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# CANADA MEDICAL RECORD

DECEMBER, 1898.

## TWO CASES OF TUBAL PREGNANCY—OPERATION—RECOVERY.

By A. LAPHORN SMITH, B.A., M.D., M.R.C.S., Eng.

Fellow of the American Gynecological Society; Fellow of the British Gynecological Society; Gynecologist to the Montreal Dispensary; Professor of Clinical Gynecology in Bishop's University; Surgeon-in-Chief of the Samaritan Hospital for Women; Surgeon to the Western Hospital.

Mrs. B., aet. 33. Came under my care on 5th October. As a girl enjoyed good health. Married at 21. Had three children; last 6 years of age, after which she became a widow. Married again two years ago, since which has been ill. Conception thought to have occurred on three or four occasions, but always aborted at third month with hemorrhage and pains. Had had no menstruation for three months previous to present flow, which came on about a month ago with severe pains. Four days ago she was taken with a slight flooding and such severe pains that she became unconscious, and does not know what came away. Her physician, who had attended her for five weeks, and already diagnosed disease of the ovaries and tubes, now came to the conclusion that there might be a tubal pregnancy, and called me in consultation. I confirmed both diagnoses; that is, the presence of ruptured tubal pregnancy in a diseased tube, and advised her being brought to the Samaritan in order to remove it. She came at once in the ambulance, but her pulse was 110°, and she was vomiting constantly, so I decided to wait until she was in better condition, at the same time

being fully prepared to operate at a moment's notice should there be any sign of another hemorrhage into the peritoneum. A mass could be felt as large as a cocoon on right side, the uterus being pushed over to the left by it, and the ovary I thought was imprisoned in the mass, because the slightest pressure on the mass caused severe vomiting for several hours. She was put on a stomach preparation and carefully fed until the 25th October, when her pulse and temperature came down to normal. She took  $\frac{1}{16}$  gr. of strychnine three times a day during three weeks, and her bowels were put in good order. As the lump projected up under the abdominal wall I made a long incision, and on opening the abdomen found that the omentum had cleverly come to the rescue by walling off the ruptured tube and blood clot from the rest of the peritoneal cavity. The adhesions were quite firm, but were finally detached, revealing a mass of blood clot with a foetus five inches long among them slightly macerated. She was cleaned out, and then the densely adherent right tube and ovary together with the vermiform appendix in an inseparable mass was with difficulty shelled out. The ovarian artery was tied separately and also the uterus at the cornu, and the tube and ovary removed. The vermiform appendix was cut off level with the caecum, and the hole in the bowel closed with two rows of fine silk sutures. The other end of the appendix is still buried in the mass of inflammatory exudate in the ovary. There was no bleeding at the operation. The pulse went up to  $140^{\circ}$  and temperature  $101^{\circ}$  the night of the operation, but both were normal on the third day, and have remained so since, now four weeks since the operation. She has had no nausea or vomiting since the day after the operation, although before it she had been vomiting almost regularly for five weeks. No pain at all since the operation; has good appetite and feels well in every way. Left ovary was allowed to remain in order to avoid the discomforts of the premature menopause. Left tube was diseased and removed close to the cornu. This was my eleventh case of tubal pregnancy, all of whom recovered, and are alive and well.

My twelfth case consulted me at the Montreal Dis-

penary. She was a Mrs. McC., 38 years of age, mother of six living children, the two last being twins, which were born four years ago. Before the birth of the twins, she says she had kept herself from bearing any children for eight years by taking large doses of senna and salts before each period was due. Several times during these eight years she had miscarriages at two or three months. She appears to have menstruated on the 7th August, the flow lasting till the 20th August. This stopped then for seven weeks, until the 9th October, when she began to flow freely, and the flow was accompanied with great pain. I sent her into the Samaritan Hospital, but she delayed until the loss of blood became quite serious, and it was not until the 23rd November that she was operated upon. By this time the left tube could be felt larger than the thumb, but fairly moveable. The uterus was dilated and curetted, although it was quite empty, but rather large, and iodine and carbolic were applied to the endometrium very thoroughly. A lacerated cervix was also repaired. Then the anterior vaginal wall was opened, and the fundus and ovaries and tubes were brought out and inspected. The procedure was difficult owing to adhesions of the ovaries and tubes on both sides, and owing to the enlargement of the left tube. It was finally brought out and tied off at the cornu of the uterus. A few cysts on the ovaries were opened, and they and the uterus were replaced and the vagina closed, one stitch taking in the fundus of the uterus. She made an excellent recovery. On cutting open the specimen, only blood clot is seen by naked eye, but I will gladly hand the specimen to the pathologist of the Society for a careful search for chorionic tissue. It was generally remarked by the medical and nursing staff of the hospital that this patient made a much more rapid recovery than after the smallest laparotomy. They all agreed that I would have completed the operation in half the time, namely, in thirteen or fifteen minutes, by the abdomen instead of half an hour, which it took by the vagina. But, from the patient's point of view the time was well spent, as she has no scar, no chance of hernia, and she had much less pain and a shorter convalescence. Although I mentioned the

possibility of tubal pregnancy, yet I was not at all sure of it, so I will classify this case as one undiagnosed before rupture and before operation. Out of the twelve, in five the abdomen was full of blood.

## CLINICAL LECTURE ON BELL'S PARALYSIS.

DELIVERED AT THE MONTREAL GENERAL HOSPITAL.

By FRANCIS W. CAMPBELL, M.D., L.R.C.P.L., D.C.L.

Professor of Medicine and Neurology, Faculty of Medicine, University of Bishop's College.

The patient before you presents a typical case of what is generally called Bell's Paralysis. He comes to the Hospital to-day for the first time, though as a matter of fact he has had it for several weeks. He claims that it came on during the night, he having the previous evening, when in a state of perspiration, sat at an open window, through which a cool draught of air was blowing. The disease is also sometimes, from its situation, called Facial Paralysis. It is due to the motor division of the 7th nerve, the Portio Dura or facial nerve being involved in various ways. Its conducting power is lost, and the muscles which receive its distributing branches are paralyzed. The most common cause is a cold wind blowing on the side of the face, sitting at an open window in a room, or of a railroad car, sleeping near a cold damp wall; even exposure of the whole body to a low temperature has caused it. The pathological condition is believed to be a slight inflammatory swelling of the peripheral part of the nerve, which leads to compression of its fibres. Parotitis, tumours, swelling of the cervical glands and wounds of the cheek are also causes. In the course of the nerve within the Aqueductus Fallopii it is very apt to be involved in the severe forms of disease of the petrous portion of the temporal bone; caries and necrosis depending upon scrofulous inflammation of the tympanum. A box on the ear has produced it, and the result in more than one such case has been the discovery of a small clot pressing on the nerve in some part of its course. Inside the skull the nerve may be implicated in tumours at the base of the brain.

In such cases other nerves are generally involved, and there is distinct evidence of cerebral disturbance.

*Symptoms.*—Inability to move the muscles supplied by the facial nerve. If the patient laughs, frowns or smiles, one side of the face remains quiescent, and therefore destitute of expression; he cannot wrinkle the forehead, there are no creases round the eye, no dimples on the cheek or chin. The eyelid cannot be closed; in the effort the eyeball is turned up and in till it is almost lost to sight. Whistling, blowing or spitting cannot be performed. The side of the mouth cannot be drawn up. The cheek is not held close to the teeth by the buccinator muscle, and bulges out when the breath is propelled against it. For the same reason the food collects on the affected side outside of the teeth, so that it has to be dislodged by the finger. In speaking the labial consonants are uttered indistinctly. In some the mouth is drawn well over by the power of the healthy muscles of the other side, the eye stares fixedly and the entire expression of the face is comical. The exposure of the conjunctiva gives rise to a certain degree of conjunctivitis, but not so much as might be feared. This is believed to be due to the fact observed in many cases during sleep that the eyelids close either completely or very nearly. Goldzieter relates a hitherto unknown symptom. He affirms that in complete paralysis of the face, in which there is also paralysis of the velum palati, there is no lachrymation, and on the affected side the eye is perfectly dry. Smell is sometimes lost, or at least perverted, due to the dry condition of the corresponding nostril, this being due to the tears flowing over the cheek. Taste is also perverted, due to the conducting power being lost in a branch of the 7th nerve, the chorda tympani. Hearing is often abnormally acute, and is said to be a result of paralysis of the stapedius muscle, which receives a branch of the facial nerve; its antagonist, the tensor tympani, being no longer opposed, keeps the membrane too much on the stretch. Occasionally we meet with double facial paralysis when the disease is called "diplegia facialis." The whole face is expressionless and peculiar. Such cases are very often due to a growth or syphilitic gumma, involving both nerves

at the base of the brain. It is also sometimes caused by disease in the petrous portion of both temporal bones. The disease may come on gradually or suddenly. Among the first indications of its approach is inability to spit or whistle, or on waking in the morning is surprised to find his face all drawn to one side.

When the disease is fully developed, the diagnosis is easy. The only point is carefully to take note if any other nerve is involved. If such should be the case, there will be reason to suspect the presence of some basilar cranial trouble—possibly of syphilitic origin.

The prognosis is favorable in simple cases, but will take from six weeks to six months. There are, of course, cases, such as when there is necrosis of the petrous portion of the temporal bone, which are incurable. Again, a few cases get well very rapidly, say in a couple of weeks. I have had many cases of this disease under my care, but even simple cases did not show haste in cure.

*Treatment.*—Duchene advises farization, and insists on its value. Others think that some evidence of the conductivity of the nerve should be in evidence before electricity is used. When such is the case, Erbe is in favor of its employment. He advises that the anode be placed behind the ear and the cathode moved over the paralyzed side of the face, or that the two poles be placed over each mastoid process, the side affected receiving the anode. If there is any ear affection seek surgical aid. If you believe syphilis is the cause, iodide of potash, mercury, or both. In cases due to cold, counter irritation is especially called for and cantharidal collodion, fly-blisters, or even the actual cautery behind the ear, or over the occiput, are very useful. The bowels should be freely opened and diaphoretics or hot baths or alkaline diuretics administered—later, mercuri iodid and general tonics will be in order.

# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine  
University of Bishop's College; Physician Western Hospital.

### THE TREATMENT OF CHOREA.

By W. ESSEX WYNTER, M. D., F. R. C. P.

Assistant Physician to and Medical Officer to the Electrical Department of the Middlesex Hospital.

In perhaps the greater number of disorders of the nervous system, the chief interest centres in exact diagnosis, owing to the complexity of the mechanism involved and the refinement of the symptomatic manifestations, together with the inaccessibility (comparative only in the days of modern surgery) of the nerve centres. The modern history of abdominal and pelvic diseases shows that with increased facility and security in direct investigation and interference the interest in inferential diagnosis is subordinated to ocular demonstration of the exact pathological condition. Such may one day be the case in some diseases of the nervous system. The very features, however, which compel our interest in diagnosis in the case of nervous diseases tend to render their treatment more difficult and perhaps less hopeful.

St Vitus' dance stands rather in contrast to most diseases of this class, inasmuch as the nature of the disorder is usually manifest, even to unskilled observers, from the first, and happily also in the prospect of recovery being complete and capable of acceleration by suitable remedies. The frequent association of chorea with a rheumatic history or actual rheumatic attack, nearly half the cases occurring subsequently to rheumatism or scarlatina, and about the same proportion being followed by functional or organic heart disease, points to the necessity of more care in such cases than is commonly exercised. It is a general practice to keep a patient with rheumatic fever to his bed long after this is necessitated by pain or fever, because of the probable involvement of his heart in the morbid process, yet the proportion of cardiac affections after rheumatism scarcely exceeds that following chorea. As a counterpart to the joint pain of rheumatism, which does not tolerate movement, may be instanced the sense of unrest in chorea, which makes control of the movements unbearable, but which is in part relieved by rest in bed; and this may also be counted on to save the physical fatigue of the movements and the state of apprehension and excitability of the mind, besides keeping the child in a place of security out of the reach of sources of excitement, persecution and accident at a time when she is unfit to take part in the studies or amusements of her companions.



