenum. The strictured piece of bowel, over an inch in length, was removed, and the upper and lower ends of the bowel were attached to the abdominal wall. The child died soon after. On examination there was found to be a cyst differing in structure from the intestine. It was difficult to say how that cyst had come to be there. There were no adhesions. It might possibly have been due to invagination of the intestines.

Dr. Shepherd thought that it was not due to arrest of development, but to over-development.

Dr. Johnson also showed a specimen of gunshot wound of the skull, for Dr. Fenwick. The patient had committed suicide.

Dr. Armstrong showed a specimen of perforating ulcer of the stomach, which had been taken from a girl 18 years of age. She had been at a ball one evening, when she was taken suddenly with severe pain. Next day she was found to have general peritonitis, and her abdomen became tympanitic. There had been a history of sudden pain once before. As the case was desperate the abdomen was opened,

and the vermiform appendix being found distended with feculent matter and gritty particles, it was removed. Only the right ovary was seen, and it was normal in appearance. The patient died seven days latter, and at the autopsy the left ovary was found to have been the seat of a cyst which had ruptured. The stomach was found to have two ulcers which had perforated through and allowed the milky contents to escape into the abdominal cavity. The patient had been dyspeptic, but she had never had any vomiting or well defined pain to suggest ulcer of the stomach.

Dr. James Bell thought that the rupture of the ovarian cyst was the immediate cause of the peritonitis, and that the ulcers had sloughed out in the last hours of life.

Dr. Shepherd thought that the appendix had had no part in causing death. He was surprised that such large ulcers had not caused any inflammation.

Dr. Alloway did not agree with Dr. Bell in thinking that a small cyst of the ovary would set up general peritonitis by its rupture. In his opinion the ulcer of the stomach was the cause of the whole trouble. Anæmia was generally associated with this condition.

Dr. Finley thought that the perforation of the stomach was the cause of the peritonitis.

Dr. Johnson inquired whether violent peristaltic movements of the intestine might not tear up an ulcer.

In reply to several questions, Dr. Armstrong replied that the patient had always referred the pain to the epigastric region, and never to the lower abdomen, from which he inferred that the stomach had been the initial cause of the trouble. He had removed the appendix because it looked as if it might cause trouble at some future time. There was about a pint of liquid in the peritoneal cavity at the post mortem, although she had taken about fifteen pints of nourishment during her illness. But he had kept the peritoneal cavity drained all the time by saline cathartics.

Dr. DeCow showed a stomach with one large perforating ulcer and several smaller ones which had not perforated, situated at the back of the viscus. The patient had suffered from anæmia, from which she had recovered nicely. She went to a ball on a Friday night and on Saturday morning at six she ate a hearty supper of hard-boiled eggs and beer. Soon after she was taken with severe pain at the cardiac region of the stomach, and a few hours later general peritonitis set in without, however, any rise of temperature or increase of pulse rate, and she died on Sunday afternoon. She had been employed in the Canada Rubber Co., and he wondered whether that occupation had anything to do with the case.

Dr. McCarthy had been called in by Dr. DeCow, and from the symptoms he had had no doubt that the case was one of ulcer of the stomach. The question which he had asked himself was whether surgical interference would have given the patient any better chance of recovery.

In the absence of Dr. Prager, of Nanaimo, his paper on a case of cholecystectomy was read by the Secretary.

The patient was an elderly lady who had been suffering for several years from gall stones, the gall bladder being obstructed and easily mapped out through the abdomen. Dr. Prager had cut down and removed the gall bladder, which was very largely distended. The patient died a few days later from too many hypodermics, which had been given in the operator's absence.

Dr. Johnson thought there was obstruction of the common bile duct.

Dr. Shepherd said this was the first time that this operation had been performed in Canada, but he thought that cholecystotomy, or sewing the gall bladder to the abdominal wall before opening it, and thus establishing a fistulous opening for the bile, would have been better.

Dr. Bell remarked that conditions requiring operations on the gall bladder were very rare in this country.

Dr. Bell reported a curious case of poisoning from a belladonna plaster four inches square. The patient was found lying on the floor picking imaginary things off the carpet, and the pupils were widely dilated.

Dr. Stewart said that these cases were by no means rare.

Dr. Shepherd reported a case of idiosyncrasy for quinine in a patient in whom five grains of citrate of iron and quinine, which contains only one grain of quinine, caused a scarlatinal rash and desquamation of the skin. On repeating the dose ten days later, the patient went through the same severe process a second time.

Regular Meeting, 2nd May, 1890.

DR. ARMSTRONG, PRESIDENT, IN THE CHAIR.

Present: Drs. Birkett, Johnson, K. Campbell, James Stewart, Allan, Trenholme, James Bell, Schmidt, J. A. Macdonald, Hutchison, England, F. W. Campbell, Reed, Blackader, Jr., Gurd, Geo. Ross, Springle, G. Stewart and Laphorn Smith.

Dr. Johnson exhibited some card specimens.

Dr. Laphorn Smith then read a paper on "Four Abdominal Sections," which appears in another column.

DISCUSSION.—Dr. Trenholme agreed with the reader of the paper in holding that only those who were going to devote themselves to gynecology should undertake abdominal surgery. He

laid great stress on the importance of attention to the minutest antiseptic details, which, he confessed, he had not thought of sufficiently in the past. He paid a high compliment to the carefulness, in this respect, of the reader of the paper, whom he had assisted at all of these operations. With regard to pelvic abscesses connected with the rectum, he thought it was best to remove them by abdominal section and drain through the abdomen.

Dr. James Bell said that his experience of abdominal section had been limited to eight (8) cases of removal of ovarian cysts, which were all successful, and in none of which did he think the pain was unendurable. He had had no experience of pelvic abscesses, but he thought that the method adopted by the reader of the paper was the best.

Dr. Armstrong could remember at least two cases of pelvic abscesses connecting with the rectum in which he was able to see the entrance to the cavity with a duck bill speculum. He had treated them both in the same way: dilating the opening, washing the abscess cavity out and putting in a drainage tube. He found these very unsatisfactory, one of the patients having died from exhaustion, and the other remaining no better until she disappeared from his observation. He could remember several other cases, however, in which a pelvic abscess had broken into the rectum, and, after emptying itself, had gradually got well.

Dr. Hutchison read the following paper:—

RHEUMATISM.—McDonald was seen by me on March 16th, '90.

Family history good; boy looks healthy, with rather a heavy, dull face. Had been suffering for a few days previous to my visit from pains in the larger joints, fever, lassitude and restlessness.

Exam. T. 102½, P. 110; R. slightly quickened; both ankles hot, swollen and painful; fair amount perspiration.

Put on soda salicy., 5 grs. every 4 hours. March 17, T. 102, general symptoms improving; March 18th, T. 100, improving; suffering no pain; felt comfortable and quiet. At 9 p.m. I was called suddenly, and found patient in violent spasms, head thrown back, back arched, body resting on heels and back of head; patient apparently completely unconscious; pupils markedly dilated, responding very little and very slowly to light; the muscles of the arms so flexed that pulse could not be counted, but at the heart 120 to the minute, T 100. Each time spasm came on it was accompanied by a peculiar loud cry; so loud that house was surrounded by anxious neighbors when I arrived; some vomiting between the spasms. No cause could be assigned by the family for this condition, which had developed half an hour before my arrival. I had about made up my mind that it was strychnine poisoning, and had dispatched

my cab for a medical friend to divide responsibility, when I heard a laugh from the patient resembling that of hysteria. I immediately applied cold flagelations, which as quickly stopped the cries and spasms, which never returned again, but patient was still unconscious, in which condition he was on Dr. E.'s arrival. After watching patient for half an hour we returned home. On following morning I found he had wakened up at 4 a.m., feeling sore and tired, and without any knowledge of what had occurred; P. normal. I kept him in bed for following week, and he has had no return of the symptoms.

A COMPLICATION OF PNEUMONIA.—Ac. pneumonia, c. subsequent delirium. Arthur C., aged 33 years; good family history; no insanity.

Personal History.—Always been healthy; never suffered from any serious illness.

Present Attack.—I saw this patient on March 13th, '90. He had taken a chill the day before while at work; returned home and went to bed at once. Physical examination showed pneumonia of the right base; P. 104.

Condition continued much the same for the next three days, when he was attacked with very severe continuous pain on right side. On examination a loud friction murmur was heard.

On the seventh or 8th day P. fell to normal; resolution was going on; percussion note slightly dull. About this time I noticed that the patient, although knowing the attendants and myself was acting under a delusion, in fact talking about things altogether foreign to his sickness and employment, and was prepared to argue the point. The attendants had told me that for two or three days he had been acting strangely; but thinking it was the ordinary delirium of exhaustion, took no notice of it. This delirium lasted about two weeks, during which time T., P. and R. were normal, condition of lung improving, and cough somewhat troublesome. I thought of typhoid fever, but could find no evidence of it, except a slight bleeding of the nose during the third week of the illness. A few days after this complete consciousness returned and the patient was convalescent.

