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Journal of Medical Science

VOL. II.

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No. 12.

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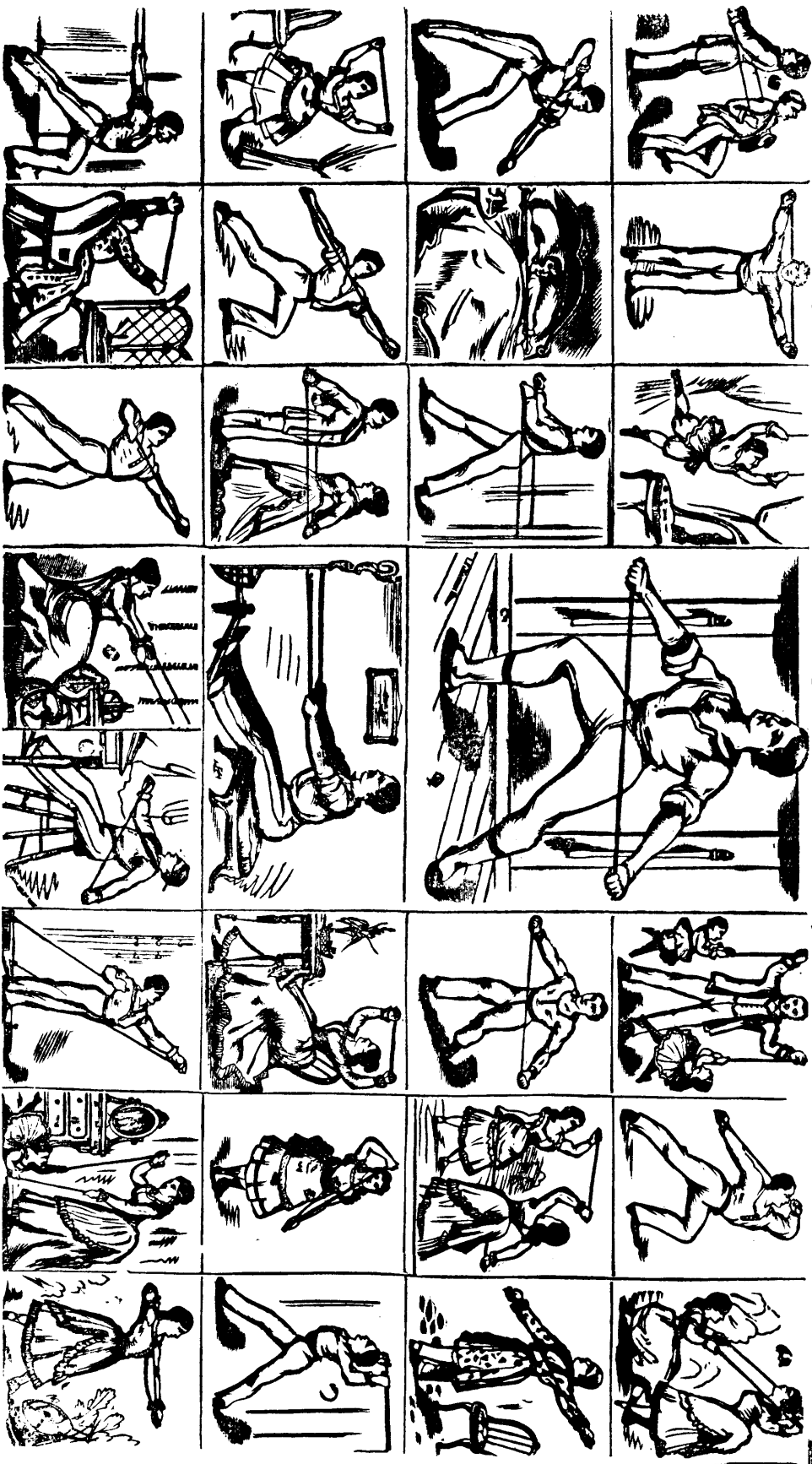
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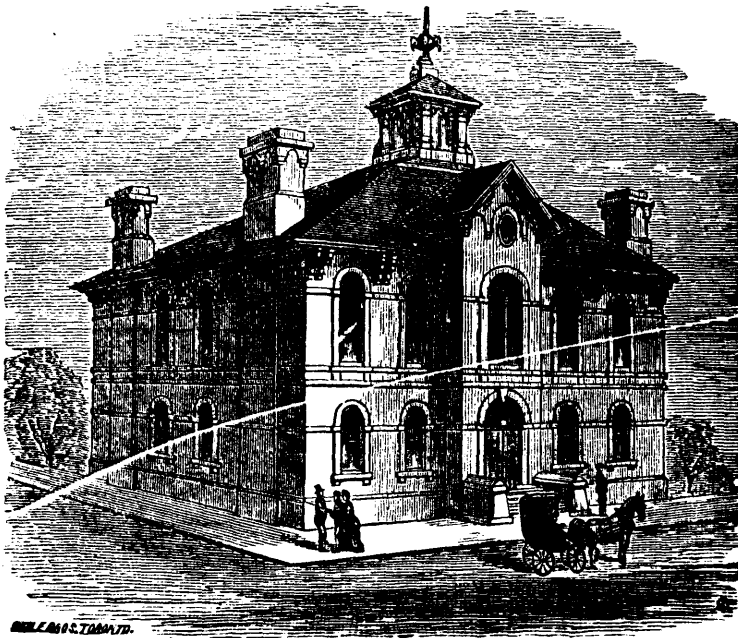


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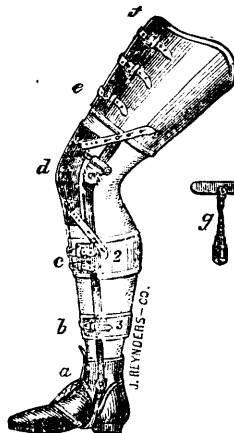
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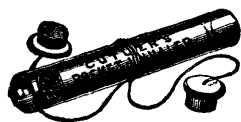
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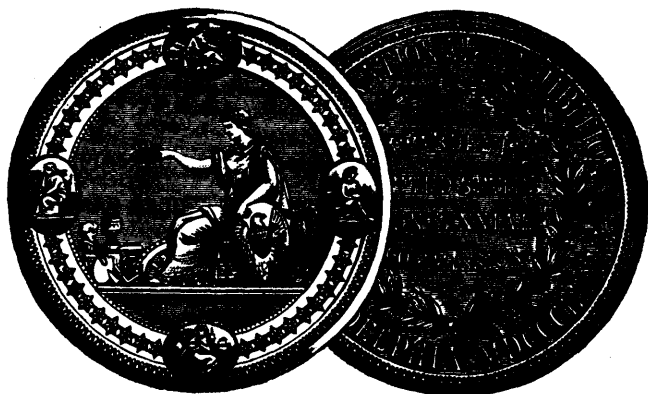
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Selections: Medicine.

PROGNOSIS AND TREATMENT OF DIPHTHERIA.

BY J. LEWIS SMITH, M.D.

Death in diphtheria may result from—

- 1st. Diphtheritic blood-poisoning.
- 2nd. Probably, also, from septic blood-poisoning produced by absorption from the under surface of the decomposing pseudo-membrane. But it is difficult to distinguish the constitutional effect of sepsis, from those produced by the diphtheritic poison. Septic poisoning is obviously most apt to occur in those cases in which the pseudo-membrane is extensive, and deeply imbedded, and its decomposition attended by an offensive effluvia. Cervical cellulitis, and adenitis, which when severe cause very considerable swelling of the neck, appear to be often, if not usually, due to septic absorption from the faucial surface, the inflammation extending from the absorbents to the glands and connective tissue. Considerable tumefaction of the neck therefore seldom occurs in diphtheria or scarlet fever, without manifest symptoms of toxæmia, and is to be regarded as a sign of its presence.
- 3rd. Obstructive laryngitis.
- 4th. Uræmia.
- 5th. Sudden failure of the heart's action, either from the anæmia, and general feebleness, from granulo-fatty degeneration of the muscular fibres of the heart, which is liable to occur in all infectious diseases of a malignant type, or from ante-mortem heart clots.
- 6th. Suddenly developed passive congestion and œdema of the lungs, probably due to

feebleness of the heart's action, or to paralysis of the respiratory muscles.

That physician obviously is least apt to err in prognosis, who recognizes the fact that patients are liable to perish in any of these different ways, and carefully examines in reference to all the conditions which involve danger. Many physicians, as I have had the opportunity to observe, are remiss in not examining more frequently the urine of diphtheritic patients, for there is often a large amount of albumen in the urine in diphtheria, indicating a poisonous quantity of urea in the blood, and yet the appearance of the urine to the naked eye is probably normal.

Among the symptoms which render the prognosis unfavourable are, repugnance to food, vomiting, pallor of countenance, with progressive weakness and emaciation from the blood-poisoning; a large amount of albumen with casts in the urine, showing uræmia, to which the vomiting is sometimes, but not always, attributable; a free discharge from the nostrils, or occlusion of them by inflammatory thickening, and exudation, showing that a considerable portion of the Schneiderian membrane is involved, hæmorrhage from the nostrils or fauces, and obstructed respiration. One, at least, of these symptoms has been present in most of the fatal cases which have fallen under my observation.

Whatever the theory, experience gradually establishes the fact, in the minds of all observing physicians, that constitutional treatment is of paramount importance in diphtheria, as it is in that other malady, which, in my opinion, is most nearly akin to it, namely, scarlet fever, except when the danger is located in the larynx.

I am persuaded that, in order to secure the best treatment, constitutional and local, of diphtheria, it is necessary that the physician should accept the following propositions:—

1st. The specific principle of diphtheria, in all probability, enters the blood, in ordinary cases, through the lungs; and after an incubative period, which varies from a few hours to seven or eight days, produces the symptoms which characterize the disease.

2nd. Facts do not justify the belief that the system can be protected by antiseptic or preservative medicines administered internally. A quantity of this kind of medicine, introduced into the system, sufficient to preserve the blood and tissues from the action of the diphtheritic virus, would, there is every reason to think, be so large as to arrest molecular action, and therefore the functions of organs, and occasion death.

3rd. There is no known antidote for diphtheria, in the sense in which quinia is an antidote for malarial diseases, and no more probability that such an antidote will be discovered than for scarlet fever or typhoid fever.

4th. Diphtheria, like erysipelas, has no fixed duration—It may cease in two or three days or continue as many weeks; but the specific poison acts with more intensity in the commencement than subsequently, and its energy gradually abates. Hence, a diphtheritic inflammation, which arises in the beginning of diphtheria, as laryngitis, is more severe and dangerous than when the malady has continued a few days.

5th. The indication of treatment is to sustain the patient by the most nutritious diet, by tonics, and stimulants; and to employ other measures, general and local, as adjuvants, to meet special indications which may arise. The rules of treatment appropriate for scarlet fever, apply for the most part to diphtheria. Local treatment of the inflammations should be unirritating, and designed to prevent putrefactive changes, and septic poisoning. Irritating applications which produce pain lasting more than a few minutes, or which increase the area or degree of redness, are apt to do

harm, and increase the extent and thickness of the pseudo-membrane.

General Treatment.—This may be conveniently considered under the three heads, food, stimulants, and tonics. All physicians of experience recognize the importance of the use of the most nutritious and easily digested food, and the preservation of the appetite—for the safety of the patient requires that he should retain, as far as possible, his flesh and strength. The more nutritious and easily digested the food, given in sufficient quantity, with the appetite preserved, the less, obviously, the danger of the fatal prostration, which so frequently occurs suddenly and unexpectedly in grave cases. Beef-tea, or the expressed juice of meat, milk with farinaceous food, etc., should be administered every two or three hours, or to the full extent, without overtaxing digestion. Failure of the appetite, and refusal to take food, are justly regarded as very unfavourable signs. One objection to the use of the brush, instead of spraying the fauces, with the atomizer, is that it is more apt to provoke vomiting, by which nutriment, that is so much required, is lost. In malignant cases of diphtheria, as in scarlet fever of a similar type, patients are sometimes allowed to slumber too long without nutriment. It is the slumber of toxæmia, and should be interrupted at stated times, in order to give the food.

The same rule holds true in diphtheria as in other acute infectious maladies, that while mild cases do well without alcoholic stimulants, they are required in all cases of a severe type, and should be administered in large and frequent doses, whenever pallor and loss of appetite, or of strength and flesh, indicate danger from the diphtheritic or septic infection. It matters little how the stimulant is administered, whether milk-punch or wine-why, provided that the proper quantity is employed. Were I to accept the theory that the cause of diphtheria is a vegetable organism, and were to search for a medicinal agent, employed internally, which would be most likely to destroy it, or retard its reproduction and development, I should accept the opinion of Sanne that the alcoholic preparations more

nearly fulfil the indication than any other agent.

Of the vegetable tonics, cinchona, or its important alkaloid principle, quinia, is more commonly employed than any other medicine, and there is probably none which answers the purpose better. The compound tincture of cinchona, and the fluid extract, have been used and recommended by physicians of experience; but quinia is more commonly employed, and is regarded by a large proportion of physicians as the most useful of all therapeutic agents in the treatment of this malady. But there is great difference of opinion in regard to the quantity which is required each day, or the size and frequency of the doses. It is sometimes administered in small doses, as one grain every three or four hours, for its supposed tonic effect; and again in doses sufficiently large to produce an antipyretic effect, as from twenty to forty grains per day. It is prescribed by some physicians in two or three large doses per diem, as ten or fifteen grains, and by others in small and frequent doses. That quinia does not exert any special or peculiar action in diphtheria, and is beneficial in the same way, and no further than in other acute infectious diseases, is, I think, generally admitted by the profession; for large doses do not exert that controlling effect which we would expect from a specific.

The internal treatment which I have found most satisfactory for a child of five years is the following:—

R. Quiniae sulphat. ʒss; elix. adjuvantis (Caswell and Hazard's), vel elix. tarax. comp. ʒij. Misce. Give one teaspoonful every two to four hours; and hourly, between, one teaspoonful of the following:—

R. Tinc. ferri chloridi, ʒij; potas. chlorat. ʒij; syr. simpl. ʒiv. Misce.

The tonic effect of the iron is not impaired by the chlorate of potassa, which is added to the mixture, on account of its local action on the inflamed surface.

The citrate of iron and ammonia alone, or in combination with carbonate of ammonia, may be given in two grain doses, dissolved in simple syrup, in place of the above mixture, when the inflammation of the fauces has

considerably abated or is moderate. If the patient improve, and the disease begins to abate, the intervals between the doses may be lengthened, but the tonics should not be entirely discontinued, until the patient is far advanced in recovery, on account of the dangerous sequelae, which take their origin in an impoverished state of the blood.

Local Treatment.—It is important to keep in mind the purpose for which local measures should be employed, as stated above. It is to reduce the inflammation of the mucous surfaces, and destroy the diphtheritic poison, and contagious properties in the pseudo-membrane, and to destroy the septic poison, and prevent its absorption, if any forms. forcible removal of the pseudo-membrane, irritating applications, the use of a sponge or other rough instrument, for making the applications, should be avoided as likely to do harm. The applications should be made either with a large camel's hair pencil, or, better for most of the mixtures employed, with the atomizer. The hand atomizer, like Delano's, which is cheap and of simple construction, while it carries a heavy spray from the curved tube, which is introduced over the tongue, is very useful, but the constant spray of the steam atomizer is more effectual, and is preferable in severe cases.

The following mixtures I am in the habit of using with the atomizer:—

1. *R.* Acid. salicylic. ʒss; glycerinæ, ʒij; aq. calcis, ʒviiij. Misce.

2. Acid. carbolic. gtt. xxxij; glycerinæ, ʒij; aq. calcis, ʒvj. Misce.

3. Acid. carbolic. gtt. xxxij; potas. chlorat. ʒij; glycerinæ, ʒij; aquæ, ʒv. Misce.

Half a dozen to a dozen compressions of the bulb of the hand atomizer cover the surface of the throat more effectually with the liquid than can be done by several applications of the brush, and it is usually not dreaded by the patient. Diminution of size of the pseudo-membrane under the use of the spray is a favourable sign, but if it do not diminish, its presence can do little harm, provided that it is properly disinfected.

