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The Canada Medical Record

Vol. XX.

MONTREAL, FEBRUARY, 1892.

No. 5

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Original Communications.

A NEW FLEXIBLE INTRA-UTERINE ELECTRODE FOR POSITIVE GALVANO-CAUTERIZATIONS.

By A. Laphorn Smith, Professor of Gynecology in Bishop's University, Montreal.

Among the most troublesome cases presenting themselves to the gynecologist who desires to give them the benefit of Apostoli's treatment, are those of uterine fibroids in which the canal of the uterus is so tortuous that it is impossible to introduce either Apostoli's platinum sound or his carbon electrodes mounted on a solid stem. On some of these cases I have spent as many as eight seances without having once been able to introduce the electrode beyond the internal os, and this while every day was of importance on account of the severity of the hemorrhage and the patient's growing scepticism as to the result of the treatment. In a paper entitled "Why Apostoli's Method Sometimes Fails," which I read a year ago before the Canada Medical Association, at Toronto, I pointed out that this impossibility of reaching the diseased and bleeding endometrium was due to one or several fibroids projecting into the cavity of the uterus from opposite sides so that the uterine canal was no longer straight or slightly curved but consisted of

several curves in the form of the letter "S". When a patient therefore comes to us with fibroids we should in every case begin by exploring the uterine canal with a flexible bougie which will follow all the sinuosities of the canal, and having ascertained that the depth of the canal is 5 or 6 inches we should not be satisfied with a positive electrode any shorter than this. But the question arises, how can we introduce a metal sound which will resist the action at the positive pole of the electric current? Simply by covering a flexible bougie with wire, either platinum or aluminum, for a distance of one, two, three or even four or five inches from its extremity. The first cost of platinum wire would be greater since to-day it is worth \$10.50 an ounce while aluminum wire is only worth about ten cents an ounce. In the first ones I made the wire was put on in the following way: the ivory end of a medium sized bougie was cut off and a steel wire passed down the centre until it was arrested about a quarter of an inch from the olive-pointed end. This point was marked on the outside by withdrawing the wire and measuring the distance it had entered. A needle hole was then made at this point and one end of the platinum or aluminum wire was threaded into it and passed out at the other end. The wire was then wound around onto this

bougie for the required distance and then another pinhole was made into which the end of the wire was again threaded into the hollow of the longie and drawn tight. The two ends of the wire were then attached to a connecting tip to which the wire from the positive pole was attached.

At the request of several colleagues I have handed one of these to Messrs. Waite & Bartlett, the well known manufacturers of electrodes, who will in future keep them in stock. It may be objected that they will wear out, but I have found that one of them would generally last through the treatment of one case, and their price is so low that we can afford to throw it away. The best means of keeping them clean is to wash them with soap and water at the end of an application and then put them in a jar of pure glycerine until required again. The small part of the bougie at the end not covered with metal is a great safeguard, as burning a hole in the uterus is thus prevented, an accident which is possible when the metallic end of sound is pressed firmly against the fundus uteri and a heavy current turned on.

WHAT'S THE MATTER WITH THE OVARIES?

By Robt. T. Morris, M.D., New York.

Jennie is not well nowadays. Do you remember what a tomboy of a girl she used to be, and how hearty and rosy she was before her marriage two years ago last September? There ought to be a baby in the family by this time; but her cheeks are very pale and she does not often get down town of late to do shopping. 'Twas an untamed bachelor who described woman as an artistically prepared object with a pain in its back and constipated bowels, but that description fits Jennie now, poor thing! and there's more than that to say too, for there are pelvic pains and distress that never leave her for a moment. One acute attack of pelvic peritonitis she has had, and another will come on before long. Dr. Grebb examined her the other day. He asked her to lie down upon the bed and then without loosening the corset he poked a cold sturdy finger into the vagina and make out as well as he could that the uterus was retroverted. So he took down a pessary in the afternoon and fitted it snugly. He did not feel the ovaries and tubes, because somehow or

another he never did seem to have much luck at finding them and he wondered if anybody really ever did if the truth were told. "Come up to the office on Monday, Jennie," he said cheerily, "and we'll see if that pessary has'nt made a change. I've had lots of cases that picked right straight up just as soon as we got the uterus in place." But the pessary started up the old irritation of the bladder and the neuralgia of the left leg, and then came a flush upon the pallid cheeks, but no one would have mistaken it for the color that Dr. Grebb wanted to see. Mrs. Harvey was a sympathetic caller when she led her romping little Joe in to see her former gay schoolmate "Oh, Jennie," she said, "I wouldn't have that horrid old Grebb around me His cases always go like yours. If you would only call in my doctor—Doctor Selker—he's just too lovely for anything, and you will be just as well as I am if you only give him a chance to help you." What a pleasant face Dr. Selker showed at the door next day, and as he laid his hat and gloves gracefully upon the table and told grandma that she was looking younger every year, and patted Rover's head until the shaggy black tail wagged hard and fast in response, anybody could tell that he was a kind man who would do all he could to help a sufferer, especially one whom he had known as a boyhood friend. "Jennie! Ah, yes! more than your share of trouble, haven't you, poor girl," he said with feeling. She was lying upon a lounge in her mother Hubbard wrapper. "I won't hurt you a bit," said he, "but in order to find out exactly what the matter is I must make an examination. Neen't move any! There now! Sort of unpleasant, isn't it, but you know we doctors must do it if we are going to do our duty by little patients who put confidence in us." So Dr. Selker examined just as Dr. Grebb had done and found the same thing and a little more, that the uterus did not move very freely and there was a good deal of tenderness up in there somewhere. "Pelvic cellulitis! Hot douches are the thing for you," he said confidently. Didn't Dr. Grebb say there was pelvic cellulitis? Oh, well! Oversight on his part! Grebb is a good fellow, but sometimes a little careless about all the points in a case."

A week passed and Jennie was better. "Told you so!" said Dr. Selker. "Hot douches always do that, and now, Jennie, you just keep on with them, and you won't need to see us doctors any more."

How could Jennie know that when she married her Sam he had a trifling gleet that Dr. Grebb had said wouldn't be any obstacle to marriage? But her whom he loved so dearly, he had attacked, and had fired at her a weapon loaded with a charge more cruel than buckshot; so that years of suffering were to be her lot. The hot douching made her better but it tired

her a good deal, and by and by she didn't bother to use quite so much water or to have it of just the right temperature, and it was not long before she had again relapsed into the condition of the chronic pelvic invalid.

Gradually she will fade away with recurring attacks of pelvic peritonitis or will finally make a miserable recovery in a childless and dreary old age of nervous discomfort.

Her doctors might call in a surgeon or a gynecologist from the city, but Sam and Jennie have hardly started in as a young married couple and they are already handhapped by doctor's bills. There are a good many specially qualified younger men in the profession who would be glad to go out and help the patient for small fees, but her doctors have not yet heard of them and the men of whom they have heard are so well known that they cannot afford to care for any such case. So there the matter stands! Then again surgeons always want to cut, don't you know! and that's bad for the patient—that is—if the patient don't need it. And there's the thought too that Jennie may get well anyway if Dr. Grebb and Dr. Selker can only have patience to wait long enough. It is easy for the two strong, busy men to wait. If they were to actually make a diagnosis in the case then they would at least know what was best for the patient. Why don't they help her up on the kitchen table, clad only in a night-gown, and put each of her feet on a chair so that the knees and the hips are flexed and the abdomen is relaxed, and then pull the buttocks just over the edge of the table. After that the ovaries and tubes could be examined, but not unless the examining finger were introduced with the nail up. The edges of the finger tip would be depended upon principally for feeling purposes, and the fist would come just exactly right to crowd up the perineum so far that the examining finger would reach full three inches higher than it would if it were inserted with the nail down, and the fist in the way at that. *Pollice presso.* The patient dies! That's odd enough to be remembered.

But yet the proper insertion of the finger is not enough. A fist or the finger tips of an open hand must be pressed upon the abdomen firmly enough to crowd the pelvic organs down upon the examining finger, and even that is not enough. The fine sense of touch is all lost if the doctor pushes with his arm, and grunts, and lets a drop of sweat hang on the end of his nose. His elbow must be placed against his own hip or abdomen when the finger is in the vagina, and then his body forces the arm and hand forward so easily and with so little effort that the finger is at liberty to do its level best.

Smile, experts, if you will, at this simple and elaborate description of your trick, but remember the way in which that good old family physician, your respected preceptor, used to ex-

amine pelvic cases and tell us by-the-way if it was from him that you learned how to find ovaries and tubes. Remember, too, that the highly educated neurologist has told you that his cases of puerperal insanity have an elevated temperature; and he was not familiar enough with the pelvis to know that the temperature was associated with pus down there. With heads he deals and if the case turns up otherwise he loses. Remember that in every city block and in every country hamlet there are women languishing with pelvic disease. Their physicians are willing helpers, and practical men, and yet they do not make a diagnosis for lack of knowledge of a little trick or two. "Pelvic peritonitis" isn't a diagnosis. "Pelvic cellulitis" is worse yet.

Jennie is not going to get better. She has a pair of pus tubes and the ovaries are cystic and throttled with adhesions. She could never have a child even if the offending members were in the slop pail, but she could regain the rosy cheeks and the hearty laugh, and could be a useful member of the community and help her ambitious husband.

Doctor! Don't you know Jennie?

ANTI-KAMNIA AND THE ATMOSPHERIC TRACTOR IN OBSTETRICS.

By J. B. Riley M.D., St. Joseph, Mo.

Custom has ever allowed woman to bear the pains of the first stage of labor, however severe and prolonged it might be, without an effort to assuage their sharpness, or hasten the process of dilatation; in fact, any assistance offered at this stage was considered meddlesome midwifery, and condemned by the profession.

"Let nature take its course" has been religiously adhered to, and is responsible for much suffering that could have been relieved.

In a series of our last twenty cases of labor, we have adopted a uniform method of procedure, which has been satisfactory in the highest degree in every case. Our object has been to hasten delivery, beginning with the advent of labor, as well as to control the sharpness and severity of the pains of the first stage. Since the general adoption of chloroform in obstetric practice, the second and third stages have been rendered almost, and generally, entirely painless but the lacerating pains of dilatation have been left unrelieved. My custom is to administer a full dose of antikamnia soon as labor was announced by regularity of pains, gradually increasing in frequency and severity, and general relaxation of the generative passage. In a few minutes, generally in about twenty minutes after administering the quieting dose of antikamnia, we ordered a vaginal douche of warm water, about the temperature of the body, with castile soap, and soon as the first stage was completed, we applied the tractor, and complet-

ed labor as soon as possible, using chloroform in those more sensitive patients, in fact, in those who asked for it, or who suffered severely without it. In the twenty cases, there were six primipara, two of whom were aged twenty-nine and thirty-five respectively.

The average duration of labor was two hours and forty minutes, and this from the beginning of the first stage to the completion of the third. We will relate a few of them to show the results in individual cases :

Mrs. M., aged 41 years, fourth confinement. Was called at 4 p. m. Found pains light but regular, os size of a quarter. Gave ten gr. antikamnia, and in twenty minutes used prolonged douche at 100° F. In half an hour dilatation was completed. Applied tractor and completed labor at 5:40

Mrs. S., aged 26 ; third confinement ; very spare, and delicate constitution. I arrived at 11:20 p. m. ; found first stage completed, and pains very weak and irregular. Applied tractor and by light traction the pains were re-established, and labor completed at 11:55, under chloroform.

Miss W., aged 19 ; stout and fleshy ; called at 1:30 a. m. ; pains regular and severe ; patient denied that she was pregnant and refused any assistance. I called again at 7 a. m., and found her calling for relief. Os size of half dollar during pain. Gave ten grains antikamnia and douche, and at 7:45 the first stage was completed. Applied tractor and delivered without chloroform at 8:30.

Mrs. H., aged 36, primipera, and of a very nervous temperament. Had made up her mind that she would die in confinement. Called at 3:20 a. m. ; pains were short, but sharp and regular. Os admitted index finger. Gave ten grains antikamnia, and used the douch, during which patient fell asleep ; wakened in half hour, and the first stage was nearly completed. Applied tractor and delivered in an hour and twenty minutes without chloroform.

Mrs. P., aged 29, primipara, short and fleshy. Lived six miles in country. Arrived at 2:30 ; found first stage completed, and patient nervous and noisy, calling for chloroform, which I gave her, and applied the tractor and delivered in thirty minutes

Mrs. B., 31 years old, fifth confinement : called at 8 p. m. Said she had suffered severely all day with "nagging" pains. Os size of nickel. Gave full dose of antikamnia, and called again at 9:20 ; found the first stage nearly completed, and the patient resting comfortably ; said her pains had bothered her very little, and that she had napped some. I applied tractor, and completed labor at 10:30 without chloroform.

