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CANADA MEDICAL RECORD

OCTOBER, 1901.

Original Communications.

AUTHOR'S ABSTRACT.

TWO CASES OF BLADDER SURGERY. TRANSPLANTATION OF THE URETER FOR URETERO-VAGINAL FISTULA ; AND A SEVERE CASE OF VESICO-VAGINAL FISTULA CURED BY AN IMPROVED METHOD.

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., England.

Professor of Surgical Diseases of Women in the University of Vermont, Burlington, and Professor of Clinical Gynecology in Bishop's University, Montreal ; Fellow of the British Gynecological Society and Fellow of the American Gynecological Society ; Gynecologist to the Montreal Dispensary, and Consulting Gynecologist to the Women's Hospital ; Surgeon in Chief of the Samaritan Free Hospital for Women and Surgeon to the Western General Hospital, Montreal.

Case 1. Patient had her first child at the age of thirty-five, and having besides a male type of pelvis, the labour was very difficult.

Residing a long way out in the country from Vancouver it was difficult for her physician to obtain help, and when it came, the pressure of the child's head during several hours had already caused sloughing of the vagina and about an inch of the ureter. The damaged part was replaced by a cicatricial tissue, but a uretero-vaginal fistula remained. Nearly all the urine from the right kidney came away, causing the vulva to become covered with painful ulcers. After two years of great misery she decided to go to England to have an operation, partly because she had friends there. She was admitted to St. Bartholomew's Hospital, where she underwent two operations on the

vagina for closure of the fistula, but both of them failed, because the cicatricial tissue allowed the stitches to cut out.

A third operation was proposed, but she refused it and returned to Canada, being admitted soon after to the Western Hospital under my care. After making a series of careful experiments to ascertain whether it was really a uretero-vaginal fistula or not, plastic operations on the vagina were twice repeated without any result, but she was promised that if they failed, she would be cured by a more serious operation, which she readily consented to. Accordingly, on the 15th Aug., transplantation of the ureter was undertaken as follows: the abdominal wall was incised down to, but not through the peritoneum, and the latter was pushed off the pelvic wall until the ureter was found. This was tied, and cut off close to the cicatricial tissue surrounding its lower end about one inch from the bladder; the proximal end was not tied nor hurt in any way, but was gently held in a gauze sponge until it was introduced into a diagonal opening in the upper and anterior surface of the bladder, where it was firmly attached by fine catgut stitches, suturing the mucous membrane of the ureter to the mucous membrane of the bladder, and silk stitches fastening the fibrous coat of the ureter to the muscular wall of the bladder. For fear of accidents, a drainage tube and gauze were left in for a day or two, but there was no leakage. An important precaution was the leaving of a glass catheter *a demeure* for four or five days. Not a drop of urine has come by vagina since, and six weeks after the transplantation, when she left the hospital, she was able to hold her water four hours.

Case II. This was a very stout and flabby woman of forty, who was delivered of a very large child with great difficulty by the aid of forceps, the male blade of which caught the anterior lip of the uterus, the vagina and bladder against the arch of the pubis, making a diagonal cut through all three of them, extending from the urethra to the left vaginal fornix, and making an opening through which three fingers could be introduced into the bladder.

This was certainly a bad case, and would have been doubtful of cure by the ordinary method, while it was permanently cured at the first attempt, and without the slightest difficulty by the method now described, and which has proved equally satisfactory in several other cases.

Instead of paring the edges and suturing, the cervix was separated from the vagina and bladder as in the first step of vaginal hysterectomy, and when this was accomplished, the long gash in the side of the cervix required very little more paring of the edges to make it ready for suturing with catgut. The anterior vaginal wall was then separated from the bladder with the finger, except at the edges of the fistula where they were adherent, and where the scissors were required. The hole in the bladder was then closed by a fine running suture of chromicised catgut, taking in the muscular wall of the bladder only, which turned the mucous membrane in and left a thick ridge at the place of the tear. The bladder was then tested with sterilized milk under high pressure and there was no leakage. But this row of sutures was reinforced by sliding the bladder half an inch to the right, and when sewing up the vagina with silk worm gut, each interrupted suture took in a bite of the muscular wall of the bladder half an inch to the right of the line of the tear. A self-retaining catheter was kept in for four days, although it was hardly required, for, having become blocked by a small blood clot at the end of twelve hours, the family physician, Dr. Virrol, removed it and cleaned it, and on reintroducing it, sixteen ounces of water came away. The silkworm gut stitches were removed in ten days, and the woman got up and has done her work ever since without the slightest sign of leakage, now three months ago. This operation has the advantage of making the most difficult cases easier than the easiest by the old method of paring the edges.

SEBORRHOEIC DERMATITIS.

By J. Leslie Foley, M. D., L. R. C. P., London.

Physician to the Skin Department of the Western Hospital.

Unna claims seborrhoeic eczema or seborrhoeic dermatitis to be now one of the common forms of skin disease.

Certainly, when confronted by one of the multiform varieties of eczema, one should make sure that one has not got a case of this kind on hand.

To mistake it for an ordinary case of eczema would be direful in results as regards treatment, as what would be suitable for an ordinary eczema would not be beneficial in a seborrhoeic eczema.

According to Crocker, seborrhoeic dermatitis may be divided into three forms: seborrhoea eczemaformis, resembling eczema; seborrhoea psoriasiformis, resembling psoriasis; seborrhoea papulosa seu lichenoides, resembling lichen.

There is also a form of seborrhoeic dermatitis occurring in children.

What are symptoms of seborrhoeic dermatitis?

The eruption usually begins on the scalp as a seborrhoeic sicca, and then spreads downwards over the body. The itching may be severe or scarcely noticeable.

Morris says the course of the eruption is as follows: beginning on the head it extends over the scalp, thence to the ears, forehead and cheek, the neck and down the front of the chest and back, especially into the interscapular furrow, into the axillae and bends of the elbows and hands, into the groin and crura-scrotal fold, over the genitals, behind the knees and between the toes. The affection begins as a latent catarrh; first manifests itself by an agglutination of epidermic scales, which are thrown off in large lamellae.

There is a faulty distribution of fat in the skin, hair becomes abnormally dry, while the epidermis and exfoliating scales are abnormally fatty. Scales may increase in quantity or become massed into fatty crusts between the hairs, leaving a bald spot on the top of the head.

Skin may become red and swollen, and weeps profusely. Fatty scales do not form, or are washed away by

the discharge. The rete may be laid bare. Unna calls these the scaly, crusty and moist forms.

In seborrhoeic eczemaformis the eruption resembles an eczema under depressing influences, either mental worry or anxiety or bodily illness. Acute inflammation supervenes, scalp becomes hot and red, covered with flaky and abundant scales. Scales are softer and less adherent than in ordinary eczema. The nose, cheeks and forehead are independently attacked with a mild inflammation, being pale red with defined margin and dry, scaly surface.

Seborrhoea psoriasiformis, resembling psoriasis, consists of well-defined and bright red patches, with scanty, scaly and fatty crusts. Eruption met, chiefly in axillae and on the trunk. The scales are more fatty and less abundant than in ordinary psoriasis.

Seborrhoea papulosa resembles somewhat lichen, slight itching, limited to front of chest and interscapular region. Begins as a group of rounded, small, pin-head-sized, bright red papules with scales at their apex, which coalesce into a disc. Have a red, slightly raised papular margin, occur in circles or segment of circles, are slightly scaly and greasy. Seborrhoea of scalp is often associated with it. This occurs in people who sweat much, and in England is known as the flannel rash.

Whether seborrhoeic dermatitis is of a parasitic nature is still a moot point. What part the bottle bacillus of Unna plays, it is still undecided. Unna claims the pathological lesion to be in the coil glands and not in sebaceous glands.

About three years ago I had under my care at the Western Hospital a case illustrating the eczema form of seborrhoeic dermatitis. A waiter by occupation, 25 years of age, of temperate habits. No history of cutaneous disease in family.

The eruption was exclusively distributed over the scalp, forehead, upper and lower extremities and abdomen. On the scalp it was of the pustulo crustaceous character, with fatty scales. The eruption was more abundant here

than anywhere else. The indication for treatment in these cases are, first, to remove crusts with olive oil or alkaline baths. To tone up the system with tonics and employ anti-parasitic ointments or lotions; resorcin, sulphur, acid salicylic, etc.

The treatment I adopted in the above case was, for the scalp, : euophen, gr. v.; hydr. ammoniatum, gr. xx.; vaseline ʒi. For the forehead, hydr. ammoniatum, gr. xx.; vaseline, ʒi. For the body, resorcin, gr. xv.; oleum olivæ, ʒii.; lanolin, ʒi. Internally, the administration of a bitter tonic.

In about three weeks' time the patient left the hospital cured. Seborrhoea and syphilis are frequent concomitants.

Selected Articles.

DIAGNOSIS IN DISEASES OF INFANCY.

By JOHN ZAHORSKY, M. D., St. Louis.

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Attending Physician to the Bethesda Foundling Home.

FEVER.

In a previous article, fever in its diagnostic significance was discussed. It is only necessary here to refer to it, and repeating that fever, as a rule, indicates the presence of an infectious disease. It is the task of the physician to locate the infection and determine its character. In practice, however, we find certain clinical pictures, as I prefer to call them, some of which we will consider at present.

1. *The Child has high fever (102 to 108 degrees) and no other special symptoms are present.*

This is one of the most frequent group of symptoms in infancy. The mother informs the physician that the infant has had fever for one to two days, but can give no other definite information. There is no cough, no crying and no intestinal disturbance. No symptom present points to any particular organ of the body.

Having excluded thermic fever by the absence of excessive heat we recognize that the disease is an infection, and we must seek its location. In spite of the fact that no symptoms point to any particular organ, we successively

examine the chest, the abdomen, the limbs, the nervous system, and finally the throat. In the vast majority of acute fevers, having no special symptoms, the throat is the site of infection. If nothing is found in any of these regions, we present ourselves two possibilities :

(1) There is a blood infection.

(2) The infection is in a place where a local manifestation requires longer than the existence of the present fever.

1. INFECTIONS OF THE BLOOD.

Is the disease malaria? We know how easily physicians who practice in malarial districts make this diagnosis. But we must seek for corroborative signs. In malaria the fever is often preceded by a chill in older children, and infants by blueness and coldness of the extremity. The liver and sometimes the spleen are swollen. The skin has a slightly yellowish hue. The fever is intermittent or distinctly remittent. Perhaps there have been previous attacks, or the season is one in which mosquitoes are very active. But the crucial test is finding the plasmodia in the blood, and finding an absence of leucocytosis, the therapeutic test—the subsidence of the symptoms on the administration of quinine is practically worthless in isolated cases, since so many febrile movements in children are fleeting, and quinine acts beneficially in a variety of infectious diseases.

If there exist certain facts opposed to malaria, or if the plasmodia is not found, we consider other blood infections. Typhoid fever has a gradual onset, and children are sick several days before a physician is called.