The first matter of importance, then, in the cure of chorea consists in keeping the child in bed, necessitated by the tendency to endocarditis, and emphasized by its beneficial effect in shortening the disease or in bringing about a speedy cure in cases where it has existed without material benefit from drugs for weeks and months while the child remained up and about.

The drugs which have been found most useful are antipyrin and arsenic; the first in early stages and acute disease, the latter in later stages and chronic or recurrent cases. In evidence of the value of antipyrin may be quoted two cases recently treated among my out-patients at the Middlesex Hospital: (1) William A——, 16, losing the use of the right side, and suffering from jerking movements for three weeks, for whom antipyrin was prescribed in 5-grain doses three times a day, increased by 5-grains at intervals of three days till 15-grain doses were reached at the end of a week, maintained for three days, and then reduced. As the movements had almost subsided, smaller doses were continued for a week, making seventeen days in all, followed by arsenic and iron for a couple of weeks. (2) Pattie B——, 9, suffered from chorea three months. The movements affected the right arm, face and legs, the left arm being "useless." Antipyrin in 5-grain doses was given for three weeks, by which time the movements had subsided, and subsequently small doses of arsenic and iron were given for a month as a general tonic on account of weakness and anæmia. These cases were treated at a disadvantage as out-patients, the pressure on beds in a general hospital rendering their admission inconvenient. Their recovery was rapid, however, and there were no evidences of cardiac disease while under observation.

A further disadvantage in treating such cases while up and about is that a prolongation of antipyrin treatment, particularly in large doses, may bring out a pink erythematous eruption, giving rise to the supposition that the child has measles, which sometimes leads to interruption in attendance.

The efficiency of treatment by arsenic is often marred by insufficiency of dose. It is common practice in the case of children, who make the bulk of patients with chorea, to prescribe 2 or 3 drops of Fowler's solution. This may answer in a few mild cases, but in the majority it is insufficient, and the dose must be increased to 10 or even 15 drops in the course of ten days or a fortnight if the symptoms do not decline. A good example of this was afforded by a child of five, who was admitted to the Middlesex Hospital with extensive movements, and in whom a dose of 3 min. given for some weeks produced little or no effect; but on doubling the dose for three days, and then quadrupling it, the movements rapidly subsided. Toleration is readily secured, provided the drug is not given in too large a dose at first or the dose increased too rapidly, the medicine always being given, with sufficient dilution, immediately after food.

That the exhibition of arsenic may in some cases be carried too far and produce serious neuritis is exemplified in cases exhibited at the Clinical Society during the current year by Dr. Batten, in which 15 min. of Fowler's solution had been given three times a day. As

in the case of antipyrin rash, this accident is more likely to occur when the patient is not kept in bed, so that the intensity and duration of medication are increased to combat the unfavourable influence of activity and excitement. This furnishes an additional reason for keeping the patients in bed and under close observation during treatment by powerful drugs.

In all the cases a liberal diet is required without stimulants, the subjects of chorea being usually of a thin and nervous type, and the disease is itself exhausting and commonly associated with anæmia and debility.

The principal complications are endo or pericarditis, which in the acute stage are best treated with salicylates, as in rheumatism. The indications are chiefly a hurried, weak pulse, with palpitation, some præcordial discomfort, and perhaps a soft blowing murmur or friction sound. They are so slight, and may be so ill-developed, that in a restless child it is easy to overlook them. Only in the later stage, contraction deformity of the valves, do the rough murmurs with evidence of cardiac enlargement and back-working show themselves.

In a few cases, in which the actual movements are so violent and continuous as to bring about contusion and abrasion of skin, with exhaustion, wasting, and loss of sleep, direct sedatives are required. Chloral and the bromides are then generally serviceable, the dose being daily increased from 10 to 20 grains until either the symptom is subdued or physiological effects of the drugs produced. If this treatment fails, recourse must be had to subcutaneous injections of morphia or even the inhalation of chloroform.

When the active phase of the disease declines, the patient still needs care and treatment on account of the remaining anæmia and debility, the mental condition of hebeude and intractability, and the tendency to recurrence of the malady, apart from the more serious heart complications which may have resulted.

The best tonics are the milder preparations of iron, either the wine or citrate, with liquor arsenicalis in comparatively small doses (3 to 5 min.), or cod-liver oil; absence from competition with others, either in school or playground, for some months, which are best spent at the sea-side or in the country, where quiet amusement can be obtained without books or boisterous companions. In protracted cases and during convalescence great benefit may be derived from massage, passive exercises, or such diversion as may be obtained in the use of a skipping-rope or hoop. For the most part, it is best to avoid books and such toys as appeal to the imagination and provoke spontaneous activity of the brain.—*Treatment.*

## IS THE URIC ACID DIATHESIS AN IMPORTANT FACTOR IN PATHOLOGY.

This is the title of an article by Dr. James Tyson in the *Philadelphia Medical Journal* for July 16, 1898.

At the outset Dr. Tyson defines what he understands by the uric acid diathesis. A person the subject of this diathesis secretes habitually or frequently acid, scanty, high-coloured urine, which

promptly deposits uric acid and mixed urates and oxalates. This is a clear and distinct definition, and it would be well if, in all discussions on this vexed question, the ground were as thoroughly cleared at the start.

Six divisions of the diathesis follow, in each of which some one or other of its numerous manifestations are made the characteristic feature. In the first group Dr. Tyson places the tendency to uric acid, gravel and calculus. This is a division which all will admit; but when the author proceeds to describe interstitial nephritis as due to the irritative action of the same urine on the kidney structures, he would seem to be passing from plain statements of fact into those of theory. It is impossible to prove, that interstitial nephritis has any such origin, though as a theory it is plausible. In his next division Dr. Tyson includes gout. Here also all will agree with him. But here, again, we are invited to regard the not infrequent presence of interstitial nephritis in gouty subjects as due to the uric acid irritating the kidney, which is surely an unwarranted assumption. In his third group the author places a manifestation of the uric acid diathesis which used to be described as lithæmia. This term was, we believe, first used by the late Dr. Murchison in connection with what he described as functional derangements of the liver. The author attributes "bilious attacks," bad temper and irritability to this lithæmia. He also considers that this condition explains certain psychical peculiarities, such as "extreme modesty, a want of self-reliance, and a disposition to avoid society." This seems to us to place such a strain on the uric acid diathesis theory as it is unable to bear. In view of the extraordinary tendency of some observers to attribute all the ills that flesh is heir to to this uric acid diathesis, we think it a pity to discredit what is really, in proper limits, sound enough pathology, by the attempt to make it of universal application. Dr. Tyson in his fourth class places certain cases of migraine, and brings forward a case which admirably illustrates his argument. We are pleased to see, however, that he does not believe that all cases of migraine are due to uric acid in the blood, and for this we are thankful. In the fifth class we find that high tension in arteries and a tendency to arterial degeneration are included as the result of the uric acid diathesis. This may or may not be the case, but it is equally probable that both high tension and arterial degeneration may be due to some altered condition of blood due to renal disease, and totally unconnected with uric acid in any form. In his sixth and last class stands vertigo.

In the whole of these six classes the author attributes the phenomena to the action of uric acid and allied substances acting through the blood, in which they are in solution. We have already dwelt upon the danger of stretching this theory too far, and with one or two exceptions we think that this has not been done by Dr. Tyson, whose claims for the evil effects of uric acid are quite modest in comparison with those of some uric acid enthusiasts.

In the latter part of his paper the author discusses the relationship, if any, between the uric acid diathesis and rheumatism, rheumatoid arthritis, sore throat, bronchitis and asthma and diabetes.

This subject is fully and ably discussed, and we are glad to see that Dr. Tyson is far from accepting such evidence as has been brought forward to prove that uric acid in the blood is the cause of these various maladies. Incidentally, he refers to the condition which is implied under the barbarous term *uric acidæmia*. Surely it is time to protest against the introduction of such extraordinary jargon into medical literature.—*Treatment.*

### WHICH CASES OF CHOLELITHIASIS ARE SUITABLE FOR SPA-TREATMENT, AND WHICH FOR OPERATION.

Dr. Hans Kehr, of Halberstadt (*Munchener Med. Woch.*, September 20, 1898), who has gained a great reputation for his operations in gallstone cases, considers it certainly wrong to send every case of cholelithiasis, without distinction, to Carlsbad, only operating when the Carlsbad treatment proves useless. He comes to the conclusion that medical treatment (Carlsbad courses, etc.) may be recommended in the following classes of patients :

1. Cases with acute obstruction in the common bile-duct, at least in the ordinary cases.
2. Cases with inflammatory processes in the gall-bladder, with or without jaundice, if the attacks occur seldom, and are not too severe.
3. Cases with frequent attacks of colic, when gall-stones are passed each time ; but if the attacks of colic recur very often, without the passage of gall-stones, an operation is indicated.
4. Patient with obesity, gout, or diabetes, or when narcosis is dangerous on account of disease of the heart, lungs, kidneys or liver.
5. Patients after operations for gall-stone.

On the other hand, Kehr considers operation indicated in :

1. Acute sero-purulent cholecystitis and pericholecystitis.
2. Adhesions resulting from pericholecystitis, binding the gall-bladder to the bowel, stomach, or omentum, provided that symptoms (pains, inflammation about the pylorus, stenosis of the pylorus, stenosis of the duodenum, ileus, etc.) are present.
3. Chronic obstruction in the common bile-duct.
4. Chronic obstruction in the cystic duct (so-called dropsy or empyema of the gall-bladder).
5. All forms of cholelithiasis, which, though slight at the commencement, have resisted all balneotherapeutic and pharmaceutical treatment, and by giving rise to chronic disturbances (feeling of pressure in the stomach; wasting) embitter the patient's life and prevent him doing his work.
6. Purulent cholangitis and hepatic abscess.
7. Perforation of the bile-ducts and peritonitis.
8. Morphineism resulting from the troubles of cholelithiasis.

Kehr thinks an exploratory operation may be performed when there are frequent troublesome symptoms, and the diagnosis is uncertain. The exact diagnosis (position of the stone, etc.) and due

consideration of the patient's age, sex and social position are most important in deciding what course is to be advised. For instance, Kehr only undertakes an operation on patients over sixty years of age when their life is in danger (as by empyema of the gall-bladder, or chronic occlusion of the common bile-duct).—*Treatment.*

## DONT'S FOR THE TREATMENT OF PNEUMONIA.

Dr. Thomas J. Mays, in the *Philadelphia Polyclinic* (Vol. VII, No. 19), gives the following list of what *not* to do in the treatment of pneumonia :

Don't believe that acute pneumonia is a self-limited disease and will get along as well without treatment as with it.

Don't hug the delusion that fever in any degree is a benefit to the patient.

Don't fancy that you can always tell croupous from catarrhal pneumonia.

Don't allow pain in the abdomen to draw your attention away from the chest. Frequently the beginning of pneumonia is accompanied by severe pain in the right groin, which may lead one to suspect the onset of typhoid fever.

Don't direct your treatment more towards the heart than towards the lungs.

Don't fail to recognize the great influence of the brain and nervous system.

Don't lose sight of the serious indication of rapid and laborious breathing.

Don't be afraid of applying ice to the chest in rubber bags. It will do no harm.

Don't fail to apply as many bags as are necessary to cover the area of inflammation.

Don't think that you can get as good results from a tub-bath or from cold general spongings, as you can from the local application of ice.

Don't become alarmed when the ice produces a sudden drop in the temperature and think the patient is going into collapse.

Don't fail to retain the ice so long as fever is present, and resolution has not taken place.

Don't omit to apply one or two ice-bags to the head.

Don't overlook the beneficial influence of strychnine in combating pneumonia. Administer 1-20 of a grain by the mouth every three or four hours, and besides give the same dose hypodermically once or twice a day, until the system becomes irritable.

Don't omit the hypodermic injection of 1-4 of a grain of morphine once or twice a day to secure rest and sleep.

Don't fail to administer oxygen by inhalation more or less constantly if the patient is cyanotic or short of breath.

Don't fail to bleed if cyanosis and dyspnea are not relieved by oxygen inhalation.