My object in bringing this case before the society was to try and decide the cause of the delirium. It was totally unlike the cases of nervous exhaustion I had seen, and reminded me somewhat of the case of Dr. Campbell's some time ago, which ultimately turned out to be miliary tuberculosis of the brain.

S. H., aged 13 months. On the 27th March, '90, was given a portion of egg which contained some egg shell, by a small brother; child immediately commenced to cough and choke; coughed up a little blood and mucous, but no shell.

I saw the child an hour afterward, he looked perfectly well, and continued so till the 3rd day when gradual laryngeal obstruction was

noticed, accompanied by underate degree of pyrexia, the obstruction increased to such a degree on the 4th day, that I asked my friend Dr. Armstrong to see the case with me late at night to consider the advisability of intubation or tracheotomy.

It was decided to delay a few hours, during which time general condition improved and the necessity for operation disappeared; on the 8th day child seemed perfectly well, with exception of loss of voice, slept and took food well, and just an occasional cough, normal temperature.

On the 13th day, child suddenly choked, coughed a great deal and brought up a comparatively large piece of egg shell, with some blood; voice immediately returned and child has since had no further trouble.

The peculiar points to my mind were:

1st.—The absence of the ordinary symptoms of a foreign body in the throat.

2nd.—The laryngitis was apparently due to a foreign body which had done damage and disappeared.

3rd.—That so large a foreign body as the specimen exhibited could remain so long in so small a throat without causing continued symptoms of obstruction.

I may say that the throat was illuminated and a careful examination made by Dr. A. and myself, but nothing could be found or seen in the upper part of the throat.

DISCUSSION.—Dr. Trenholme related a case of a boy who kept a nail in his windpipe for several years without much inconvenience.

Dr. F. W. Campbell related a case which had occurred that very day of an officer getting a piece of fish bone in his throat, causing him to become aphonic and cyanosed, but finally coughing it up in a few minutes. With regard to Dr. Hutchison's case of delirium after pneumonia, he had often seen it in patients who had been hard drinkers, and who had been deprived of their liquor. But it was rare to see this at the end of the disease when the patient was convalescent. The condition of hysteria in the male must also be very rare, for he had only seen three cases in twenty-six years.

Dr. Geo. Ross expressed his appreciation of Dr. Hutchison's paper; the three cases were of great clinical interest. There was no doubt that the first case was one of hysteria; the reader of the paper had been fortunate in not expressing his suspicion of strychnine poisoning. Dr. Ross had never met with such a condition coming on during an acute illness. The condition of mania coming on after pneumonia was also rare, although quite common after typhoid. The prognosis in such cases was generally very favorable.

Dr. James Stewart thought it was rather a case of mania than delirium, very much resembling the mania of the puerperal state.

Dr. Laphorn Smith had very frequently seen a similar condition in patients with acute rheumatism, in whom he was pushing the doses of salicylate of soda. In fact he did push this drug until either the patient was relieved or until delirium set in. He had never regarded it as anything serious, as it passed off in a few hours after suspending administration. He asked whether other members had not noticed this effect of the salicylates.

Dr. Geo. Ross had seen several severe cases of delirium following large doses of salicylate, especially several years ago when the drug first came into prominence; but he thought that the delirium was in part due to impurities in the salt, because he did not meet with these untoward effects so often now as formerly.

In reply to Dr. Campbell, Dr. Hutchison said that the pneumonia patient had always been very temperate in his habits.

Dr. Armstrong confirmed Dr. Hutchison's report of two of the cases to which he had been called in consultation.

Dr. Laphorn Smith reported a case of almost fatal heart failure during anaesthesia, in which the patient's life had been saved by promptly standing her on her head. He was performing the operation of curretting and tamponing the uterus, when his assistants reported that the patient's pulse and breathing had suddenly stopped simultaneously. A battery was at once procured and artificial respiration started, when the operator remembered Nelaton's plan of inverting the patient, which was done by turning the operating table and patient on end together, with the result that the pulse slowly returned and a few seconds later the breathing also. This reminded him of the case of a young lady who several years ago fainted while walking on St. Catherine street, but who was unfortunately carefully carried by two polite young gentlemen into a neighboring drug store and kept sitting bolt upright for a quarter of an hour while a physician was being searched for. The speaker was taking a bath at the time, but hurriedly dressed and went to her at Dr. Reddy's office, whither she had been carried in a cab after having been taken to several other doctors' offices, but he found her dead. There is no doubt that if she had been promptly inverted her life would have been saved, as there was also no doubt that the patient on whom Dr. Smith was operating would have died had this means not been employed. He mentioned the case to impress upon the minds of others the importance of immediately turning patient's with heart failure upside down.

Dr. F. W. Campbell reported a case of heart failure in a dentist's chair occurring to a member of the same family, to whom he promptly applied this method with the most satisfactory result. He also reported a case of aphonia in a singer, which had been promptly relieved by

nitric acid, which was a well known and very old remedy for aphonia, but which was at present very seldom used.

Dr. Gurd exhibited a calculus as large as a bean, passed per urethram from a gentleman who had been suffering from renal colic, and to whom he had administered several doses containing carbonate of lithia 5 grains, and bicarbonate of potash 10 grains. He also showed a specimen of enostosis of the lower jaw set up by the irritation of a diseased molar tooth. It was of consistence of ivory and seemed to have been sequestered, as it was removed without much difficulty.

There being no other business the meeting adjourned.

Progress of Science.

MEETING OF THE CANADIAN MEDICAL ASSOCIATION.

The 23rd annual meeting of the Canadian Medical Association will be held this year in Toronto, on the 9th, 10th and 11th of September.

LEGACY TO THE POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL.

Among the legacies of the late Honorable Daniel B. St. John, of Newburgh, N.Y., was one of ten thousand dollars to the above-named institution.

RESORCIN FOR RODENT ULCER.

Dr. Chas. Szadek, in the *Satellite*, recommends resorcin for various forms of skin diseases, particularly condyloma and verrucae, in the form of ointment and powder. He reports a case of cure of rodent ulcer by using an ointment of resorcin and vaseline (25 per cent).

IMPERFORATE VAGINA—CRANIOTOMY.

Dr. Jas. B. Neal, of Tunghowfu, has reported a case that seems unique. A woman, 23 years of age, presented herself with a tumor in the abdomen, which was found to be a retained foetus. The vagina was imperforate, resulting from ulceration. If the woman's story was correct, she had carried a dead child for three months past the time when she should have been delivered, when she had pains, but the native midwives denied that she was pregnant. After delivery, by section and craniotomy, she made a rapid recovery.—*Satellite*, April, 1890.

PRURITUS.

In the treatment of general cutaneous pruritus, Dr. Wertheimer, in the *Münchener Med. Wechenschrift*, Nov. 4, 1889, recommends a tablespoonful of a three per cent. solution of salicylate of soda, three times a day. This treatment will not only ameliorate the unpleasant symptoms of pruritus, but is said to completely eradicate the disease in a short time.—*Med. and Surg. Reporter*.

SALOLIZED COLLODION FOR RHEUMATIC JOINTS.

The following prescription, to be used as an external application in acute rheumatism, is quoted by the *London Medical Recorder* :

R.—Salol, } of each 4 parts.
Ether, }
Collodion 30 parts.—M.

TEST FOR EXALGIN.

According to the *American Journal of Pharmacy*, exalgin may be distinguished from acetanilid and phenacetin by the following simple test:—1 grain is dissolved in 2 cc. of chloroform and 20 cc. of petroleum ether added. If the exalgin is unadulterated the solution will remain clear. Moreover, phenacetin requires 20 cc. of chloroform and acetanilid 6 cc. for solution.

PRESCRIPTION FOR RICKETS.

Kassowitz prescribes the following mixture to children suffering from rachitis :

R.—Phosphorus, $\frac{1}{2}$ grain.
Liparin, $7\frac{1}{2}$ drachms.
White sugar, } of each $3\frac{1}{2}$ drachms.
Acacia, }
Distilled water, $1\frac{1}{4}$ ounces.—M.

One teaspoonful three times daily.—*Der Kinder-Artz*, January, 1890.—*Medical News*.

PRESCRIPTION FOR THE FEVER OF PHTHISIS.

The *Reveu de Therapeutique* quotes the following prescription, which is said to be used by Liebermeister in the hectic fever of phthisis :

R.—Sulphate of quinine, 30 grains.
Pulverized digitalis, $7\frac{1}{2}$ grains.
Extract of gentian—sufficient quantity.

Mix, and divide into forty pills, of which from six to ten may be taken daily.