Various forms of septicemia depend for their existence on a local infection, and then the latter exists, the former may be diagnosed. Very puzzling are those forms depending on some micro-organism in the blood and which terminate in endocarditis and cardiac valvulitis. Fever may exist for several days before a cardiac murmur is audible.

2. LATENT LOCAL INFECTIONS.

The infection may be situated in some internal organ, but on account of its depth or the smallness of the tissue involved it may escape observation. This happens very frequently in the lung. Two or three days may elapse before the inflammation has spread sufficiently to be recognized, but rapid respiration, a suppressed cough and

the expiratory moan are rarely absent, even when physical signs are wanting. Then the blood shows a marked leucocytosis.

The disease may be in the intestinal canal. The decomposed putrefactive intestinal contents may as yet not have been expelled. During the summer months infection of the intestinal contents must constantly be borne in mind. A purgative will usually bring to light the infected mass of food.

In diseases of the colon, the fever may be present from a few hours to two days before the bloody mucous stools reveal the presence of a colitis.

Meningitis in infants may exist for a few days without any cerebral symptoms. I have seen cases in which high fever existed and the infant was playful and apparently only slightly ill. A bulging fontanelle should make us suspicious.

Influenza may occur without local manifestations. Here the diagnosis is possible only when other members of the family have the typical form of this disease.

At the onset of many acute infectious diseases it may be impossible to make a positive diagnosis. In mumps, measles, scarlet fever, small-pox and anterior poliomyelitis a diagnosis may not be made at our first visit. It is best to state to those interested that a diagnosis has not been made rather than to make a guess.

The occurrence of suppurative inflammation in various internal organs may give no local signs, and are extremely puzzling, particularly in infants. Older children may assist in locating the trouble, by pointing to the place of pain. In this class are suppurations in the liver, kidney, spleen, appendix, pleura, brain and deep intermuscular tissue. In the absence of any local signs we must be content to wait. A good sign, however, is the fact that these diseases are often very painful, and it is this element which should make us suspicious.

In all these infections the blood shows a marked leucocytosis.

While the terrestrial temperature is over 95°, we should suspect thermic fever. By the exclusion of all infections, and by the presence of causes which retard heat dissipation from the body, this disease is corroborated. A diminished water supply is usually found to be present.

In the newly-born who receive as yet no mother's milk and who are deprived of water, thermic fever frequently develops. Here it is known as *inanition* fever.

The newly-born are usually kept too warm. It is rarely necessary to resort to the theory of reflex action to account for a fever.

Lithiasis, teething, intestinal worms, irritation of the skin, and others—all these have been placed in the etiology of fevers, but as our knowledge of the infectious diseases extend these causes are relegated to the rear.—*Medical Fortnightly*.

THE ANTISEPTIC TREATMENT OF TYPHOID FEVER.

By CHARLES F. HOPE, M. D., of Coatesville, In 1.

(Abstract from the *Wisconsin Medical Recorder*, Jan., 1901.)

The ingenuity of the human mind has evolved many methods of treatment for typhoid fever and some so-called specimens have been introduced, but, with a few exceptions, these latter innovations have lapsed into innocuous desuetude.

There seems to be a growing tendency on the part of many clinicians and hospital staff-physicians to question the reliability of any method of treatment except by means of hydrotherapy, but the fact remains that a vast majority use drug antipyretics and intestinal antiseptics in the treatment of typhoid fever. In this connection it may not be improper to quote a paragraph from Dr. John V. Shoemaker, who says in his *Treatise on Materia Medica and Therapeutics* in reference to a well-recognized intestinal antiseptic: "Betanaphthol is administered chiefly as a means of securing antiseptis. Being almost insoluble, it is one of the best agents at our command for disinfection of the alimentary tract. In typhoid fever it mitigates the severity of the disease and reduces the rate of mortality. These results, announced by Professor Buchard, have been amply confirmed by the writer and numerous observers."

During the last year I have treated cases of undoubted typhoid fever of average severity; in each instance some effort was made at intestinal antiseptis. By this I do not mean that the typhoid bacilli were absolutely destroyed by a germicidal action of the remedies used, but that some noticeable beneficial effects were produced I feel certain. It is entirely possible to render the foul and offensive typhoid stools free from putrefactive odours, and the tympanites, ordinarily a distressing symptom, may be eliminated.

It may be futile to address antiseptic remedies to the bacillus of Eberth, but remedies properly selected will strengthen the wall of the bowel and prevent sloughing up

of the intestinal lesions. In addition, they will ameliorate the profound symptoms of septicæmia, and, as a consequence, the attack is shortened and rendered far less dangerous.

A measure to be used in connection with this antiseptic treatment of typhoid fever is thermol. While this new remedy is not an intestinal antiseptic in the same sense as zinc sulphocarbolate, or thymol, but rather belonging to the class of antipyretics and analgesics, yet its use will inhibit the cultures of the germ of the disease in the body of a patient suffering from typhoid toxæmia. In this manner excessive tissue waste and combustion are prevented. Elimination from the excretory organs is promoted, the activity of the skin and glandular system is increased, and thus the patient is enabled to dispose of the poisonous products during the career of the fever instead of during convalescence.

Flint says in regard to the treatment of typhoid fever: "Of all therapeutic measures, those directed toward the reduction of the fever take the first rank." Accepting this dictum, even though we do not consider a moderate elevation of temperature dangerous, *per se*, we have in thermol a remedial agent much more convenient of administration than the cold bath treatment, and one which will not only reduce the high temperature with greater apparent safety, but will lessen the symptoms denoting severity of infection, such as stupor and other ataxic disturbances.

In proper doses thermol may be used continuously from the very inception of typhoid fever until convalescence is completely established without any unfavourable influence upon the circulatory system or other vital organs. In a disease of an asthenic character, such as pneumonia, influenza, malaria and typhoid, I know that it is positively non-toxic and cumulative in reasonable dosage. In a disease like typhoid fever, a disease in which depression must be studiously avoided, the main question to settle in the use of this drug is its absolute and universal safety, because after only a superficial trial, the valuable properties which make it an effective and gratifying remedy are so apparent that the least observant physician would be cognizant of the happy effects.

The angry protests and pitiful entreaties of patient and friends, the shivering and chattering teeth, the gasping respiration, the dread and the multitude of annoyances to the patient, nurse, physician and family, occasioned by the cold bath process, are avoided, and still the patient

experienced all the comforts to be derived from that system, and finally he did not linger on and on as not infrequently happens with hydrotherapy.

Experience has demonstrated that thermol should be administered to an adult typhoid patient in doses of approximately $2\frac{1}{2}$ grains every two hours throughout the whole duration of the disease, irrespective of the records on the temperature chart or the thermometric reading.

I feel justified in claiming that there is evidence to support the belief that the rational use of thermol will rob typhoid fever of many of its terrors and dangers, that thus used it will beyond a doubt to some extent shorten the duration of the disease, and lessen greatly the tendency to relapse, that it will certainly be productive of much physical and mental comfort to the patient in reducing the fever, and at the same time cause the skin and mucous membranes, including the tongue, to be moist, that the respiratory, circulatory, intestinal, nervous and all other special symptoms will be reduced to a minimum.

Progress of Medical Science.

MEDICINE AND NEUROLOGY

IN CHARGE OF

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SLEEPLESSNESS IN HEART DISEASE AND ITS TREATMENT.

Gibbes states, in the *Chemical Journal* of January 16, 1901, that in all cases of heart disease our first treatment should be directed to relieving, if possible, the most urgent symptoms. Sleeplessness, if it is present to any great extent, must always be a serious symptom, and is bound to make itself felt in all cases, being in some a matter of vital importance.

We have, therefore, to decide when hypnotics are required, and what character of drug should be given. The ill effect produced from the persistent and unregulated use of sleeping draughts by the general public cannot be too strongly condemned, and it enforces

upon us the necessity of using the greatest caution in prescribing them. They should be used either to break the habit of sleeplessness, which the system may have acquired, or to give rest when it is urgently needed. In the former instance, the influence should be kept up for three or four nights, or a speedy relapse will follow. In many cases we obtain far better results by giving three or four smaller doses during the day than from a larger amount given in one dose at night ; this specially applies to opium, chloretone and bromide. Our choice of drugs must always depend on the character of the case and the complications that are present. To describe the various hypnotics that have been recommended would be waste of time ; therefore, only those drugs are given which the author has used and found most successful.

Opium and morphine are among our most reliable sleep producers, and when pain is present are invaluable ; they can be safely given in any uncomplicated form of heart disease, and the presence of lung and kidney complication is by no means such a rigid bar to their administration as some would lead us to suppose. Greater care is, of course, required under these circumstances, and their effects must be carefully watched, but they have been frequently used by Dr. Gibbes with the greatest benefit when the lungs have been clogged and a large quantity of albumen present, after having failed to obtain sleep by any other means. If pain is very severe, and immediate results are required, morphine should be given hypodermically, care being taken in extreme cases to minimize the shock of inserting the needle as much as possible. While opium and morphine can always be relied on to relieve pain, they do not necessarily act as hypnotics, unless the dose is larger than we may wish to give for the writer frequently finds their action delayed, the patient not getting to sleep for hours and sleeping better the second night than the first. Sometimes he can obtain a much better hypnotic result by giving a quarter or half grain dose of opium three or four times during the day than two or three grains at night ; in other cases one-sixth of a grain of opium every hour for five or six doses during the latter part of the day will produce a more satisfactory result.

Chloral hydrate should only be given when the arterial tension is high, and its depressant action on the heart is beneficial, as is sometimes the case in acute alcoholism. He has not, however, derived any special-advantages from its use in other conditions to compensate for its depressing effects.

Chloralmitide acts in the same manner as chloral, but has the advantage of being less of a depressant. It has been strongly recommended, but Gibbes has not found its action as speedy as some other hypnotics.

Trional is very useful, and acts speedily. It has no special action on the circulation or respiration, and can, consequently, be given in any form of heart disease, but he has not found it satisfactory when pain is present. Sulphonal acts in the same manner as trional, but as a hypnotic its delayed action is much against it. The combination of the two in 10 or 15 grain doses each has a more satisfactory effect than if they are given separately. If much prostration is present, as is sometimes seen after influenza, it is advisable to avoid their use.

Paraldehyde is a very useful hypnotic. It has no effect on the circulation or respiration, and can be given in any form of heart disease. As, however, it has a slight irritant effect on the gastric mucous membrane, it is not always advisable to administer it when the cardiac sleeplessness is complicated by dyspeptic troubles.