Don't lose sight of the great value of tincture of capsicum in relieving great nervous depression, delirium, dry black-coated tongue, picking at the bed-clothes, etc., give it in from a half to one teaspoonful doses in water every two or three hours, or oftener, in alcoholic pneumonia.

Don't fail to give sodium salicylate, ammonium acetate, potassium acetate, and potassium citrate, three grains of each, in a dessertspoonful of peppermint-water, every three or four hours, if there is the least evidence of a rheumatic complication.

Don't overlook the important action of quinine in this disease.

Don't fail to support the patient with an abundance of nourishing food, such as milk, freshly expressed beef-juice, etc.  
—*American Medico-Surgical Bulletin.*

## HYPNOTIC SUGGESTION IN MEDICAL PRACTICE.

In the Blackpool probate case, which occupied several days before Mr. Justice Barnes and a special jury, there has been a considerable amount of evidence of special interest to medical practitioners. The deceased, Mrs. Howard, was a patient of Dr. Kingsbury, of Blackpool, who was a member of the British Medical Association appointed in 1890 to investigate the phenomena of hypnotism, and who had previously published a book on the subject. The deceased left £30,000 to Dr. Kingsbury, and he appears to have obtained large sums of money, apart from those fees to which he was entitled, during her lifetime. The other side was particularly anxious to prove that at the time the will was made the testatrix was of unsound mind, and that Dr. Kingsbury was unduly interested in her will-making and hypnotised her. That she was weak-minded, even for a woman, is beyond all doubt, but that she was of unsound mind and of testamentary incapacity is not so clear. Dr. Kingsbury admitted he had tried to hypnotize her. On the whole, his evidence did not show him in a very favourable light, and his position did not improve during the searching cross-examination of Mr. Carson. We must agree with Mr. Carson that this was a case of

very great importance in the interest of the general public, and, we may add, also in the interest of the medical profession. He asked the jury to remember that hypnotic practice is a very serious business, only to be employed by practitioners with very great caution. Dr. Kingsbury denied he had hypnotised this old lady, although there were entries of his own in his diary in which he stated that he had done so. Mr. Carson did not suggest that hypnotism in 1894 had anything to do with the will of 1897, but what he did state was that if the patient had been hypnotised in 1894 she would remain an easy prey to hypnosis at any subsequent time, and mere "suggestion" would be sufficient to influence her in a given direction. We must dispute the statement of Dr. Kingsbury that the morals of patients could not be affected by hypnotism. Any open-minded observer who knows anything of mind must admit that in the hypnotic state the moral senses are more or less suspended, and that the dangers of hypnotism are thereby very much aggravated. A great deal of evidence on the subject of hypnotism brings clearly before us that the hypnotic subject is morally paralysed, and Dr. Kingsbury is evidently wrong in denying what is now largely accepted, though denial was the only obvious course for him. The hypnotised subject is the mere tool, not the accomplice, of the hypnotiser, who makes him or her sign documents, or commit wrong acts, and is in a state of moral suspension as surely as the epileptic in his automatic states, or the man who commits a crime in a state of somnambulism. This notable case, which has excited so much interest, comes opportunely to check effectually any disposition which may still linger to employ hypnotism as a therapeutic agent. This is but one of many alleged abuses which may be suggested by suspicious people; and medical men in their own interest will do well to give hypnotic practice, except in rare instances and in conjunction with *bonâ-fide* medical and nursing witnesses, a very wide berth. The summing up of Mr. Justice Barnes was strictly technical, and gives no indication of his views of the merits of the case. The jury could scarcely have decided otherwise than they did, because the evidence for the defence—*i. e.*, against Dr. Kingsbury, was distinctly weak. It is most unfortunate for our profession that such cases should come into court, for the public are apt to believe the worst of a medical man who extracts so much financial assistance from his patient. All the same, it will do good, if it impresses on medical men the necessity of the most scrupulous disinterestedness in their dealings with patients.—*The Medical Press*, July 27, 1898.

## A PECULIAR EFFECT OF THE TOXIN OF THE BACILLUS TUBERCULOSIS.

If there be one feature more than another which characterises the mental condition of tuberculous patients, it is the tendency to take a cheerful view of the future. Curiously enough this physical aberration exhibits a tendency to become more and more pronounced as the disease advances, reaching its acme during the terminal period. When the patient first seeks medical advice he displays a very natural apprehension concerning the condition of his lungs, and is greatly depressed when he learns that there is actual disease thereof. This state of mental depression persists for some time, indeed, if circumstances are favourable and partial recovery ensues, it may last almost indefinitely. As soon, however, as the disease becomes more or less generalized the sanguine disposition takes the upper hand, and the most disconcerting facts cannot do more than provoke an ephemeral spasm of depression. When such a patient undertakes a sea voyage in order to have a better chance of recovery, that is to say, at a comparatively early stage of the disease, he expresses gloomy apprehensions lest he should never see his native shores again, but when death is at hand he no longer hesitates to plan undertakings, which cannot possibly be executed until long after the time when he will have been laid to rest. This is not a question of individual temperament, indeed it may fairly be described as incidental to the disease. We know that certain drugs are provocative of mirth, while others leave unequivocal indications of mental depression, and it is not unreasonable to suppose that the toxin secreted by the bacillus of tuberculosis exerts a specific action in this direction. Certain it is, that in no other disease, with the exception, perhaps, of certain cerebral lesions, do we meet with this extraordinary hopefulness in the face of the most disquieting symptoms, and the uniformity with which it is met with implies the presence in the organism of a disturbing influence which is constant in its incidence and exerts a disorganizing effect on the higher cerebral functions.—*The Medical Press*, July, 1898.

### THE URINE OF HEALTHY INFANTS AND CHILDREN.

By FRANK S. CHURCHILL, M. D., CHICAGO.

*Amount.*—The daily amount of urine passed by his cases is much less than that recorded by most authors whom he had been able to consult, except Herz, whose analyses upon sixty cases, thirty girls and thirty boys, between six and fourteen



years of age, corresponded approximately with the author's experience. A comparison of his results, with those quoted by Rotth and Holt, however, showed a marked discrepancy, for which he was unable to account. He would suspect that he had not been successful in getting the whole amount of urine in his cases, had he not taken especial care in this direction. Moreover, the specific gravity confirmed the amount.

*Specific Gravity.*—He found a higher average than is given by the authors already quoted, a condition we should naturally expect in the urine of children passing but a small amount. Had he failed to collect the total amount, he should expect a lower specific gravity than is recorded, inasmuch as even those cases which have been thrown out had a fair admixture of night and day urine. Reliable as are the observers quoted, should we not expect to find a comparatively high specific gravity in the urine of children of this age, at a period of great physical activity with consequently greater elimination of urea? The specific gravity of the one young infant which he had been able to record is low, coinciding with the well-known observation at this period; it ranged from 1,001 to 1,005 from the twelfth day to four weeks. It is, however, generally higher during the first two days of life, before the establishment of the breast-milk. It drops after this, and continues low throughout the first year, owing to the fluid character of the infant's food. During the second year, solid food being added to the diet, the specific gravity rises, and in four cases, aged respectively twelve, thirteen, eighteen, and twenty months, he found it ranging from 1,026 to 1,030, the urine being a mixture of the day and night eliminations.

*Urea.*—The estimation of this constituent is perhaps the most important of all the urinary solids, being as it is an index of general metabolic activity. As we should expect from their greater activity, and as Purdy and Foster state, we find the urea excretion in children relatively higher than that in adults. The low percentage noted during early infancy is, of course, due to the quiescent state of the child. Martin and Ruge, however, report wide variations in single specimens during the first ten days of life, ranging from 0.6 per cent. to 1.9 per cent. Shiff also gives wide variations, placing averages at from .28 per cent. to 1.7 per cent. during the first fourteen days. Why there should be such a wide range in the excretion of this substance at a time of such quiescence is difficult to see. Possibly greater metabolic activity after nursing may account for it. He had no statistics upon the relative amount of urea in urine passed just before, just after and some time after feeding. The few observations he made at this age showed, with-

out exception, very low percentages, from  $\frac{1}{10}$  per cent. to 0.4 per cent. lower than those cited. After the first year it rises, and from three to twelve years 133 specimens show a higher general average than that usually given. He thought Verordt's percentage, based on only seven cases, was too low. He records it as 1.1 per cent. to 2 per cent., four being below 2 per cent., one 2 per cent., and two 2.6 per cent., and one not given. This represents the adult average, whereas, so great is the physical activity of the growing child, so active is his metabolism, that a large amount of urea is formed, and while it may be argued that most of his nitrogenous food goes to the building up of the rapidly growing body, and thus the amount of urea formed in the urine would naturally be less, it would seem more rational to expect a greater elimination of this substance. Not only were his average percentages higher than the average given for adults, but individual cases showed a remarkably high percentage of elimination of urea: eight children having over 3 per cent, the highest being 3.7 per cent. The amount of urea per kilogram of body weight, while slightly higher than the ratio given for adults, is lower than that given by other observers, as we should expect from the smaller amount of urine.

*Chlorides.*—The chlorides were found quite constant at about 11 per cent. up to seven years, after which they were about 9 per cent.

*Phosphates.*—The phosphates were found to be from 8 per cent. to 11 per cent. from three to five years; 5 per cent. to 7 per cent. from six to twelve years, the adult range being about 8 per cent. It has been suggested that the smaller amount of phosphates found in the urine of children is due to the fact of the phosphoric acid being retained in the body for the growth of bone. One specimen from year-old boy showed 16 per cent., and as he was somewhat slow about teething, though otherwise perfectly healthy, the question suggested itself as to whether substances which normally go to build up the teeth were being eliminated as phosphates, and, if so, why? Digestion was absolutely normal. No conclusions, however, can be drawn from one solitary instance; the observation is merely of speculative interest.

*Sulphates.*—The percentage of sulphates was 1 to 1.2 per cent., slightly higher than in adults, 0.8 per cent. being their average. Purdy states that the sulphates run parallel with the urea.

*Albumin and Sugar.*—Neither albumin nor sugar were detected in any specimen. So much has been said about a physiological albuminuria that he had expected to find

albumin in one or more specimens. It must be remembered, however, that his cases were examined but two or three times, and some only once, and that therefore a transient temporary albuminuria might have come and gone between examinations. No deductions can be made on this point.

*Sediment.*—Examinations of the sediment showed nothing of especial interest in any case.

*Reaction.*—The reaction was acid in all cases, though, of course, varying in intensity in different specimens.

*Color.*—The color in most cases was pale, in the rest normal. Looked at as a whole, the records show three factors of chief importance: the small amount of urine, the high percentage of urea, and a natural result of these two, a high specific gravity. In other words, these children are passing a comparatively concentrated urine. They are all healthy, robust children, eating, sleeping, and digesting well, and of average weight. Do these records of their urine represent the urine of average American children, or of average children living under American customs and *regime*? Does the difference in nationality account for the difference in results as obtained by the investigations cited, and by those of the author. Their cases were all German children and the author's cases were American, though mostly of foreign parentage and living in an asylum. Or, is it merely a coincidence, happening among this small number of children, that they all pass a urine small in amount, concentrated in character? The number of cases is too small to draw conclusions as to the effect of race, national habits and customs of life.

An interesting feature in the table presented was a diminution in the excretion of urea per kilogram body weight at the seventh year to 0.296. During the other years, from three to twelve, the amount of urea per kilogram varied from 0.468 to 0.655.—*Pediatrics*, July, 1898.