THE INFLUENZA IN BULGARIA.

An interesting report is made by Dr. A. A. Golewina, of Verna, Bulgaria, in the *SATELLITE*, for April. In a very mixed population it is instructive to notice the greater prevalence of the disease among those who observed the least regard for hygienic conditions, as the Turks. The fatal cases were principally among old persons and children.

ACNE

Dr. Isaac recommends the following :—

R Resorcini, 2.50-5.00 gram. (gr. xxxvi-xxxvii).
Zinci oxidi,
Amyli, āā 5.00 grammes (gr. lxxv).
Vasellini, 12.50 grammes (ʒiij gr. viij).

M. Sig. : Leave this paste on the skin for a day, and the next day rub it off with cotton or oil. The good effects are seen in three to five days.—*L'Union Médicale*, 1889.

PRESCRIPTION FOR ACNE.

The following is quoted in the *Centralblatt für die Gesamte Therapie*, March, 1890 :

R.—Salicylic acid, } of each 52 grains.
Sodium borate, }
Boric acid, 40 grains.
Alcohol, } of each $1\frac{1}{2}$ ounces.
Glycerin, }
Oil of bergamot, 5 drops.

To be used as a wash three times a day.—*Med. News*.

UTERINE CANCER.

De Sinéty gives the following disinfecting lotions :—

1. R Potassi permang., 20 parts.
Aqueæ destillate, 500 parts.—M.

Or

2. R Acidi thymici, 10 parts.
Spts. vini rectific., 200 parts.

M. Sig. : Dissolve. A tablespoonful of either solution in a glass of water used as an irrigating lotion to dissipate the odor.—*L'Union Médicale*.

PRESCRIPTION FOR ECZEMA.

According to the *Centralblatt für die Gesamte Therapie*, Saalfeld uses the following ointment in cases of pustular eczema :

R.—Potassium carbonate, 15 grains.
Salol, 75 grains.
Olive oil, 150 minims.
Sulphur, $1\frac{1}{2}$ drachms.
Zinc oxide, } of each $3\frac{1}{2}$ drachms.
Starch, }
Lanolin, sufficient to make, 6 ounces. M.

—*Med. News*.

DEODORIZING INJECTION IN UTERINE CANCER.

In *L'Union Médicale*, Dr. Chéron recommends the following injection as efficient in destroying the fetid odor of uterine cancers :

R. Acid. salicylic,	gr. ij.
Sodium salicylate,	gr. xl.
Tinct. eucalypt.	fl. dr. jss.
Vinegar,	fl. oz. jss.—M.

This is to be added in one or two pints of water and used as a douche every few hours.

IODOFORM IN ENDOMETRITIS

Jacob uses the following emulsion in the treatment of endometritis :

R. Iodoform,	dr. v.
Glycerin,	dr. vj.
Aquæ,	fl. dr. jss.
Tragacanth,	gr. jss.—M.

From one-half to one drachm of this is injected into the cavity of the womb two or three times a week.—*Therapeutische Monatshefte—Medical News*.

HYPERHYDROSIS PEDUM (FETID FEET).

Dr. Panienski (*Noviny lek.*, 1889, No 8), in fifty cases of excessive sweating of the feet which had resisted other treatment, has used a 5-per-cent. solution of chromic acid painted on the soles, which gratifying results. Of the fifty cases thirty-six were entirely cured; the remaining ones were much benefited. The treatment consists in painting the affected soles with the solution once, or, in rebellious cases, three or four times in five to eight days, and in case the trouble returns after a few weeks the treatment is repeated once or twice. The author has not observed any accident resulting from this treatment.—*Deutsche Med. Wochenschrift*, 1889.—*Satellite*.

ANTIPYRIN IN INCONTINENCE OF URINE.

There seems to be no limit to the beneficial effects to be obtained from this valuable addition to our therapeutical resources. Several cases of inveterate incontinence of urine in children between four and eight years of age, are reported to have been immediately relieved and ultimately cured by the administration of from ten to fifteen grains of the drug at six o'clock in the evening, the dose being repeated at eight or nine o'clock. The effects are said to be certain and immediate, and if so it will prove a boon to practitioners, who have exhausted their stock of remedies without any adequate result in these troublesome and oftentimes obstinate cases.—*Medical Press*.

INJECTIONS OF CARBOLIC ACID IN ANTHRAX.

Two severe cases of anthrax which recently presented themselves at Bordeaux, are reported to have been cured by the subcutaneous injection of a ten per cent. solution of carbolic acid around the periphery of the inflamed area. The pain attending the injections was great, but the beneficial effects, both locally and constitutionally, were immediate and pronounced, and within twenty-four hours recovery could be safely predicted. It is worthy of remark that in spite of the large amount of the acid injected, no poisonous symptoms manifested themselves. It is probable that the same effects might be obtained by means of a five per cent. solution, and the extreme pain consequent on the use of a stronger one would be avoided.—*Med. Press*.

BLOODLESS TREATMENT OF FISTULÆ.

In the Moscow therapeutic weekly *Novosti Terapii* No. 11, 1889, Dr. Georgy I. Tarabrin, of Ekaterinovka, warmly recommends the treatment of incomplete fistulæ (sinuses) by the intra-fistulous injection of a two per cent. solution of carbolic acid or a solution of corrosive sublimate (from three to ten grains to six ounces of distilled water), repeated two or three times a day. The injection should be preceded by probing (in order to determine the direction which the jet should take.) It is advisable to commence the treatment with a weak solution and then to gradually pass to stronger ones. The treatment is said to prove successful in a couple of weeks even in old cases of deep fistulæ penetrating into bone.—*Reporter*.

TREATMENT FOR CHRONIC LEG ULCERS.

Dr. Ivan A. Praxin, of St Petersburg, warmly recommends a simple method of treatment, successfully practiced by him in atonic crural ulcers with sclerotized edges. The method consists in making multiple radiating incisions, penetrating through the whole thickness of the edge, and situated so that the inner third of each incision divides the granulating bottom of the ulcer, the middle one its edge, and the outer third the adjacent healthy skin. The distances between the incisions should be equal approximately to two or three breadths of the edge. To secure gaping, plugs should be inserted into each wound for a few days. When treated after this plan, callous ulcers, varying in size from a dime to half of the palm, are said to heal as swiftly as any simple ulcer, provided their neighborhood is free from inflammatory œdema and venous congestion.—*Weekly Medical Review—Medical News*.

PATHOLOGY OF EXTENSIVE BURNS.

Oscar Silbermann, of Bresslau, finds that in extensive burns the corpuscles alter their form, and are able to exert less than their normal resistance to heat, drying, compression and staining. In consequence of these changes, thrombosis and stasis in different organs are very frequent, especially in the lungs, kidneys, stomach, bowels, spleen, liver, skin and brain, and most of all, in the smaller branches of the pulmonary artery. The stasis in the lungs produces a very considerable impediment to the emptying of the right ventricle, with enormous venous congestion and dangerous arterial anæmia. This again leads to apoplexies and parenchymatous alterations in the above-mentioned organs, also to dyspnoea, cyanosis, coma, a small pulse, angina pectoris, eclampsia, anuria and to a diminution of the surface temperature.—*Lancet*.

IODOFORM IN CHRONIC CYSTITIS.

M. L. Frey recommends strongly iodoform, which is an active, lasting antiseptic, an analgesic and deodorizer. After washing out the bladder with tepid water he injects a table-spoonful of the following emulsion dissolved in a half pint of warm water:—

R̄ Iodoformi, 50.00 grammes (ʒxiiss).
Glycerinæ, 40.00 grammes (ʒx).
Gum. tragacanth., 0.25 grammes (gr. iv).
Aquæ destillatæ, 10.00 grammes (ʒiiss).—M.
This injection is repeated every three days. Usually three or four injections are sufficient. Twenty-three cases, under the care of Mosetig-Moorhof, were placed under this treatment. They were all cured, or at least very much improved. Not a single case of iodoform intoxication was observed.—*Wiener Med. Presse*, 1889, No 20; *Centralbl. f. Chir.*, 1889, p. 5•3. —*Satellite*.

SOLUBILITY OF QUININE-SALTS INCREASED BY ANTIPIRYN.

Triulzi (in the *Bollet. Farmac.*) gives the results of his experiments: One part quin. hydrochlor. with four-tenths to five-tenths parts or antipyrin dissolves in two parts of water at 20° to 25° R. (77° to 88½° F.), and one part quin. hydrochlor. with two-tenths to one-fourth parts antipyrin dissolves in two parts of water at 35° to 40° R. (110½° to 122° F.). One part quin. hydrochlor. without antipyrin dissolves in two parts of water at 42° to 45° R. (126½° to 133½° F.), but on cooling the greater part deposits in crystals. The valerianate of quinine behaves in a similar manner.