Chlorotone is one of the most recent additions to our list of hypnotics, and is very useful in heart disease. It has no depressant action on the circulation, can safely be given when kidney or lung complications are present, and is quick in its action; its special usefulness, however, in heart disease is due to the fact that it is not only a perfectly safe hypnotic, but a powerful germicide and anaesthetic as well; relieving the dyspeptic symptoms so commonly present by anaesthetizing the coats of the stomach and arresting fermentation. It is a perfectly safe hypnotic, a case having been recorded in which 120 grains were given in 24 hours without serious result. As a hypnotic, Dr. Gibbes generally gives 15 grains at bedtime, and repeats in two hours if required; when there is much excitation of the nervous system 1 1-2 or 2 grains three times a day with a 15 grain dose at night has an even more than beneficial effect, and produces sleep the second night without any further dose being given. The bromide salts are chiefly indicated where the neurotic element predominates, and if given three or four times a day will often relieve sleeplessness, but the writer has frequently found them fail when any one of them is given as a pure hypnotic in one dose at night.

Alcohol will in many instances promote sleep before heart failure has far advanced, and where restlessness is great; it should, however, only be given in small doses just as the patient is settling down to sleep. If the ar-

terial tension is high it is worse than useless, as it may increase the sleeplessness. In the later stages it may have a soothing, but not a hypnotic, effect (*Therapeutic Gazette*, May 15, 1901).

In prescribing morphia and opium in cases of heart disease, complicated by the presence of albumen in the urine, I have noticed in several patients that the administration of morphia or opium by the mouth has set up alarming symptoms. One patient, I remember, went into a convulsive state by giving 1-4 grain morphia sulph. in tablet by the mouth, and another into a comatose condition from 15 drops of liq. opii sedative; to both of these patients I have given 1-4 grains morphia sulphate hypodermically since. I now always use this drug hypodermically in these cases with no untoward effects. Chloral hydrate is best dispensed with syrup of licorice. As it sometimes has an irritant effect on the gastric mucosa, it is contra-indicated in neurotic cases except in small doses combined with bromides.

Trional and sulphonal should be dispensed in konseals, in 20 to 30 grain doses, followed by hot drink. Paraldehyde dose, 30 to 60 minims soluble 1-10 water, best prescribed with glycerine or syrup of orange. Chloretone best prescribed in konseals, 20 grains, or in pills, 3 grains, very reliable. Like chloral, trional and paraldehyde are of little use if there is much pain. Bromides are best prescribed in 30 grain doses, combined with syrup of orange or fluid extract of glycyrrhiza and syrup.—*Can. Jour. of Med. and Surg.*

A CONTRIBUTION TO THE TECHNIC OF THE WIDAL TEST.

By Dr. A. Robin. (*Jour. Appl. Mic.*, p. 1434, August, 1901).

Four problems present themselves to the bacteriologist who attempts to perform the Widal test in the diagnosis of typhoid fever, viz.: 1. The dilution. 2. The best way of obtaining a motile culture free from "natural" clumps. 3. The differentiation between a true and a pseudo-reaction. 4. The time limit.

To these problems Dr. Robin offers solutions which, in his experience, have proved most practical and satisfactory.

1. Accurate dilutions are obtained by means of the simple medicine dropper device described in Vol. III., No. 8, p. 962 of the *Journal*.

2. Motile organism may be readily obtained for the test by keeping at hand pure cultures of typhoid bacilli in

hermatically sealed tubes. When a test is to be made, a fresh agar or bouillon culture is made from the stock culture and kept in the incubator for eighteen to twenty-four hours. It was found that the temperature of a fairly warmed room produced just as good, if not better results than the incubator. The author deems the bouillon culture unsatisfactory, and has adopted the following medium: An agar culture is kept in the incubator or at room temperature for twelve to eighteen hours, when two or three loopfuls are transferred into bouillon until a marked turbidity results, or a small quantity of bouillon is added to the agar culture and enough of the growth scraped off to produce a uniform cloudiness. The latter course is preferable, and if carefully followed, the "natural" clumps, so frequently observed in bouillon cultures, are entirely avoided.

3. The third problem is met by using a slide with two concavities, around the edges of each of which is a ring of vaseline. On each of two clean cover-glasses is deposited a loopful of the culture; to one a loopful of the blood, diluted 1:20 to 1:40, is added, while the other serves as a control. The behaviour of the bacilli on each cover may be readily observed. If the reaction is positive, the bacilli on the test cover will gather in clumps of two, three or a dozen and will soon lose their motility, while in the pseudo-reaction only a few clumps will form, the rest of the bacilli remaining separated.

The time given to determine whether a reaction is positive or negative varies greatly with different bacteriologists. Dr. Robin proposes the adoption of a uniform limit and offers the following: Dilution 1:10, time limit, 5 to 15 minutes; 1:20, 15 to 20 minutes; 1:40 to 1:100, 30 to 60 minutes; 1:100 to 1:200, 1 to 2 hours. That is, if within the specified time, a considerable number of the bacilli are found actively motile, or, if dead, fail to arrange themselves in clumps, the reaction is negative, irrespective of the clumps which have already formed.—*Dr. A. Robin, Jour. Appl. Mic.*

RELATIONS BETWEEN TUBERCULOSIS AND CARDIAC DISEASE.

The association of pulmonary tubercle and heart disease is a question which has attracted attention at various times and has been stated in very different ways. The idea was formerly held, and is so still to a certain extent, that there is an antagonism between the two conditions. Potain has quite recently considered the matter in a clini-

cal lecture, and shows that not only may valvular disease of the heart and tubercle of the lungs co-exist, but there is even a relation between certainly some forms of heart disease and tubercle. First, pulmonary stenosis, be it due to a primitive lesion of that vessel or from some cause of compression, seems to render the lungs very susceptible to tubercle. Secondly, mitral stenosis is not infrequently associated with tubercle, as very many patients, the subjects of that disease, show signs of the latter, and the author looks upon this combination as by far the most frequent, although he states that various other diseases of the heart may also be combined. In cases where pulmonary tubercle is pre-existent the heart may show disease in the three following forms: Tubercle may invade the myocardium itself, or, what is very rare, the endocardium; secondly, it may determine an ulcerative or infective endocarditis, due apparently to a secondary infection of the tuberculous areas by putrefactive organisms, as pneumococci and streptococci are certainly present, not tubercle bacillus; in the third form, according to Potain the most frequent, the form of heart disease is a sclerosing endocarditis. As a matter of fact, it is quite common to see small white spots on the endocardium of phthisical patients. This is the earliest manifestation of a fibrous transformation which may result in a mitral stenosis of the valve, and, according to Potain, a pure form of stenosis is produced, as no retraction of the cusps seems to take place, and thus there is no incompetence. This is contrary to what is met with as the result of rheumatism, in which there is a thickening of the tissues as far as the base of the valves, and thus more or less retraction is caused, resulting in mitral incompetence. Although Potain argues for a casual relation between tubercle and pure mitral stenosis, he distinctly states that valvular disease is not met with in the more rapid forms of phthisis. It is rather the fibrosing varieties that are accompanied by sclerotic disease generally, a sclerosis which is not confined to the endocardium, as even the arterioles, liver and kidney may be affected. Another point is that the subjects of this condition may be arthritic either in a hereditary or acquired form. It would seem that mitral stenosis is not infrequently overlooked in the presence of pulmonary disease, but careful attention to auscultation of the first sound with the presystolic *roulement*, together with duplication of the second, ought to demonstrate its presence. At the same time the auscultatory signs are very variable, and it may be necessary to examine several times. The course and prognosis vary. In some cases the condition of the patient

seems to be stationary. In other cases it is progressive, and the patient becomes a case of heart disease and ceases to be one of tubercle, and the progression of cardiac lesion, at times, would appear to cause arrest of the tuberculous. Generally speaking, it would seem that the pulmonary lesion becomes quiescent. From this it may be gathered that the cardiac disease is the one which calls for treatment, and although the sclerotic process seems to exert a beneficial influence on the lungs, it requires to be kept within bounds by using preparations of iodine and arsenic, together with strict attention to hygienic and general conditions.—*Journ. de Med.*

COLLECTIVE INVESTIGATION OF THE INFLUENCE OF THE SILVER NITRATE INJECTIONS ON PHTHISIS.

In 1892 the undersigned began a collective investigation of the action of cold in the treatment of acute pneumonia, and there is reason for believing that this procedure, which resulted in gathering four hundred cases of this disease thus treated, with a death-rate not quite five per cent., was an important factor in calling attention to the utility of that treatment and in introducing it to the profession of this country. That research was based on the conviction that no remedy can be called truly successful until it has passed the exacting crucible of clinical experience, and it is now proposed to apply the same ordeal to the silver-injection treatment of phthisis, which, in a large hospital, dispensary and private practice, reaching over a period of three years, and during which many thousand injections were administered, has given me greater satisfaction than any other method that I have ever employed. In keeping with the above expressed feeling, a cordial invitation is herewith extended to those members of the profession who have the inclination and opportunity to investigate this method of treating phthisis, and to whom a reprint on the subject, with full information and blanks to report cases, will be cheerfully sent on application.

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SURGERY.

IN CHARGE OF

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TREATMENT OF ACCIDENTS UNDER CHLOROFORM.

The treatment of accidents under chloroform is a question full of interest to most medical men and one, too, on which all who undertake to administer the drug should have formed some definite opinion. In the recent numbers of the *Manchester Medical Chronicle* Mr. Wilson, administrator of anaesthetics, Royal Infirmary, Manchester, endeavours to classify the different accidents which are likely to occur, and to consider the mode of action and range of utility of the various remedies which have been suggested. The three classes which he adopts are shortly :—1. Irregular and uncontrolled action of muscles during the stage of excitement. 2. Paralysis or loss of tone of muscles altering the potency of the respiratory passages and so causing mechanical obstruction to the breathing. 3. Specific paralysing action of the drug on the fundamental nerve centres in the medulla. It is obvious that few cases of danger can be allocated to any one of these classes, for even presuming that the danger arises at first from the irregular action of certain muscles interfering with respiration, still what makes this really serious is the danger of the sudden onset of the specific paralysing action of the drug on the medullary centres. It is probable that any classification of accidents would be open to similar objections, but if it enables the administrator to grasp more clearly the general principles of danger it must be considered to have answered a useful purpose. The indications for treating these accidents are three-fold—to remove the anaesthetic-laden air from the lungs, to encourage the flow of blood to the nerve centres, and to stimulate the circulation and respiration. The various methods which are used to attain these ends Mr. Wilson groups into five classes—1. External reflex respiratory stimulants ; 2. Direct mechanical or electrical stimulation of the heart ; 3. The mechanical performance of natural functions such as artificial respiration ; 4. Mechanical measures designed to counteract the effects of the failure of the circulation by raising the general

blood pressure; 5. Drugs administered to stimulate the depressed nerve centres. Of the first group, the best that can be said is that they do no harm unless persevered in to the detriment of more important measures, and of the second, that they are either impracticable or positively harmful. Faradic stimulation of the precordial area, if any of the current reaches the heart, probably inhibits its action. Acupuncture of the heart is equally useless, and direct manipulation of the heart after opening the chest is a remedy which requires more evidence of its utility before it can be recommended. Mr. Wilson believes that as good, if not better, results, can be obtained by intermittent pressure on the chest wall, accompanied by alternately raising and lowering the patient so as to empty and fill the heart. The difficult question has first to be decided whether the circulatory failure is the result of paralytic dilatation of the heart, or of paralysis of the vaso-motor mechanism. The methods of treatment suitable for each of these cases are absolutely antagonistic, and it is by no means easy to say which is the cause in any given case. It would appear that sudden failure of the circulation, accompanied by pallor of the face and accelerated or gasping respirations denotes vaso-motor paralysis and requires inversion of the patient with pressure on the abdomen. On the other hand, if the dangerous symptoms are preceded by struggling, and the face is suffused with signs of venous engorgement, the patient should be alternately raised to nearly the vertical position in order to empty the heart, and then returned to the horizontal position. Artificial respiration should be systematically persevered in each case. If there is actual failure of the circulation little that is useful can be done by efforts to raise the blood pressure by such means as transfusion, etc. The same objection also applies to the use of drugs. Where there is failure of the respiration or circulation, the difficulty is to get the drug to the nerve centre which it is to stimulate. In those cases in which this can be effected, hypodermic injections of strychnia and the extract of suprarenal capsule, with inhalation of ether, are probably the most useful.—*Editorial in Med. Press.*

SURGICAL INTERFERENCE IN APPENDICITIS.