## THE CAUSES AND TREATMENT OF HABITUAL CONSTIPATION IN INFANCY.

Dr. Thomas S. Southworth read a paper with this title in the section on Pediatrics, New York Academy of Medicine. He said that from being regarded as a disease *per se*, amenable only to drugs, constipation had come to be looked upon as due to various functional disturbances of the organism. Much had been written from a theoretical standpoint regarding the peculiar anatomical conditions found in the sigmoid flexure, but his own observations on this point had

led him to the opinion that their bearing upon the occurrence of constipation had been greatly exaggerated. Among the prominent causes of infantile constipation are deficient muscular power, disturbed peristalsis, and altered consistency of the fecal masses. To these must be added the absence of voluntary effort in the infant. The speaker said that constipation in most fairly nourished infants yielded readily to a simple treatment which was largely dietetic. The fecal masses themselves should be inspected, dissolved and broken up by the physician, and in some cases even subjected to chemical analysis. We should have more extensive analyses of the healthy, normal stools in the different periods of infancy so as to establish the variations within the limits of health. It had been shown that the milk of the nursing mother could be materially modified. The percentage of fat and the total quantity of the breast milk are the chief factors to be considered in connection with the subject of constipation. Too high a proteid percentage apparently produces looseness of the bowel and colic. The quantity of the mammary secretion could be increased by giving the mother more fluid food such as cow's milk, cocoa, thin gruels made from cornmeal and well cooked flour. The extracts of malt increase the quantity of fat. Regurgitation by the infant of small quantities of milk after nursing usually indicates that the fat percentage has been increased too far. If the constipation be coincident with stationary weight, supplementary feedings are indicated. The stools would be found made up of small firm scybalæ which, when broken up, are found to contain no curds, and seem to be well digested. A constipated child may show a fair gain in weight. Good results sometimes follow the addition of cream to the dietary given before each nursing, when the stools are dry and hard. Regulation of the mother's bowels should be undertaken, and occasionally assists in remedying infantile constipation. The commonest errors in diet leading to constipation are the giving of insufficient fat or proteid, or an excess of proteid. This insufficiency may depend upon excessive or insufficient dilution with water. Many children who thrive to all appearances on commercial condensed milk are constipated in spite of the large quantity of cane sugar present, because, as usually diluted, the fat and proteids are very low and the unabsorbed residue very small. The deficiency in the proteids results in a poor development of the muscles of the abdominal wall and of the intestine. To increase the amount of condensed milk is to increase proportionately the amount of cane sugar, which is not always advisable. The alternative is to change the food or to add a teaspoonful of cream for each teaspoonful of

condensed milk. The same difficulty might arise where plain milk was given much diluted with water, and might be remedied by increasing the quantity of milk by adding cream or by the use of "top milk." The addition of both fats and proteids proves the most serviceable in the larger number of cases. One part of condensed milk represents only  $2\frac{1}{2}$  parts of ordinary milk. An error met with very commonly in artificial feeding is that of giving plain milk too little diluted. If dyspepsia does not ensue, there are usually colic and constipation, the stools being hard, and when broken up, showing undigested casein. The proper dilution of the milk and the addition of cream will usually remedy the constipation. The use of well cooked oatmeal gruel or jelly may sometimes be of service as a diluent for the milk. Certain non-alcoholic preparations of malt may occasionally be beneficial. The juice of half an orange may sometimes be given, twice a day, in the intervals of feeding, although it sometimes gives rise to troublesome urticaria.

Two special types of constipation remain to be considered. The first of these is the rhachitic, in which the diet must be regulated and the starchy elements reduced; the second, or that form of chronic intestinal indigestion characterized by large, light colored stools of the consistency of putty. The influence of habit in securing regularity of evacuation from the bowel has long been recognized, but is often not sufficiently appreciated. It has been found that if very young infants are placed over a warm chamber at regular intervals after feeding they will very quickly be induced to have regular evacuations. It is important that children old enough to sit at stool should be provided with a support for the feet, otherwise the abdominal muscles cannot be properly brought into play. Abdominal massage would be found peculiarly useful in training the bowel to act at different periods. The child should be laid on the back and the warmed hand introduced from below upwards underneath some light covering. The tips of the fingers should then be carried from the ileo-cecal region in small circles up to the transverse colon, then across and down along the descending colon to the region of the cecum, and then the process should be repeated beginning at the same point as before. If the fingers are warm and the pressure is very light the child is not apt to cry. Five or ten minutes of such massage once or twice a day would usually be sufficient. No lubricant should be used, as it is desirable that the tissues underneath should be moved. At the conclusion of the seance, the child should be placed upon the chamber. When there is crying with defecation, and sometimes in its absence, anal fissures should be sought for.—*Pediatrics*

## TEMPORARY RELIEF OF TOOTHACHE.

Under this heading we are told by Ackland in *Treatment* of June 23, 1898, to treat toothache in the following manner:—

First syringe and well wash out the cavity or cavities with a solution of carbolic acid in water (one in forty) to remove the mechanical or chemical irritants as far as possible. Now take two pieces of cotton-wool and prepare them as follows:—The first, a mere shred, soak in carbolic and water, one in twenty; the second and larger—of a size so as to nearly fill the cavity when slightly compressed—soak in ordinary surgical colodion. Then dry out the cavity with a piece of cotton-wool, using an ordinary pair of dressing forceps, and immediately insert the shred of cotton-wool wet with the carbolic solution, followed as quickly by the large pellet of collodion wool. Should the shape of the cavity be against its retaining this temporary stopping, try to use a surface of an adjoining tooth to help to keep it in. The collodion precipitates in the meshes of the cotton, and will soon form a temporary stopping, which, although not of course preventing further decay, will generally tide the patient over for a time, without further pain. If there be more than one sensitive cavity, put a temporary stopping in each.

Inflammation of the peridental membrane and periosteum is generally a result of the death of the tooth following on the further development of a foregoing pulpitis. It is generally very easy to diagnose, as the slightest pressure on the affected tooth causes pain, and tenderness on the gum over the root or roots is always present. In the mild form it is best treated by drying the gum and painting on a liniment made up as follows:—

Liniment iodi,  
Tincture aconiti, of each 1 minim;  
Chloroformi, 10 minims.

In this form it is sometimes associated with pulpitis, in which case treat the pulp first and paint on the liniment after. In a latter stage, but before suppuration has taken place, inject into the periosteum three or four minims of a one-per-cent solution of cocaine, freshly made with distilled water, or, failing cocaine, use distilled water only. Hold the point of the needle obliquely against the side of the tooth so as to guide it into the interval between the root and the alveolar bone. In the suppurative and abscess stages, poppyhead fomentations held hot in the mouth is generally the most effective treatment. They are best made by taking two ounces

of poppyheads and boiling them in a pint of water sufficiently to evaporate to half a pint in volume, straining off the liquid and using it hot. Leeches, with or without a tube, can be applied if the patient will undergo the treatment. If an abscess be present it should be drained if possible.

A great deal of relief is often given by general treatment, such as the use of calomel and mild purges.—*Therapeutic Gazette.*

## THE EXERCISE TREATMENT OF LOCOMOTOR ATAXIA.

The treatment of locomotor ataxia by exercises calculated to teach the patient again the co-ordination of muscles that has been lost by degeneration of the lower sensory neurons has recently attracted considerable attention, and has won for itself the support of many neurologists, among whom may be mentioned Leydon, Jolly, Mendel, Eulenberg, Oppenheim, Gerhardt and Remak. This method of treatment was first introduced by Frankel, and has for its prime object the conversion of the simplest ataxic movement into a normal one.

In a communication to the *Deutsche Medicinische Wochenschrift*, of December 17, 1897, Frankel describes the various exercises for the hands, arms, body and legs. For exercising the upper extremities the following directions are given:—Sit in front of a table, place the hand upon it, then elevate each finger as far as possible; raise the hand slightly, extend, and then flex each finger and thumb as far as possible; do this with the right and then with the left hand. Touch with the end of the thumb each finger-tip separately and accurately; then touch the middle of each phalanx with the tip of the thumb. Sit at the table with a large sheet of paper and a pencil; make a dot at each corner of the paper and one in the center, and draw lines from the corner dots to the center dot, first with the right and then with the left hand. Put ten coins on the paper, pick them up and place them in a single pile, first with the right and then with the left hand.

For the body and legs, sample exercises:—Sit in a chair, rise slowly to erect position without help [of cane or arms of chair; then sit down slowly; stand with cane, feet together; advance left foot and return it, then the same with right. Walk slowly ten steps forward and five back with help of canes. Stand without cane, but with feet a little apart and the hands on the hips; in this position stoop down by flex-

ing the knees, and rise slowly. Stand without cane with the feet separated; raise the hands from sides above the head; carry them downward and forward, and try to touch the toes. Walk along a fixed line on the floor by help of cane, placing each foot in turn on the line; then repeat without using the cane. Most of these exercises should be repeated several times, and the movements should be made with the eyes both open and closed.

Owing to disturbance of the sensory paths tabetics have lost the sense of fatigue, so there is some danger in overdoing the treatment. Two things are therefore insisted upon:—first, every movement must be done with the greatest possible exactitude, since it is not simply physical exercise that is aimed at so much as training in co-ordination; and, second, the *séance* should not last more than eight or ten minutes, and no more than two should be allowed a day.

In the preataxic stage the exercise treatment has in a number of cases prevented the development of inco-ordination. Even in advanced sclerosis remarkable results may be obtained; in a number of instances patients bedridden for three, four and five years have been taught to walk without assistance. The improvement may last for years, if the disease is stationary or only slowly progressive. According to Frankel, the treatment is absolutely contra-indicated in cases of acute or subacute ataxia.

Kalinin (*Vratch*, No. 7, 1897), who has used Frankel's method in five cases of locomotor ataxia, draws the following conclusions:—By this treatment the loss of motion can be restored to a satisfactory degree, the gait and locomotion gradually becoming safer and firmer. The sense of locality and that of movement, and the skin sensibility, are but little improved. Romberg's symptom very soon became less pronounced. The duration of treatment should entirely depend upon the prognosis and the degree of motor disturbances present, but in any case it should not be less than a month. No ill effects were observed when the treatment was interrupted at short intervals of two or three weeks, but not longer.

Raichline, who has treated twelve cases with complete success in eight, concludes that the conditions of success are a long, as opposed to a short, course of treatment, a well nourished condition, good sight necessary for watching the movements accurately, a certain amount of energy and intelligence, not complete loss of sensibility, and the absence of arthropathies.—*University Medical Magazine*, May, 1898.



## THE TREATMENT OF INCONTINENCE OF URINE IN CHILDREN WITH THE LIQUID EXTRACT OF RHUS AROMATICA.

In a recent issue of *Treatment* we find that Freyberger has used this drug with great success. He gives us a brief summary of the thirty cases of enuresis which he has treated with rhus aromatica.

In all cases spoken of "as cured" at least nine months have elapsed since enuresis had occurred for the last time.

Of the thirty patients treated with rhus aromatica, twelve are boys and eighteen girls; their ages vary from three to eleven and a half years.

At the time when treatment was begun one child suffered from anemia, two from rickets, one from rheumatism, two from chorea, five from morbus cordis, five from large tonsils and adenoids, one from somnambulism, one from pulmonary tuberculosis, and one was microcephalic; while in eleven children no concomitant affection could be found.

One boy suffered from diurnal enuresis; five boys and fifteen girls presented the combined (or continuous) form of enuresis.

The average duration of the treatment was forty days, thirty-five days in boys and forty-five in girls.

The first signs of improvement occurred on an average on or about the seventh day of treatment; the earliest on the third, the latest on the twenty-third day.

Thirty-three days on an average were sufficient to produce a permanent cure, fifty-three days to effect a permanent improvement.

Eleven boys and seven girls were permanently cured; one boy and nine girls were permanently relieved; in two girls no improvement could be achieved. A relapse occurred in three girls after an interval of some months.

A temporary exacerbation of the enuresis was noted in eight cases, three boys and five girls; it occurred during or towards the end of the first week in five cases, and during the second week in three cases. While this exacerbation lasted, the patients not only wetted their beds two or three times every night, but the quantity of urine passed into the bed each time was considerably increased. This interesting though somewhat unpleasant phenomenon lasted from four to six days, and in all cases terminated rather abruptly. During this period of flooding, the urine was always very pale; its specific gravity varied between 1002 and 1007. Considering the great disappointment which parents must necessarily feel

at this apparent change for the worse, the author made it a rule to tell the parents beforehand that such a recrudescence might possibly occur, but that it would not last long, and in all probability would soon be followed by a decided improvement.

It would be rash to claim for *rhus aromatica* the qualities of a specific in the treatment of enuresis in children as long as our knowledge of this drug and its action is based upon the results observed in barely one hundred cases on which reports have been published ; but so much may be said in its favor that it appears to be as efficacious as belladonna, that it may be given for however so long without the slightest ill effect, and that good results may be obtained with it where belladonna proves ineffective.