As the solution prepared with antipyrin is easily made, as well as permanent, it may be used with advantage for subcutaneous injection.—*Wiener Med. Presse*, 1889; *Deutsche Med. Wochenschrift*, 1889.—*Satellite*.

THE DANGEROUS FRENCH STOVE.

The Paris Academy of Medicine has had its attention directed to the defective and dangerous form of portable stoves which are such a frequent source of carbonic-oxide poisoning. M. Lancereaux and others considered the subject of so much importance to the public health as to require governmental supervision and control; others considered that it would only be necessary to inform the public of the dangers of this mode of heating. According to Laborde, the presence of 1 part of carbonic oxide in 650 parts of air is injurious to life and may cause death. The advocates of supervision carried their point, and the Academy passed resolutions condemning the slow-draught or air-tight stove in nurseries, schools, colleges and sleeping-rooms. It also called the attention of the authorities to the dangers of this mode of heating, and petitioned for remedial legislation.—Report of Dr. Prosper de Pietra Santa, in the *Satellite* for April, 1890.

CREOLIN INJECTIONS IN DYSENTERY.

Dr. Sosovski has found large enemata of dilute creolin very useful in dysentery. He employed a one-half per cent. solution injected into the bowel twice or sometimes three or four times daily, the quantity used for each enema being generally about five pints. The patients did not experience any burning sensation or abdominal pain. The treatment was employed in sixteen cases, not one of which proved fatal, although a considerable number of patients succumbed to the disease during the same epidemic. In two cases the disease was arrested after the second enema, in nine cases the bloody stools ceased on the third day, in two cases on the fifth day, in one on the sixth, and in one on the ninth. The remaining case, though more obstinate, ultimately recovered completely. In addition to these, two children under a year old were treated successfully by means of creolin enemata. Again, another Russian physician, Dr. Kolokoloff, has used 1 per cent. solution in a number of cases of adults with complete success.—*Lancet*.

SALICYLIC ACID IN SOFT CHANCRES AND SYPHILITIC CONDYLOMATA.

In the St. Petersburg weekly *Voënno-Sanitarnoiè Dëlo*, No. 21, 1889, p. 263, Dr. Leopold K. Golistewski, of Poti, draws attention to the abortive treatment of soft chancres according to Hebra's method, consisting in powdering the chancres with pure salicylic acid daily. Two or three applications (after previously cleansing and drying the ulcer) are said to be sufficient for transforming the chancre into a simple ulcer, which heals kindly in two or three days.

In a case adduced by the author, which had remained without any treatment for fifteen days, a complete cicatrization ensued about nine days after the first powdering. The method seems to be equally successful in syphilitic condylomata, as is illustrated by a case of Dr. Golistewski in which multiple perineal warts (resisting the influence of calomel, mercurial inunctions, etc.), disappeared tracelessly in a week, after five applications of the acid. The same may be said in regard to suppurating buboes.

—*Med. and Surg. Reporter.*

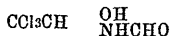
CHLORALAMID.

Dr. Konrad Alt, of Halle, as the result of extended use of this new hypnotic, discovered by von Mering, gives the following formula:—

R Chloralamid, 10.00 grammes (ʒiiss).
Aquæ destill., 120.00 grammes (ʒiij ʒvj).
Syr. rubi id., 30.00 grammes (ʒviiss).

M. Sig.: Two to four tablespoonful one hour before retiring.

Chloralamid is a combination product of chloralanhidride and formamid, from the formula:—



It is a colorless, crystalline substance, soluble in fifteen parts of water, and in one and one-half parts of alcohol (96 per cent.). It has a somewhat bitter taste, which remains but a few minutes. There is no unpleasant taste after using or any odor to the exhaled breath.

In a watery, slightly acid solution, it is stable unless exposed to a temperature exceeding 60° C. (140° F.). Chloralamid may be given in powder, tablets, or, for immediate use, in solution (*vide supra*) in the dose of 2.0 to 4.0 grammes (ʒss-j). —*Berliner Klin. Wochenschrift*, 1889. — *The Satellite*.

THE TREATMENT OF TYPHOID FEVER BY WARM BATHS.

Here, as elsewhere, the treatment of typhoid fever by cold or tepid baths, although looked upon as the best and most reliable method known, is gradually falling into disuse as a matter of routine. Some distinctly object to it, and amongst the number of these Dr. Anuschat has lately published his objection in a recent number of the same paper. (D. Med. Z., 53, '89) Dr. Anuschat believes that it is not the cold but the water that ought to be credited with the good obtained, and he believes he is justified in this opinion by the results of his successful treatment of 150 cases by what he calls the warm bath. The treatment he employs is as follows:—A bath three times a day of 28 R., when the temperature is 38 to 39 C., when it is from 39 to 40 C., 27 R., and 26 R., when it is over 40 C. (i.e., from 95 to 90 F.) The action

of the baths is said to be favorable. Improvement generally sets in after three days. Their beneficial effect is best seen, however, in the almost complete absence of complications, and in the shortening of the illness. With the exception of five cases, all were less than four weeks in bed. In explanation of the good effects of the warm baths treatment, he assumes a special catalytic action on the part of the water. As regards diet and medicines, he follows the classical lines.

In particular, he makes free use of port, sherry and madeira. —*Medical Press*.

REMOVAL OF RENAL CALCULI BY TOXIC DOSES OF BELLADONNA.

In the *Prov. Med. Jour.*, October, 1889, Dr. Murray states that, in his experience, belladonna is more beneficial than opium in relieving the pain of renal colic. In cases of renal colic, moreover, the author contends that if the drug is pushed sufficiently long, and in large enough doses, the entire removal of the calculus—first from the pelvis of the kidney to the bladder, and then from the bladder *per urethram* often follows. Some cases are quoted illustrating this assertion. One patient had suffered for several months from repeated attack of renal colic, during the last of which he was seen by the author, who gave belladonna until its physiological action on the eye and throat was evident, and then it was pushed further, so that in a few hours a lithic acid calculus was passed as large as an almond. In another case a youth suffered so severely from renal pain that it was decided to operate, but, before consenting, the parents consulted Dr. Murry; he ordered twenty drops of tincture of belladonna every hour, and at the end of five hours a round rough calculus was passed. The special point to be remembered in these cases is to push the drug to its toxical stage, and keep up its action after the pain has been relieved, until a fair time has been allowed for the expulsion of the stone. You may begin with forty minims of the tincture, and repeat it every two hours, increasing or diminishing the dose according to its effect on the pain. —*London Med. Recorder*, Nov. 20, 1889.

CATARRH OF PHARYNX.

The following is claimed to be a useful gargle in catarrh of the pharynx:

R Sulph. zinci, gr. xv.
Thymoli, gr. ʒ.
Alcoholic, } aa f ʒ jss.
Glycerini puri,
Aq. Ment. pip. f ʒ x.

M.

—*Med. and Surg. Reporter.*

CHLOROFORM AND LOCOMOTOR ATAXY.

Dr. Thiem, having had to give a patient with signs of locomotor ataxy, chloroform for the purpose of examining an abdominal tumor, was surprised to notice that as she was being helped from the room, while still somewhat under the influence of the chloroform, she walked with a typical ataxic gait, though this symptom was not ordinarily present. On watching other patients who were not suffering from this affection trying to walk while still partially under the influence of chloroform, Dr. Thiem convinced himself that the peculiar gait only occurred in the subjects of ataxia in whom the semi-narcotic state brings out the want of coördination in the movements of the legs. The explanation would appear to be that inasmuch as the peculiar gait is not due to any paralysis of the muscles, but only to the want of coördinating power, which is set in action by the control exerted by the muscular sense and the sense of sight, when, as in the case of a half-chloroformed subject of locomotor ataxy, both the central coördinating apparatus and the peripheral regulating machinery are in a more or less inactive condition, there is a double reason for the existence of the well-known jerking and sliding movements of these patients. It would appear, then, that in doubtful cases of locomotor ataxy some assistance towards a correct diagnosis might sometimes be obtained by partially anæsthetizing the patient and then observing his gait as he walks across the room.—*Lancet*, Nov. 16, 1889.—*Medical and Surgical Reporter*.

DOES SMOKING PROTECT AGAINST INFECTION ?