The question of the surgical interference in cases of appendicitis is one which as yet can hardly be said to be satisfactorily settled either from the point of view of the physician or the surgeon. In the August number of the *Edinburgh Medical Journal*, Mr. Walter Spencer helps

materially towards its solution. Mr. Spencer classifies these cases clinically as follows: (1) Caecal distension. In these cases the treatment is purely medical and the prognosis good. (2) Perityphlitis. This may yield to medical treatment, but if it produces adhesions they may necessitate surgical interference later. (3) Appendicitis proper, of which there are four varieties. (a) Acute perforation in which early operation affords the only chance of success. (b) Suppurative appendicitis in which extra-peritoneal draining of the abscess should be done as early as the diagnosis can be made. (c) Relapsing and recurring appendicitis, which must be distinguished by careful examination after the attack, and if the signs of chronic appendicitis are found the appendix must be removed at once. (d) Chronic latent appendicitis with septic anaemia is the most difficult of all varieties to diagnose, and there is great danger that it will not be recognised till too late for useful surgical interference.—*Ed. Medical Press.*

SUGAR-FREE MILK AS A FOOD FOR DIABETICS.

Robert Hutchison, in *The Lancet* of June 22, 1901, says a difficulty in practice is in providing a patient suffering from diabetes with a diet free from carbohydrates and which can be taken for a long time. The nutritive constituents must consist largely of proteid and fat, but when carbohydrates are taken out of the diet it is difficult to replace them by sufficient fat. Fat in the form of bacon is palatable, and more or less fat can be added to meat and fish. Butter is difficult to administer, except when taken, as is commonly the case, with carbohydrates. This difficulty in the ingestion of fats is met by separating the sugar from milk, thus furnishing a food rich in proteid and fat, but without a carbohydrate. Mr. Morris, chief dispenser to the London Hospitals, has prepared a very perfect milk in which sugar has been removed, which resembles a rich specimen of ordinary milk. It can be administered plain, or with some effervescing water, or added to tea, coffee, or cocoa. With eggs it can be made into a custard, thus adding a palatable and agreeable food to the limited range permitted the diabetic. Sugar-free milk contains approximately three per cent. of proteid and five per cent. of fat; if three pints are taken in a day the food value amounts to 990 calories, or nearly one-third of the total amount required, while the amount of fat which the patient obtains is equivalent to fully three ounces of butter.

In cases in which a small amount of carbohydrate is desirable, it is sometimes best to substitute sugar-free milk, and give carbohydrates in the form of potatoes or bread, as this enables the patient to ingest a larger amount of fat.— *Medicine.*

INDICATIONS FOR AND AGAINST TOTAL REMOVAL OF THE STOMACH.

G. C. Macdonald, San Francisco, thinks that few cases of cancer of the stomach permit the radical operation. Unless in patients of extreme vitality, he would limit the operation to the age of 55 in men and 60 in women. Leucocytosis is not present in uncomplicated gastric cancer, and, if found, tends to show either that the metasis has already commenced, or that some other complication exists. A high percentage of white cells is unfavourable to surgical interference. The absolute integrity of the heart must be assured, and most cardiac and circulatory lesions absolutely preclude operation. Other things being equal, working men and women furnish a more favourable prognosis than those of sedentary habits. We must be sure that there is a gastric cancer. The most favourable indications are a moderately dilated viscus with a freely movable tumour situated to the right of the median line. A contracted or very dilated stomach, with a fixed or non-palpable tumour, or one located on a line from the epigastrium to the left anterior superior spine of the ilium are unfavourable. If the disease has existed 12 to 14 months, it will be hardly suitable for operation. The preparation of the patient should include absolute rest in bed for 4 to 6 days or more, lavage of the stomach with antiseptics daily, and administration of podophyllin resin and calomel to stimulate the liver and bowels.— *Am. Med.*

HOME MADE SPLINTS.

Dissolve one pint of gum shellac in one pint and a half of ninety-five per cent. alcohol, with one drachm borax. Let the mixture stand until all of the shellac has been dissolved; then it is ready to be applied. Old cloth makes the best splints. I generally use an old pair of trousers. Apply the solution to one side of the woolen cloth with a brush and dry thoroughly before a hot fire. It takes about one hour to dry properly. Then apply a second coat on the same side and dry as before. You will then have a single piece, but if you wish a stronger piece, apply the solution on one side of two pieces that have

already been prepared, dry them, place them together and press with a hot iron, and they will unite and become as one piece. Always be sure to dry out all of the alcohol. To temper the cloth for use hold before a hot fire until soft, then apply. It will adapt itself to the shape of the limb at once. To make it set quickly hold in cold atmosphere or dip in cold water.—*Red Cross Notes.*

REMARKS ON SPINAL SURGERY, WITH ILLUSTRATIVE CASES.

By Dr. Andrew J. McCosh.—The author's conclusions are: (1) The risk of the operation of laminectomy is slight; (2) early operation is of the greatest importance; operate before the onset of degenerative changes; (3) in tumour cases do not waste time with antisyphilitic treatment; (4) operate rapidly; employ but few artery forceps or ligatures; (5) support of the spinal column after operation is generally unnecessary.—*J. A. M. A. and N. Y. Med. Jour.*

IMPORTANT POINTS TO BE BORNE IN MIND IN THE SURGICAL TREATMENT OF HERNIA.

Abstract of paper read by Dr. A. J. Ochsner, M.D., of Chicago, before the Austin Flint Medical Society, at Clear Lake, Iowa, July 17, 1901.

The permanent success following herniotomy depends upon a comparatively small number of practical points which must be observed in order to secure satisfactory results regularly.

1. The wound must heal primarily because suppuration results in an abundance of cicatricial tissue, and this is most unstable.

2. The stitches must not be drawn tightly in order to avoid pressure necrosis.

3. The edges of the wound to be united must be free from fat and other unstable tissues.

4. The wound should be supported by broad rubber adhesive plaster strips until healed.

5. The patient should be kept in bed two or three weeks.

6. After the operation abnormal intra-abdominal pressure should be eliminated by avoiding constipation, etc.

I. In Inguinal Hernia. (1) The entire sac should be removed.

(2) It is especially important to remove all the loose tissue between the transversalis and internal oblique muscles on one side and Poupert's ligament on the other.

(3) The upper portion of this canal should be closed with especial care.

(4) In case of a long thin omentum this should be resected.

II. In Femoral Hernia the canal through which the sac protrudes is a perfect ring, and, consequently, if the entire sac is removed this ring will invariably close and there can be no recurrence. All meddlesome operations contemplating the closure of this ring cause a certain percentage of recurrences.

III. In Ventral Hernia following laparotomy.

The original layers should be laid bare and then the corresponding layers should be carefully united. The author prefers deep silk wormgut stay sutures to be tied after each layer has been united separately with chromicized catgut sutures.

IV. In Umbilical Hernia the ingenious operation first described by Dr. W. J. Mayo, of Rochester, consisting of an overlapping of the edges of the hernial ring from above downward or from side to side for a distance of one and one-half inches has given complete satisfaction.—*Iowa Medical Journal*.

CHRONIC SEMINAL VESICULITIS.

Arthur L. Clute and Richard F. O'Neil, in the *Boston Medical and Surgical Journal* of June 13, 1901, publish their individual observations upon this disease, which is much neglected, notwithstanding Fuller's excellent study. Their general work in a large dispensary leads them to think that this condition is more common than is generally supposed. That they have seen this complication with unusual frequency may be due to the fact that they have an unusually large number of chronic and intractable cases of gonorrhœa coming to their clinic. No systematic study was made of all the cases in reference to involvement of the vesicles, but only those which presented symptoms that pointed with some probability to involvement of the posterior urethra and prostate.

The symptoms of vesiculitis are divided into those that are direct and reflex, though combinations of the two are frequent. In the long-standing cases reflex symptoms are most characteristic. Among the direct symptoms are vague feelings of discomfort in the rectum and perineum, pain on

defecation, persistence of discharge of shreds in patients in whom stricture can be ruled out; particularly suggestive is the presence of small, comma-shaped shreds from the prostatic urethra. Another common symptom is the starting up, without any indiscretion on the part of the patient, of a urethral discharge which had nearly or quite stopped. The reflex symptoms commonly include those which are spoken of as sexual neurasthenia, suprapubic pain, pain in the back or in the head, and tender points along the urethra. Pain along the spermatic cord may occur, and when the disease involves but one vesicle the pain is upon the corresponding side. Irregularities in the sexual functions combined with these neurasthenic symptoms are very frequently associated with vesiculitis.

In investigating the condition of the vesicles the rectum should be emptied and the bladder moderately distended. The patient should stand with the feet apart, bent well forward over a chair, the legs being straight at the knee. The digital examination is helped by the examiner making suprapubic pressure with the hand or with the closed fist, forcing the pelvic viscera downward and rendering the vesicles more accessible. Sometimes the vesicles can be felt enlarged and tender; more frequently only a diffused enlargement of the prostate, associated with inflammatory exudate along the base of the bladder. Most commonly there is an involvement of the vesicle unilaterally. The prostate is commonly tender, sometimes greatly enlarged, and occasionally has the conventional heart-shape with the base below. This is probably due to the exudate over the ducts, which fuses the structures together and makes it impossible to sharply define the upper border. The upper boundary of the prostate may have a boggy feel, which pits upon pressure. One characteristic symptom is the material obtained by stripping the rectum. The urine voided after massage of the base of the bladder is commonly turbid, containing cheese-like masses made up of epithelial and pus cells.