In many cases of diphtheritic inflammation of the fauces the spray suffices for local

treatment, but the following mixture, applied by a large camel's hair pencil, is also very effectual, immediately converting the pseudo-membrane into an inert mass, and putting a stop to all movements of the bacteria which swarm in it, as I have observed under the microscope:—

R. Acid. carbolic. gtt. viij; liq. ferri sulphat. ʒij-ij; glycerinæ, ʒj. Misc.

This may be used two or three times daily, between the spraying, or oftener without the spraying. It is not irritating (such an effect would condemn it), but it is dreaded by most children, on account of the unpleasant "puckering" which it produces.

That form of diphtheritic inflammation which most imperatively requires local treatment, and in which local measures are of more importance than the constitutional, is obviously the laryngitis. Catarrhal laryngitis sometimes occurs in diphtheria, as I have had the opportunity to observe in the dead-house, without producing any marked symptoms, but the pseudo-membranous laryngitis of diphtheria is also common, and, as all know, is one of the most dangerous forms of disease.

But those who observe carefully the effects of the spray (lime-water being used in the atomizer, as the most powerful solvent which can be safely employed) must admit that it is the most effectual agent at our command, for treating this very fatal affection.

Even mild cases of diphtheritic laryngitis may end fatally by systemic infection after the obstruction in the larynx is removed as in the above case, in which tracheotomy was performed, although the temperature during the period of the dyspnoea had been constantly under 100°.

Unless in comparatively rare instances, there is only one other diphtheritic inflammation which requires especial treatment, namely, that affecting the Schneiderian membrane. This membrane, in sensitiveness and liability to irritation, is intermediate between the conjunctiva and buccal or faucial membrane, and, therefore, when inflamed it requires milder applications than such as are appropriate for the fauces. Applications suitable for the fauces would, if thrown into the nostrils be,

too painful, and might increase the inflammation. I know no better treatment of the nostrils, than to inject with a small syringe one to two teaspoonfuls of the following mixture every third or fourth hour. It should be used at the temperature of the body, with the head thrown back and the eyes covered with a cloth: Acid. carbolic. gtt. xxiv; glycerinæ, ʒij; aque, ʒvj.—*American Journal of Medical Sciences.*

SALICYLATES IN DIABETES. — Dr. Muller Warnech, of Kiel (*Berlin. Klin. Wochensh.*), has tried the salicylate of soda in two cases of diabetes mellitus, and finds:—

1. That it removes the symptoms, though not always permanently.
2. The symptoms disappear the more rapidly the larger the dose.
3. In moderate doses (9 or 10 grammes daily), its influence soon becomes exhausted, but larger daily doses (14 to 16 grammes) exert an increasing effect on the diabetes.
4. Salicylate of soda can be used without disturbance of the general health for a long time in diabetes. Any symptoms of poisoning at once disappear on stopping the medicine for a time.
5. Salicylate of soda has only a slight irritating effect, even if given for a long time, on the kidneys.

Sebstein, of Gillingen, used it in diabetes in 1876, with great benefit.—*Med. and Surg. Reporter.*

EVACUATION OF PUS FROM THE PLEURA BY INVERSION OF THE BODY.—Dr. Raynaud has tried with success the following method: A girl, fifteen years of age, convalescing from typhoid fever, contracted a purulent pleurisy, and after a time there was pulmonary perforation followed by a considerable vomica. The expectoration was insufficient to empty the liquid contained in the pleura, and in consequence the general condition became constantly worse. Dr. Raynaud then placed the child with her head below the border of the bed, and this manœuvre was followed by an abundant expectoration. This process, repeated several times, emptied the pleura of its purulent contents, and the child rapidly recovered its strength and was soon quite well.—*N. Y. Med. Journal.*

HOW TO EMPLOY MASSAGE.

We select the following from the chapter on Massage in Dr. S. Weir Mitchell's excellent little work on "Fat and Blood, and How to Make Them:"

After a few days' milk diet, with which my treatment ordinarily begins, the masseur or masseuse is set to work. An hour is chosen midway between two meals, and, the patient lying in bed, the manipulator starts at the feet, and gently, but firmly, pinches up the skin, rolling it lightly between his fingers, and going carefully over the whole foot, then the toes are bent and moved about in every direction; and next, with the thumbs and fingers, the little muscles of the foot are kneaded and pinched more largely, and the inter-osseous groups worked at with the finger tips between the bones. At last the whole tissues of the foot are seized with both hands and somewhat firmly rolled about. Next the ankles are dealt with in like fashion, all the crevices between the articulating bones being sought out and kneaded, while the joint is put in every possible position. The leg is next treated, first by surface-pinching, and then by deeper grasping of the areolar tissue, and lastly by industrious and deeper pinching of the large muscular masses, which for this purpose are put in a position of the utmost relaxation. The grasp of the muscles is momentary, and for the large muscles of the calf and thigh both hands act, the one contracting as the other loosens its grip. In treating the firm muscles in front of the leg, the fingers are made to roll the muscle under the cushions of the finger-tips. At brief intervals the manipulator seizes the limb in both hands and lightly runs the grasp upwards, so as to favor the flow of venous blood-currents, and then returns to the kneading of the muscles.

The same process is carried on in every part of the body, and especial care is given to the muscles of the loins and spine, while usually the face is not touched. The belly is first treated by pinching the skin, then by deeply grasping and rolling the muscular walls in the hands, and at last the whole belly is kneaded with the heel of the hand in a succession of rapid deep movements, passing around in the direction of the colon.

It depends very much on the strength, endurance, and practice of the manipulator how much good is done by these manœuvres. At first or for a few sittings they are to be very gentle, but by degrees they may be made more rough, and if the masseur be a good one, it is astonishing how much strength may be used without hurting the patient.

The early treatments should last half an hour and should be increased by degrees to one hour, after which should follow an hour of absolute repose.

After the first few days I like the rubber to keep the part constantly lubricated with cocoa-oil, which is agreeable in odor, and which keeps well, even in warm weather, if a little lime-water be left standing on the top of it. Vaseline is also a good lubricant, and both of these agents make the skin smooth and soft and supple.

As soon as a part has been manipulated it should be at once wrapped up.

In men who are hairy it is often needful to have the limbs shaved, because the constant pull made on the hairs gives rise to very troublesome and painful boils.

The early use of massage is apt in some nervous women to cause increased nervousness, and even loss of sleep; but these symptoms may safely be disregarded, because they pass away in a few days, and very soon the patient begins to find the massage delightfully soothing, and to complain when it is omitted. Women who have a sensitive abdominal surface or ovarian tenderness, have, of course, to be handled with care, but in a few days a practised rubber will by degrees intrude upon the tender regions, and will end by kneading them with all desirable force. The same remarks apply to the spine when it is hurt by a touch, and it is very rare indeed to find persons whose irritable spots can not at last be rubbed and kneaded to their permanent profit.

The daily massage is kept up through at least six weeks, and then, if everything seems to me to be going along well, I direct the rubber to spend half of the hour in exercising the limbs as a preparation for walking. This is done after the Swedish plan, by making movements of flexion and extension, which the patient is taught to resist.

At the seventh week the treatment is used on alternate days, and is commonly laid aside when the patient gets up and begins to move about."
—*Clinic.*

ACONITINE IN CARDIAC DISEASE AND NEURALGIA.

M. Gabler says in the *Journal de Therapeutique*: The cardiac disease was so marked in a young woman with organic disease of the heart after a small dose of aconitine, in my *clientele*, that she prayed to have the medicine stopped. Liegeois and Hottot have already demonstrated in aconitism, paresis of the heart and paralysis, from the action of the alkaloid. Under whatever form we employ it, as the amorphous aconitine, or the crystallized azotate of Duquesnel, it is a medicine difficult to manage, and we should use it with care.

It is better to give it in solution than in granules, as the latter are often inactive, and we are tempted to increase the number, owing to the seeming insensibility of the patient to the medicament. By using the solution, owing to its certain absorption, we avoid the danger of the accumulation of the poison, and we should begin with half a milligramme, progressively increasing the dose if necessary, as some patients bear even six milligrammes. I have never seen any bad results from its employment if it is given with care and in therapeutical doses.

Its disadvantages are nothing compared with its benefits.

In facial neuralgia its practical importance is very great, and it may be looked upon almost as a specific.

In neuralgia of the fifth pair, and even in tic douloureux, I have never known it fail, and I may mention two severe cases of facial neuralgia which yielded completely to the use of the azotate in progressively increasing doses.

The alkaloid is principally recommended in the congestive form of facial neuralgia; its effects are curative when there is no nervous lesion—palliative when the lesion is established. I am of opinion that all neuroses end by giving place to nervous alterations.

Aconitine, when given in the beginning, will completely cure facial neuralgia, and in those cases where the disease is advanced it will immediately afford relief; but unfortunately this action does not extend to other forms of neuralgia.—*Medical and Surgical Reporter.*

Surgery.

THE DIFFICULTIES OF DIAGNOSIS AND PROGNOSIS IN CERTAIN VENE- REAL LESIONS.

BY W. A. HARDAWAY, M. D.,

Member of the American Dermatological Association.

It is commonly esteemed a not very difficult task to determine at first glance the diagnosis and prognosis of the hard and soft venereal sores, and to satisfactorily differentiate the various lesions which most resemble them. But in spite of the rules laid down in the books, an extended experience in this direction has taught me that their proper recognition, in some cases, even after repeated observations, is far from easy. This diagnostic confidence is in a great manner due to the wide-spread acceptance of the dualistic doctrine as it was taught a few years ago, and the dogmatic laws enunciated by that school of syphilographers. As this paper, however, is not intended for the specialist, but for the information and guidance of the general practitioner, I shall not inquire here into the truth or falsity of theories. I wish merely to offer facts in corroboration of the assertion as to the difficulty and uncertainty of diagnosis and prognosis under certain circumstances.

The principal affections that are most apt to give rise to doubt and confusion in the observer's mind are the chancre and chancroid, herpetic eruptions, abrasions, and systemic syphilitic manifestations; but as the central point of inquiry both with the physician and patient is in regard to the question of syphilis, I shall examine the other lesions mainly in reference to the infecting or true chancre. Generally, it is of very little medical importance whether the true character of an ulcer is made out a month earlier or later, as the treatment is, or should be, purely local at first; but as the men who consult a physician on these subjects usually have some knowledge of syphilis, they are naturally extremely solicitous for an opinion. I believe that there are few cases in which an immediate or even proximately immediate opinion can be safely given; but that in by far the majority, from numerous modifying causes and from the present inexact state of our knowledge, it would

be better for the judicious physician to leave the question to be decided by time. How much time is required is to be determined by the varying conditions found upon repeated examinations.

If our patients came to us with clear antecedent histories, with especially typical lesions, and these unaltered in appearance, untouched by caustic, and unirritated in any way, the difficulty in arriving at some definite conclusion would be materially lessened. But as a matter of practical fact the chancre and chancroid, the herpetic eruption, abrasion, etc., of the books, rarely fall under the notice of the medical man; or at any rate the cases are numerous where the aspect of sores is so changed by a variety of causes that the recorded descriptions are more a source of fallacy than instruction. Then again, there are venereal ulcerations in which none of the usual causes of obscurity obtain, but in which no immediate diagnosis is possible. It is these last cases especially which show that there is a great deal to learn and a great deal to unlearn as to the hard and soft sores. To my mind the question of pathology involved is still a very open one.

I am sustained in much that I have already stated by the experience of Mr. Jonathan Hutchinson, who writes* that, "patients will come to you with sores contracted a few days or a week or two before, and will expect you to be able to tell them whether or not, they are likely to have syphilis. Now, there is never anything in the conditions which are either present or absent that will justify the most practised observer in giving any opinion at such a stage. It is very rare indeed that an infecting sore acquires any induration within three weeks of the date of contagion, and more commonly it is a month or five weeks. Until such induration takes place, nobody can tell whether it is coming or not."

In experimental inoculation, whether with pus from the chancroid or with the secretion from the chancre, very constant local results are obtained—the pustule in one and the papule in the other sore—but in the consulting room, as observed by both Vidal and Baeumler, these lesions have no exclusive form, so as to enable one, without other concomitant circumstances,

to pronounce definitely upon their nature. It must be admitted, however, that the ordinary chancroid presents much more constant characteristics than the chancre; for the local contagious ulcer, while itself stimulated by other conditions, never assumes any of the various features of the chancre, while the latter, when suppurating or ulcerating through any cause, may closely imitate the former. There is, however, a condition of the chancroid, mentioned by Hill, and which I have often seen, where syphilitic induration is closely imitated, if the inflammatory action of the simple ulcer has been kept up by repeated cauterizations. But presuming that a sore does present all the classical appearances of a chancroid, are we perfectly safe in assuring our patient that he is secure from constitutional infection? I emphatically say we are not. While I know by an every-day experience that the great majority of chancroids end as they began, a purely local difficulty; yet the instances are not infrequent where soft sores, multiple and auto-inoculable at that, have been followed by general syphilis. This fact no one can successfully deny, and it remains a practical warning to the physician when making his prognosis, whether he holds with the dualist in his theory of "mixed chancre" or believes with the unitist in the ultimate relationship of the two poisons. Mr. Lane, of London, who is evidently a unitist in theory, recently delivered a lecture (*Lancet*, May, 1877) on syphilis before the Harveian Society, and offered some of his extensive experience on this subject, which I shall quote and allow the reader to explain by any theory he may happen to entertain: "I have repeatedly seen suppurating sores, which I have had the opportunity of watching throughout their course, and which have never shown any induration that I could discover, but which have nevertheless been followed by constitutional disease. * * * * * It is unsafe to predict confidently that any venereal ulcer, even a soft sore attended with suppurating bubo, will entail no further consequences. There is a strong probability that an indurated sore will prove infecting, and there is a probability, though not nearly so strong, that a soft suppurating sore will not; but exceptions to

* London *Lancet*, quoted in St. Louis, *Clinical Record*, November, 1875.

both these general rules will be met with, and there really is no absolute proof of the infecting nature of any sore but the fact of infection itself."

Baeumler,* who is a very decided dualist, by the way, states that the local primary manifestations, even when produced by true syphilitic virus, in certain rare cases, recede without general symptoms following. He further declares that, "In another class of no less exceptional cases, probably under the influence of a personal predisposition, there occurs, immediately after the inoculation, a local inflammatory process, with ulceration, as in the *soft chancre*, by means of which the syphilitic poison is, very likely, counteracted in the part affected, and the poison may be thus destroyed. But under certain circumstances, where, notwithstanding this, the syphilitic poison takes, induration will follow later, together with general syphilis."

Great stress is usually placed upon the period of incubation of a sore as determining its character. When one can obtain a truthful statement—a matter of difficulty in itself—from his patient as to the date of last exposure, this is a most important and valuable method of diagnosis. While the infecting chancre generally observes a period of incubation of from two to three weeks, the fact should never be lost sight of that this period may be considerably longer or considerably shorter. The confusion which a very long period of incubation may occasion, I shall refer to subsequently when discussing abrasions. Dr. Hammond gives the circumstantial history of a case, where the period between the exposure and the appearance of an indurated sore was but thirty-six hours. Otis mentions in detail the case of a Confederate surgeon, who amputated the limb of a soldier, the subject of secondary syphilis, and who, during the operation, pricked his finger with a spicula of bone. Evidence of contamination ensued within twenty-four hours, and in due course of time was followed by the usual symptoms. R. W. Taylor has likewise published two cases, wherein the inoculation period was, respectively, twenty-four hours and one week. Rollet, in a patient of his, noted a

period of nine days.* In a patient of mine the period of quiescence appeared to be but seven days, and I have observed several cases where it was within ten days.