This subject has been closely investigated by Dr. S. Hajek, of Vienna. Tassinari, of Pisa, has already demonstrated by experiment that tobacco smoke destroys germs. Hajek found, by consulting statistics, that men who smoked were far less susceptible to the infection than the remainder of a population during an epidemic of diphtheria. Professor Osler has noted that in a certain outbreak of typhus three times as many women as men were attacked. It has already been pointed out that men, especially in cities, get more fresh air, as a rule, and follow healthier avocations than women. This fact must not be overlooked during the consideration of Dr. Hajek's theories. Again, very robust men, who resist infection, being "euseptic," as Carlyle said of Field-Marshal Daun, can also tolerate a large amount of tobacco. It is true that Dr. Neudorfer has found that tobacco smoke contains pyridine, a destroyer of bacteria. If, however, persons not accustomed to smoke were to take to pipes, cigars or cigarettes, on the outbreak of an epidemic, they would probably make themselves very unwell and especially

predisposed to fall victims to the prevailing pestilence. The mental condition of a man who has smoked tobacco too strong for him is a state of extreme depression, most unfavorable for his welfare during an epidemic. We advise non-smokers not to put their trust in pyridine during the prevalence of fevers, and to remember that their tobacco-loving friends owe their immunity to good health and strength, which enables them to stand tobacco, and, at the same time, to resist infection.—*Brit. Med. Jour.*

CARBOLIC ACID INJECTIONS IN ERYSIPELAS.

Dr. Paul Samter claims that cutaneous erysipelas can be safely aborted by the use of carbolic acid injections. The solution, which is injected by a hypodermic syringe, is made as follows:—

R Acidi carbolici puri,
Alcoholi absoluti, āā 3 parts.
Aquæ destillatæ, 94 parts.—M.

The solution should be freshly prepared at the time of using. The injection should be made in the sound skin one to two centimetres (three-eighths to three-fourths inch) from the edge of the affected portion. Without pinching up the skin, the hypodermic needle is plunged through the skin almost horizontally in a direction toward the affected part, so that the solution shall lie in contact, as near as possible, with the deeper layers of the skin. The point of the needle should be gently moved from side to side and the contents of one-half to a whole Pravaz syringe slowly injected. The injection produces only a slight burning sensation, except it be used on the face. The distance between the points of puncture depends upon whether a single puncture or many are required, and varies from two to three or five to six centimetres (three-fourths to one and one-eighth or two to two and three-eighths inches). The average quantity used for the lower extremity of an adult is ten to fifteen grammes ($3\frac{1}{2}$ - $3\frac{3}{4}$) of a 3-per-cent. solution. On the upper extremity and in young persons somewhat less is used, six to ten grammes ($3\frac{1}{2}$ - $2\frac{1}{2}$) being sufficient.

The remaining treatment is of secondary importance, bathing the inflamed part with carbolized oil (3 per cent.), wrapping it in cotton, and stimulants internally, are all that are required. As a prophylactic measure for the prevention of carbolic-acid intoxication from the preceding injections, sulphate of soda in large doses (a tablespoonful of a 5-per-cent solution every hour) is given. In typical cases a rapid improvement takes place, the temperature becoming normal in twelve to twenty-four hours.—*Deutsche Med. Wochenschrift*, 1889.—*Satellite*.

THE TONSILS IN PHTHISIS.

Dr. Dmokhovski publishes in a Polish medical journal, the *Gazeta Lekarski*, some important observations on the condition of the tonsils and the follicular glands at the base of the tongue in phthisical subjects. Strassmann had previously made some observations on the tonsils, and had found them affected in thirteen cases out of twenty-one which he examined. Dr. Dmokhovski was able to show some affection of the tonsils in every one of the fifteen cases examined post mortem, the lymphatic glands at the base of the tongue being also affected in nine of these cases. The lungs were in every instance decidedly affected, and in five there was slight tuberculous ulceration of the larynx. The ages of the subjects varied from eighteen to fifty-six. Presumably the tonsils were infected from the mouth, the bacillary infection at first affecting the epithelial layers and subsequently the deeper tissues—viz., the lymphatic sinuses and the follicles themselves. The tuberculous character of these changes was made manifest either by the existence of large disseminated collections of Koch's bacilli, or by the concomitant signs of general inflammation of the connective tissue, or by the occurrence of fully developed tubercles. These showed themselves first of all in the connective tissue between the follicles along the lymphatic vessels leading to the neighboring lymphatic glands. Ulcerations of the tonsils were observed in the crypts, but never on the free surface of the glands; sometimes cavities were found in the tonsils. In the living subject no marked affection could ever be detected by the naked eye in the tonsils. The absence of disposition to external ulceration is explained by the supposition that the deeper tissues form a far more suitable soil for the development of the tubercle bacilli than the superficial tissues—that is, the mucous membrane covering the surface of the glands.—*Lancet*.

THE INFECTIVITY OF A CORPSE.

The question as to how far a corpse can be considered infectious is one concerning which very considerable difference of opinion exists. We have ourselves recently been the medium of the expression of the two sides of the matter—much, we fear, to the unsettling of the views of those who ventured to ask for a definite answer to a question that, in our present state of knowledge, really admits of no such definite answer. In a northern town much controversy has recently arisen respecting the prohibition to admit into the cemetery chapel any corpse of a child dying of whooping-cough, lest the disease be transmitted therefrom to those entering the chapel. As regards this particular disease, the question of post-mortem infectivity might, perhaps, be decided by the bare fact that, as it is

probable that the expired breath is the carrier of the "germ" or "virul," the risk of such contagion is reduced to a minimum when the act of respiration has ceased; and that only by assuming the retention of the infective agent in clothing, &c., could the corpse strictly be said to be infectious. Yet it is only a matter of opinion, and we are not aware of any facts to warrant the assertion that whooping cough has never been so transmitted. We should, however, consider it as the *ne plus ultra* of sanitary caution to enforce such a prohibition as that named. Perhaps some of our readers could adduce instances of post-mortem infection in the case of whooping-cough or allied diseases. If so, we shall be glad to receive them, and they may then afford some basis for a line of action which must be thought to be somewhat arbitrary with present knowledge. It is otherwise with diseases where the virus is more likely to be given off from the surface of the body—as scarlet fever, measles or small-pox; but even in these cases records are very few of infection being transmitted by a corpse.—*Lancet*—*Maryland Med. Journal*.

AMMONIA IN COCAINE POISONING.

A case of poisoning by a very moderate quantity of cocaine is reported by Dr. Golovkoff, in the Proceedings of the Caucasian Medical Society, where ammonia was used with good effect to restore the patient. The patient was a somewhat delicate woman, who was suffering severely from toothache. The pain becoming unbearable, Dr. Golovkoff injected fifteen minims of a two per cent. solution of the hydrochlorate of cocaine under the skin of the left cheek, which gave relief for three or four hours, when the pain returned as acutely as ever. A second fifteen minims were injected, and in about five minutes time the patient became restless, her pupils dilated, the surface of the skin became pale, the pulse and likewise the respirations became rapid, and shivering came on; the respirations soon ran up to 200 per minute, and were labored. A curious effect, too, was produced on the sounds of the heart, causing them to be audible at the distance of two paces from the patient. There was great pain over the cardiac region and back, together with a dread of death and convulsive movements of the limbs. There was some liquor ammoniæ at hand, and this the patient was given to smell and a few drops was given internally every five or ten minutes. Amyl nitrite was also employed, but the latter seemed to do more harm than good, while the ammonia soon brought the pulse and respiration, and indeed the general condition of the patient, into something more like their natural condition, so that in about a couple of hours she had quite recovered. Dr. Golovkoff remarks that the only case he has

been able to find in medical literature where ammonia was used as an antidote in cocaine poisoning was by Dr. Gooding, of Barbadoes, reported in *The Lancet* of 1888, vol. i, p. 394, and copied into the *Méditsinskôe Obozrénie*. (This was a case of a negress who had developed alarming symptoms after less than half a grain had been injected into the gum; she was treated by hypodermic injections of ether and ammonia.)—*Lancet*, Nov. 30, 1889.

INFANTILE DIARRHŒA.

At a meeting of the Harveian Society of London, held November 7, 1889, and reported in the *Medical Press and Circular*, on the causation and the treatment of that variety of acute infantile diarrhœa produced by irritative products, resulting from fermentations set up in milk, either previous to or after ingestion. While admitting that though probably several irritating substances resulting from the fermentation of milk are factors in production of the form of acute infantile diarrhœa under consideration, he contended that the principal share of blame rests with milk or cheese ptomaine tyrotoxin produced during the fermentation of milk under certain conditions. The treatment of acute infantile diarrhœa, with the view of arresting the abnormal intestinal fermentation was then considered. Carbolic acid, creosote, resorcin, salicylic acid, salicylate of soda, naphthol, and salol have been given in the hope of checking the putrefactive changes in the bowels. Ringer has recommended the administration of a weak solution of bichloride of mercury in infantile diarrhœa attended with very slimy stools. Dr. Luff then referred to Hlingworth's antiseptic treatment of infantile diarrhœa, which he had himself found most useful, and the employment of which had first directed his attention to the treatment he had employed. This consists in drug treatment and diet treatment combined. The drug treatment consists in the administration of one-fiftieth of a grain doses of chloral hydrate. It was shown experimentally that the biniodide of mercury is an extremely soluble and diffusible salt, and that it possesses the property of combining with and rendering insoluble the milk ptomaine tyrotoxin. As regards the diffusibility of the biniodide of mercury, Dr. Luff has detected it in the urine within two hours of its administration. Dr. Luff had never found that soluble biniodide of mercury itself acts as an intestinal irritant. Of eighty cases of acute infantile diarrhœa treated by this method the diarrhœa ceased within two days in seventy-two of the cases, in five out of the remaining eight cases it ceased within four days, and in no case did it last seven days.—*Medical and Surgical Reporter*.