The astringent taste and disagreeable odor of the liquid extract of *rhus aromatica* are sufficiently disguised by *syrupus aromaticus*.

The dose employed was:—Five to ten minims for children two to five years old ; fifteen to twenty minims for older children.

A very convenient formula is the following:—

℞ Ext. *rhus aromatica* fl., 10 minims ;  
Syrup. aromatici, 20 minims ;  
Aq. distillatæ, ad 1 drachm.

S.: This amount to be given three times a day.

## EXPERIMENTAL RESEARCHES ON THE EFFECTS OF DIFFERENT ANESTHETICS.

This important subject has again been taken up by Thomas and Kemp in the *Medical Record* of September 3, 1898. They tell us that, as regards ether, it would appear that this agent produces a special contraction of the renal arterioles, with a constant damaging effect upon the renal secretory cells similar to those which follow clamping the renal artery. The kidney shrinks in bulk, with consequent fall of the oncometric tracing, and accompanied by a diminution of secretion, marked albuminuria, and finally suppression. As remarked before, this condition of the kidney is not due to any change in the general arterial circulation.

These facts would seem to contra-indicate the use of ether as an anesthetic when renal disease is present, and particularly when with albuminuria there is a tendency to pulmonary edema.

The effect of chloroform upon the kidney seems to be *nil*. The oncometric curves are nearly normal, and are affected only through sharing in general circulatory changes. The secretion of urine continues up to the last moment of life, and the albuminuria is so slight that its presence at all is apparently due only to respiratory interference. Meantime the action of chloroform on the heart, as shown by carotid tracings, is directly depressing. Ether, on the other hand, shows evidence of cardiac stimulation throughout.

The A. C. E. mixture shows the special effects both of ether on the kidneys and of chloroform on the heart, either being predominant according to the mode of the administration. If a large percentage of air be simultaneously inhaled, as is the case when chloroform alone is administered, the effect is that of chloroform cardiac depression without the effect of ether upon the kidney. If, however, the A. C. E. mixture be administered more as ether is when used alone, then a study of the carotid and kidney tracing shows clearly that we have both the cardiac depression of chloroform and the renal derangement of ether combined. This seemed to cause such powerful effects upon the breathing and upon the heart that artificial respiration had to be resorted to in every dog to which this mixture was freely administered, which was not the case with either ether or chloroform. As far as the author's observations go, therefore, they fail to see any advantage in this mixture of chloroform and ether, but rather the reverse.

These objections appear to be still more applicable to Schleich's anesthetic. The cardiac depression of chloroform and the renal disturbance of ether are simultaneously developed in the tracings, similar to but to a greater degree than with the A. C. E. mixture. Schleich claims that mixtures of different anesthetics of different boiling—*i. e.*, maximum evaporation—points are safer than the administration of the anesthetic alone, on the assumption that the absorption of an anesthetic as to quantity depends upon its boiling point. The more volatile an anesthetic is, the less will be absorbed into the blood in a given time. Hence, ether, the boiling point of which is  $93^{\circ}$  F., will not be absorbed so rapidly as chloroform, whose boiling point is  $143^{\circ}$  F. If, therefore, an anesthetic could be produced whose boiling point was the same as the normal temperature of the blood, the exact amount absorbed with each inspiration would be eliminated by each expiration. By causing the mixture to be at different degrees above this point, he claims that we can regulate at will the excess which the expiration would not remove,

and thus the amount of the anesthetic retained in the blood. His addition of petroleum ether or benzine to sulphuric ether and chloroform was further to facilitate the formation of a mixture or solution of anesthetics which would afford a safer means of absorption.

The authors believe that practically this reasoning is fallacious, because it assumes that these mixtures or solutions constitute a new chemical homogeneous compound which will always be inhaled as one substance in definite chemical proportions, just as a compound salt is one substance when swallowed after solution in water; whereas the fact is that ether remains ether and chloroform stays chloroform during the inhalation, and the proportion of ether which will be absorbed will depend upon the mode of administration, a tight cone allowing an amount of chloroform to be taken which would be extremely dangerous, while the free admixture with air would so lessen the absorption of ether that its specific effects would be proportionately lessened. Meantime the adoption of benzine is not the adoption of an anesthetic, for Dr. S. T. Meltzer, in a communication to the writers on his experiments upon rabbits with petroleum ether, by inhalation through mouth and nose, as well as through a tracheal canula, says:—"Petrol ether is not a narcotic. If a rabbit was put under deep anesthesia by ether, and then ether suspended and petrol ether administered, the lid reflex soon re-appeared and the rabbit woke up. The inhalation of pure petrol ether alone soon brings out a distinct tetanus and opisthotonos, to which the animal soon succumbs if the inhalation be continued. If the inhalation be discontinued at the appearance of the convulsions, the animal survives the tetanus, but this is then followed by a distinct paresis of all the extremities. If ether is given with the petrol ether, the tetanus movements are suspended, but not so paralytic after-effects; the rabbit dies of paralysis of the respiratory muscles.

There is, moreover, a physical reason for doubting the manageability of mixed anesthetics, due to the fact that if two agents of different maximum points of evaporation be mixed together, the more volatile of them will increase the evaporation of the other by carrying off more of the less volatile one than if the latter were vaporized by itself. Thus more chloroform would be inhaled if mixed with ether than if it were administered separately.

That Schleich's mixtures have been used in a number of cases without dangerous effects is no evidence that they are safe, for the same may be said of chloroform and of ether the world over. Mixed anesthetics of any kind might be em-

ployed in hundreds of instances without unpleasant results, though actually they were more dangerous than unmixed agents, for with chloroform itself surgeons have published reports of ten thousand administrations of it without one serious accident.

## HYSTERIA AND BRAIN TUMORS.

Krauss (*Buffalo Medical Journal*, August, 1898) in considering the differential diagnosis of these affections, of cardinal importance to the surgeon, calls attention to the fact that all cases of suspected brain tumor with hysterical manifestations must not be considered as having been absolutely organic because death has occurred, since it is a well-known fact that a fatal termination may sometimes result from the different effects of hysteria, and it is quite a mistake to look upon the disease as always having a favorable prognosis, so far as life is concerned.

Fournier and Sollier have observed cases of spasm of the glottis in hysterical girls so severe that death ensued; also in hysterical angina pectoris, which is generally curable, yet Potain reported a case in which death took place and in which on post-mortem examination absolutely nothing was found.

Fournier and Sollier also refer to hysterical anorexia in which there is sometimes a fatal termination, and, even should recourse be had to artificial feeding, there seems to be no power of absorption. The wasting continues and the patient dies. They also refer to the danger of forcible feeding in such cases. One of their patients who presented a marked degree of anorexia expressed a wish for some cheese, and died the same evening that she ate it. The authors point out that sudden death may occur after hysterical vomiting, and they give the notes of one such case, no lesion of any kind being found on post-mortem examination. Thus it will be seen that the utmost care is necessary in making the examination, and still greater care and caution in interpreting the meaning of the different symptoms. In a previous paper Krauss has called attention to three groups of symptoms occurring in tumors of the brain, viz., the early symptoms, the classical symptoms, and the decisive symptoms.

The early symptoms are similar to those met with in neurasthenia and hysteria, as headaches, incapacity for mental work, disordered digestion, nervous irritability, and a general malaise. The classical symptoms enumerated in the order of their importance are: (1) head pain; (2) optic

neuritis ; (3) mental apathy ; (4) nausea and vomiting ; and as a special localizing symptom to be added to this group must be included (5) paralysis. The decisive symptom, choked disc, is the only symptom which has never been observed in the varied symptomatology of hysteria, whereas all the early and classical symptoms have been frequently noted in functional diseases. It is therefore of extreme importance that this sign should be sought for, not only at the first examination, but at every subsequent examination until its presence is determined, or its absence along with continued improvement signifies a purely functional disturbance in the patient.—*Therapeutic Gazette.*

### THE PRESENT ASPECT OF THE FOOD PROBLEM OF INFANTS SUFFERING WITH GASTRO-INTESTINAL AFFECTIONS.

Prof. Ad. Czerny (*Allg. med. Central. Ztg.*, 1898, 26 and 27 ; *Pediatrics*) does not discuss the treatment of the several forms of gastro-intestinal affections in the infant, but only confines himself to the generally important points which have a bearing on the therapy of feeding.

The older views are based on the rule relating to well known foods, until the right one is found ; and we must admit that not a single one of these foods is injurious, and that each occasionally affords good results. But we have not yet discovered accurate indications for each individual food.

If we would, however, pursue a plan of feeding which will surely lead to the end in view, we are met by the idea that the greatest stress should be laid on the number of bacteria it contains, or on the quality or quantity of the food. We only seem to agree that, under all circumstances, the ingestion of food should, in acute gastro-intestinal affections, be altogether discontinued for a time, say about twenty-four to twenty-eight hours, until the condition of the feces indicates that the intestine has been thoroughly emptied.

Infants suffering with gastro-intestinal affections, according to experience, bear the deprivation of food very well. If we allow them to drink bland liquids, water or tea, their weight is not diminished, but is eventually increased.

In like manner it is undoubtedly true that, under like circumstances, if we are dealing with a bottle-fed child, the introduction of mother's milk as food is greatly to be desired. In many cases this measure becomes life-saving ; in others, improvement does not take place. In these latter cases the

cause of our non-success can hardly be found in the quality of the breast-milk, if this comes from a well-secreting gland.

Only the milk from a gland which is in course of retrogression, especially from one in which the secretion is rapidly lost, is undesirable, for the reason that the soluble constituents of the milk, stagnating in the breast, the sugar of milk, and also the fat of milk, are reabsorbed and respectively thrown out.

This stagnation may, however, also take place when the gland is only partly emptied. Thus it may occur where a wet-nurse takes to the breast a very sick, poorly nursing, infant.

It is, then, wrongly said: "The wet-nurse has lost her milk."

The best measure, under these circumstances, is to nurse a healthy child together with the sick one; all instruments invented for the purpose of artificially emptying the breast are imperfect.

We are obliged frequently, under these conditions, to be satisfied (when the sick baby gradually loses the gastro-intestinal symptoms), if the bodily weight only slightly increases, or even remains the same, perhaps for weeks, and we should be careful not to change the wet-nurse, or take refuge in artificial food. Vomiting is, as a rule, the last symptom to disappear.

One group of gastro-intestinal affections in all breast-babies and children, during the first few years of life, is characterized by mucous stools.

These cases, according to general experience, are most rapidly cured by a diet of cereals, with the absolute exclusion of albumen and fat. The hope which was entertained, that we might be able, perhaps, to bring about a cure of the diseased stomach and intestines by administering food free from germs, was not realized. This may, perhaps, prevent the disease, however.

Sterilization of the milk, carried to the extreme, has even produced a very disagreeable result—Barlow's disease.

The author recommends that the milk be boiled not longer than ten minutes. Neither does he believe that the curdling, in large flakes, of cow's milk is of great importance in feeding.

The endeavor of Heubner and Hofmann to increase the caloric heat-producing power of diluted cow's milk by the addition of sugar of milk is designated by the author, at least as far as sick infants are concerned, as having miscarried.

The methods of Gaertner and Backhausen to render all

oxydizable constituents of cow's milk, including the fat, equal to that of mother's milk, have also failed in the sick infant. "Fettmilch" does not quiet vomiting, but often causes it. It is to be recommended where constipation is present. But a large number of sick babies do not thrive on it.

Keller, in his experiments, has shown that the great emaciation of children suffering with gastro-intestinal diseases is caused by a disturbance of oxydation, which finds its expression in the large excretion of ammonia, *i. e.*, the acids in the circulation are not destroyed, as in the healthy infant, but are retained in the blood, and continually interfere with metabolism. It is mainly important to know, not how many calories is contained in the infant food, and how many of them are absorbed, but how many of them are oxygenated; and it is of importance to know that an infant suffering with a gastro-intestinal affection does not at once improve even when it is fed with good breast milk, for the reason that this is not as yet perfectly oxydated, the sugar of milk remaining in part undestroyed, and therefore a great amount of ammonia is excreted.