The presence or absence of induration is an important factor in differentiation, and Bumstead goes so far as to say that he would not hesitate to regard its absence, at the termination of three weeks, both in the sore itself and in the neighbouring ganglia, an indication that the patient was free from constitutional infection.†

This emphatic statement, agreed to in the main by all the early dualists, is scarcely considered tenable now, even by its author. Every practical observer must have met with case after case, where no induration could be made out in the sore, yet in which syphilis subsequently followed. The dualists of to-day, however, do not consider so much the appearance of the sore as its source. This view of the question was forced upon them by common experience. Thus, Baeumler says, ulcers may occur on the genitals which show a distinct hardness, but which are not followed by syphilis, and for the simple reason that they were not produced by the syphilitic poison; on the other hand, the induration may be very inconsiderable or obscure in local affections which are followed by constitutional syphilis. Clerc met with ten cases of early syphilis, in the course of a couple of years, where he could determine no primary manifestations whatever; but as he also mentions a case where the induration disappeared in twelve days, Berkley Hill thinks it probable that when induration is supposed to be absent, it has simply been unobserved. Enlargement of the lymphatic glands near the point of primary lesion, is far more valuable in a diagnostic point of view than changes in the sore. Fournier found it missing in only three cases out of 265 men, and three out of 223 women. I believe that a certain amount of glandular engorgement follows all of the so-called hard chancres; still it sometimes happens that it is more or less difficult, or even impossible to make out, as, for instance, where the adenitis is slight and the parts are

* These cases are quoted by Otis in the *N. Y. Medical Gazette*, June, 1877.

† On Venereal Diseases.

* Ziemssen's Cyclopadia, Vol. III.

covered with much adipose tissue, and in certain scrofulous conditions which I shall refer to later.

Papular eruptions occasionally indurate on the penis, and if irritated or neglected sometimes ulcerate, thus bearing a strong resemblance to a true chancre. Tough, indurated cicatrices are not uncommon at the entrance of the vagina in uncleanly prostitutes, and when inflamed by filth and inattention imitate the initial manifestation of syphilis very accurately (Hill).

Fibroid gummy deposits, under certain circumstances, put on a very similar appearance to the venereal ulcer.

It is a matter of the greatest difficulty to determine the nature of ulcerations occurring in the female, and often it is only by symptoms external to them that their character can be recognized. Such is the rapidity of the evolution of chancres on the mucous membrane in women, and the difficulty of exploration that we obtain little or no result from the most minute examination (Cullerier). It is likewise no easy task to judge of the character of a concealed chancre—urethral and phimotic—particularly if the history is obscure or especial characteristics lacking. Ulceration, phagedenic or otherwise, may completely mask the induration of a sore, and accidental inflammation may altogether alter in character an accompanying specific adenitis.

Chafings, abrasions and herpetic eruptions give rise to very annoying doubts sometimes, and this arises in great measure from the vicious habit, not alone confined to the laity, of touching every suspicious point with caustic. If untouched in the beginning, these insignificant lesions heal in a few days under the most simple dressing; but the slightest cauterization, especially of herpetic vesicles, I have seen occasion most obstinate and persistent ulcerations, and when thus disguised by officious and useless interference, their real origin remains a question of uncertainty for weeks.

The ever present danger of the syphilitic virus gaining admission through an abrasion should never be forgotten, and it is a duty

which the physician owes to his own reputation to inform his patient, when consulted on that account, of the possibility of such a danger. Under such circumstances, the natural inquiry is as to how long before local symptoms of infection will show themselves. The limits of safety in this respect are very hard to establish, and it is more prudent to defer it to a longer than a shorter period. As remarked before, the incubation stage may be a great deal more or a great deal less than the average. Martin reports the case of a girl confined in the St. Lazare prison, where the period of incubation was seventy-two days; M. Fournier one with an incubation of seventy days; Bumstead one of fifty days.

Then again it must be remembered that in some instances the local expression of infection is so slight as to be practically worthless for diagnosis, and after all we are obliged to wait through the period of second incubation before any opinion can be given.

The only condition of the lymphatic glands at all similar to specific induration with which I am acquainted, is to be found in scrofulous subjects. If an ulcer consequent upon exposure should be coincident with scrofulous engorgement of the ganglia much confusion would be the result, if a clear history were not obtainable. Epithelial growth on the glans penis or vulva, where they are rare, are frequently taken for chancres, and chancres on the lips, where epithelial growths are so often seen, are not infrequently mistakenaken for that form of cancer.

I am aware that I have given but an imperfect account of the various lesions that go to make up the perplexities of diagnosis and prognosis in venereal practice, but I believe that I have enumerated the more important ones. In this paper I have particularly concerned myself with the exceptions to the general rules—those cases in which, owing to many circumstances, no absolute and immediate opinion can be adventured upon; and I think that I have shown that the exceptions are sufficiently numerous to justify the greatest caution in prognosis, even at the hands of the most experienced observers.—*St. Louis Clinical Record.*

TREATMENT OF GLANDULAR SWELLINGS AND ABSCESSSES.—M. Quinart has had excellent success in twelve cases of adenitis, which he has treated in the hospital of Ghent, by means of blisters. He is not content with attacking simple engorgement of the glandular tissue at the outset with a series of blisters, as Nelaton advised, but he employs the same treatment when pus has already formed. He has in this way succeeded in obtaining resolution of suppurating glands, that have contained several ounces of pus. When the suppuration is already advanced, and threatens to perforate the skin, he punctures the sac, not through the spot where the skin is already thinned, but at the most dependent part of the tumour, where the instrument must traverse a larger extent of healthy cellular tissue. When the sac is emptied it is covered, whatever its extent, by a blister which overlaps it on all sides by one or one and a-half inches. On the next day the blister is dressed with mercurial ointment; as soon as the skin begins to cicatrize, a second blister is applied, and so on. By this procedure, M. Quinart has succeeded in curing an abscess that extended from the angle of the jaw to the clavicle, and which contained over ten and a-half ounces of pus. An opening was threatened in the centre of the tumour, where the skin was thinned. The tumour was punctured just above the clavicle, and then entirely covered by a large blister. On the next day the little wound was reopened by means of a stylet, and a quantity of serous pus escaped. On the third day the greater part of the sac was closed; the fluid that accumulated in the most dependent part was reabsorbed, and the patient now presents no mark of his immense abscess, except a small cicatrix above the clavicle.—*Gazette Medicale de Paris. Medical Record.*

THE INTERNAL ADMINISTRATION OF OPIUM FOR THE PHOTOPHOBIA OF SCROFULOUS CHILDREN.—Dr. F. Betz (*Memorabilien*, 7 Heft, 1877) states that the external application of opiates in this affection is impracticable, and that the greater ease and exactitude of carrying

it out would soon cause it to supersede the atropine treatment. It being impossible for us to always keep these cases directly under our charge, the following plan seemed to him the best to be adopted. He begins by ordering 5-6 drops of tincture of opium to children, two or three years of age, just before retiring; older children receiving corresponding doses. Besides this, a compress dipped into cold water, and folded 6-8 times, is bound to the face as to cover the forehead and upper part of the face, extending at the same time well over both eyes. In very severe cases the compress may be dipped into ice-water. At any rate, the opiate is the principal feature, and the dose of this is gradually increased until quiet sleep is secured. Photophobic children are usually quite restless during their sleep, turning and crying out every few minutes. The opiate controls this symptom. The first local sign of improvement is that the children open their eyes earlier in the morning. The action of the opiate is often so prompt that a remarkable improvement is observed after a single administration, and now and then a complete disappearance of photophobia after a few days' treatment. Other local complications often require treatment for a longer time. The great change in the disposition of the heretofore peevish and irritable child shows how much the pain produced by too bright a light affects the entire sensitive nervous system. To guard against relapses, Betz continues the evening dose of opium for a considerable period, and expresses the opinion that the general nutrition is improved thereby.—*Allgemeine Wiener Med. Zeitung*, No. 35, 1877.—*Clinic.*

COAGULATION OF PUS BY FREEZING THE SKIN OVER SUPERFICIAL ABSCESSSES.—M. Obissier, of Bordeaux, states that, on attempting to empty an abscess with the aspirator under local anæsthesia with ether, the operation was arrested by the plugging of the canula with a fatty cylinder. He believed the latter to have been coagulated pus, because two hours latter, without anæsthesia, he was able to extract 200 grammes of pus.—*Gazz. Med. Ital. Venete.*—*N. Y. Med. Journal.*

Midwifery.

THE INVESTIGATION OF THE INTERIOR OF THE UTERUS BY THE CARBOLISED HAND AT LONG INTERVALS AFTER DELIVERY.

BY J. MATTHEWS DUNCAN, M.D., F.R.C.P.E.,

Obstetric Physician to St. Bartholomew's Hospital.

Mrs. A. B. was confined at her home in the south of Scotland on June 5th, 1876. The child born was her second. She was attended by her physician, who lived in the neighbourhood, and to him I owe most of the details now to be given of her case. The labour was easy, natural, and lasted four hours. The placenta was removed without difficulty about fifteen minutes after the birth of the child. The membranes were twisted to ensure their complete withdrawal, and then a dose of ergot was administered. At 9 a.m., all was completed and well. In the evening of the 6th, Mrs. A. B. had a feeling of cold in the back and severe lumbar pain. On the morning of the 7th, her pulse was 120, and at night it was 140, at which rate it continued till after my visit on the 8th. The temperature rose correspondingly, but no note of its height is preserved.

In response to a telegraphic message, I saw the patient on the afternoon of the 8th, eighty hours, or nearly three days and a-half, after her confinement. I found her with every appearance of having an attack of pyæmia or puerperal fever *post partum*. The abdomen was slightly tympanitic, the uterus somewhat tender.

The circumstances of the case, both intrinsic and extrinsic, rendered the crisis extremely alarming and important. The lochial discharge was natural, and reported as having no fetor. Nevertheless, I made a vaginal examination, pushing the finger into the cervix uteri, and hooking away shreds of clot, which were unexpectedly found to be distinctly putrid. A second attempt brought away a small bit of membrane, putrid. Being at a great distance from proper instruments to complete what I regarded as the desirable treatment—namely, the

removal by forceps of any other pieces of membrane or decidua—and time being very valuable, I had chloroform administered, with a view to the introduction of my hand into the vagina and of my fingers into the uterus, to effect the exploration and removal of what might be found that should be taken away. During this, I gradually penetrated farther and farther into the uterus without finding anything. At last my whole hand was inside the organ, which felt not unlike an uterus only recently evacuated. In the fundus of the uterus, it was now my extreme good fortune to find adherent an irregular lacerated patch of chorionic membrane, about four inches long and an inch broad. It was found to be fetid. After this, I left the patient.

Both pulse and temperature fell in a marked manner after this operation. The alarming appearance and symptoms disappeared. The pulse remained high for several days; but the extreme anxiety of the physician and friends was subdued for good.

The fetor of the discharge was recognised by the nurse after my visit, but only at first, or for less than a day.

While, as is well known, there is often insuperable difficulty in classifying cases of so-called puerperal fever under the heads pyæmia, septicæmia, ichoræmia, there can in this instance be no hesitation in designating the disease as simple septicæmia. Such cases are familiar to the gynaecologist. A decomposing uterine fibroid, a decomposing blood-clot in a hæmatocele, produce shiverings, sweatings, vomiting, delirium, high pulse, high temperature: a most alarming combination of symptoms, which, on the removal of their cause, is dissipated with extraordinary rapidity, in a few hours, as if by a charm. Such was the fortunate course of events in the case just narrated; but, had the putrefying membrane continued much longer in a puerperal uterus, a fatal result was probable.

In the case which I have narrated, the greatest care and attention did not secure the complete withdrawal of the membranes. The position of the persistently remaining shred renders it unlikely that any forceps would have reached it and removed it entirely; nor is it

probable that it would have come away in the discharges early enough to allow of the preservation of life, already most seriously threatened. It is under these circumstances that I propose the new operation of investigating the interior of the uterus by the carefully carbolic hand of the accoucheur, with a view to finding and removing decomposing substance. In such a state of matters, I have hitherto used the practice of Baudelocque; namely, antiseptic intra-uterine injections. I employ a double catheter, and I have repeatedly had reason to be satisfied with the results. But, in the cases where I have used this treatment successfully, there has not been washed out by the injections any shred of hidden membrane; and I very much doubt whether injections, in the case which I have narrated, would have produced this supreme result; for, besides the difficulty of directing the current so as to envelope and remove the adherent membrane, there is the absence of any knowledge where the hidden membrane is—absence, perhaps, even of suspicion of its presence.

There is, of course, as yet, no properly formed professional opinion as to the length of time after delivery during which it is possible to introduce the whole hand into the uterus in a natural case; and it is the whole hand that has to be introduced with a view to doing completely the operation I propose.

Some years ago, I was called in consultation by the late Dr. Coldstream, and removed an adherent placenta more than two days after the birth of the child. There had been great flooding. No difficulty was experienced in introducing the hand into the uterus.

The records of midwifery and ordinary experience show that the difficulty arises from uterine spasm, affecting generally the cervix, and especially its internal os, or rather the lowest part of the body of the uterus; and this is naturally expected, for it is the seat of the first obstruction to be overcome. But I am decidedly of opinion that it is not only the first met, but also the chief difficulty. The lowest part of the body of the uterus, or internal os of the cervix, is, in natural and morbid conditions, more difficult of dilatation than the parts of the body of the uterus above it. The history of

natural pregnancy, cases of retained placenta, many cases of hourglass contraction, the dilatation of the unimpregnated uterus by tents, all combine to demonstrate this. Besides, many cases are on record where, long after delivery, as long as twelve or even nineteen days, the body of the uterus was large and dilated by contents, while the cervix was contracted. But the whole subject demands more and deeper study and investigation.

When the cervix is passed by the hand, there may yet be great difficulty; but there will probably be none, unless there is a morbid spasm higher up in the uterus than the internal os of the cervix. On the dilatation of the body of the uterus, I shall offer a few concluding remarks. While there are on record cases in which the hand has been introduced into the uterus several days after delivery, when it contained blood or placenta, there is none in which this operation has been done merely for the discovery and removal of a small piece of membrane, whose size involves no distension of the uterine cavity. That the novel operation, which I performed three days and a-half after delivery, may, with advantage, be done even considerably later, I do not doubt. But at present the whole subject, of the capability of the uterine body to admit the hand at long intervals of time from delivery, is in an unsettled state, and demands the clinical investigation of obstetricians on account of its evident practical importance.

The rapid dilatation of the uterine body many days after delivery is not very rarely illustrated in those cases of simple secondary hæmorrhage, and of secondary hæmorrhage with retained placenta or portion of placenta, when blood rapidly accumulates in the uterus, just as it does immediately after delivery. It is only this rapid dilatation of the uterine cavity that can be used to throw light on the operative procedure which I am in this paper proposing; but it may not be altogether out of place to remark that its slower dilatation, as in pregnancy, in simple hæmatométra, with or without atresia, and in operative procedures, demands careful study, which cannot but result in knowledge that will contribute to the elucidation of this subject.—*British Med. Journal.*

Original Communications.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

INTERMEDIATE V. MEDICAL MATRICULATION.

DEAR SIR,—In a recent issue of the *Kingston Whig*, is an article under the above heading, to which I desire briefly to refer.

The writer refers to the fact, that certain students who had successfully passed what is known as the "Intermediate Examination" of the High Schools had failed in the Medical Council Matriculation examination as conducted by Mr. Wood of Kingston, and he would seem to have the public infer that this result was due in part to the fact that Mr. Wood's examinations were more thorough. I do not altogether concur in such an inference. Of Mr. Wood's competence as an examiner, there can be no two opinions. His standing as a literary man of the highest type is beyond controversy. Nor do I desire to offer the slightest objection to his method of conducting examinations, because I believe him to be, in every respect, equal to the responsibility, and entirely above suspicion, so far as fair and honourable dealing is concerned. But I do think that the intimation that Mr. Wood's method of conducting examinations is so far superior to that of others quite as competent as he, that—the above—mentioned failures have been the consequence—is not susceptible of proof. Any one at all conversant with examinations knows that a student only indifferently acquainted with the various subjects required for matriculation might happen, with one examiner, to get a set of questions with which he was sufficiently familiar to obtain the requisite number of marks to pass him, while with another, such questions might be put as to completely baffle him. This, I think it will be admitted, is an almost every-day occurrence for which no examiner can be held responsible. If a student reaches the requisite percentage in his examination neither Mr. Wood nor anyone else can refuse to pass him. But no one will deny that such a student may have but a very indifferent acquaintance with his subject; and that it would be quite possible to propound questions to him which, while perfectly legitimate and reasonable, might result in his complete

and absolute failure. It is not, therefore, doing justice to the other examiners for the Medical Council, nor to those conducting the Intermediate, to intimate that, because certain students who passed the Intermediate Examinations, failed under Mr. Wood, those who conducted the Intermediate failed to discharge their duty. Nor is it any evidence that the requirements of the Intermediate are any less searching or stringent than the Matriculation Examination demanded by the Council.