Mrs. S., 23 years old, second confinement ; had been in labor twelve hours. I was called in by her physician, who said that he found the first stage completed four hours before, and her

pains stopped. He advised a dose of ergot. We suggested the use of the tractor, which he used, and re-established pains immediately by light traction, and completed labor in forty minutes.

In a number of cases the first stage was more prolonged, but the suffering was uniformly controlled by the use of antikamnia. In every case it favored relaxation and an outpouring of secretions which softened and relaxed the perinæum, and by using the tractor delivery of the head was accomplished, in the majority of cases, in the interval of pains, and in but one of the twenty cases was there a perineal rupture, and that one very slight.

In a good per cent. of the cases the dilating pains were almost entirely destroyed and in several I found the first stage nearly completed, and the patient had said that "dose of medicine stopped my labor." Not every case tended to so rapid a termination, but in none was there hemorrhage or exhaustion.

Antskamnia is prompter and more decided in its action in labor than opium, and has none of the unpleasant after effects. It may be continued in smaller doses to control after pains, and rather favors than interferes with the secretion of milk. The tractor, if not used to hasten delivery, is indispensable in delivering the head during the interval of pains, thus protecting the perinæum.

Society Proceedings

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Dec. 18th, 1891.

F. BULLER, M.D., PRESIDENT, IN THE CHAIR.

Sarcoma of the Testicle.—Dr. Lafleur exhibited the specimen of a testicle uniformly enlarged, surface smooth, and tunica thickened. On cutting it open some soft substance bulged beyond the tunica. On section, the thickened tunica is seen with a new growth, consisting of sharply circumscribed areas of a dull yellow colour, while a grumous material filled up the spaces between these areas. Microscopically it is a round-celled growth, the cells being a little smaller in size than leucocytes, and have deeply-staining nuclei. Mixed in with the fibrillated substance there are spindle-shaped cells with oval nuclei. The yellow areas consist of necrotic tissue, are structureless, and do not take the stains. The softer portions consist of a broken-down mass of detritus with cells here and there that will take the stain. He could give no history of the case, but from the appearance of

the testicle the disease was probably of very rapid growth.

Cancer of the Lower Jaw.—Dr. Hingston exhibited two lower maxillæ which illustrated the two modes of invasion of the disease. In the first case the disease had begun in the bone itself, and in which the loss of substance was about the size of a finger, and had slightly involved the submaxillary gland. In the second case the disease had appeared on the outer surface of the bone as a result of extension from secondary disease of the submaxillary gland, a cancer of the lip having been removed a year before. When the disease begins in the bone itself the patient has a very much greater chance of recovery than when it is due to extension from the gland. He thought that he had better results after the operation for removal of the jaw for cancer in well chosen cases than he had after the removal of the breast. In one case he had removed the upper jaw and there was no return. In another case where he had removed the upper jaw the patient died of old age. It is necessary to make a clean sweep of all the diseased parts to have a satisfactory result.

Dislocation of the Astragalus.—Dr. Hingston exhibited a specimen and related the history of a complete enucleation of the astragalus. The patient, a powerful young man, got his foot caught in a strap in close proximity to a circular saw, and on making a very violent effort to escape produced this peculiar condition. There was a large projection on the inner side of the foot, over which the skin was much torn, and by simply enlarging the incision and with the aid of the bone forceps the astragalus was removed. There was also rupture of the tendo-Achilles, but the malleoli and the other bones of the tarsus were uninjured.

Enlarged Spleen.—Dr. Hingston related the history of a woman from whom he had, two weeks previous, removed the spleen, which weighed 13 lbs. The organ extended down into the pelvis and in front beyond the middle line, and had been of slow growth. The operation had been performed at the urgent request of the patient, and Dr. Hingston did not think that it was an operation he would care to repeat. After separating the connections with the stomach and liver he came down on the pedicle, which was found to be very short, it being necessary to encroach on the substance of the spleen before a sufficient hold could be obtained on the vessels to cut them, the pedicle that was removed with the spleen being only three-quarters of an inch in length, consisting of the remains of the splenic artery one-quarter of an inch. The substance was very friable and was easily torn, consequently hemorrhage was very great. The patient died seven hours after the operation. The removal of the spleen when there is an impoverished condition of the blood,

when the white corpuscles are in excess, is not a successful operation.

Dr. Shepherd did not think that primary cancer of the lower jaw was common. When a growth started about a tooth it was usually an epulis. He had removed many jaws, but had only one that did not recur, and asked if a microscopical examination had confirmed the diagnosis of cancer. He agreed with Dr. Hingston in regard to the bad prognosis in cases like the second. He had had three cases of removal of the astragalus for dislocation; in one case the man had a compound fracture of the opposite leg to the one in which the dislocation occurred, the result being an equal shortening of both legs. The spleen usually has a very long pedicle. He cited a case of removal of the spleen performed by Dr. Roddick in 1885 for severe laceration, part of the injured organ protruding through a wound. The patient died several hours after, when it was found that both the liver and kidneys were ruptured.

Dr. Hingston, in reply, said that a microscopic examination had confirmed the diagnosis of cancer. As a surgeon, he would rather trust to his sense of sight and touch, even if such an examination was not confirmatory.

Dr. Lafleur cited a case in which the tongue had been removed for supposed cancer, which on microscopic examination proved to be tuberculosis, and the patient died two weeks after the operation which acute miliary tuberculosis.

Nephro-Lithotomy.—Dr. Shepherd exhibited a large branched kidney calculus which he had removed a week before from a lady aged 50. She had suffered from symptoms of stone in the kidney for some thirteen years, and recently, after an attack of renal colic, a tumour developed in left loin and pus ceased to appear in the urine. The temperature ranged from 101° to 105°, with rigors and sweatings. On cutting down in the left loin the kidney was found perfectly movable. When incised a large amount of pus escaped, and on introducing the finger a branched calculus was felt in the pelvis of the organ and with difficulty extracted, as some of the branches breaking off remained encysted and were very hard to enucleate. The kidney was very much disorganized, and was of large size. The patient, at the time the report was made, was doing very well, and the temperature was perfectly normal. Dr. Shepherd remarked that he had previously removed the kidney for a similar condition, but now he preferred to remove all the stone, break open all pus pockets, and then drain freely. In this way what remains of the kidney substances continues to do its work, and the patient's chances are so much the better in the future in case the other kidney becomes similarly affected. In addition to this reason, he stated that nephro-lithotomy was a much less dangerous operation than nephrectomy. Dr. Shepherd related a case where he had

removed one kidney for calculous pyelitis, and four years after the other kidney became disorganized from the presence of a calculus. Operation was refused because patient had only one kidney, and she died uræmic a few days after entering hospital.

Placenta Prævia.—Dr. Springle gave the history of the case.

Two Cases of Nephro-Lithotomy.—Dr. Springle exhibited the calculi and gave the histories of the cases.

Dr. Shepherd congratulated Dr. Springle on his diagnosis. He had on several occasions cut down on the kidney for pain and found nothing, but at a subsequent operation he discovered a stone. In the case where pus still continues to be present in the urine, he thought that some fragments of stone must still be present in the kidney, and advised further exploration.

Dr. Armstrong said that cutting into a healthy kidney was a new operation; that the diagnosis is often difficult, and failure to find the stone does not indicate an error of diagnosis, for it may be discovered at a subsequent operation.

Stated Meeting, January 8th, 1892.

F. BULLER, M.D., PRESIDENT, IN THE CHAIR.

Anatomical Anomalies.—Dr. Shepherd exhibited the following:

(1) A case of *Persistence of the Right Aortic Root* in a female. In this case the right subclavian artery arose from the descending arch of the aorta and passed up to the first rib behind the trachea and œsophagus. The fourth arch having disappeared, there was no recurrence of the inferior laryngeal nerve round the subclavian. The nerve passed directly to the larynx.

(2) A *Skull*, in which there was a well-marked *par-occipital process* on each side of the occipital bone. This condition is normal in many carnivorous and graminivorous animals, but is of rare occurrence in man. This process is the homologue of the transverse process of vertebræ, and usually exists as the jugular process.

(3) A *Sternum* with well-marked *ossa suprasternalis* united by ligaments to the sternum and covered with cartilage. These bones are vestiges of the episternal bones of monotremes and lizards, and are of great rarity in man, this being the first specimen Dr. Shepherd had seen. It is supposed by morphologists that the meniscus seen in the sterno-clavicular articulation represents a remnant of this bone.

(4) A case in which there were patches of *calcification on the dura mater*. No history.

(5) A case of *Rheumatoid Arthritis* involving the joint between the odontoid process of the axis and the anterior arch of the atlas, forming a cap for the upper end of the odontoid. No history.

Lymphatic Leukæmia.—Dr. Lafleur exhibited specimens of glands from a woman aged 50,

who had suffered from rapid anæmia and glandular enlargement in the neck; no positive diagnosis had been arrived at before death. At the autopsy, on opening the abdomen the spleen was seen projecting three inches below the costal margin, and it measured about thirteen inches in length, six or seven in breadth, and four in thickness; was soft and the pulp diffuent; the colour was normal, and no growth was found in its substance. The glands all over the body were enlarged, and were similar in all the situations. They were isolated, smooth, and rather soft. On section, they were of a pinkish-red colour, while a number showed ecchymoses. From the medullary spaces of the sternum and ribs a light reddish semi-fluid material could be compressed. There was no opportunity of examining the marrow of the other bones. No other notable changes were observed. The liver was normal in size; there were no lymphoid nodules. The kidneys were slightly hyperæmic. No examination of the blood had been made before death, and the blood obtained at the autopsy was disorganized; all that could be made out was a moderate increase of white cells. In the pharynx the lymphoid structures were swollen; the lingual tonsil and tonsils stood out as prominent white tumours, and were ulcerated on the opposing surfaces. In both the glands and spleen there was simple hyperplasia of the lymphoid cells. The question arose, Under what head should this condition be diagnosed? Lymphatic leukæmia, rapidly growing sarcoma, or Hodgkin's disease? As the condition of the blood was not known it is difficult to make a positive diagnosis. The characters and enlargement of the glands are like those seen in Hodgkin's disease, yet there were no lymphomatous nodules present in the spleen.

Dr. Schmidt, who had attended the case, said that he had been called to see the patient about eight days before death. She was a widow, aged 62 years, and for two months had been suffering from symptoms referable to the stomach, vomiting and pain. He found her in bed, suffering from weakness and dyspnoea, with expression of much suffering; dry, sallow skin, and unable to lie on the right side on account of the pain produced in the left. Liquid food only could be taken. A tumour was felt in the epigastric region extending from under the ribs to almost the level of umbilicus, and was tender to the touch. The right leg was much swollen. A few days before death a sore throat was noticed, which was, to all appearances, of the nature of diphtheria. The tonsils were covered with a thick yellowish-white membrane, and here and there on the mouth were small white patches, probably of an aphthous nature. Only one record of the temperature and pulse had been taken, and that a day before death, the temperature being 99.4° and pulse 108. At this time she passed a black stool mixed with

some bright blood. Glandular enlargement in the neck was only noticed two days before death. From the general appearances, Dr. Schmidt thought that it was probably a case of cancer of the stomach.

Ulcerative Endocarditis.—Dr. Lafleur exhibited a very typical specimen of this condition. The patient, a negro, aged 40, had an attack of rheumatism (the first attack) six months before, and had been in the hospital for three months. Clinically there could be detected signs of an endocarditis with insufficiency of both aortic and mitral valves. At the autopsy there was found hypertrophy and dilatation of both ventricles and left auricle, the hypertrophy about compensating dilatation. There was old disease of the mitral valve, while on the ventral flap there was a large vegetation, having a hole in the centre, and to it was attached a large fibrinous clot, which was divided into threads at the end, caused by its flapping backwards and forwards in the blood-stream. There is an erosion and rupture of the tendinous cordons attached to one of the papillary muscles, which is very characteristic of malignant endocarditis. There is general thickening of the aortic valves, with vegetations where the valve-touch each other. There is a distinct loss of substance, which is encircled by a rim of vegetations. There were no septic emboli found in any part of the body. This is rather unusual, as the proportion of non-embolic to embolic cases is small. Other lesions in the body were those of chronic heart disease. The immediate cause of death was a lobular pneumonia.

Dr. Mills asked if the pneumonia could be traced to the condition of the heart.

The President said that it is not an infrequent occurrence to come across an embolus of the central artery of the retina, and he could not think that this vessel could be the only one singled out. He had seen cases which had been so diagnosed when no changes could be found in the heart or vessels, and thought if the diagnosis was correct there must be some further explanation of the occurrence of these emboli.