In the treatment of this condition the best results have been obtained from massage, which in every case has included the prostate, as it is impossible to massage the vesicles alone. In carrying out the procedure the patient is placed in the same position as during the examination. When the vesicles are very tender the time of massage is short; the treatment should be repeated at intervals of from five days to a week. In cases where the bladder cannot be evacuated shortly after

the massage it should be washed out, otherwise mild cystitis may be set up. Commonly, the massage is followed by improvement objectively, as well as subjectively; the hard and indurated prostates become softer, and those that are large and sodden shrink to more normal proportions. The treatment, as a rule, gives better results in young patients, and most cases of vesiculitis can be greatly benefited by careful treatment. In the majority the subjective symptoms can be made to disappear for a considerable time. In older patients the occasional use of massage will give them great comfort. The writers believe that a certain number of cases of impotence and sterility may be due to a vesiculitis, and they advise the prostatic examination of all patients with urethral disease of recent or long standing which is not progressing favourably, particularly in those cases showing the so-called neurasthenic symptoms.—*Medicine.*

THE TREATMENT OF CYSTITIS.

The management of a patient with acute inflammation of the bladder is usually simple enough, and in uncomplicated cases recovery is prompt; but when the disease becomes chronic we often have a condition which taxes our patience severely. The treatment of those forms of cystitis which are caused by calculus, gonorrhœa, new growth, or stricture, must, of course, depend upon the removal of the cause, since the inflammation is distinctly secondary to such conditions, but these conditions are not responsible for the very large proportion of cases of cystitis in which the disease is of a tuberculous nature, and it is tuberculous cystitis which requires such long and patient treatment, both of local and general conditions, and which is so difficult to deal with satisfactorily by surgical means. Von Hofmann has recently (*Die Moderne Therapie der Cystitis*, 1901) contributed an interesting monograph on this subject, and he devotes much space to the treatment of tuberculous cystitis, which he considers the most important form of the disease. His main idea is that the disease should be considered general as well as local, and that very active systemic treatment should be instituted. In this regard, creosote and guaiacol, and their preparations, seem to be the best drugs, but the question of nutrition is also of great importance, just as it is in pulmonary tuberculosis. Surgery has been called upon in many cases of tuberculous cystitis, but the most that can usually be done is

to establish drainage, unless we should be so fortunate as to meet a case with a circumscribed ulcerative process, which could be treated by scraping or cauterization.

As is well known, the establishment of permanent drainage is, as a rule, followed by amelioration in the patient's condition, since, by it, the bladder is placed completely at rest; but when we want the fistula to close it will not always do so, and the results are very uncertain as to permanent benefit, no matter what treatment is employed in addition to the drainage. Von Hofmann recommends as useful preparations several salts of guaiacol, and specially notices the cinnylate, and he also insists upon the importance of pushing the patient's nutrition as much as possible.

The local applications which will do good in cases of tuberculous cystitis are various solutions having germicidal qualities, and among other preparations may be mentioned several salts of silver and mercury. Patients will be found to differ in their tolerance of these preparations, and trial alone will show which is best and what strength individual cases will require. The most important reason for failure in treating this unpleasant disease is that the tuberculous process is rarely limited to the bladder, but commonly involves other parts of the genital tract, from which it is difficult or impossible to eradicate it. Our treatment of tuberculous cystitis must, therefore, remain much as it has been, systemic and local; the former consisting in pushing nutrition as much as possible and using some of the drugs which have been mentioned, and the latter consisting in the employment of those operative means which place the bladder at rest or eradicate any accessible foci of disease, and the use of appropriate local treatment by means of germicides and antiseptics. Many patients will improve under such a regimen, but the condition is one of the most unsatisfactory with which the surgeon is called upon to deal. We might add that Von Hofmann looks upon the development of cystitis in a patient with an enlarged prostate as a serious matter to be avoided by rigid observance of catheter precautions. If cystitis does occur in such cases he relies on nitrate-of-silver irrigation and the internal administration of a urinary antiseptic. Good results in genito-urinary surgery sometimes follow the substitution of an organic compound of silver for the nitrate.—*Editorial N. Y. Med. Jour.*

THE TREATMENT OF GONORRHOEA WITH ICHTHARGAN.

DR. MORITZ FURST, of Hamburg, reports the results which he obtained with ichthargan in the treatment of gonorrhœal urethritis. He employed it in 75 cases, both in dispensary and in private practice. He says that in spite of the superabundance of antigonorrhœal remedies we have a perfect right to investigate any new compound if its chemical composition is of such a nature as to warrant the belief that it will prove effective in the treatment of that obstinate affection. That ichthargan—a combination of the well-tried and proven silver nitrate with the bactericidal, siccative, and anodyne ichthyol—is such a compound, theoretically at least, no one will deny. And practical results fully justify the *a priori* expectations.

Of the 75 cases treated by the author 25 were first cases, while 49 were suffering from the second, third, etc., attack of gonorrhœa. Of these 6 were cured in from 5 to 8 days, 24 in one to two weeks, twelve in three to four weeks, and 13 in more than four weeks. Of the last 13 cases the author considers four cases not cured because they still have a slight discharge, though free from gonococci. All the other cases were entirely cured.

The ordinary method of using the ichthargan was by means of injection. The patients were directed to use solutions of 1-3rd to 1 grain of ichthargan to 7 oz. of water. The stronger solutions were given in the beginning in acute cases with purulent discharge full of gonococci; the weak solutions were used toward the end as an astringent. The patients repeated the injections 4 to 5 times a day, after urination, and they were instructed to retain the solution for 5 to 10 minutes. In cases in which the posterior urethra was affected 6 to 10 drops of a 3 per cent. ichthargan solution were instilled by means of Guyon's urethral syringe.

The superiority of this solution over nitrate of silver was at once apparent, as the pain was much less, and the constant irritation and desire to urinate, which are produced by silver nitrate, were absent. The author also used ichthargan in the form of suppositories, made up with cacao butter, and containing from 3-4th to 1½ grains of ichthargan each. As a prophylactic after suspicious coitus the author advises the instillation of 3 to 4 drops of a 10 per cent. solution into the fossa navicularis. The author considers ich-

thargan, on the whole, a most excellent anti-gonorrhœal, greatly superior to protargol, with which he has also had extensive experience.

In conclusion, Dr. Furst calls attention to the fact that, taking into consideration the high percentage of silver in ichthargan—containing, as it does, 30 per cent. of silver, while protargol contains only 8 per cent.—and the potency of the drug, which makes even very weak solutions effective, it is the cheapest of the organic silver compounds used for anti-gonorrhœal purposes.—*Deut. Med. Wochensch*

PAGENSTECHER'S CELLULOID THREAD.

B. C. Stevens, in *The Lancet* of April 20, 1901, says that the introduction of this thread is a decided advance in operative surgery, especially in abdominal surgery. The smaller sizes form an ideal suture for the peritoneum; they do not slip, are easily threaded, and are very flexible. The tensile strength of the thread in proportion to its caliber is remarkable. The strength is, if anything, increased by the process of sterilization. A slight swelling of the thread occurs after boiling, but any water which it absorbs is readily removed by alcohol. Buried sutures of this material cause no irritation, though it is probable that they are not absorbed. The thick threads are useful in ligating the large blood-vessels or pedicles of tumours. Frequent boiling does not cause deterioration. It should supersede silk, as it is cheaper, more reliable, stronger, and lends itself to suturing much better. It should be sterilized by cutting into suitable lengths and winding on a glass reel. It is then removed and placed in a five-per-cent. solution of phenol or methylated spirit, which preserves it indefinitely.

TRIMANUAL METHOD OF PERCUSSION IN THE DIAGNOSIS OF FLUID WITHIN THE ABDOMEN.

J. G. Clark, in the *University of Pennsylvania Medical Bulletin* for May, 1901, refers to the difficulty of distinguishing between soft tumour masses and encapsulated fluid. A tense hydrosalpinx or pyosalpinx may also be easily mistaken for a solid tumour, or a distended gall-bladder for a tumour of the liver or kidneys. Similarly, a deep-seated collection of pus about the appendix may be mistaken for a tumour of the cæcum. For the detection of tumour in these

obscure cases he employs what he describes as a tri-manual method of percussion, which in many cases clears up an otherwise doubtful diagnosis. In bi-manual examination of a pelvic mass of questionable consistence the intestines intervening between the anterior abdominal wall and the tumour may dissipate the percussion impulse of the abdominal hand, and while fluid may be present a wave of sufficient intensity to be felt by the vaginal touch is not induced. To overcome this difficulty the tumour is confined as closely as possible between the two examining hands, while percussion is made by an assistant. A few little quick taps will, in this way, if fluid is present, give the sensation of a wave passing to the pelvic hand. In the same way an adherent and distended gall bladder may be easily outlined, one hand pressing deeply over the hypochondrium, while with the other deep counter-pressure is made just below the fixed ribs. If fluid is present light percussions over the upper hand will give an unmistakable wave.—*Medicine.*

DIAGNOSIS AND TREATMENT OF INTUSSUSCEPTION.

Charles P. B. Clubbe (*The British Med. Jour.*) speaks of the importance of an early diagnosis in these cases in children. During the last seven years, out of 49 children treated for this complication, 45 were operated upon, of whom 21 died. In the successful cases the delay between the onset of the trouble and the time of operation averaged only twenty-four hours, while in the fatal cases the average time was fifty-six hours. In the four cases not operated upon the intussusception was reduced by injections alone. This simple procedure is always useful and safe, and should be tried first, no matter in what stage the case is seen. From ten ounces to a pint of warm water and oil should be injected, the child being anaesthetized and the hips well elevated. After the fluid has escaped, if examination shows that the sausage-shaped tumour has vanished, the child should be put to bed and a minute dose of morphine given. Careful examination should be made every six hours for forty-eight hours to guard against a return of the trouble. Neglect of this precaution has led many to underestimate the value of this mode of treatment. Even if complete reduction is not accomplished by the injection, it often reduces the mass somewhat and renders subsequent operation easier. In cases, however, where the surroundings are such as to render an operation inadvisable, even if found necessary, no time should be wasted in preliminary injections at the home.

Diagnosis.—In a large number of cases there is a history of sudden screaming, pallor and vomiting, followed from two to ten hours later by the passage of blood and slime. In the interval between the first attack of pain and the bloody movement the child may have been comparatively quiet, or have had several short attacks of pain and crying. The pulse rate and temperature are not far from normal. With such a history careful examination of the abdomen is demanded, and where the muscles are held rigid a little chloroform should be given. Examination by rectum is rarely useful or necessary. In the early stage nothing can be learned in that way, and later on it is unnecessary, as the tumour can be felt through the abdomen. A word of warning as to cases where the intussusception has descended into the rectum or even out through the anus should be given. Such cases have been mistaken for prolapse of the bowel. Children suffering from diarrhoea may have this complication, and the passage of blood-stained movements may have occurred before the intussusception, leading to the intussusception, when it occurs, being mistaken for an exacerbation of the enteritis. Such cases result fatally, without any recognition of the true state of affairs.

In some cases these signs are all absent, and there is merely restlessness, distension of the bowel, vomiting now and then and possibly slight looseness of the bowels. After twenty-four hours, if the intussusception is at all severe, there will be grave symptoms of obstruction.