It may be fairly questioned whether the Council's interfering with the literary requirements of intending students further than demanding a *bona fide* certificate from any authorized University of their having successfully passed its Matriculation Examination, was a necessary arrangement. I am aware that such legislation was by some considered necessary during the early history of the Medical Council. But I fail to see that in order to avoid such irregularities as prompted this legislation, it was the only remedy. It will be remembered that before the incorporation of the Medical Council, grave irregularities were disclosed as to the manner in which students were permitted to pass their Matriculation Examinations before some of the schools. Moreover, at the time to which we refer, each University possessed the licensing power, and so had the entire control of the education of its medical students, not only as regarded their literary, but also their professional qualifications. Then it was quite possible, if the authorities of any University were lax enough in the control they exercised over the Medical School in affiliation with them, for the managers of such a school to admit students to their professional studies whose preliminary education was of the most indifferent character.

And thus students whose preparatory training was but trifling, and who had no ambition to acquire a higher standard of preliminary education, were attracted to the medical institution where the bugbear of Matriculation offered the least cause for embarrassment. But from the moment the Medical Council had an existence in its present shape, and the licensing power of the Universities was cancelled, any encouragement that may have been offered for such irreg-

ularities as were complained of, was removed. No teaching body could serve any purpose either to itself or any one else by submitting its students to an indifferent matriculation examination; and they certainly would be risking their reputation very seriously, as well as leaving the students insufficiently qualified for the pursuit of their medical studies, so that, if a duly authenticated certificate of matriculation from some authorized University were received by the Medical Council and all students were required to come to the same *medical* standard, all the checks and guarantees that were necessary would have been demanded. This, I think, might have been done. I am quite sure that no University would attach its seal to a certificate of matriculation with the risk that the holder of it might afterwards display such ignorance of the subjects required for matriculation as would compromise that institution.

It may be said that, even yet, if the preparatory education of students were left in the hands of all Universities, it might be made the means by which those Universities having Medical Schools more or less intimately identified with them, could attract a larger number than at present. This objection will, on a little reflection, I think, be found to be purely sentimental. If all students must pass through the same ordeal before obtaining license in medicine, and it be granted that the more thorough preparatory education secures the more complete discipline for the pursuit of professional studies, I apprehend that young men will seek their preliminary education just where they find it can best be attained. More than this, I believe young men will, as a general rule, be attracted just where they can secure the most thorough discipline in their medical studies and no where else.

But what is now proposed, according to the *Kingston Whig*?—After refusing hitherto to accept the matriculation of any of the Universities, we are informed that the Council is *seriously considering* the propriety of accepting the Intermediate Examination as an equivalent for its own matriculation, and that a committee has been appointed to deliberate and report upon the subject at its next annual session.

This, if true, and I am assured it is, does strike me as somewhat extraordinary. Since its inception, the Council has refused most persistently to accept the matriculation of any University. It is now gravely considering the propriety of accepting the Intermediate Examination of the preparatory schools to these Universities, which, to say the most of it, is certainly a no higher standard than that required by any University in this country, and of still ignoring the Universities. And we are informed by some of the advocates of such a measure, in all seriousness, that the High Schools will be more likely than the Universities to act in good faith in the conducting of these matriculation examinations. This, with the most liberal construction, is not paying a very high compliment to the honour and honesty of the authorities of our Canadian Universities. To say that any University would display such an utter disregard of its duties to the students whose education has been entrusted to it as to give its endorsement to a certificate of matriculation unmerited by the holder of it, is a statement which, I honestly believe, is entirely undeserved. I have no hesitation in characterizing such legislation as ill-judged on the part of its promoters; and I do hope that, for the credit of the Council, it will not be entertained for a moment. There is not one substantial reason for the adoption of such a measure. If all students are compelled to submit to the same medical standard, who is to suffer if their preliminary education be insufficient? I apprehend that, if the Medical Council exercises due vigilance as regards the professional training of the students seeking its authority to pursue the practice of medicine, for a period of four years, its responsibility may reasonably be regarded as ending there, and that to the Universities may *safely* be committed the responsibility of directing their preliminary education. If these Universities are entrusted with the matriculation examination, no one of them will run the risk of compromising itself so far as to certify to the qualifications of a man whose ignorance might afterwards reflect discreditably upon the thoroughness of its discipline.

The Council has already established a prece-

dent such as would amply justify the full surrender to the Universities of the right to direct the preliminary education of intending medical students, by accepting, as *bona fide* evidence of general education, their degrees in arts. Has it any more right to doubt the sincerity of the Universities in the matter of matriculation than in that of degrees? I honestly think not; and I should be very glad to see the entire matter of preliminary education left in the hands of the Universities. I would be quite willing to advocate even a higher standard of education than that now required by the Medical Council for matriculation, if such was thought desirable. I have no doubt that the time is not far distant when the higher mental discipline secured by the pursuit of the subjects of general education much farther than what is now demanded, will be regarded as an important desideratum to the more thorough preparation of the student for the effective pursuit of his professional studies. But, in order to meet the circumstances of many worthy young men, I would be satisfied to see the standard of preliminary education put at a *bona fide* matriculation in any recognized University. This would save very considerable expense to the Council, and would, in my judgment, secure all that we have by the present arrangement. On no account, however, should the Council allow itself to be committed to a course which, in the first place, is retrogression, and secondly, is a direct reflection upon the honesty of the several Universities. If it cannot entrust the Universities with this matter, it would be far better to allow it to remain in its present shape.

W.

In a communication to *New Remedies* Wm. T. Plant, Registrar of Syracuse University, states that they subject students to a preliminary examination; their college year is nine months long; they insist upon attendance throughout the entire year of all candidates for the degree; they make a systematic division of studies and insist upon each regular student following the prescribed course. Harvard, Syracuse, and Ann Arbor are the only schools in the States that compel a nine months' course.

Hospital Reports.

(REPORTED BY MR. BURTON.)

CLINICAL LECTURE ON SYCOSIS.

BY DR. J. E. GRAHAM.

James T.—, age 23, single, waggon-maker by trade. Perfectly well in every other respect, cleanly in habits, never had any constitutional disease. Relations healthy. In the fall of 1875, was shaved by a barber, who inflicted a slight wound on lower and outer aspect of right side of chin. Soon afterwards at this spot, little blotches were noticed of whitish-yellow colour, containing pus. These on being opened discharged their contents and scabbed over with a firm, dry, well-marked crust. On dessication taking place the underlying skin was found to be reddened and inflamed. The disease gradually spread over the right side of the face first, then over the front of the chin and upper lip, and lastly, commencing from a fresh nucleus at the upper part of the left cheek, spread downwards to the chin. It attained these dimensions in about a year's time.

In the fall of 1876, had a severe attack of typhoid fever, during which, the disease entirely disappeared, only to return, however, upon the departure of the fever. Admitted into the Toronto General Hospital October, 1877. Both sides of face, upper lip and chin, of a darkish red colour, dotted here and there with small pimples containing pus. Is in excellent health in all other respects.

This, gentlemen, is a case of sycosis menti, or, as it is commonly called, barber's itch.

There are two forms of sycosis, True Sycosis and Sycosis Parasitaria. This is an example of true sycosis. The principal points to be noted are: the location of the disease and the form of the pustules. You see that the eruption covers only that part of the face, usually occupied by a growth of hair, and there are no indications of its presence on other parts of the body. The pustules you perceive are isolated, and if you observe them closely you will distinguish the presence of a hair growing out from the centre of each papule. This is highly characteristic of true sycosis.

At the outset of the disease, tumours appear about the size of millet seeds or larger. These develop into pustules, which dry to sharply-defined scabs. The pustules are pierced by a hair, whose root when withdrawn is found enlarged and saturated with pus. The skin around the pustules is often greatly swollen and œdematous. It is not so in this case, however. Later in the disease the whole bearded skin is full of sharply-defined abscesses of the size of a hazel nut.

The parts generally attacked by true sycosis are, as I have already pointed out, the hairy parts of the face, chin and neck, but it may appear on the parts of the nasal mucous membrane which have hairs. The eyelids and eyebrows, and in rare cases the hairs of the forehead and temples (especially after recent eczema) may be attacked, but the rest of the head is never involved. It has occasionally been observed in the hairs of the genitals of both sexes. Sycosis of the face, however, occurs only in bearded men.

Treatment.—We pull out the hairs or epilate as it is called. You would think that this would destroy the growth of hair, but on the contrary it rather favours it by removing the *materia morbi* which ultimately destroys the hair follicle. The hair should not be pulled out, however, till suppuration has taken place in the pustule. If scabs or scales are present, apply sweet oil, followed by poultices. When they are completely removed and the surface of the skin is brought to view, various applications may be made. In this case I used citrine ointment for some time. Occasionally a stronger treatment is resorted to and a solution of hydrarg. bichlor. gr. ij to ʒvj of water is used; but great care must be taken in its application, as it sometimes causes excessive irritation of the skin. This patient was put under the course at one period, and after using it for a few days in his own home in the country, when the effects could not be watched, he came in to us with his face swollen and painful from the irritation produced by the lotion. He is now taking potass. iodid. and liq. arsenicalis internally, and applying the unguent, diachyli, which consists of equal parts of olive oil and empt. plumbi, externally.

The pathology of the disease is obscure.

Some think that this inflammation begins in the interior of the hair follicle with a consequent suppuration of the same. I hold in my hand a pamphlet written by Dr. Robinson of New York, a fellow graduate of mine, who has devoted himself to the study of dermatology, where he expresses the opinion that the inflammation commences in the tissues surrounding the hair follicle, and only subsequently attacks the follicle itself and the hair contained therein, pus forming around the root of the hair as a consequence.

We are equally in the dark as to the causes of sycosis. The great German dermatologist, Hebra, thinks it possible that the inflammation may be excited within the follicle by the development of a new hair from its base, where the papilla is located before the old hair falls out. Wertheim considers that the disposition to sycosis is explained by the diameter of the hair being too great when compared with that of the hair follicle. Others think that the use of dull razors is the cause. The hair of the beard is stronger and thicker than that of any other part of the body, and when the skin is in an irritable condition, passing a blunt razor over the stiffened hair disturbs their roots and brings on the disease. Hebra, however, has found that sycosis occurs more frequently in those who do not shave. The action of heat and uncleanness are other causes assigned for it, but it has been repeatedly observed, as in the present case, in those who are cleanly in their habits.

We have to diagnose true sycosis principally from three diseases—sycosis parasitaria, eczema, and lupus erythematoses. In sycosis parasitaria, the microscope shows us the parasite and ring-worm is discoverable in other parts of the body. The papules are not so distinct as in true sycosis. The hairs are first affected, which in the true form they do not alter till afterwards; that is, when the exudation into the follicle has become purulent. It makes rapid progress, while the true form may remain stationary for months or years. It is nearly always preceded by herpes tonsurans. In eczema barbæ, or eczema of the face, the pustules are confluent, not distinct, and moreover are not pierced by a hair as in true sycosis; there is itching and great moisture.

In lupus erythematoses there are no pustules.

It occasions a loss of substance. The scales are very adherent, and when removed, present villous prolongations on their under surface, consisting of masses of sebum which are drawn out from the follicles, either alone or together with the walls of the same. Does not confine itself to hairy parts of the face, but attacks chiefly the nose.

COMPOUND FRACTURE OF THE HUMERUS AND OS CALCIS.

[Under the care of DR. AIKINS.]

Thomas G——, aged 19, while officiating as brakeman on the Grand Trunk Railway, in February, 1876, fell down between the tracks, nine cars and a van passing over him. Found to have sustained compound comminuted fracture of the left humerus at the junction of the upper with the middle thirds, and also a severe contused wound of the tissues surrounding the right os calcis, with comminuted fracture of the posterior and inferior half of that bone. The patient believes that the latter injuries were caused by an attempt on his part, while under the cars, to push himself into the centre of the track, the flanges of one or two wheels passing over his heel. Was seen by two practitioners, who decided to amputate at the left shoulder joint, and immediately above the right ankle. Two days after the accident, and prior to the operation, Dr. Aikins being called in consultation, found on examination that the circulatory and nervous supplies of the wounded extremities were in a good state, considering the amount of injury sustained. The pulsations of the brachial and posterior tibial arteries were distinctly felt below the points of fracture. The nerves of the hand though partly paralyzed still responded to irritation, while the grand nerve trunks at the heel were unaffected, the point of injury being below and behind their course. The Dr. gave it as his opinion that the limbs could be saved. They were immediately elevated to a height of eighteen inches respectively, and extension made by means of a weight of nine pounds on the fractured humerus. About a week after the accident, owing to sloughing of the part, the posterior and inferior half of the right os calcis was removed, together

with the injured tissues surrounding it. Linseed poultices were applied to both wounds and hygienic and nutritive measures were adopted. Two months subsequently three pieces of necrosed bone were detached from the injured arm, which speedily regained its normal power, the fingers only continuing a little stiff. About the same time water dressing was substituted for the poultices on the foot, and grafting was repeatedly tried, with tolerable success. The external wound having now nearly closed, the patient was allowed to move about, but on taking liberties with his freedom, the grafts and surrounding tissues ulcerated away. Entered Toronto General Hospital in August, 1876, and was discharged in January of the following year with the wound perfectly healed up. He now went to work, constantly walking about with the help of a stick, but, owing to the chafing produced by the pressure of a shoe on the cicatrix, this again ulcerated, and he was obliged to return to the Toronto General Hospital in September, 1877, where, after a month's rest, the wound is cicatrizing favourably.

DIABETES MELLITUS: OTITIS PYCÆMIA.

BY DR. J. E. GRAHAM.

Robert T——, age 33, married. Was a sober, temperate man till February, 1873, when, owing to heavy domestic afflictions, he began to drink heavily, continuing the same till May, 1874. In November, 1876, had an attack of dyspepsia, and for two or three days his urine was thick, dark coloured and did not flow easily, and then for some days was normal. This was repeated several times. Pain was also present across the lumbar and abdominal regions. The urinary symptoms disappeared speedily, but the pains continued till February of the ensuing year 1877. In May, 1877, had bilious fever and underwent three relapses. During second relapse, his urine began to flow copiously, but this was checked by medicines. About the last of August, 1877, this symptom returned, and has continued ever since. Entered Toronto General Hospital September 19th, 1877. Diagnosed saccharine

diabetes. Quantity of urine passed per 24 hours, about 9 pints. Sp. grav. as voided, 1036. As shown with yeast test, 1005. This gives 31 grains of sugar per oz.

Treatment.—Milk, meat, etc., abstaining from all farinaceous food. Medicines, tonics and liq. opii sed.

Sept. 27th.—Caught cold by sitting in a draught, this brought on slight congestion of the lungs with severe febrile symptoms, and internal otitis on the left side.

Oct. 1st.—Complains of hemicrania on left side, heaviness and dulness.

Amount of urine passed per 24 hours, 13 pints 9 oz; sp. grav., 1032. Tested with yeast, 1006—equal to 26 grs. sugar per oz. R, lactic acid and tinct. chiretta.

Oct. 6th.—Commenced Bethesda water and bran biscuits.

Oct. 10th.—Amount of urine passed per 24 hours, Ovj., $\bar{\text{x}}\text{ij}$.

Oct. 11th.—Abscess in internal ear of left side opened externally, giving relief. Complains of great weakness.

Oct. 15th.—Supply of Bethesda water finished.

Oct. 16th.—Bran biscuits gave out. Immediately on the stoppage of these supplies, the urine was augmented in quantity, Ovj. $\bar{\text{z}}\text{iv}$. per 24 hours.

Oct. 18th.—Fresh supply of Bethesda water.

Oct. 23rd.—Weak. Profuse perspiration. Desquamation of cutaneous epithelium, constituting the condition known as brany skin. Amount of urine, Oxij. $\bar{\text{z}}\text{iv}$. per 24 hours.