Dr. Lafleur, in reply to Dr. Mills, said that there was no evidence connecting the pneumonia with the heart lesion. In answer to Dr. Buller, he said that the only explanation he could give was that the ophthalmologist takes much greater notice of minutiae than the general practitioner. There may be many emboli all over the body which could not be diagnosed except by such direct examination as by the use of the ophthalmoscope.

Multilocular Ovarian Cyst containing Bone and Cartilage.—Dr. E. A. McGannon of Brockville exhibited the specimens, which he had removed from a girl of 16 on Dec. 30th, 1891, and gave the following history of the case:

The patient had always been healthy, though

somewhat anæmic for the last two years. Menstruation began at 14½ years, had always been regular and of the twenty-eight day type, flow lasting for three days, being scanty and without pain. She first came under my notice complaining of lancinating pains in the left inguinal region. On examination, an abdominal tumour was found, which I diagnosed as ovarian. Consent was withheld until a short time previous to the date of the operation. The patient was then put into the St. Vincent de Paul Hospital and subjected to the usual preparation for abdominal section. On Dec. 30th, assisted by Drs. M. C. McGannon, T. F. Robertson and J. W. Lane, I opened the abdomen and removed the specimens now presented. The pedicles were ligated with silk and the stumps carefully covered with peritoneum, catgut being used in this procedure, and the dropped. The abdominal wall, as a whole, was taken up by silkworm gut sutures, but before tying them each layer of the wall was brought together with catgut. The patient made an uninterrupted recovery, the temperature reaching on one day only 99½°.

I must ask your pardon for thus going into some of the details of this operation when presenting a specimen; but I desire to invite discussion on some points of interest other than those presented by the specimen. First as to the specimen. The larger of these tumours was taken from the right side, and, as you see, is a mixed tumour, being a multilocular cyst containing cartilage and bone—a rather rare variety of tumour, and one that I believe occurs oftener in women of from 15 to 25 years. The smaller tumour, taken from the left side, is simply a cystic ovary showing well the marks of ovulation. This patient began to menstruate only eighteen months ago, yet these ovaries have been active and these tumours have been developing much longer than eighteen months, which is, in my opinion, strong evidence in support of the theory that ovulation has little to do with menstruation, and goes on long before that function is established. Second, I would invite criticism on the utility of carefully covering the stumps with peritoneum, thereby avoiding adhesions. Third, as to the closing of the abdominal wound. Hernia following laparotomy or abdominal section is, unfortunately, not rare, and is a very embarrassing sequela. It is no doubt frequently, if not always, due to some particles of fat or muscle getting between the fibrous layers of the abdominal wall and preventing their union. Primary union may occur in the skin, but the skin is an elastic tissue and plays no part in supporting or keeping *in situ* the abdominal contents. It is very essential that good union should be had between the fibrous layers, and to this end they should be brought together. The time is coming, if it has not already arrived, when hernia following abdominal section will be charged (and properly)

so) against the operator who neglects to thus close the abdominal wall. The sutures through the whole act as supports or splints, and though silkworm gut is efficient, silver wire, in my estimation, would be better.

Dr. Wm. Gardner considered the specimen of great interest, as such a condition is very rare. There is nothing of the dermoid nature about it. He had removed many dermoids, but had never come across a cyst containing bone and cartilage. It is very generally admitted that menstruation may exist independently of ovulation; the persistence of menstruation after the removal of the ovaries may be accounted for by some portion of the ovarian stroma being left behind at the time of the operation, or that ovarian stroma may have existed in some other situation as between the layers of the broad ligaments. It often, unhappily, occurs that menstruation and pain are not relieved by the removal of the ovaries. Regular menstrual discharge also persists in double ovarian tumours, due, probably, to some of the stroma remaining unaffected. In regard to the technique suggested, he thought it a very complicated method. In his experience hernia is exceedingly rare, and he had never taken such precautions. Mr Tait, in a lecture which appeared in a recent number of the *London Lancet* (Sept. 12, 1891), laid great emphasis on not making the incision in the linea alba, but on opening the sheath of one of the recti muscles, and by this procedure claimed that the danger of hernia is lessened. He (Dr. Gardner) simply repeated the statement, but was not able to confirm it. If a splint was needed for the abdominal incision, he thought silkworm gut was infinitely superior to catgut, as it could be buried and would be permanent. Speaking of catgut as a material for ligatures, he said that he had, during the last few months, used a large quantity of it, and it had never showed any evidence of setting up trouble. He had much more confidence in it now than formerly, and in plastic operations on the vagina nothing was equal to it.

Dr. Mills said that in the lower animals, what corresponded to menstruation is always associated with ovulation, and he thought that as the process of civilization had produced disturbances of the menstrual function, so there may also be a more or less dislocation of the two processes. Again, as the genital organs constitute a complex whole governed by a complex nervous mechanism, there may be other influences that tend to bring about menstruation independent of the reflex action from the ovaries. Periodicity may also account for the appearance of menstruation after the removal of the ovaries.

Dr. Shepherd thought that the tumour was congenital; it was something like a tumour he had seen in the floor of the mouth. As for closing the abdominal wound with buried sutures, it was very good in theory, but he did

not know if it had been proved that hernia occurred after such a proceeding. He had only one case of hernia following abdominal section, and that was in a case where there was a large stinking abscess about the appendix, which was plugged with gauze and allowed to heal by granulations. In using catgut, he never felt sure that it was aseptic. He preferred the finest silk for buried sutures, and thought that it was the safest material that could be used.

State Meeting, January 22nd, 1892.

WESLEY MILLS, M.D., IN THE CHAIR.

Carcinoma of the Ovary.—Dr. Alloway exhibited the specimens and gave a detailed account of the case.

Dr. Laphorn Smith congratulated Dr. Alloway on his presence of mind. He said that it was formerly the custom to apply a tight binder about the abdomen to prevent the blood flowing into large abdominal veins after the pressure of the fluid or the tumour had been removed, and thus increased the pressure in the coronary arteries. He thought that the salt solution in this case acted in the same way.

Dr. W. Gardner could not explain why collapse had come on so long after the operation. He asked why Dr. Alloway had used such a strong salt solution; that which he was accustomed to use was very much weaker. He noticed that the ovaries were very small for this condition, and asked Dr. Alloway if he thought that the disease was primary in the ovaries, with secondary deposits in the omentum and retroperitoneal glands. He had had a number of cases of carcinoma of the ovary with ascites, but always found the organs markedly enlarged.

Dr. Alloway replied that he thought the disease was primary in the ovaries; he could give no reason for their being small. The disease appears in both ovaries nearly twice as often as in one. The only explanation he could give for the syncope not occurring at the time of the operation was the stimulating effect of the ether, and when that passed off the diaphragm dropped and removed support from the vessels, and the patient was literally bleeding to death within her own veins. In carcinoma the ascitic fluid is poured out and is not absorbed, because the lymphatics are blocked.

Dr. J. E. Molson asked how, then, was the salt solution absorbed?

Dr. Alloway said that the salt solution was much more absorbent than the grumous ascitic fluid.

Dr. Mills was glad Dr. Alloway did not explain the absorption of the salt solution on the theory of osmosis; he had always opposed this theory, and thought that before very long it would disappear from physiology. Would the saline fluid be so rapidly absorbed as to raise the

blood-pressure and to cause the heart to act so much better? He rather favoured the view that the warmth acted as a stimulant to the nervous system, for in experimenting on frogs' hearts, if after the heart has ceased to beat, salt solution is run through it, it will be stimulated into activity. The stimulating effect of the warm bath is familiar to all. He thought that sterilized water would have acted in a similar manner. He looked upon the ascitic fluid as an excretion, and being such could not be absorbed again.

Ovarian Cyst and Chronic Salpingitis.—Dr. A. L. Smith exhibited the specimens and read the following report of the case:—

Mrs. B., aged 41, was sent into the Woman's Hospital by Dr. England. She came under my care there on January 1, 1892. She was a tall, rather thin, but wiry-looking woman, and bore on her face the traces of prolonged suffering. She was married, the mother of six children, and had her last child six years ago. She had no miscarriages. Menstruation had been normal as a girl; since marriage it had been normal, but for the last six years it has been exceedingly painful, irregular, and profuse. She enjoyed fairly good health until three years ago, when she was taken ill with inflammation of the bowels (pelvic peritonitis), which confined her to bed for seven weeks, five of which were in hospital. She has never been a day well since. Locomotion has been painful, and there has been unbearable dyspareunia. She was unable to work, and had to spend the most of her time in bed or lying around. On examination, the cervix was found to be lacerated and hypertrophied, but slightly movable; the fundus was firmly fixed. Just above the cervix, in Douglas' pouch there was a sharp angle, into which the finger tip could be introduced, and above that a large, round, sensitive swelling which felt like a retroflexed fundus. Pressure on this caused a sickening sensation and the sound entered the uterus forwards. All above and on both sides of the uterus the pelvis was filled with a hard mass which could not be moved. Diagnosis before operation was, therefore, pyosalpinx with local peritonitic effusion binding down the ovaries and tubes in Douglas' cul-de-sac.

Operation.—After several days of preparatory treatment—hot baths, purgatives, hot douches and dieting—the patient was anaesthetised with the A.C.E. mixture at 12.30 on the 9th Jan. Dr. England assisted me, and there were present Drs. Campbell, Reddy, Bruere, and the members of my class. The abdomen was shaved and scrubbed with soap and water and bichloride. A three-inch incision was made in the median line, and on introducing two fingers of my left hand into the abdomen I found the true pelvis walled off from the rest of the abdominal cavity by a false membrane, which I had to go through in order to reach the uterus on the left side. My

finger then came upon a fluctuating sac about the size of a small orange which was continuous with the tube. With the greatest difficulty I managed to dig this out of the mass of adhesions in which it was buried, which I had to dissect with my finger until I reached the bottom of Douglas' pouch. The cyst proved to be the ovary with the tube enlarged and adherent to it. On the right side, deep down, I dug out without much difficulty what proved to be a coil of small intestine. On trying again I brought up the very much thickened right tube, which I ligated and cut off. The right ovary seemed normal, and I therefore left it. The cut ends of both tubes were touched with Paquelin's cautery. The peritoneal cavity was then flushed with a gallon or two of boiled water at 110°F. until it came fairly clear; some of this water was left in. A long glass drainage tube, open at both ends and perforated on the sides, was introduced to the bottom of Douglas' pouch, and the abdominal incision was closed with six silk-worm gut sutures passed through the entire wall three-quarters of an inch from the edge. The drainage tube was fastened to the nearest of these stitches and filled with a strip or wick of sterilized gauze. The wound was then buried in a thick layer of boracic acid and a dressing of gauze placed over it, the drainage tube being closed with absorbent cotton. The vomiting after the operation was very severe, and persisted for several days. The tube was removed at the end of forty-eight hours, and was found to be full of coagulated bloody lymph which the wick had failed to aspirate. Efforts were made to move bowels with Rochelle salts at the end of twenty-four hours, and were repeated every four hours for two days before anything passed through. A great many things were tried to stop the vomiting, but what succeeded best was one grain of calomel and five grains of bicarbonate of soda every hour. A turpentine enema and turpentine stupes brought away the first wind and promptly reduced the commencing tympanitis. I allowed her one small hypodermic of Battley immediately after the operation, and the house surgeon gave her another the second night. After that the pain was relieved with hot fomentations, which were very effective. The temperature has been $98\frac{1}{2}^{\circ}$ most of the time, except on the evening of the fourth day, when it rose to $101\frac{1}{2}$, and two or three other times when it reached $100\frac{1}{2}$. This is now the fourteenth day and there is every prospect of her recovery from the operation.

Dr. A. Bruere gave the following report of the microscopical examination: The transverse sections of the tube reveal round-celled infiltration of the fibrous connective tissue of the mucosa. In many of the folds of the mucous membrane these cells have undergone fatty degeneration, and fat globules and detritus are to be seen. The ciliated epithelial cells lining the mucous

membrane have undergone proliferation in some places. Several layers of non-ciliated epithelial cells, irregular in shape, are to be seen. Between the circular and longitudinal layers of the muscular coat the fibrous tissue is more dense than normal, but there does not seem to be any atrophy of the muscular elements. In the serous coat most of the small veins and capillaries are distended with blood, and there are also extravasations of blood. A large number of small round cells are to be seen in some parts of the fibrous tissue. Dr Bruere showed several of the sections under the microscope.

Dr. Alloway asked Dr. Smith why he removed the right tube and not the right ovary. The object of the operation was to bring the menopause.

Dr. Wm. Gardner also thought that the ovary should have been removed. He did not think that the menopause would occur. He said that he had repeatedly found blood-clot in the drainage tube, and he preferred the sucking method of cleansing it. There is a decided reaction going on against the drainage tube. Howard Kelly had not used it in his last forty cases, as he had learned to trust more to the power of absorption possessed by the peritoneum. If the use of the drainage tube can be avoided the patient will be in a much safer condition, for it is a source of danger, being liable to become infected. Abdominal surgery of the present day without the drainage tube is not what it was ten years ago without the drainage tube, for we have learned that if the peritoneum is aseptic it may be trusted to absorb any blood that may escape into it.