CAUSE AND TREATMENT OF THE VOMITING OF PREGNANCY.

At a meeting of the Paris academy of medicine, Dr. Guéniot said that the idea of combating the intractable vomiting of pregnancy with a single medicament appeared to him erroneous, as experience has shown. The numerous observations published up to the present time show that the cures obtained with therapeutic agents were obtained after trying various remedies without any particular one having shown a specific action.

Three organs concur in the production of the vomiting of pregnancy: First, the uterus, which is at once the seat of pregnancy and the source of special excitation to other organs; second, the nervous system (spinal and ganglionic), which transmits excitations to distant parts; finally, the stomach, which feels in an exaggerated manner the action of the uterine stimulus.

In order to combat the vomiting, not with a doubtful accidental result, but with almost constant success, it is necessary to resort to a complex treatment directed simultaneously to the three sources of the disease. The following fundamental indications must be fulfilled:

1. To calm the morbid excitement of the uterus by correcting the abnormal conditions which give rise to it. For this purpose the most valuable agents are belladonna, cocaine, morphine, vaginal injections, or appropriate topical applications, Gariel's pessary, cauterization, or even artificial dilatation of the neck of the uterus, according to the indications.

2. To diminish or suppress the exaggeration of reflex impressions, either by the use of chloral, or bromide, or refrigeration of the spinal region, moral influences, etc.

3. To combat the intolerance of the stomach, treating the different affections of which it might be the seat, and calming its erethism with the following measures: Almost absolute diet: abstinence from every sour drink, wine, juice of oranges, grapes, etc.; use of alkaline waters and ice in very small quantities; a fly blister with morphine to the epigastrium, and at times laxatives or other purgatives to regulate the functions of the intestines.

In order to insure the success of this medication, it is necessary to spare the stomach as much labor as possible. For the remedies, the intestinal tract should be used in preference to the stomach, and next in order the skin (hypodermically).—*Revista de Ciencias Medicas, of Barcelona*.—*New Orleans Med. and Surg. Journal*.

STERILIZATION OF FÆCES.

Dr. Charles J. Foote has made some very interesting and instructive experiments, in the laboratories of the Yale Medical School, to

determine the value of corrosive sublimate as a disinfectant for fæces, and, if useless, whether this is due to the formation of inert insoluble compounds of mercury with the fæces; and, further, to determine the relative value of certain other disinfectants used for this purpose. The solutions used were mixed with the fæces, and after a certain time culture media were inoculated from this mixture, and thus it was determined whether the mixture was sterile or not.

Standard solutions of disinfectants to be tested were made after the following formulæ:—

R Corrosive subl.,	ʒij.
Water,	Cj.
R Chlde. of lime (U.S.P.),	ʒiv.
Water,	Cj.
R Sulphate of iron,	ʒxviiij.
Water,	Cj.
R Corrosive subl.,	ʒij.
Tartaric acid,	ʒx.
Water,	Cj.
R Hydrochloric acid,	1 per cent. (ʒx to Cj).
R Corrosive subl.,	ʒij.
Hydrochloric acid.	ʒx.
Water,	Cj.
R Carbolic acid,	5 per cent. (ʒl to Cj).
R Corrosive subl.,	ʒij.
Potass. permang.,	ʒij.
Water,	Cj.

At a test-mixture, normal fæces were used thoroughly mixed with about two-thirds their bulk of decomposing urine. One part of this test-mixture was mixed with two parts of the disinfecting solution. The conclusions drawn from his experiments were as follow:—

The best disinfectants to use are the bichloride with hydrochloric acid, the bichloride with potassium permanganate, and chloride of lime.

Five-per-cent. solutions of carbolic acid and two-tenth-per-cent. solutions of the bichloride are unreliable, even when used in the proportion of one pint to every one hundred cubic centimetres of dejection.

Emphasis needs to be laid on the necessity of thorough disintegration of the fæcal matter by stirring it with the disinfectant, and on the need of allowing the mixture to stand four hours at least before emptying.

For continued use the bichloride solutions would injure lead pipe, while used for a few days only probably no injury would result. For long-continued use, where the dejections are thrown into a water-closet, chloride of lime is undoubtedly the most available disinfectant.

Solutions of chloride of lime should be kept tightly corked, and should not be used after they are a week old.—*Am. Jour. of the Med. Sci.*, 1889.

ARSENIC AND BICHLORIDE OF MERCURY IN THE TREATMENT OF ANÆMIA.

Although it is perfectly true that we have almost no knowledge of the manner in which alteratives act in instances of diseases where, through morbid functional activity, enlarged glands of growth appear, it is evident that they must act upon the trophic nerves or directly upon the nourishment of the affected parts. If they are used in large quantities they act as depressants to the normal nutrition of the body, producing primarily a decrease in the vitality of morbid growths, so that they melt down and disappear, and they may finally so reduce the condition of the healthy tissues as to cause sloughs and ulcerations. Whether these changes are due to the over-stimulation of nutrition—that is, to an excessive trophic change—or whether they depend upon actual lowering of the tone of the parts, we know not. One thing we do know, however, and that is, that small doses of most of the so-called alterative drugs act as very distinct stimulants to the development of normal structures, and in no instance do we find this more typically represented than the effect which they exert on the blood. Quite a number of years ago Keyes, of New York, emphasized the value of minute doses of mercury bichloride in syphilitic and other anæmias, and abundant clinical observation has certainly confirmed his views. The dose of bichloride of mercury in anæmia should be about one-fortieth of a grain. Not only will minute doses of the bichloride of mercury act in this way, but small amounts of calomel or mercury itself will have such an effect.

Inunctions of very small amounts of mercurial ointment, once a day, or every other day, in adults and children, will increase the fulness and redness of the cheeks and lips, and the number of the corpuscles; the piece of ointment used being no larger than the half of a very small pea. This treatment will be found of service in cases not dependent upon specific taint or scrofula. The marked increase in the nutrition of children of a syphilitic taint, who are suffering from marasmus, under the use of gray powder and inunctions, gives further evidence of this fact.

Arsenic also is of value in anæmic conditions, and may be employed in comparatively larger doses than mercury; but, nevertheless, smaller amounts than are usually given in chorea and similar states. Osler has shown the value of the drug in anæmia, and so has Barton, of University College, in England. Any one of the preparations may be employed, but not more than one-sixtieth of a grain of arsenious acid should be taken in a day, although more has been used with no less benefit to the patient. Most of the drug under these circumstances is

in excess and is cast off in the urine and feces unused and wasted, and strains and irritates the emunctories of the body during its passage through them.—*Editor Medical News.*

TREATMENT OF DYSENTERY BY ENEMATA OF CORROSIVE SUBLIMATE, ETC.

It is now generally recognized that certain morbid conditions of the intestinal tract may be favorably modified by various drugs belonging to the class of antiseptics, among which the chief are calomel, bismuth, naphthalin, and thymol. It is a noteworthy fact that these substances are all insoluble, and it is in virtue of this property that they are enabled to run the gauntlet of the absorbents and exert their specific action upon the intestinal contents. The best of all antiseptics—corrosive sublimate—has thus far been of little use for the purpose mentioned, because it was supposed that no benefit could be exerted by any but a lethal dose. While this may be true of its administration *per os*, it is shown by G. LEMOINE (*Bulletin général de Thérapeutique*, January, 1890) to be a mistake so far as concerns administration *per-rectum*.

Lemoine has treated fifty-four cases of dysentery by enemata of corrosive sublimate and with the happiest results. The strength of the solution was one to five thousand, of which, two hundred grammes were at first administered three times a day; later, two hundred grammes of a solution in one to three thousand were injected twice daily. Improvement showed itself, as a rule, after the first injection, the first symptoms to disappear being the tormina and tenesmus. In a certain number of cases the tenesmus was so great that the enema could not be administered without a preliminary treatment, which consisted in painting the sphincter with a five per cent. solution of cocaine.

In the acute cases, a cure resulted from this treatment in from three to four days; whereas, in the more chronic cases which presented themselves for treatment on account of an acute exacerbation, a cure was effected, as a rule, in one day. The latter treatment is somewhat startling in view of the well-known fact that chronic dysentery is decidedly rebellious to all the usual modes of treatment.