We have also learned from observation on children suffering from gastro-intestinal affections that in feeding with cow's milk, fat as a source of acids, which are with difficulty oxygenated, may become dangerous to the health of the infant, so also many carbo-hydrates and albuminoid bodies. We are therefore practically obliged to find a food for infants suffering with gastro-intestinal catarrh, which is readily oxygenated, in which as few as possible non-oxydizable acid products of metabolism are produced, and to meet the harmful products by supplying the system with alkalis.

The attempts to render the casein of infant foods more digestible by peptonization, have also not produced encouraging results. The author declares the peptonized milks as unsuitable to infants suffering with gastro-intestinal affections; breast-milk contains neither peptones nor albuminoids.

The method recommended by Backhausen, which consists in precipitating the casein by lablenzym, and adding a solution of albumin after destroying the enzym, has not, by any means, given encouraging results. It has, moreover, never been demonstrated that the casein of cow's milk is not easily digested; at least no proof has yet been offered that the intestine is not able readily to absorb it.

The amount of albumin which is necessary to the infant (Heuber and Rubner, 6.2-6.5, *pro die*) is present even in



strongly diluted cow's milk, and there is no necessity for giving infants a food especially rich in albuminoids.

There is no reason to doubt that infants suffering from gastro-intestinal diseases are not in want of an increased supply of albumin, otherwise they would not thrive best when receiving breast-milk (which is so greatly deficient in albumin), and all experiments with foods rich in albumin, in infants suffering from gastro-intestinal affections, would not have given such bad results. Not because a milk containing much albumin favors intestinal decomposition, but because it leads to disturbances in the intermediate metabolism, with which we are at present not well acquainted. It might also be mentioned that the deleterious influence of strongly diluted milk may, in part, be explained by the fact that the large quantity of water ingested removes much of the salty constituents of the organism. These salts may, however, be replaced by adding them to cow's milk, and their removal is certainly less injurious than over-nutrition with albumin.

The volumetric method of Eschbach, which seeks to know the amount of food necessary to the child in twenty-four hours, which would be taken by a child of the same age when nursed at the breast, gives an average figure, which is only applicable to healthy infants. Sick babies should only be fed with the smallest possible quantity which is sufficient for their existence; and the author permits sick babies to drink as much as they wish, at long intervals (four hours) only; other pediatricists reduce the quantity of single meals, and shorten the intervals.

### HOT AIR AS A HEMOSTATIC.

The jet of hot air from a Hollander apparatus directed upon the bleeding surface of a kidney, liver, or severed blood vessel, will arrest the hemorrhage by the formation of an eschar commencing around the edges and gradually spreading over the entire surface, mechanically checking the flow in experiments on animals, and Schneider concludes that it would be equally effective on man. The heat is only 39 degrees at 5 mm. from the apparatus, and hence is not sufficient to injure the organ. He found steam less effective and less convenient for several reasons, masking the field of operation, etc.—*La Semaine Méd.*, August 3.

### SODIUM SALICYLATE FOR TOOTHACHE.

Dr. Frederick C. Coley, in an article on the medical

treatment of toothache in a recent number of the *Practitioner*, states that of all medical remedies for toothache he knows of none which is so successful as sodium salicylate. He believes it is especially useful in those cases where the pain is started by "taking cold."

A dose of 15 grains will usually relieve the pain very promptly, and if this is repeated every four hours the inflammation may entirely subside, leaving, of course, a carious tooth to be disposed of according to circumstances. The addition of belladonna is often advantageous. Fifteen grains of sodium of salicylate, with 15 minims of tr. belladonna, will often procure refreshing sleep instead of a night of agony. It is especially valuable with children, when extraction of teeth is to be avoided, if possible, lest the development of the maxilla should be injured.—*Medical Times*.

#### YELLOW PALMS AS A SIGN OF TYPHOID FEVER.

Filopowicz (*Centralblatt fuer die Medizinische Wissenschaften*, 1898, No. 11; *Amer. Jour. Med. Sciences*, October) calls attention [for the second time] to a symptom of typhoid fever not generally looked for. The palms and soles acquire a yellow color, which is more marked in proportion as the skin is thickened by toil, but present even when the skin is thin. This change comes on in the early days of the disease, and lasts until the end, disappearing in convalescence. The author thinks the sign due to the changes in the circulation, especially to anemia of the skin, as the result of which the subcutaneous fat shows through.—*N. Y. Med. Jour.*

# SURGERY.

IN CHARGE OF

GEORGE FISK, M.D.

Instructor in Surgery University of Bishop's College; Assistant Surgeon Western Hospi-ta.

## TREATMENT OF PARALYSIS—TRANSPLANTATION OF TENDON.

Herr Vulpius, in speaking on the above subject before the German Surgical Society, Berlin, said that although club-foot had been successfully treated, in the paralytic form, the paralysis was not removed. This was achieved by transplantation of the tendon of a functionally active muscle. The operation was not by any means difficult. A plastic dressing was afterwards applied. Gymnastic after-treatment was of great importance. He had operated in this way in twenty-eight cases. In one case in the thigh he had transplanted the tendon of the sartorius on to the paralyzed quadriceps. The procedure was of great importance in the upper extremity. In one case of paralysis of the flexor of the fingers he had transplanted the tendon of the flexor carpi radialis on to the flexor sublimis digitorum.

Hr. Frank in a case of paralysis of the extensor of the wrist had shortened the extensor carpi radialis, and on the ulnar side had attached the extensor digitorum communis. The child, who was previously helpless, could write with the hand, knit, and dress herself. The method could also be employed in spastic paralysis.—*Medical Press, etc.*, July 13, 1898.

## PAINLESS TREATMENT OF CARBUNCLES.

Dr. Sol. W. Rosenbaum describes (*N. Y. Med. Jour.*) various methods adopted for the treatment of carbuncles. Stimson, Parker, Beck, Gross, etc., regard incision as the only radical cure. A simple painless method of treatment, introduced by Dr. George H. Swinburne, "I have followed at the Good Samaritan Dispensary in over 200 cases, with uniformly good results—never having septicæmia or pyæmic sequela"—consists in injecting the following solution as an abortive in those cases which are soft and soggy:—

R.—Glycerin..... ʒj.  
Salicylic acid..... ʒv.  
Borax.  
Boracic acid..... āā ʒiiss—M.

Fold a piece of aseptic gauze until it forms a thickness of six to eight layers, the surface area to be somewhat larger than the carbuncle to be covered. The gauze is at first thoroughly saturated with Thiersch's solution, then covered with a layer of ten per cent. ointment of ichthyol, and then applied to the carbuncle. A piece of rubber protective large enough to overlap the gauze is now placed on the same to keep in the moisture. A layer of cotton is placed on the protective, and then the bandage is applied and allowed to stay on for two days. When the patient returns to be rebandaged, and to have the dressings renewed, the cores are found to have separated from their respective walls, and at the next redressing, which is again in two days, they are found entirely separated, and can be easily and painlessly removed. At the next visit, granulation has passed the primary stage, and healing quickly results, leaving an almost invisible scar. The only constitutional treatment which I found necessary is to give cathartics, like fluid extract of cascara sagrada or castor oil, and, in individual, anemic, or cachectic cases, compound syrup of the hypophosphites.

With this simple, but very effective treatment, I have summarized the following advantages:

1. Painlessness (a great factor with many patients).
2. Quickness of healing, more so than with other methods.
3. No scar or cicatrix remaining—important when carbuncles are in visible parts.

I have treated a patient at our dispensary who had a carbuncle, situated on the median line of the back between the scapule, measuring in diameter four inches and seven eighths; including the zone of inflammation, complete measurement reached up to seven inches. The patient was cured in five visits, coming every second day. Hardly any pain was suffered during treatment, and no cicatrix remains. —*Med. and Surg. Monitor*, July, 1898.

### CARE OF SOLDIERS' FEET.

The *Medical News* of July 2, 1898, in a leading article on the care of soldiers' feet, quotes from a recent article in the *Deutsche Mil. Artz. Zeitschrift*, by Gerdeck, on the use of formalin. He recommends that undiluted formalin be pencilled over the feet three or four times at intervals of about six hours, and that four or five drops of the same fluid be dropped into the boot to disinfect it and to protect the leather. It is then a prophylactic, and enables soldiers who habitually suffer from sore feet to march without difficulty.

Even where a concentrated solution of formalin is applied to the feet a few times, the feet do not sweat again for two or three weeks.—*Treatment, Aug., 1898.*

### TREATMENT OF SENILE GANGRENE.

Prof. Thomas Jones, of the Manchester Royal Infirmary (the *Medical Chronicle*, January, 1898), formulates the following rules to be observed in cases of senile gangrene:

"1. When the gangrene is limited to one or two toes, and the patient's condition is and remains satisfactory, be content with the expectant plan of treatment, taking precautions to lessen or prevent the effects of local septic infection.

"2. When, however, the gangrene has reached the metatarsus, be prepared to carry out the high amputation—that is, amputation above the knee, or, in rare and favorable cases, through the knee-joint itself."

As the tissues of the stump may not be perfectly aseptic in these cases, it will conduce to the ultimate and more perfect union of the flaps if a drainage-tube is introduced and left in the stump for a few days.—*Treatment, Aug., 1898.*

### COLOTOMY AND COLOSTOMY.

Von Mosevig-Moorhof (*Wiener medicinische Presse* 1898, No. 3) reviews the accepted methods of forming an artificial anus, and describes a modification in technique which he has found useful in certain cases. The classical inguinal operation—that of Littré—he terms "colostomy;" it consists in bringing the descending colon up to the anterior abdominal wall, to which it is stitched, the opening into the lumen being made at once or after an interval, according to circumstances. The disadvantage of this simple operation is that it does not entirely prevent the entry of feces into the distal part of the bowel, where they stagnate and tend to set up inflammatory troubles. To prevent this, Madelung introduced true colotomy, in which the gut is cut completely across, the proximal portion brought out of the wound, and the distal closed by sutures and returned to the abdomen. This method is not entirely satisfactory, as the distal end tends to become distended by the accumulation of its own secretion, which may eventually lead to ulceration. König and Sonnenburg obviated this difficulty by leaving the upper extremity of this portion open and attached to the

abdominal wall below the artificial anus; by this means the rectum can, if desired, be irrigated from above. Another means of preventing feces from getting into the rectum is by the formation of a spur, first devised by Verneuil, whose original plan has been considerably improved by later surgeons. The disadvantage of both this method and colotomy is that they require a long and freely movable colon and mesocolon; when they are inadvisable or impracticable the author recommends the method he has himself devised. This consists in the ordinary operation of colostomy performed at one sitting, but preceded by partial occlusion of the distal portion of the bowel. A ligature is tied round this, occluding it to about one-half its diameter, and the bulging serous surfaces on either side are sewn together with interrupted stitches. An artificial construction is thus produced, which prevents the accumulation of feces in the rectum.—*University Med. Mag.*, Aug., 1898.

#### A NEW METHOD OF DRAINING THE PERITONEAL CAVITY.

Delageniere (*Bulletin et Mémoires de la Société de Chirurgie*, No. 12, 1898), holding that the means hitherto used for draining the abdomen after laparotomy are defective, proposes to drain this cavity in a similar way as a spirit lamp is drained by its wick. He employs a perforated nickel tube, in which is inserted a skein of absorbent cotton. This skein closely fits the interior of the metallic tube, and is frayed out as it projects from either end. Both the outer tube and the cotton can be readily sterilized, and the skein can be changed from time to time without removing the tube. In no case, the author states, should the metal tube be allowed to remain for a longer period than thirty-six hours. Excellent results, it is stated, have been obtained from this method of drainage, and, after long and difficult abdominal operations, the course of the after-treatment has thus been rendered absolutely apyretic. The nickel tubes used by the author vary in length from eight to ten centimetres, and in diameter from five to twenty millimetres.—*University Med. Mag.*, Aug., 1898.

# Medical Society Proceedings.

## MONTREAL MEDICO-CHIRURGICAL SOCIETY.

### ANNUAL MEETING.

The Twenty-First Annual Meeting of the Montreal Medico-Chirurgical Society was held in the rooms of the Natural History Society, on Friday evening, October the 7th, 1898.