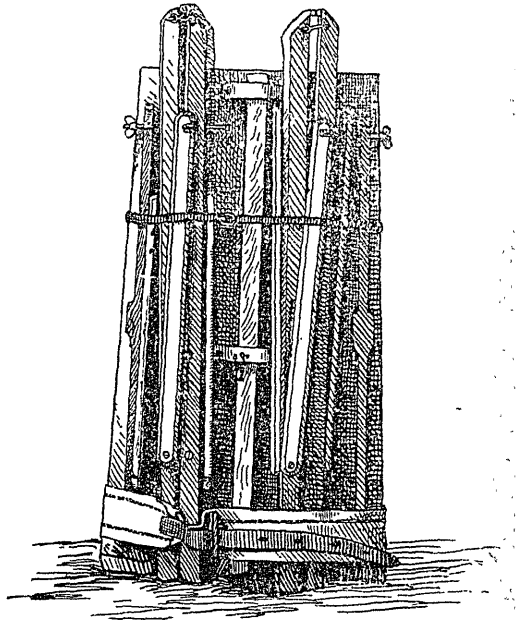
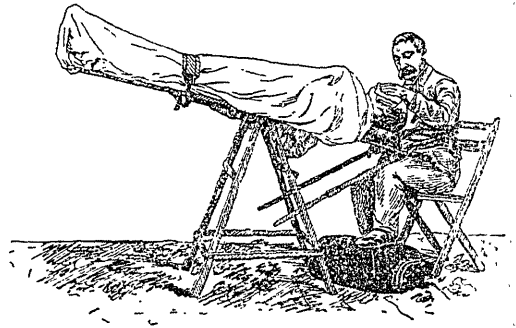
Dr. Smith, in reply, said from his experiences in a former case, where the character of the woman towards her husband had been entirely changed by the removal of the ovaries, he thought that by leaving the ovary or even a portion of one there would be enough to keep up the physical traits of sex, and he hoped that by so doing in this case the pelvic symptoms would be relieved and her character would remain unchanged.

Dr. Alloway said that it is a well known fact that the removal of the ovaries has nothing more to do with the change of character than is seen in a woman years after the menopause.

Dr. Mills thought the question was of great importance. It should be definitely settled whether a surgical operation modifies the function or not. Castration changes the nature of a dog very much more than the removal of the ovaries affects a bitch, and he regards it as an illegitimate procedure.

A New Portable Laparotomy Table.—Dr. Laphorn Smith exhibited a table of his own invention. He said that when a surgeon is suddenly called upon to perform laparotomy in a private house, the first requirement is a *clean,*

narrow table, and this is seldom available. He thought it was desirable for the laparotomist to bring his own table with him. Such a table must be of so small a compass that it can be placed in a carriage, and though strong enough for its purpose, should be light in weight, and should not be expensive. As certain steps of the operation are to be performed in the horizontal position and others in the Trendelenburg position, it is necessary that this table be so constructed that the change in position can be



readily made. The table, which he showed, possesses all these requirements. It is made of a pine ironing board, one inch thick, cut in the middle, and hinged so as to fold up, measuring six feet long when open and three when closed. It is 18 inches wide at the top and tapers down to 12 inches at the bottom. A sliding bar three feet long, made of hard wood, gives increased strength at the joint. The legs are made of inch and a half pine, and can be foled up; when opened out they form a sort of wooden horse,

three feet high, on which the table is balanced on a pinion, like a pair of scales, so that the head can be raised or lowered with the slightest pressure. Two iron bolts fasten the top of the table to the legs, and are provided with thumb-screws, which can be tightened up in a moment. The table is prevented from teetering by means of two folding bars fastened at one end to the head of the table, the other end passing through a notch in legs, where they are fixed in any position by steel pins passing through them. The legs are stayed with folding bars, one end being provided with a slot which passes over a screw head in the leg opposite to the one to which it is attached. As to strength, the table had been several times tested with persons weighing over 200 lbs. lying upon it. As to lightness, it weighs altogether only 30 lbs. It folds up so small that it may be easily carried in the hand or under the arm. It is provided with a strap of broad webbing which not only serves to bind the legs and the table together when being carried, but also to fasten the patient securely to the table. The greatest claim to originality is the *low cost*. Cleveland, Edebohls, Trendelenburg and Fœrster have each invented tables, but they are not only too heavy and bulky to be portable, being made of iron, but they are exceedingly expensive, costing from \$35 to \$150. With this description and the accompanying engravings any carpenter can make the table for about \$10. Therefore its cheapness is as valuable a quality as its comparatively great strength and portability.

Friedreich's Disease.—Dr. Schmidt regretted that he had not been able to obtain permission to bring the patient, an inmate of St. Bridget's Home, before the Society, but gave the following history of case:—The patient, a girl of 21, suffers from a train of nervous symptoms. Her mother died fourteen years ago, having been paralyzed for some time; father died three years ago of influenza; one sister is affected in the same way as the patient, and is at present confined to bed; a female cousin cannot walk, and has clonic contractions of the face and hands; and one brother died of consumption. She first noticed difficulty in walking nine years ago. She now walks with great difficulty, the gait being very ataxic, feet wide apart; the whole foot touches the ground at the same time. She looks continually on the ground, the body being bent forwards. Movement of the hands and arms also ataxic. Speech is scanning and is difficult to understand. Tremulous movements of the tongue when protruded. Slight nystagmus, but no other eye symptom discovered; pupils dilated. She can stand alone with the eyes closed, though vacillating; Sensibility of the skin unaffected. Sometimes has pains in the hands, but pain along the spine, is almost constant. There is a slight left lateral curvature of the dorsal region of the spine, the hollow of the

lumbar region almost obliterated. There is loss of patellar tendon reflex; no ankle clonus. She sleeps well and her mental condition is good.

Progress of Science.

DYSENTERY; ITS ETIOLOGY AND TREATMENT.

By J. P. Lapsley, M. D.

At the earliest periods we find dysentery was one of the most common diseases, well known both to physicians and the laity, although, as we think now, very absurd ideas were entertained as to its etiology. Herodotus first called the disease dysentery in an account of an epidemic in the Persian army as they were marching through the deserts of Thessaly. It is evident from his definition of the name that he knew the same disease we now call dysentery, although numerous other diseases were called under the same name at that time.

Etiology. The etiology of dysentery has been from time immemorial a subject of discussion and disagreement between members of the profession, and even to this day a diversity of opinion exists among authorities, but it is the almost universal opinion of those with best opportunities of observation that epidemic dysentery is due to a specific cause, a miasm which emanates from the soil; but the precise nature of the morbid agent is still unknown. More difficulty is encountered in the study of micro-organisms in diseases of the intestinal tract than in any other set of diseases, because of the great numbers of micro-organisms found in the intestines in health, since decomposition and fermentation begin in the large intestines forming the bacteria and torulæ producing these processes. It is a well-known fact that a large portion of the human feces is composed of micrococci, bacteria, and torulæ, and in dysentery, although the two former are not increased in numbers yet the torulæ are much more numerous than in health. Although the exact nature of the germ has not yet been discovered, it is a settled fact that dysentery can not be had without the presence of a specific germ, by whatever name it may in the future be called.

The numerous other factors in the etiology of the disease may be explained as influencing and producing the germ and thereby causing diseases. Dysentery may then be classed with typhoid fever as a specific and miasmatic contagious disease, due to a germ not yet isolated and possessing remarkable tenacity of life, as cases are on record where the disease has been contracted from privies and vaults being closed ten or more years after dysenteric stools have been emptied into them. Epidemics of dysentery almost always prevail in the hot seasons

of the year and in localities where vegetable decomposition is most favorable, as in moist, swampy places. Heat and moisture in ancient times were considered two of the greatest factors in the causation of the disease, but they only influence it by being favorable to the production of the germ, as in some very hot places there never was an epidemic of dysentery.

"Taking cold" is by far the most common idea of the causation of the disease, and is always the explanation of the cause of obscure cases of this disease, as well as all other diseases that human flesh is heir to, when the physician needs something behind which to hide his ignorance. Nevertheless it is a well-known fact that many cases are seen to come on after sudden changes in temperature from hot days to cold nights; the direct exposure of the abdomen to the influence of the cold causes congestion of the mucous membrane of intestine and thereby predisposes it to the action of the germ and the outbreak of the disease.

Among other indirect causes of the disease (that is, causes predisposed to the action of the germ) are enumerated nervous influences, such as anger, sorrow, long-continued mental exertion, in fact everything that may cause disturbances of the emotions; action of irritating articles of diet, such as acrid foods, unripe fruits, and decomposing and fermenting foods, impurities in drinking-water, and hardened feces remaining in the lower bowel until an inflammation is set up. To sum up the etiology of dysentery in as few words as possible, we may say that dysentery is a miasmatic, contagious disease analogous to typhoid fever and due to a specific cause or germ to be found in the air, alimentary canal, and in all other places favorable for the growth and dissemination of germs.

Pathology. Dysentery is a local affection, but if long-continued and severe will show constitutional symptoms, like all other diseases. It is usually ushered in by a gastro-intestinal catarrh, and after a few days symptoms of dyspepsia and diarrhoea set in and increase, with pain in abdomen, nausea and copious fluid discharges, violent griping and tormina with great depression. Tenesmus becomes intense and more or less constant and the discharge is attended with no relief. The region of the rectum becomes inflamed and is the seat of intolerable, burning pain. The discharges may be copious or scant, dark brown, thin and highly offensive, and containing scybala, or finally they may become so scant that with the greatest effort only very small quantities of mucus streaked or tinged with blood are passed. In some cases the discharges contain lotura carnea, sometimes the discharge is pure blood. There may or may not be fever, but the pain and discharges quickly exhaust the patient and lead to emaciation and profound prostration; skin becomes hot and dry, tongue heavily

coated, and the face wears an anxious expression characteristic of the disease. An acute case of dysentery sometimes subsides without lesions, and the duration of an attack may be cut short by proper treatment. Specific dysentery lasts from two to four weeks, but some cases show a peculiar defiance and resist all treatment, even the last resort, change of climate.

Treatment. Under favorable circumstances and proper hygiene the majority of cases of the catarrhal form recover without special treatment in from three to ten days; but epidemic dysentery has no duration and but little tendency to spontaneous cure; but the worst cases are often checked by appropriate treatment. In all cases of dysentery perfect rest is the first requisite for treatment, and absolute milk diet should be enforced. Active treatment should begin with a saline laxative, such as a seidlitz powder, a dose of Rochelle salts or sulphate of magnesia in broken doses—which in fact has been considered by some to be in itself a cure for the disease—a large dose of castor oil or from five to ten grain of calomel. For the relief of pain in lighter cases tincture of opium with camphor-water and nitric acid will be all that is necessary. Since dysentery is undoubtedly a local and specific disease, by far the most rational treatment is by irrigation of the large intestines in severer forms. Many cases will recover almost immediately after an irrigation with cold or ice-water, if the lower bowel be thoroughly irrigated and all of its contents removed. Wood highly recommends the treatment of specific dysentery by injection of nitrate of silver, ʒ to O. H₂O, three times daily, and claims some surprising cures. A very successful way of irrigating is by injecting as much water as possible with a dram of alum to the pint. Salicylic acid is in this way often a benefit, but carbolic acid can not be used on account of its toxic effects. Bichloride of mercury has also been frequently used as well as all the other antiseptics. If there is a specific in the treatment of dysentery it is pulverized ipecac. In all acute cases give from 30 to 60 grains every four hours, as it must be given in decided doses to obtain its effects. My method of using it is to give one dram, and if necessary repeat in six hours. It causes a great deal of nausea, and sometimes vomiting for two hours. Then the patient breaks out in a profuse perspiration, the pulse becomes fuller, softer and more regular, and tenesmus and abdominal pains cease and there are no more stools for from eight to twenty-four hours. Ipecac has all the advantages of mercurial purgatives without their irritating action; all the results of sudorifics without their uncertainty; all the benefits of opium without any of its disadvantages. Should the remedy fail to be of value in forty-eight hours, it should be discontinued and irri-

gations used. Turpentine, internally and externally, has had its advocates; also astringents, such as tannic acid, kino, catechu, krameria, acetate of lead, and nitrate of silver; also boric acid, opium and its preparations, and quinine. All other things failing as a cure in chronic cases, a permanent change of climate should be advised.—*Am. Pract. and News.*

CHRONIC RHEUMATISM.