In no case was there any sign of systemic poisoning. It is probable, Lemoine believes, that the mercury is not absorbed when thus employed in dysentery. In five cases he tested the urine for mercury, and in every instance with negative results. This fact seems to stand in marked contradiction with the well-known absorbent power of the large intestine, and is probably due to the intensity of the inflammation of which it was the seat.

Lemoine's cases were all treated in Algiers, and many of them were of a severe type. In view of the infectious character of dysentery, the treatment is eminently rational, and the demonstration that our most powerful germicide can be used with impunity as an intestinal antiseptic is of decided value. At the same time, in view of the accidents that have followed the employment of resorcin in lavage of the stomach, we would recommend the greatest caution in the use *per enema* of the more poisonous corrosive sublimate.—*Editor Med. News.*

THE CLIMATOLOGY OF HÆMOPTYSIS

Dr Roland G. Curtin, of Philadelphia, in an address before the American Climatological Association, June 25, 1889, tabulates the influence of climate on hæmoptysis under two heads: first, the preventive and curative, and, second, the causative:—

1. Preventive and curative elements.

Rarefied air arrests the ulceration or other diseased processes and lowers the arterial tension. This greatly overbalances the unfavorable tendency of increased heart action and loss of support to the lungs from diminished air-pressure.

Cold air contracts the tissues and blood-vessels, thus preventing a flow of blood when such tendency exists. Its general invigorating effects are beneficial.

Dry air desiccates the pulmonary tissues, decreases the fluidity of the blood, and blocks up the blood-vessels,—all favoring the arrest and prevention of bleeding.

Aseptic air favors repair and cure of lung disease, and kills or dwarfs the action of the disease-germ.

Outdoor life, when not associated with too much exposure, exertion, or fatigue, is beneficial.

Sunshine improves the general nutrition.

2. Causative elements.

Sea-level air, by its greater density, diminishes the tendency to hæmoptysis, but the increased arterial tension and the moisture usually present in such localities more than counterbalance the beneficial effect of the support given by the air-pressure.

Salt air hastens the breaking-down process in tubercular lung disease. The effect is probably good in syphilitic lung troubles, and sometimes in simple chronic inflammatory non-tuberculous lung affections.

Moist air hastens the ulcerative process, liquefies the blood and secretions, and renders the tendency to the oozing and flowing of the blood more liable.

Warm air relaxes the tissues and blood-vessels and enervates and relaxes the system at large.

Thus he concludes that each case should be carefully studied in all its phases before deciding upon a change of residence. On a high mountain (say from 5,000 to 10,000 feet [1550-3100 metres]), a residence far removed from the sea-coast, is best for a patient with a tendency to hæmoptysis. At a location of this kind one would probably have not only a rarefied, but also a cold, dry, aseptic air,—factors which would be most beneficial. Care should be taken that the elevation of the patient should be gradual and not too rapid; otherwise the early effects of a sudden elevation might be followed by unpleasant results. A case of syphilitic phthisis will probably be benefited by sea-air, while a tubercular patient would be injured by it.—*The Satellite*.

TREATMENT OF INFLAMMATORY DISEASES OF THE SKIN.

Dr. Lassar, of Berlin, recently read a very interesting paper upon the treatment of inflammatory diseases of the skin, before the section on dermatology and syphilography of the American medical association. His paper is reported in full in the *Journal of Cutaneous and Genito-Urinary Diseases* for October 1889.

The salve so well known by his name is again recommended by him as a sample of "a permanent application of emollient and indifferent preparation," and we give it for the benefit of those who are not familiar with its component parts:

R Acid, salicyl.	2.0
Vaselin, flav.	50.0
Zinc, oxid.	
Amyli,	aa 24.0

Misce leniter torendo f. pasta.

"The advantages of this paste," says the author, "are that it is generally well borne. Be it a child of a few weeks, or an old person, the influence is a benignant one. It produces a slight, soft scaling, and, besides, a constant drying, because it acts like a filter. All lymphatic exudations pass this porous layer, and are drawn out into the bandage, instead of forming a crust upon the wounded skin itself. This is an important advantage for the completion of regeneration, because the neighboring epidermis is not obstructed by masses of adherent crust. The bandages are to be made of thin layers of cotton, and some few turns of muslin, where applicable. This gives the advantage of preventing the germs in the atmosphere, as well as the dirty nails of the patient, from disturbing the process of healing."

Dr. Lassar speaks of a prescription for *pustular affections of the hairy parts of the head and beard*: "It came into my hands through a shepherd who wished to enlarge his professional knowledge by visiting my clinic.

In order to introduce himself he showed a salve which he said had a miraculous effect upon skin diseases. The chemical analysis brought out the following simple formula:

R Hydrargari sulphurati rubri,	1.0
Sulphuris sublimati,	24.0
Adipis,	75.0
Olei bergamottæ,	gtt. aliquat.

This same prescription had already been used by Dr. Bielt, of the Hôpital St. Louis, some fifty years ago, and had thus been recalled to domain of dermatology. Especially its effect is to be remarked in all impetiginous affections of the hairy regions.—*New Orleans Med. Surg. Jour.*

ANTISEPSIS IN TYPHOID FEVER.

The so-called antiseptic treatment of typhoid fever is a valuable addition to the therapeutics of this disease. Dr. John A. McCockle, in the *Brooklyn Med. Journal*, Dec. 1889, says that it is well to begin antiseptics at the mouth by strict cleanliness and antiseptic washes. Carbolic acid is a deserving remedy, and one in which he has much confidence.

R Acidi carbol,	℥ xxiv.
Glycerin,	f ʒ ii.
Liquid pepsin. aromati,	f ʒ i.
Aquæ menth. pip,	f ʒ ii.

M. Sig. A teaspoonful one hour after food.

This combination aids digestion, checks decomposition, and acts as a disinfectant.—*Med. and Surg. Reporter*.

RECENT RESEARCHES INTO DIPHTHERIA.

The important subject of the prevalence of this fatal and distressing malady in various parts of the country continues to engage the anxious attention of the Government, and fresh reports from the pens of the several Inspectors engaged in unravelling the skeins of the problem are to hand. Little that is new has been elucidated, but one or two points are of interest, and all contributions to the etiology and mode of transmission of diphtheria must be eagerly welcomed and considered. The futility is again demonstrated of attempting to get at the ultimate origin of an outbreak, especially in inquiries of this sort, which are undertaken months after the outbreak has ceased. The confusion of nomenclature, which is such a hindrance to correct registration and classification, is again apparent. Thus, a throat affection which obtains in a district is indifferently labelled "croup" or "laryngitis" or "tracheitis" for a longer or shorter time before its true nature is discovered. Indeed, in an Essex district, Dr. Bruce Low found it endowed with such various appellations as

"congested sore-throat" and "rheumatic sore-throat," as well as the ordinary ones of "tonsillitis" and "follicular tonsillitis." But Mr. Spear inclines to the view that not all the "croup," &c., is really diphtheritic in nature; though the facts adduced in his own reports seem to support the modern doctrine. The association of diphtheria with humidity of atmosphere and dwellings is again suggested by Mr. Spear; and the potent influence of school assemblage in promoting and furthering the disease is again proved to demonstration. On the question of the etiological dependence of the disease on insanitary conditions, some of the Inspectors appear to differ; for whilst Dr. Bruce Low, by proceeding on broad inductive principles, shows that localities which had the most diphtheria were the least insanitary, and the converse, and therefore, dismisses this factor from consideration, Mr. Spear, on the other hand, seems to incline to the causal connection of the two, particularly in the case of marked excremental pollution of the atmosphere produced by a bad midden system. The supporters of the latter view would naturally rely less upon the propagation of the disease by personal communication than those who deny the relation of diphtheria with insanitary conditions. And this leads us to the more novel points that present themselves in the reports that have been recently published. They are (1) the influence of factories in disseminating the disease; (2) the suggestion of mediate conveyance of diphtheria infection, *e. g.*, by the clothes of persons themselves not suffering from the complaint, by articles of clothing and manufacture proceeding from infected houses; (3) the possibility of cases discharged too soon from hospital causing recrudescence of the malady. The first two matters are laid out in Dr. Bruce Low's able Halstead Report, where it is shown that factory women employed in a town all the week, where diphtheria was prevailing, and spending their Saturday to Monday at home in villages around communicated the disease there extensively; and where instances are recorded of the families of clergymen and doctors in the rural parts owing their attacks to the head of the family bringing the disease home in his clothes, and of its being spread by means of coats and straw plait sent out from infected houses. The third point is brought out by Mr. Spear who gives an account of a case discharged from hospital after only twenty-eight days' detention being shortly followed by other cases in the same house. The possibility of the mediate infection of diphtheria is one that has not been sufficiently recognized up to the present, and we trust that future observations on the subject will not be wanting. At any rate, the evidence is sufficient to indicate the need of caution, especially by all concerned in hospital administration. Not less important is it that patients should not be

discharged from hospital before full recovery; and it is a good rule to insist upon a minimum detention of six weeks.—*Med. Press and Circular.*

NEWS ITEMS.