Before operation, strychnine and morphine should be given hypodermically. A large hot water bag should be placed on the table under the child. When the mass is small and in the ascending colon the incision may be made at the right of the rectus muscle, otherwise in the median line. The peritoneum in babies is so fine that it is well sometimes to hook an aneurism needle into the first small opening and pull the peritoneum forwards. When the mass is reached find out which is the lower part, then begin gently squeezing the intussusceptions. Just at the last an assistant may assist by gentle traction on the bowel—just above where it enters. The intussusception may sometimes be partly reduced while still in the abdomen, but the last part of the bowel that has to be uncoiled must always be brought into view. In cases that have been reduced easily there is sometimes thickening and a small cup-shaped depression at the site of the apex of the intussusception. This must be carefully pressed out and made convex, to prevent recurrence.

When the squeezing begins to cause much cracking and tearing of the peritoneal coating, this method of procedure will have to be abandoned for resection. So also in the ileo-caecal variety, where the appendix has been much pinched, or in cases where reduction is impossible, or where the bowel appears much damaged after reduction. End-to-end anastomosis with a continuous suture, of fine catgut, putting in a double row, is the best way of uniting the several ends of intestine. After washing the intestines with warm salt solution replace in the abdomen. No matter how great the difficulty of replacement, never be tempted to puncture the intestine. The abdomen is best closed by through and through sutures with no drainage.

Babies must be fed within a few hours after the operation. Mellin's food, whey and water (one drachm to two ounces), or the white of an egg in four ounces of cold boiled water, to which one drachm of somatose is added, may be given often in small quantities. After two days breast-fed babies may be nursed; others should be fed on carefully prepared foods. The child should be turned from side to side or carried about occasionally. Morphine in very small doses is usually needed during the first twenty-four hours. Strychnine and digitalin may be given hypodermically as indicated. If the bowels do not move in twenty-four hours a small dose of calomel may be given. The first movement usually occurs in twelve hours after operation and generally contains blood and mucus. The sutures should never be removed before the tenth day, and if they are giving no trouble they may be allowed to remain longer.—*Am. Gyn. and Obstet. Jour.*

THE CLINICAL ASPECTS OF ACUTE INTESTINAL OBSTRUCTION.

H. Lillenthal, New York, states that the causes which contribute most to the mortality of this affection are three in number: First, the shock incident to the strangulation of a vital organ. Secondly, there is sepsis from within the distended and congested gut even without the onset of peritonitis. Thirdly, the embarrassment of the functions of the lungs and heart by the distension itself, with consequent exhaustion of the vital forces in an already weakened individual. Either of the first two causes may be fatal without the existence of the third. The increasing frequency of abdominal section for the relief of other conditions has undoubtedly been the cause of an increase in the number of cases of ileus, and therefore all diligence

should be exercised to prevent this accident. The intestine should be handled little and with great gentleness, and drainage by irritating substances should be avoided if possible. The author is convinced that true ileus is often due to appendicitis; in several cases he has found the appendix drawn over to the left side of the abdomen by adhesions to the small intestine, with kinking and complete obstruction. Various symptoms are dwelt upon, and emphasis laid upon the importance of not overlooking or misinterpreting the expulsion of flatus in administering an enema. Air introduced with the enema may be later expelled by the patient, and reported by the nurse as the passage of flatus. Fecal vomiting is such a late sign, and of such grave prognostic import, that to wait for it practically dooms the patient. The medical treatment of intestinal obstruction of the acute kind is safe until the diagnosis is made, but no longer. From his own experience in the operative treatment, the author submits the following ideas: The stomach should be washed out before operating, and, preferably, before beginning the administration of the anaesthetic. In the most desperate cases no general anaesthetic should be employed. A small incision should first be made in the right iliac region, and if it is at once obvious that the key to the difficulty is situated here, the wound should be enlarged and the operation proceeded with; if the exploration proves negative, a long median incision should immediately be made. If a strangulation exists, the patient must not leave the table until it has been relieved. The possibility of the existence of more than one obstruction must be ever present. Enterostomy or colostomy should be performed only when there is the greatest danger that the patient may die if the operation is prolonged; the only exception to this would be in cases of acute ileus from chronic obstruction in the large intestine with enormous distension. In making an artificial anus, one must be certain that the opening is above the occlusion. Gangrenous intestine should be at once resected.—*N. Y. Med. Rec.*

SURGICAL TREATMENT OF SPINA BIFIDA.

L. Marshall, of Nottingham, calls attention to a treatment which he is using successfully. A baby a few months old was admitted into the Children's Hospital, Nottingham, with a large spina bifida in the lumbar region. Roughly, it may be described as about the size of a tangerine orange; three-fourths of the skin was translucent and very tense. An incision, at first small, to permit the

slow escape of the fluid, was made in the middle line while the child lay on its face with the head low and the buttocks raised. When the sac was empty the inner lining on either side was dissected as far as the spine. Then this was turned inward and a Lembert suture applied as in suture of the bowel. Then sufficient of the external skin—much of which recovers itself after the removal of the fluid—was placed over the inner pad and secured by silkworm gut interrupted sutures. The dressing used was collodion and cyanide gauze, applied in successive thick layers. It should be stated that the opening into the canal admitted the tip of the index finger. In the after-treatment of the case the raised position of the buttocks should be maintained for the first week in most of the cases.—*Brit. Med. Jour.*

THE PRIMARY TREATMENT OF BURNS AND SCALDS.

When the president of this association asked me to read a paper on this subject I readily acquiesced, thinking it would be a very easy matter to deal with, and would entail no great amount of labour. The very simplicity of the subject, however, makes it very much more difficult to me to give you anything that you do not already know, but I hope that the discussion which will be participated in by those who have had large experience in treating burns will bring out many practical points which will be of real service to the members. In looking over the literature of this subject I have been impressed with the number of remedies recommended, each having advocates and each giving very satisfactory results, if you are to believe in every instance the favourable reports of admirers, and possibly discoverers. This is, I take it, an evidence that we have as yet no one drug which is universally accepted as a specific. We must, therefore, aim at formulating certain principles of treatment, the carrying out of which will probably be equally well done by more than one remedy. In the first place, we must remember that the constitutional condition requires active treatment, as well as the local injury. The general treatment will depend largely upon the extent of the burn. When our patient is suffering from severe shock our first duty will be to apply suitable remedies for that condition. Warmth is of the greatest importance, and the patient should be wrapped up in warm blankets, he should be put to bed as quickly as possible, without a pillow, and the foot of the bed should be raised six or eight inches. Free stimulation is also important; perhaps the most rapid stimulant is ether

injected subcutaneously in doses of from 20 to 30 minims. If, in injecting ether, the needle of the syringe be buried in the muscle, it will avoid the sloughing of the skin, which sometimes occurs after ether is used subcutaneously. This may be repeated every fifteen minutes if necessary, and brandy may be injected in the same quantity, still more frequently; strychnine is also useful.

Stimulants should also be administered preferable in the form of a hot nutrient enema, containing half an ounce to two ounces of brandy with the yolk of an egg and an ounce of beef tea and milk. In severe shock an injection of hot normal saline solution into the rectum will be found of very great value. One or two pints may be given and repeated every two or three hours, until the pulse is of good volume. The advantage of this plan of giving salt solution over the transfusion into a vein is that the dilution of the blood does not occur so rapidly, and hence there is not the same trouble about dyspnoea. A very marked effect will be noticed in the pulse in a few hours after the injection.

When a nutrient enema has been administered it is well to wait an hour before using the saline solution. I think there can be no doubt that the shock is often to a large extent kept up by pain (which causes exhaustion of the nervous system) and it is therefore of importance to relieve this, if possible. An injection of morphine, preferable in combination with atropine, should, therefore, be given. If, after the patient recovers from the shock, symptoms of internal congestion or inflammation set in, the usual treatment for this condition will be necessary. During the stages of the sloughing and convalescence it will be necessary to support the patient's strength by a nutritious diet with plenty of milk and the use of stimulants and tonics. When the body is extensively but superficially burnt, the depression is removed and the pain relieved by placing the patient in a warm bath. Visceral complications are usually of a congestive type, and for these we must rely chiefly on stimulants. Frequent full doses of opium will be required to relieve the irritability of the nervous system.

Now, as to the local treatment. This will depend upon the degree, and we will adhere to the classic division into six degrees, as originally proposed by Dupuytren. The treatment may be considered under four heads, viz., the treatment of the first degree, that of the second, that of the third and fourth degrees, and, lastly, that of the fifth and sixth degrees.

In the first degree there is no breach of continuity, and, therefore, no danger of sepsis. Dusting the surface with any soft, simple powder relieves the pain by protecting the surface from contact with the air. Cold cream or glycerine or lead and opium lotion will also be found efficacious.

In the second degree, where blisters have formed, the cuticle should be washed antiseptically, and then the blisters punctured and the fluid allowed to escape, but the epidermis should not be removed. The opening in the blister should only be of sufficient size to allow the fluid to escape; otherwise, if made too large, the epidermis is apt to peel off, exposing the papillary layer of the skin and causing a great deal of pain and retarding the healing. The area may then be covered with some antiseptic ointment; eucalyptus ointment of the B. P. or boric acid ointment (half strength) will do very well. This should be covered over with cotton wool and left for three or four days, when the part will have quite recovered.

The third and fourth degrees: When there is partial or entire destruction of the whole thickness of the skin or of the deeper tissues, as in the remaining degrees of burn, the parts must be kept aseptic, because after recovery from shock and for the first week or two afterward the patient's greatest risks are connected with sepsis.

We must now consider the best method of securing asepsis—a very difficult problem on account of the readiness with which burnt parts absorb fluids, and especially carbolic acid. One should not use carbolic acid as a disinfectant in burns on account of the danger of poisoning. The most suitable substance is bichloride of mercury, which may be used in the strength of 1 in 1,000 without any danger of absorption. By using plenty of soap to the skin in conjunction with a sublimate solution of the strength of 1 in 1,000, rapid disinfection of the skin is effected. In burns the heat has to a certain extent disinfected the part, should there be no further soiling, and it is not necessary to use disinfectants as thoroughly as in preparing the skin for an operation. This is especially true when the burnt part has not been covered with clothes.

More care in the disinfection of the part will be necessary when covered with clothes. It may be necessary and advisable to administer a general anaesthetic—preferably ether—so as to thoroughly cleanse the part without increasing the shock; so that in bad cases the procedure will be as follows: Put the patient under an anaesthetic, soap

and wash the burnt area and the skin around, douche it over thoroughly with 1 in 1000 sublimate solution which is subsequently removed by douching with boiled water. The best dressing then is cyanide gauze wrung out of 1 in 6 or 8000 sublimate solution and over this salicylic wool.