Chronic rheumatism, including chronic articular rheumatism, and all varieties of muscular rheumatism under that heading is a very troublesome complaint, but a very important one, owing to the larger number of people, especially amongst the poorer classes, who suffer from it. The treatment is, therefore, one to be carefully considered; and in this short article I propose to give a brief resume of the methods of treatment I have found most beneficial.

The clothing of the patient must be attended to. It is essential that flannel should be worn next to the skin. The Jaeger underclothing is very good. The diet should be nourishing, and if stimulants are required, a little whiskey is, perhaps, the best. The internal treatment adopted is very various. I have found the following prescriptions most useful:

R. Pot. bicarb.	gr. xv
Pot. iod.	gr. iij
Tr. hyoscam.	m x
Spt. chlorof.	m v
Inf. gentian.	ʒ ss

Ft. haustus, ter in die.

In strong adults, a few drops of vin, colchici is beneficial. I have seen good results from three-grain doses of salicylate of soda three times daily. Guaiacum is useful in some cases.

As the patient progresses a mixture like the following may be given:

R. Ferri et ammon. cit.	gr. x
Pot. iod.	gr. iij
Pot. bicarb.	gr. xij
Spt. chlorof.	m v
Aquæ pimentæ.	ʒj

M. Sig.—Ter in die.

The syrup ferri iodidi answers well in some cases. If there be much pain, opiates, especially given subcutaneously, are often of marvellous efficacy. If the patient is debilitated, cod liver oil is useful.

Local treatment: This is a most essential part of the treatment, and here we have a large variety of means.

1. Counter-irritation by blisters and liniments.

2. Baths—hot air, vapor, hot-water, and Turkish. Massage is useful in some cases. If much pain, hot fomentations will often relieve it.

Counter-irritation: Blisters are of more use

in acute cases, but sometimes are useful in the chronic form. Amongst liniments may be mentioned camphor, belladonna, aconite; oil of eucalyptus is a most useful application, especially when continued with the belladonna; oil of winter-green mixed with equal parts of olive oil is very efficacious. I have now used this formula for several years. Its use is particularly beneficial in chronic cases attended with much pain, and if this liniment be well rubbed into the affected parts, the pain generally stops for five or six hours after application. It has only failed to relieve the pain in an extremely limited number of cases.

The liniment composed of equal parts of olive oil and the ethereal tincture of capsicum is an old remedy recently revived by Sir James Sawyer. I have now used this application in about fifty cases, and in only two did the patients fail to derive any benefit. It is also a most useful topical application for neuralgia. It must be used with care, the patient being told to use it in very small quantities, to protect his hands when so doing—gloves are generally recommended—and the patient must be warned that none of the liniment gets into his eyes.

The treatment of chronic rheumatism is, however, at the best, not entirely satisfactory, and our patient will always have to be careful about exposing himself to wind and weather, and that he is warmly clad. We must also always remember that in these chronic cases of rheumatism we often discover cardiac murmurs on auscultation, even when there has been no previous symptom of cardiac mischief.—*Hospital Gazette.*

THE ETIOLOGY OF CHEYNE-STOKES RESPIRATION.

Dr. M. A. Boyd read a paper on the etiology of Cheyne-Stokes' respiration, in which he reviewed all the physiological explanations of this phenomenon offered by writers on the subject since Stokes' time to the present day. He particularly pointed out the very rational explanations offered by Traube and Filehene, who regarded the respiratory derangement from the altered nutrition of the respiratory center point of view; and those of the Dublin School, including Hayden and Little, who regarded it primarily from the cardiac point of view, and complimented the Dublin School as offering by far the best evidence, both clinically and pathologically, in explanation of the phenomenon. Having alluded to the marked rhythmical irregularities between the heart pulse and respirations in this affection, Dr. Boyd drew attention to a point which heretofore in the literature of the subject, so far as he was aware, had not been previously alluded to—namely, that the latter portion of the forced respiratory phase of the Cheyne-Stokes' cycle is chiefly an expiratory

one, in contrast to the first portion of it, which is an inspiratory one; and that this forced expiration had a most important bearing on the weak ventricles of the heart, by helping them to squeeze the blood on the one side into the pulmonary artery, and on the other into the dilated and inelastic aorta. In proof of this he exhibited sphygmographic tracings showing that it was only during this expiratory portion of the respiration that arterial tension was raised in the arteries, and that this tension continued through the apneal period following, during which time the respiratory center was fully supplied with arterial blood and the weak and degenerated left ventricle resting. He regarded the apneal period, during which time respiration was suspended, as only an effort on the part of the higher automatic centers to rest a heart the ventricle of which is either too feeble to charge an arterial system, the aorta of which may be dilated and inelastic, or the vaso-motor control of which may be defective, and whose own blood supply may be rendered insufficient in consequence, and its nutrition enfeebled. After the intrinsic muscle of the heart has been fed by this increased arterial tension of expiratory and apneal periods, forced inspirations begin again, and the heart contractions are stronger, but they fail to fill the dilated aorta, till the forced expirations, by making pressure on the ventricles, come to their aid again. The most typical and pronounced forms of Cheyne-Stokes' respiration were to be met with in alterations of the heart and aorta produced by degeneration and disease. The form of it met with in cerebral disease or injury, and in apoplexy and uremic coma, without any primary engagement of the heart, he regarded as due to direct interference with the respiratory in the medulla, either by pressure or poisoned blood, and the phases of it were never so well marked as in those cases of the affection depending primarily on alterations of the heart. Owing to its dual origin in this way comes the differences of opinion as regards its pathology. As regards its treatment, Dr. Boyd found so much improvement following the inhalation of oxygen in all the cases where disease or degeneration of the heart produced it, that he urged a trial of this remedy in all such cases, and ventured to suggest, from his experience of the remedy, it should be tried not alone in this affection but in all cases where degeneration of the heart existed from any other cause.—*Lancet. Am. Practit.*

SANTAL OIL FOR COUGH.

Curtin finds that sandal wood oil often gives relief to the cough in phthisis, catarrhal pneumonia, chronic bronchitis with asthma and influenza. It is given on sugar or floated on water. *Am. Pract.*

HOW TO TEST THE VISION—TEST TYPES.

It is often a matter of great importance to determine whether a person sees perfectly or not. If a person has normal or perfect vision, the conclusion naturally follows that the eyes are not diseased. On the contrary, if the vision is found to be defective or imperfect, then there must be either congenital defect, some anomaly of refraction, or some inflammatory or organic disease, which causes the defective vision. In the latter event the examination must determine to which class the trouble belongs. But how can we determine whether the vision is perfect or not? For this purpose some one of the numerous test types must be used. All are based on the same fundamental idea, so it is immaterial whose test types are used, but Snellen's are in most general use. Experiments with normal eyes have proven that two points, such as two black dots, must be far enough apart to subtend an angle of one minute at the macula lutea before the eye can determine that there is any space between them. Further experiments have proven that block letters—as high as they are wide—must subtend an angle five times greater than that of the two dots to enable the normal eye to see all their parts distinctly. Consequently the test letters must subtend an angle of five minutes at the retina. This is the fundamental principle of all test types. Some letters of the same height and width can be seen distinctly much farther than others, but the principle holds good. It is immaterial how far the letters are placed from the eyes, since their size must be proportionately greater or smaller according to their distance from the eye. Suppose two straight lines start at the retina and diverge, as they extend, so as to form an angle of five minutes. Now, test letters, at whatever distance from the eye they may be placed, must be just large enough to fill the space between these diverging lines. If close to the eye, they must be very small; if twenty or more feet away, they must be proportionately larger. If one hundred feet away they must be proportionately larger. In this way it is easy to see that the same principle—an angle of five minutes—covers the test at all distances. As a matter of convenience, the test is usually made for the distance, say from ten to twenty feet from the patient. The test letters are numbered from one upwards, according to the distance in feet, they should be distinctly seen by an eye with normal or natural vision. Suppose a patient wishes to know whether he can see perfectly or not. Place him, say ten feet, before a card of test types of large and small letters. Cover one eye (for in all such tests only one eye must be tried at a time) and ask him to run over the line of letters numbered X; if he does so readily, that eye has normal vision. If he reads readily still smaller

numbers, the vision is more than perfect. If he cannot read easily No. X, the vision is defective. Suppose the eye can read promptly only No. XX at ten feet; then the degree of vision would be represented by $\frac{10}{20} = \frac{1}{2}$. Suppose the eye reads No. VIII at ten feet, then the vision would be represented by $\frac{10}{12.5} = 1\frac{1}{4}$, which means that it is one-fourth more than perfect. The other eye must be tested in the same way, and a similar record made. If each eye sees readily No. X at ten feet, the vision of both is perfect, and the record would be $\frac{10}{10} = 1$. The conclusion would be that, since the vision is perfect, there is no disease of the eyes. There is occasionally a rare exception to this conclusion, but it is a safe rule to follow.—*St. Louis Med. and Surg. Jour.*

EXAMINATION OF THE URINE FOR LIFE INSURANCE.

1. If albumin is found in the urine, do not recommend the application for insurance because the quantity of albumin present is small, even though it be mere traces.

2. If albumin is present in the urine and the applicant is over forty years of age, decline the application.

3. If albumin and renal casts are found in the urine, decline the application regardless of the age of the applicant or the quantity of albumin present.

4. If albumin is found in the urine in large amounts—two or more grammes to the litre—decline the application.

5. If the applicant is of middle age or over, and has always been a generous eater, especially of meat; and if he rises regularly at night to void considerable quantities of clear urine of low specific gravity; and if, in addition, there is decided tension of his pulse, with accentuation of the second sound of his heart, decline the application even though the urine is free from albumin.

6. If true renal casts are unmistakably present in the urine, either epithelial, granular fatty, hyaline, or composite, decline the application, even though the urine is free from albumin.

7. If the specific gravity of the urine is normal (1.020) or above, but contains albumin at times, while at other times it contains none, especially on rising in the morning, and no casts are present in the urine of an applicant who is under thirty years of age and apparently in good health. Albuminuria is doubtless of the so-called functional form, and, in the discretion of the home office, the application may be accepted for a ten-years' endowment policy. As yet, however, such risks cannot be considered altogether safe for life policies.

8. If the applicant is subject to frequent or occasional attacks of gravel—one or more of which was recent—the application should be declined.

9. If the applicant has had one or more attacks of gravel, and more or less dull pain is present in the renal region, and the urine is more or less turbid from the presence of pus, the application should be declined.

10. If the applicant has had attacks of gravel, but five years have elapsed since the last attack, the urine remaining perfectly normal, and no pain is present in the region of the kidney, the application may be accepted.

11. If the applicant is over fifty years of age, and voids his urine with more or less slowness and difficulty at times, the stream being small, forked, or dropping, and at time involuntarily shutting off before the finish, and if he rises regularly at night to void urine, and is subject to periodical attacks of frequent urination, the application should be declined, even though the urine itself is in every respect normal.

12. If the urine contains sugar, the application should be declined.

13. If the urine is turbid from admixture with pus or blood, the application should be declined.—*Purdy, New, York Medical Journal.*

THE TREATMENT OF RETROFLEXION.

Dr. Feit (*Festschrift d. Berlin. geburstshif. Gesellschaft zum X internat. med Kongress, p. 59*) notes that retroflexion of the uterus has become a surgical disease, and therefore, since all cases do not demand operation, precise indications for treatment must be laid down. Life is not endangered by this malformation; some retroflexions are readily cured by simple therapeutic measures; while, on the other hand, no operation can restore the uterus to position as long as it remains fixed. The most easy cases for permanent cure are those which occur before thirty, whether in relation to the puerperium or from more obscure causes. For the results of abnormal labors and mismanaged puerperia are not the sole cause of retroflexion. That malformation is occasionally found in newborn children, and not rarely at puberty. Here cause and effect may be confounded, for the beginning of menstruation can hardly go on so normally in a chlorotic girl with faulty position of the uterus as in a robust subject. In cases of retroflexion in young subjects the careful application of the pessary is sufficient treatment, and half the cases so treated will be permanently cured after wearing the instrument frequently changed, for about a year. The operations are ventro-fixation, shortening of the round or utero-sacral ligaments, and Schucking's vaginal hysteropexy. The results are at the best faulty, for they can not make the uterus move freely at the same time that it lies in a good position between other viscera, bladder, intestines, etc. As long as a retroflexion is movable it requires but little treatment in a woman past the change

of life. The pessary will act best when the uterus remains bulky and not atrophied. In virgins it is often best to dispense even with pessaries, and turning their attention to the condition of their genitals is most objectionable; the nervous system, if fortified by any means which divert the patient's attention from the local affection, will allow the trifling discomfort of the retroflexion to be well tolerated. Massage is of questionable value; it may increase the patient's nervousness, which is worse than the displacement. When pessaries are used, they will best avail if any pre-existing endometritis or metritis be cured. Fresh retroflexions after child-bed are the most favorable for treatment. Ergot should be first administered, nor should the pessary be applied till the eighth or tenth week, and when the instrument is changed a smaller pessary should be applied. Cutting operations are only justifiable when pessaries can not be borne and do no good. Retroflexion with fixation of the uterus may be left alone in a sterile subject; in a patient anxious to bear children and also suffering from malformation the case is different. The operations above mentioned have not been so generally adopted as to allow of judgment on their justifiability. Schucking's vaginal hysterectomy, which binds the fundus down forward behind the bladder, is bad on theoretical grounds. Freund and Frommel's shortening of the utero-sacral ligaments and forming of adhesions in Douglas' pouch, however, is more in accordance with reason.—*British Medical Journal*.