Oct. 26th.—Chills. Great pain shooting down from ear to supra orbital region and from mastoid bone to back of head. Twitching and cramps during whole night, with pains in left knee.

Nov. 1st.—Violent pain in left knee.

Nov. 5th.—Comatose, stertorous breathing, feeble pulse.

Nov. 6th.—Died.

Great emaciation. Heart and lungs healthy. Brain healthy, the sulci being very deep. Nothing noticeable found in the liver or kidneys. On examination of the left ear, an abscess was found in the labyrinth, filled with dark-coloured, bad-smelling pus. On opening the

left knee joint, it was found filled with pus. There were no other abscesses.

It would appear that the patient died of pyæmia. The morbid matter having been absorbed from the abscess in the left ear, had set up an inflammation of the knee, accompanied, or rather followed, by profuse suppuration. If pus itself or purulent thrombi had been absorbed from the abscess, they would have been deposited in the form of emboli in the lungs, but the lungs in this case were quite healthy.

SUDDEN UNILATERAL BLINDNESS CURED BY PARACENTESIS.—Dr. Berger mentioned the following case: A woman, 36 years of age, found herself suddenly blind in the left eye one morning. She had long suffered from nervous headache, and had taken a large amount of bromide of potassium. Slight temporary paralytic symptoms had recently manifested themselves in the extremities of the left side. The arteries could be seen upon ophthalmoscopic examination, but the circulation through the veins, distinctly observable in the other eye, could not here be determined; otherwise the veins seemed normal. Local abstractions of blood, residence in a darkened room, and the application of the constant current all failed, and on the fifteenth day paracentesis was performed. Upon the escape of a little fluid, she was immediately able to recognize persons and objects about her. Two days afterward, paracentesis was repeated. The cure was perfect. No cardiac lesion could be discovered. The writer explains the occurrence upon the theory of a vascular spasm. This case seems to resemble very closely the somewhat numerous cases of so-called ischæmia of the retina.—*Schmidt's Jahrbucher*, No. 7, 1877.—*Clinic*.

UNIVERSITY OF PENNSYLVANIA.—It augurs well for the future of medical education that the profession has unmistakably shown its sympathy with those schools which have honestly endeavoured to raise the standard. Contrary to the expectations of the University authorities, the class has not undergone any temporary reduction, and about 140 new students have matriculated for the three years' course.

Translations.

From *Union Medicale du Nord-est.*

ELEMENTARY ADVICE TO MOTHERS & NURSES.

At a meeting of the *Societe Medicale de Reims*, M. Bienfait read a draught of the advice to be given to mothers and nurses by the Society for the Protection of Childhood.

"Nursing.—The duty of a mother is to preserve the life of her infant by suckling it from her own breast, or, if her health will not permit of this, by providing for it a nurse. If it be absolutely impossible to give the child human milk, or if this be insufficient in quantity, it ought to be supplemented by the milk of some animal (cow, goat, &c.), for *milk is the only nourishment suitable for a child* during the early months of life. Animal milk ought to be given under those conditions which render it most like the mother's milk. It should be taken as far as possible from the same animal. It should be given, still warm, soon after it is drawn, unless it be taken fresh, in a glass which has been thoroughly cleansed between the time of milking and that of the meal. It should never be boiled. It should be diluted with slightly sweetened water, warm enough to bring the mixture to the temperature of the body (37 degrees centigrade; 98.4 Fahr.). The dilution should be made at the time of each meal: with one-half water during the first week; one-third water during the three following weeks; one-quarter water afterwards up to the fourth month. Dating from this time it should be given warmed in a water bath, not diluted, but with the addition of a very small quantity of sugar. Glass vessels only should be employed for drinking (feeding) purposes, and they should be scrupulously cleansed after each meal. The remainder of one meal should never be offered to the child again. The hours of feeding ought to be regulated. During the day a meal every two hours is necessary, but an interval of 4 or 5 hours between the two meals from the middle of the night should be reserved for the rest of the nurse. After the sixth month various milk gruels may be given or light paps of cheese farina. About

the end of the first year fat (meat) soups may be taken occasionally whilst still continuing the milk. The child will thus by degrees be prepared for weaning.

"Weaning.—The weaning ought only to be made after the eruption of from 12 to 16 first teeth, taking into account besides the season of the year and the health of the child. Even after weaning, animal milk ought still to enter largely into the diet up to the age of two years at least.

"Toilet.—Each morning, before the first meal, the child should be washed from head to foot, with water rather fresh than hot, and have his linen changed. Where needful, a hair brush and oil should be used every day to prevent the formation of *bouzel*, which is only an injurious crust (dandruff). Washing of the lower part of the body should be repeated as often as it becomes soiled with urine or the stools.

"Clothing.—The clothing will vary so as to protect the child from variations of temperature. The garments should always be large enough to permit of the greatest freedom of movements. The belly-band (binder) should form part of the clothing during the first months.

"Bed.—The mother and child should never sleep in the same bed. The cradle should be scrupulously clean; the air and the light should circulate freely around it; the curtains should be light, and should never be closed except on the side from which currents of air, too great heat of the sun, or that of a fire, might incommode the child.

"Exercise.—During the first days the newly-born should be held in the arms or on the knees for some hours; but, unless in an exceptionally mild temperature, should not be taken out before the fifteenth day. After this first going out it should be carried out every day during the mildest hours. These walks, short at first, should be gradually increased, the prolonged action of a pure air favouring in a high degree the development and health of the child. The day should then be divided between long sleeps and long walks at regular hours. In the intervals the child should be laid upon the floor upon a blanket,

free to move and roll about. He will thus learn to raise himself alone, and to walk when the time comes without running the risks which the use of carriages and wheeled panniers, &c., entails. The midday sleep should be continued up to the age of three years at least.

Medical Requirements.—The child should never be offered the breast of a nurse, other than the mother, unless she has been examined by a physician. Vaccination ought to be done by the age of five months; sooner in cases of smallpox epidemics. The preceding rules will only admit of very rare exceptions; they should not be departed from in any particular without the advice of a physician. Every indisposition of the child lasting over twenty-four hours imperiously demands the attention of a physician."

This instruction was adopted by the Society.

From *Lyon Medical*.

TREATMENT OF SIMPLE ULCER OF THE STOMACH.

BY DR. GALLARD.

In this, as in all diseases, the most important point is rest of the affected organ; but how difficult is this to obtain when the organ diseased is one whose function is indispensable! Absolute rest being impossible we are obliged to content ourselves with comparative rest, and the best means of obtaining this is to give easily assimilable foods in small quantities at a time. Among such foods milk holds the first place. But it is not always tolerated, either because the patient rebels against this aliment—one of the rarest of cases—or because the conditions under which it is administered leave something to be desired. In large cities where the milk is rarely fresh we see it turn very readily in the stomach, and it is rejected in the shape of a cheesy mass. We may obviate this by adding to it a small quantity of the bicarbonate of soda. But the true way of enabling them to retain the milk is the following:—Give milk freshly drawn, not boiled, but simply brought back to its normal temperature by a water-bath, and let it be taken in very small quantity at a time—if necessary a tablespoonful every five minutes. Many persons will thus bear the

ingestion of a considerable quantity of milk, who would not be able to digest it administered in any other way. When pure milk is well borne, when a certain quantity of it can be taken at a time we may add to it oatmeal, farinaceous matters, or biscuits, acting precisely as we would do in weaning a child.

When these porridges themselves are well borne, we may try broth, and the juice of meat in the form of soups, but should return to the milk gruels if the fatty diet is not well borne.

Besides the fat soups, as the patient's digestion becomes still better other foods are found which are more nourishing, these are: the yoke of egg and raw meat grated. The raw meat diet should be begun in small quantity, 10 to 20 grammes (150 to 300 grains) per day and increased gradually. Then at length with extreme caution we may add other articles of food, which must be interrupted and renewed again during a more or less extended period, until it becomes possible for them to eat as other people.

Patients should choose the dark meats grilled or roasted, they should avoid wines and acid fruits,—beer, especially malt beer, may be of service.

When the acidity of the gastric juice is too great, Pougues water should be used, or a few spoonfuls of lime water before meals (Vals and Vichy waters are too alkaline.) To relieve gastric pain and prevent vomiting ice or iced drinks taken in mouthfuls will be found to answer well.

But, beside this rational alimentation, it is necessary to take into account individual idiosyncrasies of the patient, who sometimes will not bear it, whilst he can digest perfectly a very different kind of food—oysters, ham, and smoked tongue, etc.

It is to the diet that we must attribute the greater share in the cure of ulcer of the stomach: therefore it comes first. However, certain remedies may assist it. We have already spoken of Pougues water; the narcotic medicines may also be of use. Opium should be administered in doses of 1 centigramme (0.15 grain) or half a centigramme before meals. M. Gallard largely employs the following formula: Chlorhydrate of morphia 10 centi-

grammes ($1\frac{1}{2}$ grains), distilled cherry-laurel water 5 grammes. Mix. One or two drops on a lump of sugar before meals. The subnitrate of bismuth and prepared chalk may also prove beneficial, by covering the ulcer with a protective film. If there be constipation English magnesia will serve the same end at the same time as it performs the office of the alkali. The nitrate of silver, vaunted by Trousseau, and the perchloride of iron have no curative or appreciable action, and the latter remedy may give rise to acute pain. As for external agents, cauteries, moxas, etc., although their indication appears rational, they possess no efficacy. This is not true of flying blisters, which have often allayed the pain and arrested vomiting. Tepid baths may also be useful when there is febrile action. As for the convalescence, it does not differ from that of other diseases. Tonics, reconstituants, sulphurous or saline baths, hydrotherapy, etc., may be advantageously employed. *Abeille Medicale*, 10th Sept., 1877.

From *Lyon Medical*.

ON DILATATION OF THE URETHRA BY THE URINE ITSELF.

This process of dilatation, which M. Berenger Ferand seeks to bring again into fashion, originated with Brunninghausen, who made it known at the end of the last century. Here is the *modus faciendi* as it is described in the *Bibliothèque Germanique Medico-Chirurgicale*:—"Bunninghausen has discovered a method, easier, more convenient, and simpler than that by bougies, and he recommends practitioners to give it a trial; it consists in dilating the urethra by the urine itself. For this purpose it is necessary for the patient each time he wishes to micturate to lightly compress the urethral canal with the fingers behind the glans. Supposing that constriction be near the neck of the canal, as often happens, the pressure ought to be sufficiently strong to prevent the urine escaping except with difficulty and after having sojourned some time in the canal, which, by this means, will be found more or less dilated throughout its whole length, and consequently at the strictured spot. The patient taking care to repeat this operation every

time he is obliged to micturate, he will obtain, little by little, by this means, the same effect as would be expected from the use of bougies, without experiencing any of the inconveniences of these latter." To the facts cited by Brunninghausen, M. Berenger Ferand adds several gathered from his own practice, and relating to old men affected with prostatic engorgement with difficult micturition. The following are the terms in which the physician in chief of the navy expresses himself upon the object and bearing of Brunninghausen's proceeding:—

1st. Dilatation of the urethra by the urine being repeated at each urination, and for a long time after an attack of blennorrhagia of a certain duration, appears to me to be, judging from the facts which have come under my observation, a prophylactic means against urethral strictures.

2nd. In cases of stricture not far advanced it appears to me, as Brunninghausen has stated, to have re-established the urethral calibre if not in its normal proportions, at least sufficient for a reasonably easy micturition.

3rd. After operations of urethrotomy it is perhaps a useful means of preventing, or at least of notably retarding the return of, the coarctation which is too often reproduced with disheartening obstinacy.

4th. In cases of prostatic varices of the neck of the bladder, and of the membranous portion of the urethra, it appears to me also calculated to be of service.

5th. There is another category of cases which do well under dilatation of the canal by the urine itself: it is those in which a partial or total hypertrophy of the prostate deforms more or less the neck of the bladder and the corresponding portion of the canal, cases which are often enough met with in old men. It happens in individuals who are thus affected that the first drops of urine, which they emit with so much difficulty and delay, act efficiently in filling the canal when the meatus is compressed. This canal once re-established in its ordinary calibre, then easily gives passage to the remainder of the contents of the bladder. The proceeding which we have just considered has then the happy effect of only allowing the difficulty of emission to exist for the first drops,

whilst if it be not employed the old man is condemned to a difficult micturition throughout the whole act, a micturition, moreover, which is accomplished intermittently, the effect of which is the soiling of the clothes, whilst the incomplete emptying of the bladder gives rise to spurious desires to urinate, which, returning and disappearing unseasonably, end in being at once a source of moral torment and a very disagreeable physical infirmity.—*Bullet. de Ther. et Chir.*

OIL AND EXTRACT OF COD'S LIVER.

There is a point in the history of cod liver oil to which the attention of our readers may be profitably turned. Are the numerous analyses of this complex substance sufficient to clearly define its active elements and to give a theory of its mode of action? At first the fatty part, as respiratory aliment, was considered to be the curative principle. Different fatty substances have been substituted for cod-liver oil, and although not altogether inert, they have always proved inferior to it. Then part of the good effects was attributed to the chlorine, bromine, iodine, and phosphorus, but their presence in the oil is in homoeopathic quantities, and attempts to substitute iodized, phosphorized, bromiodized oils or iodine butter for cod-liver oil have not been followed by satisfactory therapeutical results. A Russian professor twenty years ago originated the idea that the pre-eminently active principle of cod-liver oil was the volatile principle (isolated later in 1850 by Wertheim, and called by him propylamin), to which this oil owes its odour and taste *sui generis*, characteristic of this product. According to the opinion of Dr. Kalenickzenko, an opinion shared by a goodly number of physicians, cod-liver oil, brown and not purified, is of all kinds the most active. It is three times more active than others, and consequently can be given in one-third of the dose. He holds that its superiority is due to the elements of bile and the aromatic volatile principle contained in it. Propylamin diminishes intra-organic combustion, lowers the quantity of urea, exercises a sedative action on the nervous system, and manifestly alleviates neuralgic and rheumatic pains. M. Meynet of Paris, after careful ex-

periments, concludes that the extract obtained by concentrating the water from cod's livers by special processes is like in composition to non-purified brown oil; that it is even superior to it, in view of the proportion of its active elements, and consequently that it ought to produce the same therapeutical effects as cod-liver oil. This extract of cod's liver of M. Meynet contains more than half its weight of gaduine, (the fatty portions, intimately united with the glycogenic matter), the soluble principles of bile, a proportion relatively enormous of the metalloids—chlorine, bromine, iodine—phosphoric acid, lime, soda, azotized and ammoniacal substances, and finally propylamin. The odour and taste of this extract are still more detestable than those of cod-liver oil, and renders its administration as such impossible. But given in the form of coated pills (*pillules dragéifiées*), that is, sufficiently covered with gum and sugar, it is readily taken and very easily digested.

In France several physicians have tested this new product, and have obtained satisfactory therapeutic results from its use. These pills of Meynet should not be confounded with capsules, or pills saponified or not, containing but an insignificant and inert quantity of cod-liver oil. — *Revue de Therap. Medico-Chirurg.* — *L'Union Médicale du Canada.*

From *Lyon Medical.*

ON ARSENIC IN THE TREATMENT OF MALIGNANT LYMPHOMA.

BY DR. WINIWARTER.

In 1871 Prof. Bilroth published a case of multiple lymphoma rapidly cured by Fowler's solution internally. Since that time similar cases have multiplied, and in fact it is easy to demonstrate the happy effects of arsenic in these cases of lymphomata which have grown serious either on account of the size or the number of the tumours, and when we are no longer permitted to think of ablation of the diseased glands. Even when operation is possible there is an indication to have recourse to the arsenic in order to prevent extension of the disease to the neighbouring glands.

The arsenic is given internally, and it is at the same time administered outwardly by parenchymatous injections. Internally, they

begin with five drops of Fowler's solution combined with five drops of tincture of iron, administered morning and evening during a meal; it is afterwards increased by one drop every two or three days until the appearance of toxic symptoms; it is not then necessary to suspend the treatment, but merely to diminish the dose by one drop every two days. Usually the toxic phenomena are manifested on reaching 25 or 30 drops per day. Sometimes, however, you can reach 40 drops without accident, but you must stop there.