The retiring President, Dr. Robt. Craik, occupied the chair.

The Treasurer, Dr. J. M. Jack, read the following report for the session 1897-98.

#### Receipts.

Oct. 1.	To Cash in Bank.....		\$ 93 05
Nov. 4.	“ Rent Clinical Society, '96-97.....	\$ 19 50	
Dec. 24.	“ Cash from Lister Dinner Committee.....	37 41	
	1898.		
Jan. 22.	Interest on Cash in Bank for 1897.....	4 22	
Sep. 30.	Cash, members' subscriptions.....	560 00	
			<u>621 13</u>
			\$714 18

#### Expenditures.

By Cash to Secretary's Current Expenses, 1897-98.....	\$44 80	
“ Charges Dr. G. Campbell, Secretary, 1896-97.....	50 00	
“ Account Bentley, printing for session, 1897-98.....	36 25	
“ Charges Dr. S. R. Mackenzie, Secretary, 1897-98..	50 00	
“ Account Electric Co., lighting for 9 months, 1897-98.	14 21	
“ Charges Dr. Buller, 9 months' rent, 1897-98.....	318 75	
“ Cash, care of Hall, for 9 months.....	18 00	
“ Account E. Cox., re Lister Address.....	50 00	
“ Cash, Treasurer for postage, 1897-98.....	5 00	
“ Account Davis, type-written letters, special.....	7 50	
“ Cash, Natural History Society, rent of Hall.....	24 00	
		<u>618 51</u>
Cash Balance.....		\$ 95 67.

#### Assets.

Members' subscriptions overdue.....	\$545 00	
Society furniture.....	210 00	
Cash on hand in Bank.....	95 66	
		<u>850 67</u>
		\$850 67

#### Liabilities.

Account Dr. Lockhart, re cash paid for removing books...	3 05	
Account M. Hicks for storage on books.....	3 00	
Account Sabiston Litho. Co., printing.....	3 75	
		<u>9 80</u>
Net Assets.....		\$840 87

JAMES M. JACK,

Montreal 5th October, 1898.

Treasurer.

The Secretary, Dr. Ridley MacKenzie, reported that eighteen regular meetings had been held during the year, the average attendance being 32. Thirteen new members had been elected during the year, making the total number of ordinary members on the roll 156. With 16 temporary members the grand total numbers 172.

The work of the year had consisted of eleven papers, twenty case reports, sixteen living cases and thirty-five pathological specimens, besides the exhibition of electrical apparatus and skiagrams.

The report of the Committee on Provincial Elections was then read and adopted without discussion, the President thanking the committee on half of the Society for the faithful and efficient manner in which it had performed its work.

The following were elected officers for the ensuing year :—

President—Dr. J. G. Adami.

First Vice-President—Dr. H. A. Lafleur.

Second Vice-President—Dr. J. M. Elder.

Secretary—Dr. A. J. Bazin.

Treasurer—Dr. J. M. Jack.

Council—Drs. Robert Craik, F. J. Shepherd and James Bell.

The retiring President, Dr. Robert Craik, before reviewing the work of the past session, spoke of the unfailing courtesy and kindness shown to him by the members, which had made his duties as chairman a pleasure as well as profit. He thanked the Society for the honour they had done him in calling over the meetings after an unavoidable absence of years. Although the work of the year had all been of value, there were a few subjects of sufficient importance for special reference. Thus the modern improvements in the different departments of surgery, especially of the uterus, gall-bladder and bile ducts; and the operations for the relief of malignant disease of larynx and tongue marked an immense advance in this department to one who, like himself, had seen the beginning of the surgery of these organs. Twenty-five or thirty years ago such operations never entered into our calculations in the most remote way, yet the progress made during this period of time was but a foretaste of what the next twenty-five years would bring about. Another point to which reference was made was the growing influence of the Society in municipal affairs. During the year our advice had been sought by influential aldermen on important sanitary matters. Of still greater importance was the reform of the College of Physicians and Surgeons of the Province which our Society has been largely instrumental in bringing about.

*Stated Meeting, October 24th, 1898.*

J. G. ADAMI, M.D., PRESIDENT, IN THE CHAIR.

Drs. W. G. M. Byers, C. H. Church, H. M. Church, W. M. Fisk and C. J. Edgar were elected ordinary members.

#### PATHOLOGICAL SPECIMENS.

Dr. A. G. NICHOLS showed the pathological specimens, and gave the history of a case of appendicitis, with unusual changes in



the liver, a case of gastro-cholecystic fistula with diverticula in the duodenum, a case of cancer of the œsophagus.

#### CANCER OF THE TONGUE.

Dr. G. E. ARMSTRONG showed a man from whom he had removed one-half of the tongue by a modification of Buntin's method.

#### CHARCOT'S JOINTS.

Dr. G. E. ARMSTRONG showed a tabetic patient with marked disorganization of the right knee and left hip joints.

#### THE CRESCENT FORM OF MALARIA PLASMODIUM.

Dr. H. A. LAFLEUR exhibited specimens of blood from a case of æstivo-autumnal malaria which had been under his care in the Montreal General Hospital showing the crescent form of plasmodium.

The patient, a French-Canadian, had served in the United States Army and contracted the malaria at Santiago. At the close of the war he had come to Canada and so drifted into the hospital. One feature of interest in the case was the resistance shown by the organism to quinine. After three days of observation, quinine was commenced on the fourth day, and, although under its influence the paroxysms of fever were controlled, the plasmodium was still present in the blood, though not in such numbers, when he left the hospital on the tenth day. In the quotidian or tertian fevers usually met with in Canada, from ten to fifteen grains of quinine given in divided doses was sufficient to entirely remove the plasmodium from the blood. This was the first time that the crescents had been shown before the Society, but the speaker had seen them in one case in hospital the preceding summer.

#### HOSPITAL ABUSE.

The discussion on this subject which was to have followed the reading of Dr. Armstrong's paper at the meeting of June was continued.

Dr. H. L. REDDY said that there was very little room for hospital abuse in the Women's Hospital with which he was connected, as the conditions were such that it was to the interest of the patients themselves to obey rules. Thus the patients were all required to pay a small amount towards their board weekly if they desired to send their children to the Foundling Institutions. If they do not pay their board they are required to nurse their children. They are warned of the danger of mammary abscess if they wean the children on leaving the hospital without having the treatment which is required on such occasions. For those who are really unable to pay the small sum demanded, it was often possible to find some one responsible on whom the charge could be laid.

The matron who admits the patients under his directions generally found out the truth, and naturally a great deal depends on her to prevent abuse of the charity of the hospital. If there was no one whose duty it was to provide, and in all cases of the deserving

poor married women, they are admitted to the hospital free of charge.

Dr. T. G. RODDICK thought that Dr. Armstrong referred more especially to abuse in the out-patient departments of the general hospitals, and agreed that there was great abuse made of these charities. He felt, however, that the profession was more to blame than the public. The Montreal General Hospital had gone into this subject years ago and found that many, then, were in the habit of driving to and from the hospital in cabs. He advocated more rigid attention to receiving patients only on properly made out certificates given by responsible persons. He objected to the small charge made at most hospitals to poor patients, as these on receiving treatment were under the impression, in many instances, that they were paying for what they obtained.

Dr. H. A. LAFLEUR was of the opinion that the much vaunted certificates were worse than useless. Any clergyman or priest would give a certificate for the asking, and the only class that the certificates kept from coming to the hospital were those who would not take the trouble of procuring them.

Dr. ROBERT CRAIK thought that the system in vogue at the Roosevelt Hospital in New York was about the best remedy. This was that every applicant for treatment was obliged to go before an officer and register the name and other particulars and if obviously a suitable case, he or she was passed on to the doctor; if not, the case was investigated before it was accepted for treatment.

Dr. A. J. RICHER was afraid that the method of dealing with applicants referred to by Dr. Craik might put such difficulties in the way of admitting patients that it would make the system worse than the present one. In his experience in the hospitals of Paris, where a somewhat similar system was carried out, cases were not rare where patients had applied to the bureau and been refused, and had been picked up later on the streets dead. It might also cause abuse in the opposite direction. The officers whose duty it was to attend to the admission of patients were apt to take advantage of their position and become abusive to the poorer classes. At the same time he thought that it might be possible, through a central board as suggested by Dr. Armstrong, to obviate this difficulty, and thus try to relieve the hospitals of much of the present abuse.

Dr. J. M. ELDER held that certificates were absolutely worthless, and that the present means of preventing abuse were quite inadequate.

There was a certain definite floating population of hospital abusers, who present themselves for treatment with more or less regularity at the various hospitals. This class was able to pay for medical services and should be made to do so; but the real difficulty in dealing properly with them lay in the rivalry between the hospitals themselves for patients. The remedy was concerted action on the part of the different hospital authorities, so that each hospital should furnish to the others a sort of "black list" of these professional "hospital abusers," and thus render it impossible for them to get *gratis* medicine and advice they were well able to pay for.

Some such plan as Dr. Armstrong suggests must soon be adopted in justice to the hospitals, as well as to the outside practitioner.

Dr. A. E. GARROW agreed with Dr. Roddick that the physicians themselves were the worst offenders, as patients sent to any hospital with a doctor's certificate stating that they were suitable cases were admitted without question. The method in vogue for the past year at the Royal Victoria Hospital was somewhat like that advocated by Dr. Craik, and it had been found to work very well.

The PRESIDENT pointed out that clearly the main cause of the abuse of hospitals by the public, the hospital management and the profession, lay in the fact that no clear distinction was made between the hospital as a pure charity and the hospital as what is truly, a benefit society—and that it was the attempt with true British illogicality and desire to compromise, to run our hospitals as both at the same time, which was at the basis of the main abuses of which complaint is now being made.

If the hospital has been founded originally for the benefit of the poor, and if that hospital calls itself a charitable institution, it is, if not absolutely wrong, certainly most impolitic for such hospital to accept into its wards pay patients. Only those who are incapable of paying the usual fees of the practitioner should be admitted. There may be certain minor exceptions to this broad principle, but the principle exists, for what happens if this rule be neglected? Y. sees that X., who can perfectly well afford medical treatment, is admitted to the hospital, and not knowing the exact conditions of X.'s admission, is unable to see why he also should not use the hospital; what is more, as Dr. Armstrong has pointed out, when the subscribing public recognise this fact, and recognise also that the attention which they receive at the hospital is better than they can possibly receive at home, then these subscribers begin to be anxious themselves to use the hospital; and, once private wards are introduced, steadily, both the outside public and the staff of the hospital are led to urge that there be an increased number of such private wards, and so gradually and surely once the principle is admitted that those who can afford to pay the ordinary fee demanded by the ordinary practitioner can get treatment at the public hospital, the attempt of the paying public to utilize the hospital becomes evident and becomes successful. It was a mistake for charitable institutions, such as our larger hospitals in Montreal, to allow any corporations or combination of individuals to subscribe to the hospital funds conditionally.

The working classes now-a-days have become so accustomed to the system of medical relief afforded by the benefit societies to which they belong, that almost naturally they appear to be incapable of seeing that their subscriptions to the hospital are not of the same class as their subscriptions to their benefit society. Thus it is that foremen and others receiving high wages consider themselves absolutely entitled to treatment at the hospital to which they have subscribed.

It is for our hospitals to make it clearly understood that they

only exist for those who cannot pay the ordinary fee of the ordinary practitioner. The more the President considered this subject the more he was convinced that it was a mistaken policy to have private and public wards in the same building. Undoubtedly, the better class public has of late grown to realise the admirable service afforded in our hospitals, and is beginning to demand that it should be entitled to the same advantages as the poor can now obtain. But the well-to-do have no right to ask the charities to give them these advantages. The way to satisfy this demand is for the public or sections of the public, acting more or less in concert with the medical profession, to combine and establish pay hospitals. It would even be legitimate for the existing hospitals to establish separate buildings in which they receive well-to-do patients and to employ the profits obtained from such patients for the purposes of the charity pure and simple, but, so long as pay patients and charity patients are received into the same building, and given what is practically the same treatment, for so long is it certain that those who can perfectly well afford to pay the hospital charges and the physicians' fees will attempt to benefit from the charity.