INTESTINAL ANTISEPTICS.

The Paris correspondent of the *Medical News* states that Professor Bouchard recommends the following in cases of gastric and intestinal fermentation as found in cases of gastric dilatation, in poisoning by decayed or diseased meats, in typhilitis, dysentery and typhoid fever, and in diseases in which there is insufficient renal secretion:

R Beta-naphthol, finely pulverized ℥ss.
Salicylate of bismuth ʒij.
M. Divide in hostia No. xxx.
Sig. Give from three to ten daily.

Professor Dujardin-Beaumont recommends the following:

R Pure bisulphide of carbon gr. xxv.
Essence of peppermint gtt. xxv.
Water ʒv.

M.

Dr. Huchard recommends:

R Salicylate of bismuth }
Salicylate of magnesium } āā gr. lxxv.
Benzoate of sodium }

M. Divide in hostia No. xx.

Sig. One to be given before each meal.

—*St. Louis Med. and Surg. Jour.*

THE CLINICAL COURSE AND THE PRINCIPLES OF TREATMENT OF CHRONIC ANKLE JOINT DISEASE IN CHILDHOOD.

Dr. Charles L. Scudder says that chronic ankle joint disease usually results in a satisfactory termination of the mechanical treatment based upon established principles is carried out. In spite of these expectant methods, malignant cases of tuberculosis of the ankle joint, whether of primary, synovial or osteitic origin seem to go all to pieces. Tissue is quickly destroyed, great abscesses form and the general health fails. Nature is attempting to get rid of the diseased part, which at first is a purely local affection. A complete excision of this local disease merely interprets Nature's need and assists her. The operation may be performed at the outset of the disease, or as a last resort, or at the first appearance of malignancy. An operation is only justifiable when the evidence of malignancy remains unchecked by proper mechanical treatment. In children of poor parents who cannot give the time and proper care to expectant methods an early operation is justifiable. In determining the evidences of malignancy or need for operative interference the factors to be considered in each individual case are: The age of the patient; the duration of the disease; the previous treatment; the hereditary history; the present appearance of the part; the general condition of the patient; the circumstances of the patient. The operations on cases of ankle joint disease during twenty years at the Boston Children's Hospital warrant the following observations. Primary amputation in children and young adults is never justifiable for chronic ankle joint disease; an aseptic complete excision of the diseased bone is a safe procedure, a partial operation is, comparatively, of no value; gouging and the burr drill are blind methods, and almost worse than useless; the time of the after treatment is greatly diminished; the general health improves rapidly after excision; profuse suppuration and its attendant dangers are immediately checked; the danger from tubercular and septic infection is diminished; the extent of the disease does not contra-indicate an operation for its removal; the result as to usefulness in all cases has been good.—*Boston Medical and Surgical Journal*.—*Occidental Med. Times*.

FOR PERSISTENT DANDRUFF.

Dr. Stephen recommends that we should use a mixture of 3 scruples each of resorein, olive oil and sulphuric ether, and 6½ ounces of alcohol. To be well shaken and applied to the scalp by a bristle brush, by insinuating it with the locks of hair; the head to be well washed with soap and warm water twice a week.—*Ibid.*

LIFE INSURANCE AND SYPHILITIC "RISKS,"

Mr. Jonathan Hutchinson has published a paper in the London Practitioner on the "Modern Treatment of Syphilis," in the course of which he considers some of the more important relations of syphilis and life insurance. He states that he had recently been requested by a life insurance company to formulate a code of rules for the guidance of its examiners when considering the acceptance or rejection of applicants for insurance who have had syphilis. His advice on this subject was for the most part favorable to the applicants; with this exception, however, that he would decline those persons who at the time of their presentation, shall be undergoing the active development of secondary symptoms. These applicants, he advises, should be told to wait until these symptoms had disappeared. He based this counsel on the fact that it is always desirable to know how well or how ill the syphilitic patient sustains the specific treatment proper to the second stage of the disease, and also how willing and attentive he may be to follow out the directions of his physician. Mr. Hutchinson holds that an insurance company might make a profitable business out of syphilitic risks accepted in the early stage of the disease and taken at the ordinary rates, for he has found that the threatened life is often a long one. In his experience such syphilitic persons appear quite as likely to attain to length of days as others who have not been syphilitic. In the cases of those who present themselves free from symptoms, but who have the history of a former attack, the advice is that they be not refused, provided they have not definitely become the subject of the tertiary lesions of the disease, or have not, owing to idiosyncrasy or inadequate treatment, had a prolonged siege of secondary symptoms. But even among these there are not a few would be regarded by Mr. Hutchinson as eligible risks at ordinary rates.—*Journal American Medical Association.*

PRURITUS SENILIS.

The *Deutsche Medicinische Wochenschrift* gives the following treatment:

1. Starch or bran baths once a day.
2. At night the body should be washed with water at 104° temperature, to which the following has been added:

Carbolic acid ʒi;
Aromatic vinegar ʒvi. M.

3. A powder should then be dusted on containing

Salicylate of bismuth ʒiiiss;
Starch ʒij. M.

—*Am Practit.*

THE GREAT VALUE OF PEROXIDE OF HYDROGEN IN DIPHTHERIA.

In the next chapter, we shall give further details with regard to the treatment of diphtheria, but at this point we feel that we should not close without announcing in the most emphatic terms, that one of the most available agents that we have for the fighting of diphtheria locally, and preventing constitutional involvement, is the "Medicinal Peroxide of Hydrogen" made by Chas Marchand, of New York. We would take no chances by using any other manufacture. Charles Marchand was the pioneer in the development of this particular agent, for medical use. It is the "Medicinal" Peroxide of Hydrogen which can be depended upon to render diphtheria germs inert as thoroughly as water can be depended upon to put out a fire, or as heat can be relied upon to annihilate the icicle. We believe that every case of sore throat, whether pronounced diphtheria or not, as well as every case of scarlet fever, should have applied to the sore throat at intervals varying according to the necessities of the situation, the full strength of the Marchand's Peroxide of Hydrogen. It may be used as a gargle, though I am somewhat in favor of flushing the parts with a good syringe, or if this is not available, owing to the objection of the patient, particularly if it be a little one, atomizers are now furnished which act very efficiently, and by using them frequently, the full effect can be secured. It is well to give internally occasionally, teaspoonful doses of the peroxide. It may be diluted or not, as one pleases. All the secretion which has been swallowed will thus be acted upon in the stomach. In addition, there is a general accumulation of fermentative products in the stomach, undigested food, etc. "The oxidation of these irritants is desirable. If the patient complains that the application is irritating, it may be deluted with one or two or three parts of water.

The position which we took nearly four years ago with reference to the use of Peroxide of Hydrogen in the treatment of diphtheria in a paper read before the St. Louis Medical Society, has been strengthened with the experience which has followed. We would emphasize every material point then made in that paper. If asked "if we were to depend upon only one agent in the local treatment of diphtheria, what would we call for," the response would be emphatic, in thundering tones, "Marchand's Peroxide of Hydrogen," and if we ascertained that any druggist furnished our patient with any other than Marchand's it would be sufficient for us to condemn that druggist and rather than run the gauntlet of his repeating the offense, we would supply the medicament at our own expense.—*Medical Mirror.*

THE TREATMENT OF FURUNCULOSIS.

Dr. Viel publishes in the *Monatsschrift für Pract. Dermatologie* an interesting paper on the treatment of furunculosis. He says that the first aim of such treatment should be to destroy the pyogenic coccus in the skin by anti-parasitic remedies before necrosis of the tissues has taken place. If this necrosis has already taken place, then the separation of the necrotic mass and the expulsion of the pyogenic cocci should be accelerated as much as possible. The next aim should be to prevent by injections a new formation of boils. Lastly, the system should be prepared to resist a new invasion of the cocci. The author says that it is rarely possible to fulfil the first condition, and when once the invasion of the pyogenic cocci has produced visible alterations, such as swellings, nodes, or vesicles, necrosis has occurred, and the glandular secretory tract is occluded by pus. This prevents any antiseptics which have been applied to the skin from penetrating the pyogenic cocci at the fundus of the gland. It is therefore impossible for the carbolyzed mercurial plaster of Unna, the concentrated spirituous solutions of boracic acid recommended by Lowenberg, and many other applications, to do any good. The injection of a three-per-cent carbolic acid solution and the introduction of a wire armed with nitrate of silver are most painful and, after all, uncertain. In speaking of the next condition of treatment the author decidedly recommends the old method of hot poultices. He considers that no remedy leads so quickly and certainly to the desired result. To prevent infection of the neighboring tissues he recommends washing the skin with cotton-wool dipped in a one-per-cent solution of corrosive sublimate, or, when the skin is very sensitive, of a four-per-cent aqueous solution of boracic acid, before the application of each poultice. At night the boil is covered with a paste of equal parts of zinc and vaseline with four-per-cent of boracic acid on lint. He also recommends that very indolent boils should be opened, and thinks that it is wrong to squeeze them too soon. The paste also serves to guard the neighboring glands from infection. When a bath can be borne, the author prescribes sublimate baths. He gives his patients highly nourishing food, and when they are anemic preparations of iron.—*London Lancet*.

TARTAR EMETIC FOR CONSTIPATION.

In constipation occurring in the thin and anemic, the efficacy of sulphate of magnesium can be much increased by the addition of gr. j-ij of sulphate of iron, taken before breakfast each morning. However, if the patient be of full health, robust and plethoric, you can add to the Epsom salt with much advantage gr. 1-16-1-12 of tartar emetic.—*Western Med Reporter*.

RULES FOR GUIDANCE IN CATARACT OPERATIONS,

H. Knapp, M. D., *Am. Lancet*;

1. Keep out bacteria, or wash them off by germless, unirritating liquids; boiled water, boric acid and other indifferent substances dissolved in boiled water.
2. Prevent the multiplication of germs by antiseptics; watery mercuric bichloride, or alcoholic bichloride, chlorine water, nitrate of silver, and other substances in very weak solutions.
3. Perform the operation with the utmost degree of neatness and accuracy, and with a minimum of traumatism, avoiding bruising, scratching, and tearing of any kind, so as to reduce septic conditions to a minimum.
4. Endeavor to obtain primary union by freeing the wound from all foreign substances, by perfect coaptation of its edges, and by maintaining the greatest possible immobility of the organ until the closure of the section is firm.
5. Avoid constitutional infection of the wound. It is dangerous to operate for cataract as long as the constitution of a patient is under the active influence of a specific disease; for instance, articular rheumatism, acute or chronic suppuration, syphilis and the like. In some incurable diseases—for instance, diabetes—we must select a time when the vitality of the patient is least reduced.—*W. Med Reporter*.

DESQUAMATION AFTER SCARLET FEVER.

Dr. Louis Starr advises the following treatment during the stage of desquamation: Anoint the entire surface of the body, including the scalp, daily, with an ointment of:

R. Acid carbolic	grs. xx
Thymol	grs. x
Vaseline vel ung. simp	ʒ j

Then put in a warm bath for five minutes, protecting from cold, and put to bed, wiping the body dry beneath the bed clothes. This has the effect of hastening desquamation and of disinfecting and preventing the dispersion of the scales, which are active vehicles of the contagion.—*Archives of Pediatrics*.

FOR HEMOPTYSIS.

R. Fl. ext ergot.	gtt. 160
Acid sulph. dil.	gtt. 320
Tr. aconite rad.	gtt. viij
Syrup limonis, of q. s., ad	f ʒ ij

M. et Sig.—A teaspoonful every half hour, or less, as required.

W. R. D. BLACKWOOD, M. D.
Philadelphia.—*Medical Summary*.

REMEDIES FOR NIGHT SWEATS.