This may be left for three or four days or even a week without changing, providing there be no evidence of sepsis as indicated by rise of temperature, etc. The great advantage of a dressing of this kind is that, while it keeps the part antiseptic, it also allows the discharge to dry on the surface. When the slough begins to separate and granulations are springing up, one of the antiseptic ointments will answer better than the cyanide dressings. Eucalyptus or the full strength boracic acid ointment does very well. When the slough has separated the wound must be treated as a healing ulcer. Lately, French authorities have recommended the use of picric acid as a dressing in burns where the cutis vera has not been entirely destroyed; it is claimed for it that it is more efficacious in allaying the intense pain (so often present) than the ordinary applications, while at the same time it possesses antiseptic properties. The vesicles are punctured and then a piece of lint soaked in a saturated solution of picric acid is applied, and over this a pad of salicylic wool is firmly bandaged. The effect of the acid is to coagulate the albuminous fluid oozing from the wound, and thus to form a protective layer over the exposed nerve endings of the skin. The application may be left undisturbed for two or three days and then soaked off with warm boric lotion and reapplied. In several cases in which this procedure has been used we have been very pleased with the result. I think, however, it is most useful in the milder degrees of burns.

Just a word in reference to certain applications commonly recommended. Carron oil, for example, is a dirty preparation, and responsible for a great deal of mortality after burns. The use of poultices, of water dressings and dusting with flour are equally bad. As far as possible, the wound should be treated aseptically. If the attempt at disinfection fails and the wound becomes septic, probably the best method of treatment is the continuous water bath. If the trunk be affected and the burn large and painful and accompanied by constitutional disturbances, the patient is placed in a bath of water at the temperature of 100° F. containing a small quantity of an antiseptic, such as Condy's Fluid or Sanitas, and changed every three or four hours. It is well to take the patient out of the bath at night and apply wet boric lint, covered

with a macintosh (previously rendered aseptic). This method should be continued until the sloughs have separated and the inflammation has subsided. Now antiseptic ointments applied as for healing ulcers should be substituted. Where the extremities are effected special baths for the part may be used. Where the slough is situated over a joint or a serous cavity, and there is danger of either being opened when the slough separates, very great care must be taken in the aseptic management of the case, lest the part become septic and acute suppuration of the articular or serous cavity supervene.

The fifth and sixth degree: The treatment of these has to be considered in regard to the extremities alone; if the burn be situated elsewhere the patient usually dies at once. Should, however, either of these degrees of burns be upon the skull or trunk, and the patient live, we must endeavour to keep the part aseptic and support the patient's strength and wait until the slough separates; then if no vital part be involved, the defect will be gradually filled in with granulations and eventually skin grafting will expedite a cure. In the case of extremities, however, when the tissues down to and including the bone are completely charred, or when only the fifth degree is reached, and the tissues are destroyed over a large area, the question of primary amputation arises. Where the limb is hopelessly destroyed there can be no question as to amputation, the only point to be considered is where and when the amputation should be performed. Generally, speaking, it is better to wait until the shock has passed off, for if we operate before this the shock is apt to be increased, bringing about a fatal result. If the part be roughly disinfected and wrapped up in an antiseptic dressing it is usually quite safe to wait twelve or twenty-four hours till the shock is partly recovered from, and then by employing all the measures calculated to minimize shock, amputation may be proceeded with. As regards the seat of amputation, it is not necessary to go far above the charred tissue; certainly not above the region of the erythema.

It might be well for me just to mention some other applications used in the treatment of burns. Tillman prefers aseptic dry powdered dressings to ointments or solutions. McInnis states that spirits of turpentine applied to a burn of either the first or second or third degree almost at once relieves the pain, while the burn heals. After wrapping a thin layer of absorbent cotton over the burn the cotton is saturated with turpentine and

covered with bandages. Being volatile, the turpentine evaporates, and it is, therefore, necessary to keep the cotton moistened with it. When there are large vesicles these are opened on the second or third day.

Acetanilid is also used. Ichthyol, in watery solutions, or in glycerine, or even in ointment form, and the iodine derivatives, such as iodol, aristol, europen, iodoform, airol, are reliable measures; also thiol.

In cases where shreds of clothing have been burned into the skin, they should not be removed until the second dressing. Their immediate removal can only be accomplished by stripping away the flesh. While mentioning some of the many remedies useful in the treatment of burns I have tried to outline the treatment which I have seen most successful. Where we have to select some special remedy to be used by those laymen giving first aid in the case of burns, I think the best remedy we have is picric acid. I would advocate, therefore, the placing of a quantity of picric acid on every train and in every station, with printed directions that in the event of a burn or scald a solution be made in water and this applied to the part, and lint or absorbent cotton, if procurable, soaked with it and made to cover the part. Turpentine is also a very good remedy to be used by the laity. In using either of these substances the part is not rendered more difficult of being made aseptic, whereas in the oily preparations it is very difficult afterward to render the parts aseptic.—*H. A. Bruce, F. R. C. S., Eng., Toronto, in the Railway Surgeon, July, 1899.*

Therapeutic Notes.

VENEREAL WARTS.

Shoemaker recommends the following powder for small warts just back of the glans penis, and traced to the irritative action of the vaginal secretions on a surface weakened by too much venery, and insists upon continence for at least three months:—

R Hydrargyri chloridi mitis..... ʒss
 Acidi tannici..... gr. xx
 Bismuthi subnitratris ʒss

M. Sig.: Use locally as a dusting powder.—*J. A. M. A.*

SORE NIPPLES.

The nipple should be cleaned with a little water, to which has been added a small amount of borax, then apply the following :—

R_y Balsam of Peru.....
 Tr. of arnicaaa ʒss
 Ol. amygdal. dulcis.....
 Aqua calcis.....āā ʒss

M. Sig.: Shake well and apply to nipple with calmel's-hair brush.—*Med. Summary.*

TREATMENT OF DYSENTERY.

R. A. Mate has used the following formula successfully in South Africa after all other methods had failed :—

Mag. s. 'ph..... drachms j
 Ac. sulph. dil..... minims x
 Quinin sulph.... grains i
 Hydrarg. perchlor..... gran 1-32
 Tinct. opii..... minims x
 Aq. menth.....ad ounces ½

Sig. Every three hours.

Irrigations of boric acid (a drachm to the pint) also give great relief.—*British Med. Journal.*

TREATMENT OF EPISTAXIS FROM ANY CAUSE.

Dr. P. Chevallier, as quoted in *St. Paul Med. Jour.*, recommends injections of gelatinized serum prepared as follows :—

R_y Sodi chloridi ʒi
 Aq. destil..... Oii

M. To this solution add gelatin in proportion of 10 parts to the 100 and sterilize. This becomes solid when cooled, but can be warmed in a water bath when needed. As an astringent powder the following is recommended :—

R_y Acidi boricis.....
 Pulv. sacchari.....aa lxxv
 Antipyrini.....
 Acidi tannici.....aa gr. xv

M. Sig. : To be blown upon the bleeding surfaces.

If it is not then checked, packing the nostrils will have to be resorted to.—*J. A. A.*

CHRONIC ARTICULAR RHEUMATISM.

R Liq. potassii arsenitis..... ʒj.
 Potassii iodidi..... ʒiv.
 Sodii salicylatis..... ʒv.
 Syrupi sarsap. comp..... ʒiiss.
 Aq. menthæ pip..... q. s. ad ʒiv.

M. Sig. : One teaspoonful in half-glass of water after each meal. Or:—

R Potassii iodidi ʒij
 Vini colchici sem.....
 Tinct. opii camph.....aa ʒi
 Tinct. stramonii..... ʒiij
 Tinct. cimicifugæ..... q. s. ad ʒiv.

M. Sig. : One teaspoonful three times a day in water.
 —*J. A. M. A.*

Jottings.

RESUSCITATION OF THE NEW-BORN.

(Mulhern, *Phys. and Surg.*, September, 1900).—No child that does not show positive evidence of decomposition should be pronounced dead until after persistent efforts at resuscitation have been made. Failure to detect the cardiac sounds or impulse, or absence of pulsation of the cord, are not sufficient excuse for not instituting such efforts. The chances of success is greater in asphyxia livida than in asphyxia pallida. The first thing to be done is to clean out the upper air passages. If the child fails to cry within two minutes, mouth to mouth insufflation should be practiced. It is not expected that air will reach the lungs by this means, but it is useful in cleaning out the nasal passages. If abundant rales point to the presence of fluid in the trachea or bronchi a catheter should be introduced. The child should be flagellated and immersed in hot and cold water. If this does not suffice some method of artificial respiration should be practiced. Hall's and Sylvester's methods are well known. The Schultze method consists in seizing the child just below the neck, the fingers resting on the dorsum and the thumbs on the thorax, the child facing in the same direction as the operator. The child should be held hanging downward and then swung at arm's length upward over the operator's

shoulder. This should be repeated eight times a minute. The Byrd-Dew method consists in extension and flexion of the infant's body. This may be done while the child is in a hot bath, and is preferable in asphyxia pallida. The Laborde method consists in rythmic contraction of the tongue by the fingers. The number of tractions should be twenty-four per minute. The action results in a reflex irritation of the phrenic through the nerves of the tongue. The child should always be immersed in hot water to prevent chilling.

ON THE TREATMENT OF PRURITUS VALVAE.

(L. Siebourg, *Centralbl. f. Gyn.*, June 29, 1901.) First of all, those conditions which either are causative of this disease, or militate against the healing, are to be removed. An exact urinalysis is of great importance. The diet has to be regulated. Alcohol and highly seasoned food should be interdicted. Patients are to be left alone as little as possible, in order to prevent rubbing and scratching the vulva. The finger-nails should be kept short. The diseased parts are washed with soap and cold water at least twice a day, especially after the patient has urinated. The following ointment gave good, immediate and lasting results:—

R Cocaine.....	2.0 grammes
Orthoform.....	1.5 "
Menthol.....	0.5 "
Acid carbolic	1.0 "
Vaseline.....	20.0 "

If there are small excoriations, they should be cauterized with a ten per cent. solution of nitrate of silver. If the condition is chronic and the skin is not abraded, the following solution should be applied :

R Spirit. rusci.....	50.0 grammes
Acid. salicyl.....	0.5 "
Resorcin.....	1.0 "

After thorough cleansing apply with a soft brush.

Latterly the writer has found that the subcutaneous injections of about 300 cc. of normal salt solution gives good results. The injections had best be given in the evening. He explains their efficacy in this way :

"The injected fluid puffs up the skin, thus stretching the ends of the nerves, and produces a local anesthesia analogous to the anesthesia of Schleich's method."

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Editorial.

UNIVERSITY OF BISHOP'S COLLEGE.

FACULTY OF MEDICINE.