In the parenchymatous injections Fowler's solution is employed pure, of which only a few drops are injected in the one spot. Two or three injections a day may be thus made if there be no local irritation. If the injected parts inflame, the inflammation may be reduced by hot applications, as may also neuralgic pains if they appear after an injection. It is important to throw the injection into the glandular parenchyma without invading the subcutaneous connective tissue which would produce sudden and severe pain. Children bear the arsenic better than adults. Sometimes the treatment occasions agitation and insomnia and some excitement of the nervous system; all that disappears as soon as the doses are diminished. Generally, but not always, there occurs a little remittent or intermittent fever. This fever occurs about an hour after the injection; during its duration, the tumour always diminishes in size, and the fever only occurs in cases in which the tumour diminishes, it is simply a fever of absorption. There is often a little point of necrosis at the exact spot of the injection, the gland nevertheless undergoes neither suppuration nor caseation; it is probable then that the arsenic in circulation acts upon the lymphatic cells in such a way as to render them reabsorbable. Good diet and an alcoholic regimen ought to be adopted concurrently with the arsenic as a set-off to its alterative action.

We observe a very similar article in the *Gazzetta Medica Italiana* for 29th Sept., 1877, page 330. (Trans.)

At a meeting of the *Société des Sciences Médicales de Lyon*, M. Bouzol showed a patient 53 years of age affected with chorea for nine months.

From *La France Médicale*.

THE GASES OF THE STOMACH AND BOWELS AND OF FLATULENT DYSPEPSIA.

At the session of the *Académie de Médecine* on 9th Oct., M. Leven read a paper bearing this title; we append his conclusions:—"To recapitulate, alimentary substances do not appear to produce the gases, those that are found in the digestive tube come from the outer air, the blood, and the fecal matters. The gases which are produced in flatulent dyspepsia are not due to decomposition of the food, but arise from the three just mentioned sources, they are continually set in motion by the pathological contractions of the muscular fibres of the bowel, and expelled by the mouth; they are continually reproduced; their production may be incessant, as well in a fasting individual as in one who has eaten.

"This symptom, formation of gas, signifies then an irritation of the bowel which is always consecutive to a stomachal dyspepsia of long standing.

"The course of the disease, and the treatment to be followed for its removal, confirm these facts of clinical observation. There is no need to seek for a remedy against the gas; in fact, the powders which are called absorbent, such as carbon, do not absorb the gas, a fact which I have verified experimentally. Although carbon *en bloc* absorbs gases, as soon as it is reduced to powder it has lost all absorbent property."

IODOFORM.

M. Cuffer in *La France Médicale* speaks highly of the therapeutic effects of iodoform as an external application. He states that although no very appreciable benefit has followed its internal administration, its topical influence is very evident. Iodoform has a double action—anaesthetic and cicatrizing. Its anaesthetic properties render it useful in anal fissures, hemorrhoids, ulcerations of the throat and ulcerated cancers, especially those of the face, mouth, breast, and cervix uteri. It is necessary to use the remedy in fine powder and to apply it carefully to all the diseased surface. The simplest way to obtain it in fine powder is to dissolve it in ether and allow the latter to

evaporate. In using it for hæmorrhoids it should be made into suppositories. It can be applied without danger in considerable doses, no bad effects having resulted from its use.

Its cicatrizing action is astonishing in its rapidity. Soft chancres, ulcerated buboes, mucous patches, and syphilitic ulcers of any kind, yield to it. Phagedenic ulcers are often arrested in their course, and onychia are cured in a few days. Scrofulous sores, lupus and epithelioma of the lip have shown remarkable amelioration after its application. Inflammatory symptoms disappear, and exuberant granulations lose their unhealthy aspect, the progress made towards cure in a single day following the use of iodoform being often astonishing. Its penetrating odour is a great objection to its use, but nothing that has been tried as a substitute has given corresponding results. Its application requires certain precautions. The first, is to apply it after thoroughly cleansing the wound. This may be done with the spray of warm water. Then the powder is applied and the wound covered with lint, the dressing being changed daily or twice a day at first, the intervals being gradually lengthened as the cicatrization progresses. It may be applied to the throat, or to the neck of the uterus by dissolving it in ether and using the spray apparatus. (Tannin is said to disguise the smell of iodoform.)

From *L'Union Medicale*.

THE SALICYLATE OF SODA IN ARTICULAR RHEUMATISM.

During a discussion upon salicylic acid and the salicylates at the *Academie de Medecine* on the 24th July, M. Jaccoud related the particulars of 21 cases under his own observation treated by these remedies. The conclusions at which he arrives are as follows:—

1. In acute febrile articular rheumatism, without complication, the salicylate of soda, in doses of 8 to 12 grammes per 24 hours, is the most powerful therapeutic means that we possess to-day: it cures more rapidly than any other.

2. Although its action may sometimes be prompt enough to bring about a cure in an interval of from 2 to 4 days, it is not possible

to assign to the treatment a duration of 3 days. It would, indeed, be imprudent to do so, for the deceptions (failures) which would certainly follow the adoption of such a rule would have the effect of compromising a remedy, which, in suitable cases, is worthy of complete confidence.

3. The salicylate of soda does not prevent the cardiac, pulmonary, and cerebral complications of acute rheumatism.

4. When these complications exist before the employment of the remedy, it has no effect upon them.

5. In spite of its antipyretic properties, the salicylate of soda does not prevent the thermometric rise which reveals the development of visceral complications in the course of the treatment which is being employed.

6. In febrile rheumatism with slight complications, we may still employ the salicylate of soda in order to profit by its antipyretic and analgesic effects, but it is desirable, in order not to compromise the remedy, to supplement this treatment by the use of revulsives, and sometimes of stimulants.

7. In febrile rheumatism with serious complications, reliance cannot be placed on the salicylate of soda, and it is important to have recourse to other remedies.

From *Lyon Medical*

RESEARCHES UPON THE TEMPERATURE OF SARCOMATA.

Prof. S. A. Estlander (of Helsingfors) has in six cases measured the temperature of sarcomatous tumours of rapid growth. In these six cases he found that it was notably higher than on the corresponding regions of the sound side (from 0·8 to 1·5 degree of Celsius). The author took care to observe those cases only in which there were no inflammatory phenomena, and in which the skin was healthy. This heat of sarcomatous masses, a heat which, being greater than that of the arterial blood, cannot be attributed to superactivity of circulation, is probably connected, says our author, with the rapid development of the elements of the tumour. At all events, it seems that for the present we may admit that every tumour which presents an elevated temperature is in reality a sarcoma.—*Nordiskt Medicinskt Arkiv*.

PAIN IN THE PNEUMOGASTRIC NERVES AS A
SIGN OF BRONCHIAL ADENOPATHY IN
PULMONARY PHTHISIS.

M. Michel Peter in a communication to the Clinical Society of Paris draws attention to the fact that in pulmonary phtthisis, pain in the pneumogastric is a sign that the bronchial glands are affected. Pressure in the neck at the outer side of the carotid causes acute pain on the side affected or on both sides if both lungs are involved. Pain in chest on the side affected is complained of, and the epigastric region is tender on pressure. A clinging, violent, laryngeal cough, gastralgia, vomiting and distressing palpitations also point to irritation and inflammation of the pneumogastric by the pressure of enlarged bronchial glands. In a case referred in which the diagnosis of adenopathy of the right bronchial glands was fully confirmed by *post-mortem* appearances, great relief was derived from the hypodermic injection of morphia in the epigastric region morning and evening. Every distressing symptom was relieved, but the pulse was not reduced in frequency.—*La France Medicale*.

From *La Andalusia Medica*.

CRYSTALS OF GLYCERINE.

We were not hitherto aware that glycerine could assume the crystalline form. Mr. Van Hamel Roos has presented to the Chemical Society of London a magnificent sample of crystallized glycerine. This product possesses the advantage of serving to distinguish pure glycerine, since it has been found that, when it is pure and anhydrous, it crystallizes naturally when it is cooled to 26° if a crystal of glycerine be introduced into it. The crystal increases in size, and the impurities remain in the mother liquid.

Dr. Brown's Chlorodyne contains 5 parts of concentrated muriatic acid, and 10 parts each of ether, chloroform, tincture of cannabis indica, and tincture of capsicum, 2 parts each of morphia and hydrocyanic acid, 1 part oil of peppermint, 50 parts simple syrup, and 3 parts each of tincture of hyoscyamus and tincture of aconite.

Formularies.

TREATMENT OF PROLAPSUS ANI.

Foucher and Dolbeau recommend subcutaneous injections of the following to facilitate the reduction of the prolapsed mucous membrane :—

℞ Water..... 100 grammes.
Sulphate of Atropine 0.50 centigramme.

Dr. De Saint Germain recommends douching the parts night and morning for twenty or thirty days after reduction. The evaporation of ether sometimes facilitates the reduction. Bouchardat uses the following suppositories.—

1. ℞ Powdered rhatany 2 grammes.
Cocoa butter..... 18 “
2. ℞ Powdered oak bark 20 “
Honey..... 9.5 “
3. ℞ Tannin..... 1 “
Cocoa butter..... 10 “

For prolapsus ani accompanied by relaxation of the sphincter, Schwarz prescribed as follows :—

Water..... 8 grammes.
Nux vomica..... 0.05 centigr.

Two to fifteen drops of this solution to be taken every four hours according to age. Duchaussoy employed 0.05 centigrammes of strychnia endermically, on a small blistered surface. Lorigiola uses hypodermically the following :—

℞ Strychnia sulphat. 0.12 centigr.
Aq. destillat. 12 grammes.

Four to twenty drops to be injected according to age.

Langenbeck recommends ergotine hypodermically.

Boudin prescribes—

℞ Ergot..... 1.50 centigr.
Water..... 50 grammes

To be taken in three doses.

Ergot has also been used as an injection.

Boyer & Duchenne advise electrization of the sphincter; cauterization, ligature, excision, partial or total, radiating incision and stretching of the sphincter, have all been recommended.—*La France Medicale*.

POMADE FOR PITYRIASIS CAPITIS.

M. Vidal regarding pityriasis as due to the predominance of the sudoriparous over the sebaceous glands, believes that the first indication is to supply the deficiencies of the latter. With this view he uses pomades composed purely of vegetable oils, regarding animal oils as often too irritant.

He prescribes usually—

Coco^s butter 10 parts.
Castor oil..... 50 “
Oil Bergamotq.s.

—*Lyon Medical.*

From *L'Union Medicale.*

ANTIPRURITIC LOTIONS—DELIJOUX.

Borate of Soda..... 8 grammes.
Distilled Water 100 “

Dissolve.

Or, Borax..... 10 grammes.
Glycerine 20 “
Distilled Water.. 80 “

Dissolve.

This lotion is recommended in pruritus, ephelides, pityriasis, and other herpetic manifestations.

From *L'Union Medicale.*

ANTIDYSENTERIC CLYSTER—V. D'ARLON.

Sulphate of Alum and Potash 8 to 12 grammes.
(120 to 180 grains.)
Extract of Valerian 4 grammes.
(60 grains.)

Laudanum of Sydenham,
(Vin. Opii.)..... 1 gramme.
Starch 30 grammes.
(450 grains.)
Decoction of Marsh Mallow.. 500 grammes. Mix.

This quantity is enough for two injections to be taken in the 24 hours in cases of dysentery.

FOR DYSENTERY.

R Bismuth Subnit..... ½ ounce.
Salicylic Acid 6 grains.
Carbolic “ 3 drops.
Laudanum, (Sydenham's).. 1 drachm.
Tinct. Belladonn 1 “
Aqua 1 pint.

M.

Inject one ounce with baby syringe after each evacuation.

UTERINE NEURALGIA.

R Tinct. Aconit. Rad ʒiiss.
Ammon. Chlorid ʒii.
Ammon. Iod ʒi.
Tinct. Card. Co ʒi.
Syr. Aurant ʒiv.
Aq. Anisi.....ad ʒviii.

M.

Sig., one drachm every four hours.

SALICYLIC ACID MIXTURE—CASSAN.

Salicylic Acid 4 grammes.
Citrate of Ammonia.... 2 “
Rum or Cognac..... 30 “
Distilled Water 154 “

This solution contains about 25 to 30 centigrammes of salicylic acid per tablespoonful. The citrate of ammonia enables the salicylic acid to be dissolved in a smaller quantity of brandy.

VARNISH FOR BURNS.

R Common Varnish..... } 10 parts.
(1 part litharge to 25 parts of linseed oil.)
Salicylic Acid 2 parts.

—*L'Union Medicale.*

A case of axillary aneurism cured by pressure on the subclavian, by means of a shot-bag, is reported in the *New York Medical Journal* by Dr. B. A. Watson.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS, KINGSTON.—The dinner of the Students and Faculty of this institution took place last month, was well attended, and very successful. We understand that the number of students this session is large.

PARRISH HALL.—A private Medical Home for Opium *habitues* has been opened in Brooklyn, N.Y. The system pursued is the immediate reduction of the quantity of opium consumed to that amount which will suffice without suffering, and thenceforward its gradual decrease. Therapeutical and dietetic measures to suit the indications are used. Drs. J. B. Mattison and A. M. Mathias are Superintendents; Dr. Parrish, Consultor.

THE CANADIAN
Journal of Medical Science,

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by sending their addresses to the corresponding editor.*

TORONTO, DECEMBER, 1877.

CLINICAL AND PATHOLOGICAL INSTRUCTION AT THE TORONTO GENERAL HOSPITAL.

To the two hundred students sent, by the two medical schools in Toronto, for clinical instruction and the acquirement of an acquaintance with pathology and morbid anatomy, to the Toronto General Hospital, it is a matter of vital importance that the facilities and opportunities afforded by that institution should be utilized to the utmost.

In view of the fact that the hospital contains from 150 to 200 beds, and that for the most part these are continually filled, it must be apparent that the materials presented for clinical study are, in point of numbers, up to the average.

Moreover, taking into consideration the manifest desire on the part of the trustees to further, by every means in their power, the interests alike of patients and students, and the expense they have already incurred since their tenure of office to promote the same, it would occur to one, as a natural sequence of these two conditions, that the advantages for clinical and pathological instruction presented by the hospital, would be superior, if not unusual. Such, however, is not the case; and the reason is not far to seek. One stumbles across it on the very threshold of the inquiry; it lies at the door of the instructors and their system.

At present, we believe, the clinical instruction at the hospital consists in examining before the class on four or five days in the week any out-patients that may be in attendance, making a

few remarks upon the signs and symptoms as elicited by the lecturer's examination, and dictating a prescription. Then follows a didactic lecture, by courtesy called clinical because delivered in the presence of the (bedridden) patient, and afterwards a perambulation through the wards. This state of affairs is so well described and its utter uselessness so clearly pointed out by one of the greatest of British clinical teachers that we cannot refrain from quoting his remarks. Dr. Murchison, lately appointed Special Lecturer on Clinical Medicine at St. Thomas's Hospital, in his inaugural address from the newly-constituted chair, is reported to have said: "Until a few years ago there was no teaching in any of our British Medical Schools which deserved the name of clinical; and, if I am rightly informed, there are still many medical schools where the sole clinical instruction consists in the delivery by the physicians and surgeons of an occasional systematic lecture upon some disease, with one of the hospital patients, whom the majority of the audience may never have seen, to serve as a text; while the student is left to pick up what practical knowledge of disease he can in walking the wards, and these, if he be idly disposed, he may rarely, if ever, enter. At the best, the ward visit usually consists in the dictation of notes by the physician or in his calling attention to certain physical signs or symptoms in a case which by many students are unheeded, and by none are connected with the entire clinical history of the case. But medical students, in order to learn their work, must not only see the patients as they pass their beds, but handle them, question them, and use all their senses in finding out their symptoms for themselves. * * * To obtain a practical knowledge of disease and its treatment, the student must watch it in its various phases; he must learn to exercise every sense which he possesses—his eyes, ears, fingers, and even his nose—in its study; he must note the endless varieties which the same disease presents in different patients, and which he will find recorded in no other book than that of nature, and he must endeavour to discover the natural course of each disease, and how far this appears to be modified by treatment."