The practice of using gr. 1-60 or 1-120 of sulphate of atropine for night sweats is very common, but occasionally cases are met with in which unpleasant symptoms, such as a scarlatina-form rash, dry throat, restlessness, numbness, etc., arise from even the smaller dose mentioned above. It is rather remarkable that the antidote to atropia poisoning, viz: pilocarpine, should in small doses act well in such cases of night sweating. The following, taken from the *Med. News*, will be of interest in this connection: The various remedies brought forward at different times for this troublesome state have each in its turn proved useless in certain cases, and while agaricin may be mentioned as one of those which deserve the least praise, in our own experience pilocarpine amounting to the twentieth of a grain, given from one to two hours before the sweat is expected, are potent for good. The means by which this result is brought about are not far to seek. The drug in all doses greatly stimulates the peripheral ends of the nerves supplying the sweat glands. In many instances we find excessive secretion dependent upon depression of function, as in a serious diarrhoea or a local sweating of the feet. These states pass away just so soon as the parts regain their normal tone through proper treatment. The night sweats of phthisis are improved by pilocarpine, because this drug in all doses stimulates the sweat glands. In large doses this stimulation amounts to diaphoresis; but in the minute dose such as we name, the stimulation just balances the depression, and a normal tone is acquired. While it is true that pilocarpine and atropine are physiological antagonists, it will be found practically beneficial to prescribe small doses of both in such cases as refuse to respond to either one alone, as by their antagonism they prevent overaction on other parts of the body, and both act in harmony in so influencing the sweat glands as to be of service to the physician. *Western Med. Reporter.*

SALICYLATE OF LITHIUM IN RHEUMATISM.

M. Vulpian has read, before the Académie de Médecine, a summary of the result of experiments on salicylate of lithium in articular rheumatism. He states that his experiments indicate that lithium salts are not so poisonous as they are supposed to be. Salicylate of lithium is not more dangerous than salicylate of sodium, and can be administered in almost equally strong doses. In acute articular rheumatism salicylate of lithium relieves the pain which often remains in the joints after the swelling has disappeared, whereas colchicum and salicylate of sodium have no effect. M. Vulpian believes that salicylate of lithium is especially beneficial in fi-

brous rheumatism. In progressive subacute rheumatism M. Vulpian has seen salicylate of lithium produce great improvement. Salicylate of sodium has been successful in such cases, and produced amelioration of the patient's condition; but both greater and more lasting benefit is obtained by salicylate of lithium. In chronic articular rheumatism M. Vulpian has found salicylate of sodium useless, whereas salicylate of lithium has had a marked effect on the joints, which become less swollen than before the treatment. This drug sometimes induces headache and deafness, but is never followed by the distressing noises which characterize treatment by salicylate of sodium. The headache and deafness disappear quickly.—*London Medical Record.*

FOR ECZEMA AND NEARLY ALL CHRONIC ERUPTIONS OF THE SKIN.

The following has practically been found to be of great value as a purifier or cleanser of the blood in all manner of chronic eruptions of the skin. It is a grand alterative, as it were. Used in combination with the wash it will be found invaluable in many otherwise troublesome cases.

R. Potass. iodidi. ʒ ij
Soda hyposulph. ʒ iv
Aqua. ʒ ij

M. Sig.—Ten drops to one-half teaspoonful three times a day.

R. Hyd. chlor. mit. ʒ j
Acid tannic. ʒ ss
Glycerine,
Aqua camphor,
Aqua calcis, aa. ʒ ij

M. Sig.—Apply locally as a wash several times daily.

Philadelphia. *Medical Summary.*

ALOPECIA.

Charles Monin recommends the following ointment (*Union Médicale*) for alopecia:

R. Acid gallic, gr. xlv.
Olei ricini, ʒ v.
Vasolini alb, ʒ x.
Ess. lavandul, gtt. xv. m,

Sig. Apply to scalp morning and evening, rubbing in well.

A writer in the *London Lancet* recommends the following:

R. Tinct. jaborandi, ʒ ss.
Lanolini, ʒ ij.
Glycerini, ʒ ij. M.

Sig. Apply at night in small quantity.

In order to secure a good mixture, a small quantity of *sapo viridis* must be added to the above.—*St. Louis Med. and Surg. Jour.*

LOCAL TREATMENT OF DYSENTERY.

Dr. H. C. Wood calls attention to the local character of dysentery as usually seen in this climate. It is not a constitutional affection, and should be combated with local rather than general treatment. The ordinary treatment owes much of its influence to a local influence.

In acute dysentery, involving the colon high up, he has found large enemata, containing two or three drams of subnitrate of bismuth, much more efficient than the exhibition of bismuth by the mouth. When the symptoms are severe this local treatment may often be preceded with advantage by washing out the colon with large quantities of cold water. He has never used injections of nitrate of silver in acute dysentery, although the effect of the local application of the nitrate in other inflammations of the mucous membranes would justify trial of the remedy. He has seen in one or two cases large enemata of very hot water injected without affording relief, and believes that hot water enemata are, in their ordinary results, not at all comparable with large injections of ice-cold water.

When the lower part of the colon is affected the local use of ice sometimes has an almost marvelous effect. The author has seen the whole aspect of a very severe and alarming case, in which the symptoms indicated that the colon was affected high up, changed in a single hour by the continuous use of ice suppositories. While it is not necessary to have a piece of ice entirely regular in shape, care should be exercised that no sharp edges are left. The suppositories should be rapidly used, one being put into the rectum every three to five minutes, so as to give, for at least half an hour to an hour, the effect of the continuous application of cold.

When tenesmus is very severe iodoform suppositories are often much more efficient than opium in bringing relief. A remedy which has been from time to time recommended very highly in dysentery but has not been much used is ergot: and when the passages contain large quantities of blood, or are nearly pure blood, the extract of ergot would seem to be indicated. Dr. Wood has never used ergot by the mouth in these cases, but has employed suppositories containing twelve grains of extract of ergot and four grains of iodoform, used every two hours until four or five suppositories had been taken, with seemingly great advantage.

The local treatment of dysentery is not advocated as a substitute for the use of mercurials purgatives, and ipecacuanha, etc., but as a very important adjuvant to the older forms of treatment. Nevertheless, in the author's experience the effect of local remedies has been more prompt and decided than that of drugs given by the mouth; and in cases of any severity the attack upon the disease may be made from each end of the mucous tract.—*Boston Med. and Surg. Jour.*

TREATMENT OF CROUP.

Dr. H. R. Wharton says in the *Medical News*: When I see a case of croup comparatively early in the disease when the symptoms are not so urgent as to demand immediate operative interference, I also employ this course of treatment which, I feel sure, often averts the necessity of operative procedure. If the case be one in private practice, I have the patient put into a room where there is a stove, and upon this is kept constantly boiling a large pan of water to moisten the air. If the room is heated by a furnace I use a gas stove or alcohol lamp to heat the water and accomplish the same purpose.

I give the patient internally:

R	Carbonate of ammonium	gr. ij.
	Syrup of senega	m x.
	Mucilage of acacia	ʒ ij.

M.

To be given every two hours unless the patient vomits, in the event of which I diminish the frequency of the dose.

I also frequently employ a steam atomizer in the receiver of which is the following solution:

R	Sodium carbonote	ʒi-ʒijss.
	Glycerin	ʒij.
	Water q. s.	ad ʒiv.

M.

This solution was first recommended by Mr. Parker, of London.

If the patient is old enough to be manageable he should inhale the vapor from this for a short time, at intervals of fifteen or twenty minutes. If the patient is unruly or so young as not to be able to inhale the vapor, I have the bed converted into a tent by the use of a few sticks and a sheet, under which the steam atomizer is kept in operation, the spray being directed as near to the mouth as possible.—*St. Louis Med. and Surg. Jour.*

APPENDICITIS IN THE FEMALE.

As the result of his observations, Richelot presents the following conclusions: (1) On account of the proximity of the uterine annexes the diagnosis of appendicitis is more difficult in woman than in man. Suspicion is naturally around when the pain and induration are well up in the iliac fossa and entirely to the right, and should always be excited whenever the symptoms are markedly predominant on the right, even if there be evidence of lesions to the left; even if the pain be referred to the uterine annexes, and even if rectal and vaginal touch reveal induration at the right border of the uterus. (2) With the reserves already formulated surgical intervention should be bold and early. The prognosis of the disease left to itself is extremely grave. The earlier the operation the more it approaches in relative benignity the modern operations in the region of the uterus.—*Union Medicale, Occidental Medical Times.*

CHRONIC RHEUMATISM.

The clothing of the patient must be attended to. It is essential that flannel should be worn next to the skin. The diet should be nourishing, and, if stimulants be required, a little whiskey is, perhaps, the best. The internal treatment adopted is very various. I have found the following prescription most useful:

R. Pot. bicarb,	gr. xv.
Pot. iod,	gr. iij.
Tr. hyoscyam,	m x.
Spt. chlorof.,	m v.
Inf. gentian,	f ʒss.

M. S. Ft. haustus ter in die.

In strong adults a few drops of vin. colchici is beneficial. I have seen good results from three-grain doses of salicylate of soda three times daily. Guaiacum is useful in some cases.

As the patient progresses a mixture of the following may be given:

R. Ferri et ammon. cit,	gr. x.
Pot. iod,	gr. iij.
Pot. bicarb,	gr. xij.
Spt. chlorof,	m v.
Aquæ pimentæ,	f ʒss.

M. S. Ter in die.

The syrupus ferri iodidi answers well in some cases. If there be much pain opiates, especially given subcutaneously, are often of marvelous efficacy. If the patient is debilitated cod-liver oil is useful.—*Hospital Gazette*.—*Med. and Surg. Reporter*.—*Pittsburgh Med. Review*.

GUAIAIC GARGLE.

We find the following in one of our exchanges. To not a few of our practitioners who have passed their meridian, guaiacum is esteemed only a little less than a specific for "sore throat," tonsillitis especially. The following is a combination for a gargle that has been very useful:

R Ammoniated tincture of guaiac	
Compound tincture of einchona aā	ʒiv.
Chlorate of potash	ʒij.
Strained honey	ʒiv.
Powdered acacia	q. s.
Water	ʒijss.

M.

Sig. To be used as a gargle, and a teaspoonful may be swallowed every second hour.—*St. Louis Med. and Surg. Jour.*

EXALGINE IN PEDIATRICS.

Dr. Moncorovo, in the *Bulletin General de Therapeutique*, reports a series of cases illustrating the beneficial action of exalgine in various painful affections in children. Without exception the drug was always well tolerated. In not a single instance did it produce those unpleasant symptoms so frequently seen to follow its use in adults, such as apparent drunkenness, roaring in the ears, darkening of the face, etc. The remedy

was given to the children in doses ranging from 5 to 30 centigrams. As the drug does not taste badly, it was given in substance or administered in a little wine.

In all cases the action of exalgine was far superior to that of antipyrin, as in medium doses it acted equally as well as five times the same quantity of antipyrin.

In one case of incipient chorea in a little girl, the choreic movements ceased entirely after five days' use of the drug, 20 centigrams having been given daily. On the strength of his observations, Dr. Moncorovo strongly recommends the use of exalgine in pediatrics.—*Am. Practit.*

IODOFORM IN THE TREATMENT OF BURNS.

Rottenberg advocates the following method of treating burns: The blisters, if present, are pricked and a silk thread, soaked in corrosive sublimate solution, drawn through them and allowed to remain. The whole surface, no matter what the degree of burning, is coated thoroughly with a thick layer of vaseline containing 10 per cent. of iodoform, and then covered with gutta-percha. The ointment is renewed daily. The pain is always speedily lessened, and healing takes place in an eminently satisfactory manner and quickly.—*British Medical Journal*.—*Occidental Med. Times*.

TREATMENT OF PHTHISIS.

Dr. C. B. Brierly writes to *Pacific Medical Journal*. Will you give the following place in your column. I have for some time been using the following in tuberculosis: Tinct. catechu, ʒi; morph. sulph., gr. i.; acid carbolie, gtt. iv.; syr. pruni virgin., ad. ʒ viii. M. Sig: A tablespoonful every four hours.

It is not Koch's lymph by a long way, but I have found it relieves profuse expectoration, night-sweats and hectic, and in conjunction with appropriate general treatment believe it will help materially to prolong life. I would be glad to learn if others derive any benefit from it. They might try it in the county hospital as an adjunct to the lymph.—*Am. Pract.*

SULPHONAL IN DIABETES.

Dr. Casarelli mentions the favorable action of sulphonal in diabetes. The drug diminishes both the quantity of sugar and the polyuria, doses of forty-five grains *per diem* being the most effectual. The drug, however, could not be long continued in such quantities without causing giddiness and excessive sleepiness. Sulphonal was used with good results in conjunction with both a mixed diet and a strictly meat diet; in the latter case a large quantity of sugar appeared in the urine as soon as the sulphonal was stopped.—*Lancet*.

THE CANADA MEDICAL RECORD.

PUBLISHED MONTHLY.

Subscription Price, \$2.00 per annum in advance. Single Copies, 20 cts.

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Writers of original communications desiring reprints can have them at a trifling cost, by notifying THE HERALD Co. immediately on the acceptance of their article by the Editor.