The thirty-first session of the above Faculty of Medicine was opened on Tuesday, the 1st of October, by an introductory lecture by Dr. F. W. Campbell, the Dean. The attendance of professors, lecturers, demonstrators, graduates and students was very large, every available space in the largest lecture room in the College being occupied. The Dean met with a very cordial reception. In opening his lecture, he extended to all a very cordial welcome. To those who had been in attendance for varying periods of one, two or three years, he gave cordial greetings, as to old friends. There was a time, he said, not many years ago, when the interval between the winter sessions was passed largely in the pursuit of pleasure and health. It may sometimes be necessary to pass it still in pursuit of health, but the search for pleasure must now be restricted to such holidays as would be claimed by you, were you in the active pursuit of the profession of your choice. Things had indeed changed. When Bishop's College Medical Faculty opened first its classes, it had eleven teachers. To-day it had a teaching staff numbering over forty. To those who, for first time, enrolled themselves that day as students of

Medicine, he gave cordial greetings, and then said : " At the very outset of your student career I would not wish to say one word which will dampen the ardour, which I feel sure prevades each breast. Yet, I feel my duty would not be performed, did I not ask each one of you if you have well considered the important step you are now taking. If you have, and it seems to me that your answer is in the affirmative, I welcome you to the work which though arduous, and entailing constant toil, has much about it which is pleasant and agreeable. Indeed, in after years when the cares and anxieties of practice surround you, you will often look back upon your student life as being one of the green spots, an ever to be remembered land mark in your existence." Dean Campbell then briefly dwelt upon the various primary branches which form the foundation of medical science, and passed on to give his opinion on the value and necessity of devoting a large amount of time to Hospital attendance. He said, " I know of nothing more likely to come to your assistance when you first commence practice, and lack that which can alone give you confidence—experience—than the hours which you have devoted to Hospital attendance. He concluded his address in the following words :—" Our knowledge of the causes producing disease has enormously increased. Thirty-one years ago, when this Faculty was formed, the subject of bacteriology was unknown. We knew nothing of the tubercle bacillus. Consumption was then an hereditary disease—we now know it to be infectious. Typhoid fever, we knew, was communicated through the dejecta, but the typhoid bacillus was unknown. Only a year or two ago this disease was still believed to be communicated by the discharge from the bowels. To-day we know that the typhoid bacillus disappears in a few weeks from the dejecta, while it is found in the urine for months.

" Sanitation has made great progress. This is proved by the last census of Great Britain, where the increase of nearly three millions and three-quarters in the population, in spite of a steadily declining birth rate, is very largely due to decrease in the death rate, *i.e.*, extension of the average

period of human life. Use the opportunities which will soon be presented to you, so that when your period of training is over, and you leave these walls to begin the great battle with disease and death, you may be well armed and equipped for the contest. With moral principles strengthened by habits of industry and perseverance, with your intellect free from prejudice, clear seeing, well furnished with scientific and practical knowledge; with your faculties disciplined for the work you have to perform, you will show yourself not unworthy of this University, or of that profession which is confined to no people and to no country, but whose object is the relief of evils common to the whole human family.

“Do not, gentlemen, think that I have painted in too glowing colours the profession whose study you, this day, enter upon. Morally and intellectually I cannot over-rate it; and now, when toil and exertion is required, I would cheer and encourage you, by reminding you of the very great intrinsic gratification which these studies may afford, and of the nobleness of the objects for which they prepare you.”

A late writer says “it is the fashion to decry our profession, to call it a poor, a degraded profession.” If it be poor and degraded, is that the fault of the calling or of those who practice it? Is the art of healing in itself less noble, because its practitioners, too often unsustained by a consciousness of their own dignity, have not raised it to the place in society which it ought to hold? Poor it may be! Slighted it may be! but degraded it cannot, shall not be, so long as its foundation is science and its end the good of mankind.

THE FOLLY OF BOLTING FOOD.

A paper read before the British Medical Association furnishes some remarkable facts about the mastication of food. The author, an English practitioner in Venice, says that there exists a lost reflex action of the throat, whereby it refuses to swallow food unless well chewed and mixed with saliva. After five or six weeks of prolonged

and careful chewing of solids and prolonged insalivation of fluids, this reflex can be restored. The necessary condition of success is that both fluids and solids shall be dealt with in the mouth until they are reduced to a tasteless condition. The author says that by adopting his process indigestion is vanquished, the body becomes healthy, a far smaller quantity of food is required, and in one case corpulency was reduced to an extraordinary extent. If his views be accepted the treatment of many maladies will be simply revolutionized. With the modern man quick eating has become a necessity; at any rate, in the breakfast and luncheon hours. The tendency is to bolt everything at those meals, and to eat far too quickly even when there is ample time at disposal. It is clear that prolonged mastication would render a dinner of many dishes impossible. It is equally clear that most of us eat far more than is needful to satisfy our bodily requirements. That there is something to be said on the side of the quick eaters, however, may be gathered from the fact that many of them pass long lives without being overtaken by the Nemesis of dyspepsia. Among many native tribes, moreover, and with a host of carnivorous animals, it is the rule to bolt food in rapid and wholesale fashion.

THE LATE DR. JOHN DUNCAN, OF VICTORIA, B.C.

Those who had the pleasure of Dr. Duncan's acquaintance must have grieved greatly at his tragic death, on board of the steamer "Islander," wrecked lately on its way from the Yukon to Victoria. A fellow passenger saved tells us that his death was tragic and heroic, and to the last was characteristic of the man. While others were fighting like beasts for their own escape, he stood like a brave man protecting the weak, and making no effort to save himself. He finally sank from sight while endeavouring to save a woman—wife of a friend, and her child. Dr. Duncan graduated from McGill in 1884, and at once went to Victoria, B.C., and began practice. When "C" Battery, Royal Canadian Artillery, was formed, and stationed in Victoria,

he was commissioned its surgeon, and remained such till it was disbanded about 1890. As a private practitioner he had gained a large practice and his patients and friends deeply mourn his loss.

THE RIO CHEMICAL COMPANY.

This company which has, since its establishment, had its headquarters at St. Louis, Mo., have transferred business to 56 Thomas Street, New York. The reason for removal is that the business of the Company has assumed such large proportions that they desire to be at a centre, which will enable them to have better facilities for procuring the ingredients which enter into the composition of the preparations they manufacture.

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

The dates originally decided upon for the meeting of this Association having been found to conflict with the meeting of the American Medical Association at Saratoga, the date has been changed to June 17th to 20th, 1902. Dr. Burgess, of the Verdun Hospital for the Insane, is Chairman of the committee of arrangements. The meeting takes place in Montreal.

Book Reviews.

Operative Surgery. By Joseph D. Bryant, M.D., Professor of the Principles and Practice of Surgery, University and Bellevue Hospital Medical College, etc., Volume II; Operations on Mouth, Nose and Esophagus, the Viscera connected with the Peritoneum, the Thorax and Neck, Scrotum and Penis and Miscellaneous Operations. 739 pages; 827 illustrations, of which 40 are coloured. D. Appleton & Co., New York, 1901.

The author has, in this volume of his work, sustained the high standard set in the first, and it is pleasing to see a new edition of an old and favourite author. Bryant's Surgery has been studied with profit for many years by both practitioners and students, but, until recently, a new and up-to-date edition was felt to be wanted,

and volume II. fully realizes our expectations. The work being so well known, no words of praise from the reviewer could be considered flattering, nor is praise necessary, yet the new two-volume edition of Bryant is as much better than the old as the modern safety bicycle is better than the old "bone-shaker." The writer is clear and explicit in his views and sufficiently conservative to gain the confidence of his readers. This second volume contains over 600 pages, and is devoted to operations on the mouth, nose, esophagus, peritoneum and connected organs, the thorax, neck, and the male sexual organs. The volume contains 827 illustrations, forty of which are coloured. As the title indicates, it is devoted exclusively to operative surgery, there being no description of pathology or diagnosis. Volume II., dealing as it does with the peritoneal viscera, is of extraordinary interest. The illustrations are not only copious, but are plain, exact and instructive, and show surgical relations, and the descriptive text is exhaustive, leaving nothing to be desired on the part of the operator as a guide in the various surgical procedures. All the newer techniques are fully described with admirable clearness. A peculiarity of modern surgical nomenclature is shown in the work by the enormous number of operations that have been named after individuals. With the various modifications, they amount to hundreds. Perhaps this is the best method designating operations, but it imposes a serious burden on the memory. The publishers have made a handsome volume, the presswork, binding and paper being of a superior character. We can safely predict that Bryant's Surgery will continue to hold its place as a representative American text-book.

R. C.

Progressive Medicine, Vol. III., September, 1901. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 428 pages, 16 illustrations. Per annum, in four cloth-bound volumes, \$10.00. Lea Brothers & Co., Philadelphia and New York.

This volume has been issued promptly on time and is fully up to date in every way. It certainly will prove of more than usual value to the general practitioner, and, after all, to what larger constituency could a publisher appeal. Dr. Ewart presents the most recent views on pneumonia, tuberculosis and other conditions of the respiratory tract. The advances in the treatment of pneumonia and phthisis have been so remarkable in the past year that this section will be read with especial interest. The surgical treatment of various affections of the lungs and pleura has been extended of late in a manner which opens a field which gives promise of great benefit to sufferers from these conditions. In the consideration of the diseases of the heart and blood-vessels, Dr.

Ewart discusses very fully the recently exploited forms of treatment by baths medicated and otherwise.

The section on Dermatology and Syphilis by Dr. Gottheil, besides giving the most advanced information concerning the ordinary problems presented in those subjects, discusses very fully the new and important subject of photo-therapy and the Finsen light treatment, blastomycetic dermatitis and inoculation tuberculosis.

In the section on diseases of the nervous system, Dr. Spiller devotes a large portion of his space to an able discussion of tumours and abscesses of the brain. He also describes the commoner forms of the peculiar nervous diseases which are sometimes so puzzling to those who have not made a special study of neurology.

In obstetrics Dr. Norris discusses very fully the treatment of eclampsia. He gives also the most recent views on the subject of symphysiotomy, and discusses the large number of recently reported cases in which lumbar anæsthesia has been employed in obstetric practice.

In the above we have briefly outlined some of the more important features of the work. Its scope, however, includes an interesting narrative of the practical advances made in diseases of the thorax, dermatology, syphilis, diseases of the nervous system and obstetrics.

F. W. C.

A Text-Book of Pharmacology and Therapeutics; or the action of drugs in health and disease. By Arthur R. Cushny, M.A., M.D., Aberd./ Prof. of Materia-Medica in the University of Michigan; formerly Thompson Fellow in the University of Aberdeen, etc., etc. Second edition revised and enlarged. Lea Bros. & Co., Philadelphia and New York, 1901.

There is little to be added to what was said of this excellent work when it appeared in June, 1899. We congratulate the author on his deserved success. The exhaustion of the first edition in a little over one year has afforded opportunity for a revision in some subjects and the addition of others. The question of the rôle of Iron in the economy is always an entrancing one, and we could have wished a fuller article on the subject. The researches of Arthman Bruère, of Bishop's College, Montreal, now in progress, may, we hope, throw some light on this discussed point. The classification, a modification of Büchheim & Schmiedeberg, has been adhered to. On the whole, the book is much the best of its kind published today. The printing and binding are in the Lea's usual style, but *why* will they not hearken unto the plea of those for whom the book is intended, and give up the eye-destroying, glossy-surface paper, substituting the rough-non-reflecting paper so soothing to the tired eye of those who can only read after a hard day's work?

R. W.