Before proceeding to show how this eminent clinician carries out his plan of clinical instruction, we desire to admit two exceptions to the general charge of inadequate clinical instruction at the Toronto General Hospital. The first refers to the case of clinical clerks, who, of course, have access to the wards at other than the visiting hours, and enjoy the inestimable privilege of personal manipulation and interrogation of the cases. But these do not constitute a tithe of the students in attendance; and even in their case the want of personal supervision and instruction is lamentably apparent in the character of the reports of cases and the hospital records. The second applies to one of the teachers, who, we understand, conducts a private class for clinical instruction, but this is a matter of individual enterprise, and has nothing whatever to do with the systematic clinical instruction at the hospital.

We may now proceed to describe Dr. Murchison's method of clinical teaching, as a model which our clinicians would do well to copy, and in doing so we make use of his own words: "The plan, then, which we follow in the wards is this: those students who wish to take part in the clinical examinations are invited to give in their names to me, and each student so doing is examined in turn. At one time he is called upon to examine a patient who has just been admitted into the hospital. He is taught the art of eliciting by cross-examination a true account of the patient's previous medical history; he is taught never to stop short at what appears to be the first and most obvious conclusion as to the nature of the case, but to note the morbid phenomena in each physiological system of the body, the normal or abnormal physical conditions of the different internal organs, and the chemical and other changes in the various secretions. Having done all this, he is called upon to make a diagnosis of the malady, and a prognosis as to its probable cause; to suggest a line of treatment, and, if necessary, to write a prescription. At another time, he is questioned with regard to patients who have been already under observation, and whom he has seen examined at a previous visit. He is called upon briefly to recapitulate the facts made out at the former examinations, to note the changes

which have taken place since the patient's admission, to reconsider when necessary the original diagnosis, to state the remedies which were prescribed, to note whether the results expected from these remedies have been produced, and to suggest the expediency of maintaining or altering the treatment." In the course of every examination many opportunities present themselves to the physician for making clinical remarks. "By the plan which I have described, those students, who were not present at the original examination of the patient, are put in possession of the principal facts of the case, and the attention of the whole class is secured, as no student can be certain that he may not on a future occasion be called upon to undergo a similar examination upon the same case. Moreover, this plan teaches the student the art, so often wanting in medical men who may yet have a thorough knowledge of their profession, of conveying to a professional brother an accurate, and yet concise, statement of a patient's medical history, and present condition." * * * * "The student who comes forward, in the manner I have described, before the whole class, is not only taught himself, but he himself becomes a clinical teacher. His difficulties, his suggestions, and even his mistakes, become the means of teaching the rest of the class. The blunders you make show you how to avoid them for the future, and in the meantime furnish me with a capital opportunity for clinical remarks. You are to bear in mind that the best and most experienced physicians are constantly making mistakes in examining patients and in the diagnosis of their diseases."

To the objection often urged that patients come into the hospital to be cured, and will not willingly submit to the annoyance of repeated examinations at the hands of students, Dr. Murchison replies: "This objection would certainly be a very serious one if it had any real foundation, but I do not believe that it has. Most patients have the sense to see that their maladies, by the plan we follow, are being sifted to the bottom in a manner they could never hope for out of the hospital; and, instead, it has repeatedly happened that patients who have not been examined by the clinical class, although receiving all the care and attention of

ordinary hospital patients, have considered themselves neglected."

This, then, is the true way of imparting clinical instruction, and it has infinite advantages over the old plan at first described. But while we would have this done, we would not have the other left undone; for it, too, may have its uses, and we would have it made subsidiary or supplementary to the teaching in the wards. These didactic semi-clinical lectures in the theatre may thus be utilized, as suggested by Dr. Murchison, for exegetical purposes, and the lengthy elucidation of difficult cases; for placing concisely before the class "the prominent features of a number of different patients," and dwelling "particularly on the diagnosis and treatment of the diseases of which they are the subjects," and reiterating time and again "line upon line, and precept upon precept." These lectures may be also useful as affording an opportunity for discussing the prognosis "which in many cases it would not be expedient to do in the presence of the patient." Moreover, "they afford an occasion for considering the mode of termination of the maladies from which our patients suffer, for reviewing their clinical history after they have recovered, and for determining in fatal cases how far the lesions found on *post-mortem* examination harmonize, or are at variance, with the observations made during life." Lastly, they enable the clinical teacher to point out "the various morbid conditions which may give rise to the same prominent symptom (headache, dyspnoea, convulsions, jaundice, dropsy, hæmoptysis, albuminuria, the typhoid state, &c. &c.) and the means of determining the particular cause in each case."

Of course all this involves a greater expenditure of time and labour and care on the part of the teacher, yet we are persuaded that no one possessing a due sense of the responsibility of his office in educating the embryo physicians of the future, and a sincere love of his profession, will grudge the extra effort entailed upon himself; and for those whose thoughts are only selfish, if any such there be, it may be added that no man can teach another and fail to learn himself.

Having seen in what way the clinical instruction at the hospital is defective, and how it may

be remedied, let us now take a glance at the conditions surrounding the study of morbid anatomy and pathology. Here, too, the medical officers, and not the institution, are chargeable with dereliction of duty as imparters of knowledge, and neglect of opportunities for self-improvement and the instruction of others. In the first place, we are informed on credible authority, the death-rate of the hospital is up to the average, and it is a matter of personal observation that three or four *cadavera* may occasionally be seen synchronously occupying the mortuary, yet it appears that a necropsy is the exception and not the rule. Even if it be granted that those under whose care the patients may have died are so familiar with morbid appearances and pathological processes that the impressions made upon their physical and mental eye do not need refreshing by occasional (not to say constant) inspections; even if their diagnostic acumen so astute as to render superfluous any elucidation of a case by *post-mortem* examination (an opinion of their own abilities and the perfection of medical science not entertained by the distinguished pathologists of the Old World), yet a recollection of the fact that the fleeting moments of the short probationary period of the pupils whom they have undertaken to instruct, will be, for the majority of them, the only season and opportunity of learning to recognize the anatomical changes and morbid appearances effected by the ravages of disease, should at once remind them that the neglect of golden opportunities of imparting knowledge is attended with a terrible responsibility. Besides the fact that the study of morbid anatomy is too much neglected, there remains another crying evil incident to slovenly and incomplete examination in the few autopsies which are made. Speaking from personal observation, we may say that in an occasional experience of the mortuary work of this hospital extending over some years, we do not remember ever to have witnessed a complete and thorough *post-mortem* examination (even in cases of coroner's quest). The absolute necessity of a thorough examination of all systems, organs and tissues (macroscopical and if possible microscopical and chemical) before arriving at a definite conclusion in any case has been of late so strongly insisted upon by all pathologists

(of whose opinions on this subject Virchow's little book on "Post-mortem examinations" is an admirable exponent) that the careless and perfunctory performance of a *sectio* has justly come to be regarded as a waste of good material which might have served a better office in the dissecting-room. With reference to Virchow's little work on "Post-mortem Examinations," mentioned above, we may say, in passing, that, having now been translated into English, it should be in the hands (and head) of every student, and we may add, in the words of a late writer in an English Review: "No student who does not know by heart every word and every line in it should be regarded as eligible for a hospital appointment." In the meantime we would commend to all students of pathology at the Toronto General Hospital (teachers as well as pupils) the three following *regulae aureae*, quoted from a late leader in the *London Lancet*: "The first of these golden rules is to examine carefully and systematically every organ of the body, whether obviously diseased or not, and to draw no inferences, and form no opinions, until the examination is complete. The second is to note fully the condition and appearance of every part and organ at the time of the examination, and to add nothing to, and subtract nothing from these original notes. If it be added that it is always necessary to keep for further examinations everything of doubtful nature, no other general rules are needed."

We have ventured to make these remarks from no carping spirit, and with no desire to find fault for fault-finding's sake, but in the earnest hope that by directing attention to the evils complained of, their removal may be brought about to the lasting benefit of patients, pupils, and teachers, and, through them, of the community at large.

Subscribers will greatly oblige by notifying us at once if they desire any change in their address, as we have to print the mailing list for 1878 this month. We hope that all will square accounts with us without further delay.

JOURNALISTIC.—"The Monthly Journal of the Southern Illinois Medical Association" is the title of a new medical periodical.

It is our intention to add to the appearance of the Journal in January by enlarging the size of the paper in order to leave more margin for binding. Advertisements will no longer appear on the last page of reading matter, and will not, therefore, require to be bound with the Journal, as has occasionally happened in Vol I. and II.

To those who have encouraged us so far we owe and tender sincere thanks, and hope to continue to merit their good opinion by showing year by year improvements in our work. We ask our friends to assist us by obtaining subscribers, writing original communications and keeping us posted in all the medical news of their several districts.

We have to-day (November 27th) received a volume of the "Transactions of the Canada Medical Association." Subscribers should send their names at once to Dr. Osler, 1351 St. Catharine Street, Montreal.

An important advertisement of the Registrar of "The College of Physicians and Surgeons of Ontario" appears in another column.

BOOK NOTICES.

Report on Dermatology, Syphilis, and other Exanthemata. By L. P. YANDELL, Jr., M.D., Louisville. Reprinted from Transactions of Kentucky State Medical Society, 1877.

APPOINTMENTS.—Mr. Thomas Annandale has been appointed successor to Mr. Lister in the Chair of Clinical Surgery in Edinburgh University.

Dr. P. Heron Watson has been elected President of the Royal College of Surgeons of Edinburgh.

Dr. Angus Macdonald succeeds Dr. Matthews Duncan as Ordinary Physician for Diseases of Women to the Edinburgh Royal Infirmary.

Miscellaneous.

Ayer's Pills consist of pepper, colocynth, gamboge, and aloes.

Dr. Paul F. Eve, of Nashville, died on November 10th, at the age of 72.

Dr. W. R. Basham, Senior Physician to the Westminster Hospital, died on October 16th.

Professor John H. Balfour, M.D., has resigned the Deanship of the Medical Faculty of Edinburgh University.

The total number of students registered at the Royal College of Surgeons, England, is 1,879 against 1,793 last session.

The induction of reflex action by "blowing in the ear" is said to be efficient for the removal of a foreign body in the throat, such as a piece of meat.

In Paris ladies' bonnets are now trimmed with flowers dipped in chloride of cobalt, which causes them to assume in dry weather a dark-blue colour, and in the humidity preceding a rain, a pinkish hue.

The Chinese Government has passed a permissive edict calling upon the governors of the various provinces to suppress the indulgence of opium smoking. Three years' notice is given before the edict comes in force.

Mrs. Winslow's Soothing Syrup consists, says Hager, of 8 parts of white simple syrup mixed with 1 part of a tincture made by extracting 10 parts of freshly crushed fennel seed and 1 part of oil of fennel with 60 per cent. spirits.

LARGE DOSES OF IODIDE OF POTASSIUM.—In the course of the recent meeting of the American Dermatological Association, it was stated that Dr. A. Brooks, of Chicago, had given as much as one thousand grains per diem of iodide of potassium.

The widow of the late Dr. J. Rhea Barton, of Philadelphia, has endowed with fifty thousand dollars the chair of surgery in this institution. The professorship will hereafter bear the name of the distinguished surgeon to perpetuate whose memory this liberal gift was made.

Dr. C. J. Cullingworth, in the *British Medical Journal*, reports a case of cancer (cylinder-celled epithelioma) of the stomach in an infant five weeks old. The first symptoms manifested themselves on the tenth day after birth.

A Circulating Surgical Instrument Association has been started by Mr. Millikin in London. By an annual subscription of one guinea, any medical practitioner may borrow, in good working order, any surgical instrument which may be required either for operation or for the treatment of a case.

A NEW MUCILAGE.—The *Journal de Pharmacie* states that if, to a strong solution of gum arabic, measuring $8\frac{1}{3}$ fluid ounces, a solution of 30 grains of sulphate of aluminum, dissolved in two-thirds of an ounce of water, be added, a very strong mucilage is formed, capable of fastening wood together, or of mending porcelain or glass.

TREATMENT OF BLEPHAROSPASM.—Several obstinate cases of this malady, after resisting the action of all other remedies, have at last been cured by the inhalation of nitrite of amyl. The most recent is one recorded by Dr. Harlan, of America, in which the cure seems to have been permanent. — *Schmidt's Jahrbucher.—Clinic.*

TO MAKE SHOES WATER-TIGHT.—The following recipe is from the *Droguisten Zeitung*: A litre of boiled linseed-oil, 125 gm. of mutton suet, 46 gm. of wax, and 32 gm. resin, are melted together on a charcoal fire, under constant stirring, and the melted mixture applied to the well cleaned and dried shoes. The leather retains its full elasticity, and becomes absolutely impervious to water.

PREVENTION OF DENTAL CARIES.—1. Rinse the mouth thoroughly with water after the last meal of the day to remove all food. 2. Rinse immediately afterwards with an alkaline solution to neutralize any acid or its effects. 3. Brush moderately in the morning to remove any mucus secreted during the night. By these simple means toothache would be rendered as rare as it is now common.

TANNIN AS A DEODORIZER OF IODOFORM.—J. R. Cole, A.M., M.D., Resident Physician of Hot Springs, Ark., writing to the Editors of *New Remedies*, says:—Having accidentally discovered that tannin will deodorize iodoform, I take pleasure in making known this fact to you, and through you, to the profession. I use it in equal parts, as an application to chancroids and to old offensive ulcers.

McGILL MEDICAL SOCIETY.—This is a society organized by the Medical Students of McGill, which has done a good work among them. Weekly meetings were held from early summer to the end of July, at which readings and papers on medical subjects were given by the members. At present, and during the winter session, the meetings are held fortnightly. Societies of this kind are capable of doing much good, so we hope the professors of McGill will encourage it.

A meeting has recently been held in New York, to take preliminary steps towards organizing a Therapeutical Society. We have already expressed our opinion of the need which exists for such an association of physicians, and shall anticipate with great interest the development of its plan of operations, which, we understand, will aim to promote our knowledge of therapeutics by careful observations of the action of selected remedies in specified conditions.—*New Remedies*.

A CASE OF HYDROPHOBIA cured by Curare used subcutaneously is reported by a Dr. Offenburg of Wickrath, in Prussia. The injections were given at intervals of from a quarter of an hour to an hour. Two centigrammes ($\frac{1}{3}$ grain)

was the dose first administered. In four hours and a half seven injections had been given, representing 19 centigrammes of curare. The symptoms were characteristic, and were markedly alleviated by the treatment, the toxic effects of curare showing themselves. The patient was discharged cured.—*Med. Times and Gazette*.

RECOVERY AFTER TAKING EIGHTY GRAINS OF TARTAR-EMETIC.—Mr. F. Mason, of Bath, England, reports, in the *Brit. Med. Jour.*, a case of a labouring man who took, by the mistake of a prescribing druggist, eighty grains of tartar-emeti. No very serious results followed, but the use of tannin and emetics was resorted to, followed by decoctions of cinchona. The patient had been suffering with diarrhoea for several weeks, and seems really to have been benefitted rather than made worse by the rough treatment he experienced. (‡) Was that tartar-emeti pure?

INTESTINAL POLYPUS CAUSING INVAGINATION.—Intestinal polypi (except rectal) are so exceedingly rare that the following case reported by Dr. Barthel in the *St. Petersburger Med. Wochenschrift*, Sept. 15, 1877, is of peculiar interest. The woman, aged 38, was admitted to the hospital with the symptoms of gastric catarrh. These soon changed, however, and the diagnosis of intussusception was unmistakably clear. Various methods of treatment were adopted, but the patient died on the third day of peritonitis.

On post mortem examination, a small tumour about the size of a pigeon's egg was found in the ileum, about a foot above the ileo-cæcal valve. The invaginated portion measured half a foot, and at its upper extremity was found this tumour, which completely occluded the lumen of the intestine.

The polyp, a fibro-myoma, originated in the muscular layer, was covered with the normal mucosa, and had a comparatively small pedicle.

THE POISONOUS DOSE OF CASTOR-OIL SEEDS.—It has long been known that the seeds of *Ricinus Communis* contain, besides the oil, a peculiar acrid principle, which causes

WARNER & CO'S SUGAR-COATED Phosphorus Pills.