MONTREAL, FEBRUARY, 1891.

VOCAL CULTURE AS A PREVENTATIVE OF CONSUMPTION.

We receive a great many reprints from their various authors, the titles of which appear in this journal every month under the head of Book Notices and Pamphlets received; a list which our readers would do well to notice, for should any of these subjects be of particular interest to them they can generally obtain a copy of the reprint by applying to its author. One of these which we have lately received, of more than passing interest, is by Dr. Eugene Crutchfield on the application of vocal culture to the treatment of throat and pulmonary affections. In view of the very wide prevalence of consumption and the small hope of cure, any measure of treatment which holds out any prospect of preventing the attack of the fell disease deserves our closest attention. The best way to cure consumption is not to get it at all. There are two ways to reach this desirable end. The first is to refrain absolutely from exposing ourselves to the contagion, or in other words never to inhale or swallow a single tubercle bacillus. We take it for granted that all of our readers are thoroughly convinced by this time that the disease can only be acquired in one of these two ways, and that it is never inherited as was for so many years supposed.

Never to expose ourselves is of course, under present circumstances, an impossibility for, unlike smallpox patients, death-spreading cases of consumption are allowed to roam about at will, setting up fresh centres of infections; so that it is impossible to enter a room, a public building, or a railway car in which, at some time or other, a consumptive has not deposited an expectoration containing many thousands of bacilli, which only have to be dried in order to be carried by the air to our lungs. If the disease is so contagious, how is it that everybody does not acquire it, and that instead of only a few millions of people being constantly affected with it the whole population of the earth is not in consumption? Simply because there are in our systems a certain number of lymph corpuscles or fighting cells which, like sentinels, are ever on the lookout for invading bacilli, and which if the latter are not too numerous, promptly seize upon the invaders and swallow them up. In order that they may be able to win the battle it is necessary that these fighting cells be in good condition, otherwise the invaders will be stronger than they, the result being the death of the soldiers and the multiplication of the bacilli. Hence the importance of keeping the whole system in good condition and the vitality of the highest standard, for when people are in a run down condition their fighting cells or phagocytes are weak and easily conquered by the invaders. Moreover two other conditions are favorable to the growth of all the lower orders of plant life to which the tubercle bacilli belong, namely, decomposing liquids and stagnant air. They do not grow well in rapidly changing air or on a clean dry surface, and this is where the importance of Dr. Crutchfield's conclusions come in. He has found after a long and careful investigation that out of hundreds of professional singers, only one or two at the most were ever supposed to have died from consumption, and even about these two there seems to have been considerable doubt.

While consumption among players on wind instruments is almost unknown, on the other hand the disease is especially prevalent among dress-makers and nuns, who lead a sedentary life and sit in such a position that their chest becomes contracted and their breathing capacity diminished to one-half or one-fourth. The result is that their phagocytes or fighting cells insufficiently fed with oxygen are in bad condition for waging war against the tubercle bacilli, to whose relentless attacks they are constantly exposed. It may seem strange to say that there are thousands of people who do not know how to breathe, and millions of women whose dress prevents them from breathing properly. No wonder that consumption finds the majority of its victims among the wearers of the corset. As long as consumptives are allowed to go about scattering their germs, the best thing we can do in order to avoid being attacked is to increase our lung power or respiratory capacity by every means, among the best of which is deep breathing such as is acquired in the arts of singing and elocution as pointed out by Dr. Crutchfield.

BOOK NOTICES.

The *St. Louis Medical Review* comes to us greatly enlarged and improved under the editorship of Dr. Ohmann Dumesnil. It is a weekly which has reached its twenty fifth year and is one of our most interesting exchanges. The abstracts are especially well selected and the editorials are vigorous and pointed.

ANNUAL ADDRESS BEFORE THE STATE BOARD OF HEALTH OF PENNSYLVANIA. By Prof. Samuel G. Dixon, M. D., Academy of Natural Sciences of Philadelphia. Read May 15, 1891, at the Sanitary Convention at Altoona.

APPARATUS FOR COLLECTING WATER FOR BACTERIOLOGICAL EXAMINATION. By Samuel G. Dixon, M. D., Academy of Natural Sciences, Philadelphia. Reprinted from *The Times and Register*, October 24, 1892. Philadelphia: The American Medical Press Company, Limited, 1891.

TUBERCULIN; THE VALUE AND LIMITATION OF ITS USE IN CONSUMPTION. By Charles Denison, A. M., M. D., of Denver, Col. Professor Diseases of the Chest and Climatology Medical Department University of Denver; Author of "The Rocky Mountain Health Resorts," "The Preferable Climate," "The Annual and Seasonable

Climatic Charts of the United States," Etc. Reprinted with revisions up to date, Feb. 1st, 1892, from the transactions of the Colorado State Medical Society for 1891. Denver, Colo: Press of the Medical Times Pub. Co., 609 17th Street.

- I. AN AMERICAN TEXT-BOOK OF SURGERY. By Professors Keen, White, Burnett, Conner, Dennis, Park, Nancrede, Pilcher, Senn, Shepherd, Stimson, Thomson, and Warren. Forming one handsome royal octavo volume of about 1200 pages (10 x 7 inches), profusely illustrated with wood cuts in text, and chromo-lithographic Plates. Many of them engraved from original photographs and drawings furnished by the authors. Price, cloth, \$7.00; sheep, \$8.00.
- II. AN AMERICAN TEXT-BOOK OF THE THEORY AND PRACTICE OF MEDICINE, ACCORDING TO AMERICAN TEACHERS. Edited by William Pepper, M. D., L.L.D., Provost of the University of Pennsylvania. To be completed in two handsome royal octavo volumes of about 1000 pages each with illustrations to elucidate the text wherever necessary. Price per volume, cloth, \$5; Sheep, \$6; Half Russia, \$7. For sale by subscription only. Ready for delivery about June 1, 1892. Agents wanted—for particulars address W. B. Saunders, Publisher, 913 Walnut Street, Philadelphia, Pa.

ESSENTIALS OF PHYSICS. Arranged in the form of questions and answers. Prepared especially for students of medicine. By Fred J. Brockway, M. D., Assistant Demonstrator of Anatomy at the College of Physicians and Surgeons, New York. With 155 illustrations. Price \$1 nett. Philadelphia: W. B. Saunders, 913 Walnut Street. 1892.

We quote the following from author's preface:—In preparing medical students for examination in physics, I have found Ganot too large to be used as a text-book. Some elementary books on the subject do not contain all that is necessary for the student to know.

I have endeavored to compile a book which is a mean between these two extremes. It contains nothing original. With Dr. Chandler's kind permission I have made free use of notes upon his lectures delivered at the College of Physicians and Surgeons, New York. He is in no way responsible for my mistakes of statement or quotation.

Seventeen of the cuts have been reproduced from Gage's *Elements of Physics*, by special permission of the author and the publishers, Messrs. Ginn & Co.; eight cuts have been taken from Atkinson's *Dynamical Electricity*, by permission of the author and Van Nostrand Co., publishers; the other cuts are from Ganot's *Physics*.

EPIDEMIC INFLUENZA. Notes on its origin and method of spread by Richard Sisley, M. D., M. R. C. P., London. Published by Longmans, Green & Co., 1891.

Dr. Sisley writes to establish the contagious character of Epidemic Influenza and to prove that its method of spread is by contagion alone. He quotes from the medical reports of 1782, 1803 and 1833, as well as of 1889-90, concerning the epidemic influenza of those years to sustain his contention. His inductions are carefully made and his deductions generally very just. His statistical tables are well-prepared and the results are both striking and

suggestive. He claims that influenza should be treated like scarlet fever or any other contagious disease and that in every case the patient should be promptly isolated and notification made to the municipal health authority in terms of the British Infectious Disease (Notification) Act, 1889, which he prints in full as an appendix to this volume. Whether the disease is spread by contagion only or no, there is sufficient evidence to show that it is readily spread by contagion and some such precautions as Dr. Sisley suggests seem eminently desirable in the interests of public health. Several of his illustrations, especially from the epidemics of 1782 and 1833 are very startling. The title of the volume, "Notes," describes fairly well the character. There is no pretence at exhaustive treatment of the subject. But as a contribution to the study of an alarming epidemic of a certain serious and somewhat mysterious character it cannot fail to be both helpful and suggestive to the scientific medical practitioner. He quotes a definition of the disease which is about the best we have seen:—"Influenza is a specific fever, epidemic and often pandemic, of sudden onset and short duration, attended with loss of appetite and very great prostration, associated often with more or less severe catarrh, neuralgic pains or gastro-intestinal disturbance, and especially liable to be complicated by severe respiratory affections to which the mortality of the disease is chiefly due." He considers the definition faulty by omitting any reference to its contagiousness. Moreover some of the pains are not neuralgic but muscular. Otherwise it is a good definition. We cordially commend this brochure.

TREATISE ON GYNECOLOGY, MEDICAL AND SURGICAL.
P. T. Pozzi, M. D., Professeur Agrégé à la Faculté de Médecine; Chirurgien de l'Hôpital Lourcine Pascal, Paris; Honorary Fellow of American Gynecological Society. Translated from the French edition under the supervision of and with additions by Brooks H. Wells, M. D., Lecturer on Gynecology at the New York Polyclinic; Fellow of the New York Obstetrical Society and the New York Academy of Medicine. Volume I, with 305 wood engravings and six full page plates in colors. New York. William Wood and Company, 1891.

This is beyond doubt the very best work on gynecology existing at the present day. We had the pleasure of meeting the talented author nearly every day at Martin's or Olshausen's or Gusserow's Clinic in Berlin four years ago and little thought that so young a man, who, however was always taking copious notes, would so shortly reach the proud distinction which the production of this book has given him. As the American editor truly says "The cosmopolitan spirit of its author shown in his exhaustive research and judicious appreciation of the work of other nations, together with his keen and mature judgment in utilizing the material from his own rich clinical fields, make it a clear and reliable guide to the most advanced and best practice in this specialty.

From the author's preface to the French edition we quote the following significant paragraph:—"It is impossible to ignore the great prominence which gynecology has everywhere assumed. The origin of its rapid progress is easy to trace. By the introduction of antiseptics a new era was opened to gynecology as well as to general surgery. Active intervention has become almost free from danger in many diseases which used to be aban-

doned to palliative or expectant treatment. Thanks to antiseptics new operations have been invented and old ones restored to favor. Some of the latter had been boldly conceived and brilliantly executed by our predecessors, but the terrific mortality due to surgical uncleanness had caused their abandonment. Such was the case with ovariectomy, vaginal hysterectomy, curetting and even shortening the round ligaments; their present use is merely a revival. Not so very long ago a good operator was a good surgeon; the two terms being almost synonymous. This is no longer the case. It has become of even more importance to avoid infection of the wound than to operate brilliantly."

Antisepsis takes up the first thirty pages; anaesthesia, control of hemorrhage and closure of wounds the next fifty; and gynecological examinations the fifty following pages. Nearly a hundred pages are devoted to metritis and its treatment, while the next hundred and sixteen pages are devoted to fibroids. These interesting and lately very common tumors receive a very thorough handling, the chapter on diagnosis being very complete. The treatment is viewed very fairly, equal prominence being given to all the various methods both medical and surgical. Indeed the spirit of fairness is very characteristic of the work, so that the views expressed by the author may safely be taken as the general consensus or average of opinion at the present day. Nearly one hundred pages are devoted to cancer of the uterus, the mortality up to date of the various operations being included. Displacements receive an exhaustive treatment with one hundred and fifteen pages, but disorders of menstruation are disposed of in twenty-two pages; but as they are generally symptoms of other diseases they have all been referred to already under other headings.

Two other points deserve especial mention: the liberality of the publishers in allowing no less than 305 illustrations besides the colored plates, and last but not least the charming manner in which the American editor and translator, Dr. Brooks H. Wells has performed his arduous task. In fact his easy and elegant English is the exact counterpart of Pozzi's beautiful colloquial French which lends such a charm both to his speaking and writing.

NEWS ITEMS.

IMPORTANT NOTICE AND REMOVAL.

To avoid failure or doubtful success in the use of Per Oxide of Hydrogen be sure you get *Marchand's Medicinal*. No substitute can replace it, statements of dealers, interested or unscrupulous parties to the contrary notwithstanding. There are great inducements to substitute in this article for the reason that Per Oxide made for bleaching and varying trade purposes costs to produce only a fraction of what Marchand's Medicinal cost, and the unscrupulous druggist or dealer pockets the difference in profit at the expensive reputation of the physician and Marchand's Per Oxide of Hydrogen Medicinal put up in 4 oz., 8 oz. and 16 oz. bottles only, with which every physician should be familiar in order to frustrate dishonest substitution and assure success. Drevet Manufacturing Company, 28 Prince Street, New York.