In the meantime, he was of the opinion that to lessen the evil, no better scheme could be brought forward than that suggested by Dr. Armstrong, and he hoped that this Society would use its influence to bring about the development of such a system of charity organization and enquiry into the good faith of those presenting themselves for gratuitous treatment in our public hospitals.

THE  
CANADA MEDICAL RECORD

PUBLISHED MONTHLY.

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*Subscription Price, \$1.00 per annum in advance. Single Copies, 10 cents.*

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Make all Cheques or P.O. Money Orders for subscription, or advertising, payable to JOHN LOVELL & SON, 23 St. Nicholas Street, Montreal, to whom all business communications should be addressed.

All communications for the Journal, books for review, and exchanges, should be addressed to the Editor, Box 2174, Post Office, Montreal.

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## Editorial.

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### THE CANADIAN PRACTITIONER AND MEDICAL REVIEW.

This is to be the title of a new medical journal to appear in January next, the result of an amalgamation between the two Toronto journals, *The Canadian Practitioner* and *The Canadian Medical Review*.

We are glad to hear of this union of forces. There are too many medical journals published. It would be much better to have fewer and improve the quality. Few physicians can read more than three or four, and usually do not care to subscribe for a greater number, and, if a subscriber for a journal in any district where a number exist, he is only partially informed of the work done. Whereas, a consolidation of literary efforts in organs representing wider spheres gives a more satisfactory journal to the subscriber and will lead to a more extended list of readers for the articles of contributors. We offer our congratulations on the improved prospects afforded by this union and extend our sincere wishes for its success.

# Book Reviews.

**International Clinics.**—A quarterly of clinical lectures on Medicine, Neurology, Surgery, Gynæcology, Obstetrics, Ophthalmology, Laryngology, Pharyngology, Rhinology, Otology and Dermatology, and specially prepared articles on treatment and drugs, by professors and lecturers in the leading medical colleges of the United States, Germany, Austria, France, Great Britain and Canada. Edited by Judson Daland, M.D. (University of Pennsylvania), Philadelphia; J. Mitchell Bruce, M.D., F.R.C.P., London, Eng.; David W. Finlay, M.D., F.R.C.P., Aberdeen, Scotland. Volume III., eighth series, 1898. J. B. Lippincott Co., Philadelphia, Pa.; Charles Roberts, 593 Cadieux Street, Montreal, Dominion Agent.

This volume is quite up to the standard of its predecessors in regard to the quality of the articles and the standing of the writers. Among the most interesting articles are the following. "The Therapeutic Use of Alcohol," by Henry Martyne Bracken, M.D.; "The Diagnosis and Treatment of Ocular Headaches," by Casey A. Wood, M.D.; "The Principles Underlying the Treatment of Derangements of Cardiac Function," by Augustus A. Eshner, M.D.; "The Treatment of Pertussis," by Floyd M. Crandall, M.D.; "Some Observations regarding the Treatment of the Conditions generally known as Anteversion and Anteflexion," by J. C. Webster, M.D., F.R.C.P.E., F.R.S.E.; "A Case of Acute Tuberculosis associated with Ulcerative (infective) Endocarditis leading to Acute Septicaemia fatal on the fifth day," by Sir Dyce Duckworth, M.D., LL.D., F.R.C.P.; "Physical Signs in Examination of Brain Cases," by Francis Warner, M.D. (London), F.R.C.P., F.R.C.S., Eng.; Hydrocephalus, Dermoid Cyst of the Scalp, Dupuytren Exostoses of the big toe, Epithelioma of Face involving the Orbit," by Fredrick Trendelenburg, M.D. Also articles by Joseph T. Matthews, Paul F. Munde, Seth Scott Bishop, Arthur von Harlingen and a number of other writers.

**A Manual of Venereal Diseases.**—By James R. Hayden, M.D., Chief of Clinic and Instructor in Genito-Urinary and Venereal Diseases, College of Physicians and Surgeons, New York; Professor of Genito-Urinary and Venereal Diseases in the Medical Department of the University of Vermont, etc. New (2d) edition, revised and enlarged. In one 12mo. volume of 304 pages, with 54 engravings. Cloth, \$1.50, *net*. Lea Brothers & Co., Publishers, Philadelphia and New York.

In this, the second edition of Dr. Hayden's book, the text has been thoroughly revised and brought up to date, and it is endeavored to give in a clear and compact form a *résumé* of our present knowledge of the three diseases: gonorrhoea, chancroid and syphilis. History and statistics are not included, but a practical presentation of the essential points in regard to diagnosis, prognosis, infective etiology, narcotic symptoms and treatment is given.

The numerous illustrations show the different instruments used and the method of using them, and other practical points in the management of these affections and their complications. It will be a useful addition to the library, enabling one in a very brief period to freshen the memory and fit the latest points in regard to the management of the common class of affections.

**The Physician's Visiting List for 1899.**—Forty-eighth year of its publication. P. Blakiston, Son & Co. (successors to Lindsay & Blakiston), 1012 Walnut St., Philadelphia.

This visiting list is arranged for from twenty-five to one hundred patients per day or month. Price from one dollar to two dollars and twenty-five cents. A perpetual and a monthly edition are also published. They are strongly bound in leather, compact and very conveniently arranged, and they are undoubtedly the most satisfactory of the various visiting lists we have examined, and are the ones most extensively used. We can unhesitatingly recommend them.

**La Tuberculose, sa Prophylaxie, son Traitement.** Dr. E. Vignaud, Paris, 1898, Société d'Éditions Scientifiques. Price, 3 francs.

A very interesting monograph upon tuberculosis, its prophylaxis and treatment.

This concise little book of about 160 pages treats the whole subject of tuberculosis in a most practical way. The subject is viewed in its different phases in a most able manner. The chapter upon treatment will stand the criticism of the best authorities. It gives, in a nutshell, the most enlightened ideas of the authorities of the present day, being in every way thoroughly up to date.

**Les Desequilibres des Jambes.** Dr. Gelineau, Paris, 1898, Société d'Éditions Scientifiques. Price, 3 francs.

A monograph of 120 pages, giving detailed observations upon a number of cases of a certain form of mono and sometimes para-plegia of a transient nature, which was some years ago described by Blocq as manifestations of hysteria. The author of this little book, however, disclaims this explanation, by citing minute observations made by himself of a number of cases of astasia and astasia-abasia occurring in subjects which were not hysterical.

It will prove very interesting to physicians who have to deal with neurasthenics.

**Anderson's Physical Education.**—We have just received from the publishers a copy of "Anderson's Physical Education." This is the latest work of Dr. W. G. Anderson, the well-known Professor of Gymnastics at Yale University. The book treats of every phase of body building, and is "up to date" in every particular. There are special chapters devoted to professional people, business men, women and children. It tells you how to decrease your weight if corpulent, and increase it if thin. It gives valuable measurement charts for both men and women.

Every reader interested in better health, greater strength, grace, self-control, elegant carriage, should possess a copy of this work.

The book is full of good suggestions for all classes. The parent who is anxious about the narrow chest of the child—the young man who is worried about his lungs and stooping shoulders—the business man on the verge of collapse—the busy editor, lawyer or minister alarmed because of an over-taxed brain and its resultant sleeplessness—the society woman who finds the adipose tissue is accumulating too rapidly over the abdomen—the housewife who can no longer climb the stairs without losing her breath—the young lady who is troubled about the bones in her neck showing and slight bust development can all find in this book much that will benefit and help them. We know of no work that gives as many useful and helpful suggestions in such compact and readable form. The illustrations, about one hundred in number, are taken from drawings and life.

The book will be sent post paid by the publishers for 15 cts. Address The Harold A. Wilson Co., Limited, 35 King St. West, Toronto.

**The Medical News Visiting List for 1899.** — Weekly (dated, for 30 patients); Monthly (undated, for 120 patients per month); Perpetual (undated, for 30 patients weekly per year); and Perpetual (undated, for 60 patients weekly per year). The first three styles contain 32 pages of data and 160 pages of blanks. The 60-patient Perpetual consists of 256 pages of blanks. Each style in one-wallet-shaped book, with pocket, pencil and rubber. Seal Grain Leather, \$1.25. Thumb-letter Index, 25 cents extra. Philadelphia and New York: Lea Bros. & Co.

This valuable little book appears in the same well-known form as last year with the exception that the material composing it is better if anything. To those who have used it no word of recommendation is needed, but to those who have not experienced the convenience of this compact visiting list a trial of it will reveal a boon. It contains 32 pages of data which form an invaluable guide in emergencies. The blank pages are arranged conveniently to record all manner of professional engagements and memoranda.

**Diet for the Sick.** By Miss E. Hibbard and Mrs. Emma Drant, matrons at two large hospitals in Detroit. 103 pages; board sides, postpaid, 25 cents. The Illustrated Medical Journal Co., Detroit, Mich., publishers.

This is the Third Edition of this handy and popular little bedside book. The recipes for sick dishes have all been tried, and are those largely used by the Detroit hospitals where the two contributors of them served as matrons. Added to these are various Diet Tables, as for: Anæmia, Bright's Disease, Calculus, Cancer, Consumption, Diabetes, Dyspepsia, Fevers, Gout, Obesity, Rheumatism, Uterine Fibroids, etc., as given by the highest authorities. The booklet is intended to be given to the family by the physician, and for such purposes one half dozen will be sent, prepaid, on receipt of \$1.00.



# PUBLISHERS DEPARTMENT.

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## NERVES AND FOOD.

Sir Henry Thompson, writing in the *Nineteenth Century*, makes the following remarks upon the altered diet which has become necessary, owing to the extraordinary changes affecting man in every rank of life and his surroundings in all parts of the civilized world, which have taken place during the last sixty years: "It is difficult—perhaps impossible—for the present generation to realize the contrast presented in respect of the demand now made on man's activity, especially that of his brain, during, say, the last thirty or forty years, with that which was required by the routine of life as it was in the 'thirties.' The wear and tear of existence has enormously increased, and the demand for rapid action and intense exertion by the nervous system is certainly tenfold greater now, to make a moderate estimate, than it was then. A railway appeared in the first year of the decade named; the penny post and the electric telegraph not until its close; while the press, both daily and weekly, now gigantic, was then, by comparison, insignificant and diminutive. For the great majority, even of business-men, life was tranquil and leisure plentiful, while competition was almost unknown; I need not attempt to describe what it is now. Such changes have naturally been the cause of permanent injury to many whose powers sufficed for the quiet time but gave way in large and increasing number under the inevitable struggle which issues in 'the survival of the fittest.' The necessary result of this extreme demand for brain activity, since that organ is the sole source of energy on which all the functions of the body, including that of digestion, depend, is an insufficient supply for this important process. Under these circumstances nothing can be more important than to provide food of a kind and in a form which will economise the work of the stomach. It must not be bulky; much of it may be advantageously soluble in form so as to be readily and easily assimilated, even pre-digested sometimes, and when solid not requiring much mastication. I have found nothing which fulfils these conditions so completely as the various concentrated extracts of meat which are now so extensively used. A teaspoonful of sound beef extract in a breakfast-cup of hot water when the brain is fatigued and the stomach unfit for work is often the best antidote possible, reinvigorates the system, and prepares it for a light meal or for a little more work, as the case may be—a result far too frequently sought through the pernicious habit of obtaining temporary relief in a glass of wine or spirit."

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Several features of striking interest will be found in the opening numbers of *THE LIVING AGE* for the new year. The number for January 7 contains, among other things, a pungent and wholesome lecture on Art and Morality, by M. Ferdinand Brunetiere, which is translated for the magazine and copyrighted by it; the first instalment of *The Etchingham Letters*, which are attracting wide notice in *The Cornhill* by their cleverness, and the beginning of a short serial. The number for January 14 gives the full text of Lord Rosebery's recent address on *Literary Statesmen*, which has been the subject of general comment; an article from *Blackwood's* on *The Ethics of Conquest*, which relates to the Philippines; and a bright paper on *The Madness of Mr. Kipling*.