THE WILLIAM F. JENKS MEMORIAL PRIZE.

The second triennial prize, of four hundred and fifty dollars, under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The symptomatology and treatment of the nervous disorders following the acute infectious diseases of infancy and childhood."

The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with obstetrics, or the diseases of women, or the diseases of children;" and that "the trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia."

The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1892, addressed to Louis Starr, M.D., Chairman of the William F. Jenks Prize Committee.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

The celebrated Jonathan Hutchinson recently exhibited a case of skin disease before a medical society, with the statement that he was unable to make the diagnosis.

CORYZA.

The following solution for nasal catarrh is recommended by Professor Leffert, who claims it to be most efficacious :

R. Acidi carbolici,	℥j
Sodii boratis,	ʒj
Sodii bicarbonatis,	ʒj
Glycerini,	fʒj
Aquæ rosæ,	fʒj
Aquæ, q. s. ad.,	℥j

M. Sig. : Use as a spray.

FORMULA FOR MIGRAINE.

Dr. Hammerschlag publishes, in the *Allgemeine medicinische Centralzeitung*, the following prescription which he has found valuable in migraine :

R Caffein. citrat.,	gr. jss.
Phenacetin,	gr. iij.
Sacchar. lacti,	gr. v. M.
Ft. Pulv.	

Such a powder may be taken every two hours until the patient is relieved.—*Medical News*.

TREATMENT OF BARBER'S ITCH.

Dr. Rosenthal orders the seat of the affection to be closely shaved daily, and the following ointment to be rubbed in twice a day :

R Acid. tannic.,	gr. xlv.
Lact. sulph.,	ʒ jss.
Zinc. oxid.,	
Amyl.,	āā ʒ iv.
Vaseline,	ʒ j.

M. Sig. To be used twice daily.

In a month nothing remains of the eruption but a very slow disappearing erythema.—*Weekly Med. Review*.

SWEATING OF THE FEET.

The result of extensive experiments in the German army as to the best treatment for excessive sweating of the feet has been to prove the great superiority of chromic acid over all other applications. Of 18,000 cases in which chromic acid was used, 42 per cent. were reported "cured," 50 per cent. "improved," and only 8 per cent. "unrelieved." The feet are first bathed, and, after being thoroughly dried, a 5 per cent. solution of the acid is applied with a brush. Two or three applications suffice, as a rule, but the treatment has sometimes to be repeated after a fortnight.—*Brit. Med. Jour.*

As a head wash in cases of alopecia :

R. Creolin,	0.05
Hydrarg. bichlor.,	0.001
Aq. rosæ,	100.0
Aq. distill.,	400.0 M.

—*Canada Pract.*

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MONTREAL, MAY, 1889.

THE TRADE IN DEGREES

At a time when we are all trying our best to raise the standard of medical education in this country and are congratulating ourselves on the splendid reputation which Canadian diplomas enjoy in other countries, we are exceedingly grieved to read under the above heading the following remark on the alleged action of the University of Trinity College, Toronto, in selling degrees to non-residents of this country.

But of late ugly rumours have been abroad that another university in Toronto, in no way connected with the State University, has been offering to England a more than doubtful boon in the shape of degrees *in absentia*, such as once made certain German universities notorious, and such as are still dealt in by "diploma mills" in the United States. The "University of Trinity College, Toronto," was established by Royal Charter in 1852, "for the education of youth in the doctrines and duties of the Christian Religion as inculcated by the United Church of England and Ireland, and for their instruction in the various branches of science and literature which are taught in the Universities of the United Kingdom." Sums of money were freely subscribed in England, and especially in the English universities, for its endowment. But by the side of the noble University of the Province of Ontario, founded on broad and unsectarian principles, the Episcopal College has languished, and repeated begging in its aid

would seem to have at length exhausted the charity of benevolent churchmen at home. The Council have accordingly thought fit to raise funds by offering degrees for sale, not in Canada, where the limits of their charter are probably well understood, but in this country. An English "registrar," whose address is given in some of our medical contemporaries, and a "Board of Referees" have been appointed, and degrees in music have been the first "article" in which these gentlemen have dealt. To obtain these coveted and commercially valuable distinctions, candidates who have been rejected by our universities as unqualified for graduation have only to apply to the "Registrar," a "Rev. Dr.," no residence in Toronto is required; indeed, Trinity College seems to possess no teaching faculty in music; the small sum of £16, duly paid, is all that is necessary. The abuse has reached such dimensions that a deputation of persons representing the Faculties of Music in the English universities and colleges waited recently on Lord Knutsford, the Colonial Secretary, to ask that it might be stopped. His lordship gave a reassuring reply, and we may hope that ere long the "Registrar" and his "Referees" will be driven to take their musical wares elsewhere. But if a *communiqué* in two of the medical journals is to be credited, a new traffic in M. D. degrees is to be substituted. The same "Rev. Dr." may be consulted by qualified practitioners of five years' standing; the question arises whether he proposes to gratify their aspirations for a dignified title, without the irksome condition of further study or examination. We need hardly point out that the General Medical Council is not likely to admit to registration a degree of this nature, that it can add nothing to the reputation of any medical man who is inclined to accept it, that as the object of the University in selling it is frankly to gain money, the temptation to lower the five years' qualification limit will be strong; and lastly, that the sale of degrees without examination must undermine the efforts now being made in this country to raise the standard of medical education. The developments of this trade in degrees will be closely watched, and it is to be hoped that the opposition offered to it by the medical profession will be no less jealous and energetic than raised by the profession of music.

We sincerely hope for the good name of those who have honorably won their degrees after a long and arduous course of studies and a severe examination at the various other universities in Canada, that this charge against the university of Trinity College, Toronto, is not true, in which case we hope that its representatives will lose no time in giving an indignant denial to it in

the journal in which the above appeared. We cannot afford to have the slightest slur cast upon Canadian degrees, the holders of which are not inferior to those holding English or Scotch degrees.

BOOK NOTICES.

P. Blackiston, Son & Co., Philadelphia, published March 15th, a new Medical Dictionary, by GEORGE M. GOULD, A.B., M.D. It is a compact one volume book, containing several thousand new words and definitions, collected from recent medical literature, while the total number of words is beyond that in any similar book. It includes also elaborate and useful tables of the Bacilli, Leucomaines, Ptomaines, Micrococci, etc., of the Arteries, Nerves etc., and of the Mineral Springs of the U. S., together with other collateral information.

REPRINTED FROM ANNALS OF GYNÆCOLOGY AND PEDIATRY, March, 1890. Eleven cases treated by electricity. By T. Hewson Bradford, M.D.

IMPORTANCE OF ŒDEMA OF THE VAGINAL PORTION OF THE CERVIX UTERI AS A SYMPTOM OF CHRONIC DISEASES. By Andrew F. Currier, M.D., New York. Reprint from vol. xiv. Gynecological transactions, 1889.

PRESENT STATUS AND TENDENCY OF GYNÆCOLOGICAL THERAPEUTICS. By Andrew F. Currier, M.D., of New York. Read before the annual meeting of the Woman's Hospital Alumni Association. Reprint from the New England Medical Monthly.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS, OF PHILADELPHIA. Volume the eighteenth.

With this volume is bound the William F. Jenks prize essay of the College of Physicians of Philadelphia, on the "Diagnosis and Treatment of Ex ra-uterine Pregnancy." By John Strahan, M.D., M.Ch., M.A.O., of Belfast, Ireland. Prize awarded January 29, 1889.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, consisting of original treatises and reproductions, in English, of books and monographs selected from the latest literature of foreign countries, with all illustrations, etc. Contents:—The Human Foot; its form and structure, functions and clothing. By Thomas S. Ellis. Modern Cremation; its history and practice. By Sir H. Thompson, F.R.C.S. Aphasia; a contribution to the subject of the dissolution of speech from cerebral disease. By James Ross, M.D., LL.D. Published monthly. Price, \$10.00 a year; single copies, \$1.00. April, 1890.

INJURIES OF THE BLADDER DURING LAPAROTOMY; including a report of sixty-seven cases. By A. Reeves Jackson, A.M., M.D., professor of gynecology in the College of Physicians and Surgeons, of Chicago; fellow of the American Gynecological Society; British Gynecological Society; Chicago Gynecological Society, etc. Read in the section of obstetrics and diseases of women at the fortieth annual meeting of the American Medical Association, June, 1889. Reprinted from the "Journal of the American Medical Association." February 22, 1890.