Phosphorus is an important constituent of the animal economy, particularly of the brain and nervous system, and is regarded as a valuable remedy for the following diseases:—

**Lapse of Memory, Impotency, Softening of the
Brain, Loss of Nerve Power, Phthisis,
Paralysis and Neuralgia.**

THE PILLULAR FORM HAS BEEN DEEMED THE MOST DESIRABLE FOR THE ADMINISTRATION OF PHOSPHORUS. It is in a perfect state of subdivision, as it is incorporated with the material while in solution, and is not extinguished by oxidation.

THIS METHOD OF PREPARING PHOSPHORUS HAS BEEN DISCOVERED AND BROUGHT TO PERFECTION BY US, and is thus presented in its elementary state, free from repulsive qualities, which have so long militated against the use of this potent and valuable remedy. This is a matter requiring the notice of the physician, and under all circumstances the administration of Phosphorus should be guarded with the greatest care, and a perfect preparation only used.

Its use in the above-named complaints is supported by no less authority than Prof. Delpech, Prof. Fisher of Berlin, Dr. Eames, (in the *Dublin Journal*), Dr. Burgess, and Dr. Hammond, of New York. The special treatment indicated in these cases is: 1st. Complete rest of mind, especially abstinence from all occupations resembling that upon which the mind has been overworked; 2d. The encouragement of any new hobby or study not in itself painful, which the patient might select; 3d. Tranquillity to the senses, which expressly give in these cases incorrect impressions, putting only those objects before them calculated to soothe the mind; 4th. A very nourishing diet, especially of shell-fish: 5th. *The internal administration of Phosphorus in Pillular form prepared by WILLIAM R. WARNER & CO.*

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	Price per 100.
Pil Phosphori, 1-100 gr.	WARNER & Co's \$1 00
Pil Phosphori Comp	WARNER & Co's 2 00
Phosphorus, 1-100 gr. Ext. Nuc. Vomicae, $\frac{1}{4}$ gr.	
Pil Phosphori et Nucis Vomicae	WARNER & Co's 2 00
Phosphorus, 1-50 gr. Ext. Nuc. Vomicae, $\frac{1}{8}$ gr.	
Pil Phosphori et Ferri et Nuc. Vom.	WARNER & Co's 2 00
Phosphorus, 1-100 gr. Ferri Carb. (Vallet) 1 gr. Ext. Nuc. Vom., $\frac{1}{4}$ gr.	
Pil Phosphori et Ferri et Quinia	WARNER & Co's 2 90
Phosphorus, 1-100 gr. Ferri Carb. (Vallet) 1 gr. Quinia Sulph., 1 gr.	
Pil Phosphori et Ferri et Nuc. Vom. et Quinia	WARNER & Co's 2 90
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INGLUVIN

FROM THE

VENTRICULUS CALLOSUS GALLINACEUS.

A specific for **VOMITING IN PREGNANCY**, a potent and reliable remedy for the cure of **INDIGESTION, DYSPEPSIA, and SICK STOMACH**, caused from debility of that organ. It is superior to the Pepsin Preparations, since it acts with more certainty, and effects cures where they fail. **\$1.00 Per Bottle. Sent by mail on receipt of price.**

"A NEW REMEDY, CALLED INGLUVIN."

BY A. F. SHELLY, M. D., of PHILADELPHIA.

"This is obtained from the gizzard of the domestic fowl (chicken) and is a *Specific for Vomiting in Pregnancy*. I have used this remedy for twenty-five years, and it has never failed. It is also the most *powerful and reliable* remedy for the *Cure of Indigestion, Dyspepsia, and Sick Stomach*, caused from debility of that organ. It is useful in all cases where pepsines and pancreatines are used, but with much more certainty of its good results, for it puts all those preparations, in my experience, in the background.

In complicated affections of the Stomach, such as *Inflammation, Gastralgia, Pyrosis, &c.*, it may be combined with Subnitrate of Bismuth and opiates; and in Diarrhoea and Cholera Infantum, with astringents, both vegetable and mineral. I have given the article to several prominent physicians, who have used it with the happiest results, among whom I may mention Prof. E. WALLACE, of the Jefferson Medical College; he gives me the result of seventeen cases as follows. —

In Vomiting of Pregnancy, out of nine cases he cured six, and palliated two, and in one case the remedy was not taken according to direction, and therefore had no effect.

He used it in seven cases of Sick Stomach, caused by chronic inflammation of the uterus; cured five, and two remained doubtful. He also used it in a case of very obstinate Sick Stomach, caused by an irreducible hernia, and says this was the only remedy that gave any relief.

We, who have some experience, all know that Vomiting of Pregnancy is a sore affliction, and in some cases almost unendurable, nay, indeed, putting life in jeopardy; but in INGLUVIN we have a remedy which will prove to be a great blessing to mothers, who, as yet, think vomiting must be endured as a natural consequence.

If I am able, by this publication, to induce the medical fraternity to make use of the remedy, I am positive that a great boon will be conferred upon a class of sufferers who claim our sympathy.

The dose is from five to ten grains, hardly ever more than five, except in obstinate cases. For children, from one to five grains. My mode of administering it is in a spoonful of water or tea, or it may be strewn on a piece of bread and covered over with a little butter; it is, however, nearly tasteless. In Dyspepsia and in Vomiting of Pregnancy, I direct it to be taken half an hour or so before each meal. In other affections of the Stomach and Bowels, every two to four hours. I give it uncombined, except in complicated cases, as heretofore mentioned.

The methods by which this principle can be obtained from the viscus are various. When I commenced to employ it, I used it in rather a crude state, by pulverizing the lining membrane of the gizzard; but it requires too much care and precision in the drying and cleansing operation, in order not to destroy its virtues. There is also great inconvenience in obtaining the viscus during the heat of summer and extreme cold of winter, as temperature is one of the main things to be observed, in order to preserve its efficacy, purity and sweetness. Later, finding this mode of preparation unsatisfactory and inconvenient for the above reasons, I consulted with WM. R. WARNER & CO., 1228 Market Street, Philadelphia, who have prepared a form, designated INGLUVIN; its purity, and also its good effects, I can vouch for."

—"The Medical and Surgical Reporter," February 3rd, 1877.

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PHARMACEUTICAL CHEMISTS,

1228 MARKET STREET,

PHILADELPHIA.

NOTE—CHANGE OF NAME—

"Dr. Shelly, of this city, informs us that owing to the fact that a proprietary remedy has been on the market for some time which bears the name "DIGESTIN," he has adopted the appellation "INGLUVIN" for the preparation from the gizzard of the domestic fowl described in the Medical and Surgical Reporter, February 3d, 1877.

violent vomiting and purging, and which must be reckoned among the acrid poisons. Van Hasselts, a number of years ago, declared one seed to be sufficient to sicken a grown person, and twenty to be sufficient to kill him. This statement was contradicted by Bernelot Moens, who suspected that the seeds of another euphorbiaceous plant had been experimented with. But such was not the case; on the contrary, a number of well authenticated cases of poisoning by castor-oil seeds are on record, most of them from France, where the seeds are much in use for various purposes as a popular remedy. Chevallier mentions a case, with recovery, of a boy of seven or eight years, who had taken only one—at most, two seeds. Other cases of alarming intoxications are on record, after taking three or four seeds. In all European cases of poisoning, the number of seeds taken has rarely exceeded twenty. It should not be forgotten that the seeds are poisonous, both in their unripe and ripe state, and that the cakes remaining after the expression of the oil retain most of the acrid principle, and have often caused the death of horses and cattle.—TH. HUSEMANN, in *Pharm. Zeit.*, No. 67.—*New Remedies.*

REMOVAL OF STRONG ODOURS FROM THE HANDS.—The *Schweizerische Wochenschrift für Pharmacie* has a communication from F. Snyder, in which he states that ground mustard, mixed with a little water, is an excellent agent for cleansing the hands after handling odourous substances, such as cod-liver oil, musk, valerianic acid and its salts. Scalepans and vessels may also be readily freed from odour by the same method.

A. Huber states that all oily seeds, when powdered, answer this purpose. The explanation of this action is somewhat doubtful, but it is not improbable that the odourous bodies are dissolved in the fatty oil of the seed, and emulsified by the contact with water. In the case of bitter almonds and mustard, the development of ethereal oil, under the influence of water, may perhaps be an additional help to destroy foreign odours. The author mentions that the smell of carbolic acid may be removed

by rubbing the hands with damp flax-seed meal, and that cod-liver oil bottles may be cleansed with a little of the same or olive oil.—*Doctor.*

THE VALUE OF DRAWING.—Mr. Hensman, in his eminently practical address to the students at Middlesex Hospital, strongly insisted on the value of drawing as a means of training to hand and eye. It is more: the faculty of measuring the apparent dimensions and relative proportions of objects, plays a prominent part in the attainment of all forms of knowledge. Even an ideal subject is worked out in thought with the aid of mental forms and figures. The lecturer sees heads and subdivisions of his discourse; the lawyer, the topics and connecting link of an argument, in his "mind's eye." No practice is more generally useful to the mind as well as the body than drawing, and of all forms of this art that of sketching from memory is most exacting and educational. Let the student so examine the "appearances" before him in the dissecting-room, the museum, the pathological laboratory, and the hospital, that he may carry away a mental image of the form and colour, the relative size and the relations of the several parts. Then let him sketch from memory, and, returning to the object, verify his work, correcting its inaccuracies and supplying omissions. The mental results of this system of study will not be less beneficent than the manual. The same principle applies to note-taking. It is better to write *after* observation or hearing than during a demonstration or lecture, and it will greatly facilitate study if the jottings made are as far as possible pictorial and arranged in figure. The hint is a slight one, but if worked out intelligently it will produce good effects.—*The Lancet.*

TORONTO SCHOOL OF MEDICINE—FOURTH ANNUAL DINNER.—The fourth annual dinner of the faculty and students of the Toronto School of Medicine took place at the Rossin House, on Friday evening, Nov. 9th. As usual, the dinner was a great success, the number of students entered this year being so large, rendered it especially so in point of the

attendance of students. The bill of fare prepared by Mr. Irish for his guests was excellent, and did credit to his knowledge of the gastronomic science and art. Indeed, he, in a witty speech at the close, acknowledged that he worked his dietetics on an anatomical and physiological basis, providing for the alimentary canal in its whole extent even, to use his own words, as far as "the *vermifuge* appendix."

The chair was ably filled by Mr. J. R. Jones, the 1st and 2nd croupiers being Mr. W. Lehman and Mr. W. R. Sutherland. Mr. F. Burt, the Secretary, read letters from the Governor-General, Sir John A. Macdonald, Hon. E. Blake, Hon. Dr. Tupper, Mr. Justice Moss, Hon. O. Mowat, Hon. A. Crooks, Rev. D. J. Macdonnell, Mr. W. H. Howland, Rev. John Potts, Profs. Wilson, Ramsay Wright, Croft, and Pernet, Dr. McCaul, Hon. M. C. Cameron and others, expressing their regret at not being able to attend. The City of Toronto was represented by His Worship the Mayor. In addition to the faculty, among the old graduates and others, we noticed, Dr. Rac, of Oshawa; Dr. Frazer, Fonthill; Dr. McConnell, Thornhill; Dr. Smith, Sebringville; Dr. Riddell, Dr. A. H. Wright, Dr. Workman, Dr. Pyne, Dr. Griffin, Dr. Daniel Clark, Dr. James Ross, Dr. Winstanley, Dr. McPhedran, Dr. I. H. Cameron, Toronto; Dr. James White, Hamilton Hospital; Drs. Black and Bascom, Uxbridge; Dr. O'Rielly, Toronto Hospital. The usual toasts were cordially received and suitably responded to. Messrs. Bolster, Anderson, and the students' chorus gave vocal selections at intervals. The hall was tastefully decorated, thanks to the industry of Mr. Burton. It was mentioned during the evening that there were 135 students registered and 52 freshmen.

Births, Marriages, and Deaths.

BIRTHS.

At Dundas, on the 3rd inst., the wife of Dr. A. Halford Walker, of a daughter.

At London, on the 31st ult., the wife of Dr. Hagarty, of a son.

MARRIAGES.

On the 3rd June, at the residence of the bride's father, No. 7 Gerrard Street East, Toronto, by the Rev. A. H. Baldwin, Mr. W. H. Banks, of Rosedale, Yorkville, to Emily, second daughter of Dr. Winstanley.

At St. Peter's Church, Brockville, on Wednesday, 14th inst., by the Rev. Canon Mudoch, Archibald Edward Malloch, M.D., of Hamilton, to Frances Mary, daughter of the late Thomas Reynolds, M.D., of Brockville.

At Rosebank, at the residence of the bride's father, on Wednesday, the 14th, by the Rev. James Cameron, M.A., Millbrook, Ont., John Hunter, M.B., M.C.P.S., Millbrook, and son of the late David Hunter, Esq., St. George, County of Brant, to Lizzie, eldest daughter of John Renwick, Esq., near Orono, West Durham.

On the 14th inst., at the residence of the bride's father, No. 2 Queen's Park, by the Rev. Dr. Proudfoot, uncle of the bride, assisted by the Rev. Dr. Topp, John A. Stevenson, Esq., M.D., of London, Ont., son of Judge Stevenson, Cayuga, Ont., to Annie Isabel, eldest daughter of the Hon. Wm. Proudfoot, Vice-Chancellor of Ontario.

On Nov. 7th. 1877, at St. George's Church, St. Catharines, by the Rev. H. Holland, B.A., assisted by the Rev. C. Forrester Holmes, P. Harry Marshall, of Bedford, England, eldest son of the late Major G. A. Marshall, 18th Madras Light Infantry, H.E., I.C.S., to Susan A., eldest daughter of Augustus Jukes, Esq., M.B., F.O.S.L.

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1. Change of residence of any registered practitioner.
2. Deaths of medical men.
3. Additional qualifications with the proper vouchers attested, and the legal fees for the registration of such.
4. Any suggestions worthy of consideration to assist the Registrar to complete satisfactorily the new issue will be thankfully received.

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College of Physicians and Surgeons
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Registry Office, Toronto, Nov. 17, 1877.

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50-CENT LOT.

One Gent's Watch Chain, retail price.....	\$1 00
One pair Engraved Sleeve Buttons, retail price...	75
One Stone-Set Scarf Pin, " " " "	75
One set (3) Spiral Shirt Studs, " " " "	75
One improved shape Collar Button, " " " "	50
One heavy plain Wedding Ring, " " " "	1 25
Total.....	\$5 00

For 50 cents we will send above six articles post-paid.

\$1.00 LOT.

- One pair Sleeve Buttons, stone setting.
- One set (3) Spiral Shirt Studs.
- One heavy band Engagement Ring.
- One set (2) Engraved Bracelets.
- One Ladies' Long Guard or Neck Chain.
- One engraved Miniature Locket for the above.
- One Gent's Heavy Link Watch Chain.
- One Lake George Diamond Stud.

\$2.00 LOT.

- One Ladies' Neck Chain and Charm.
- One Ladies' Heavy Guard Chain for Watch.
- One set Pin and Ear Rings, Amethyst.
- One extra fine Miniature Locket.
- One Cameo Seal Ring.
- One very heavy Wedding or Engagement Ring.
- One Gent's heavy Watch Chain with Charm.
- One pair Pearl Inlaid Sleeve Buttons.
- One Lake George Cluster Pin.
- One pair (2) heavy band Bracelets.

The retail price of the articles in each sample lot amounts to exactly ten times the price we ask for the lot; for example, our \$1.00 lot retails for \$10.00; our \$5.00 for \$50.00.

A SOLID ROMAINE GOLD HUNTING-CASE WATCH FREE.

To any one sending us an order for the above lots by express to the amount of \$15.00, we will send FREE one Solid Gold Romaine Hunting-Case Watch, Gents' or Ladies' size, warranted to keep perfect time and look equally as well as a \$100.00 gold watch. By mail post-paid, \$15.50. This is our BEST OFFER TO AGENTS, and is worth a trial, as the watch alone will sell or trade readily for from \$20.00 to \$50.00. Gents' or Ladies' Watch alone, \$7.00 or \$8.00, with a heavy Gent's Gold Pattern Vest Chain and Charm, or Ladies' Opera Chain with slide and tassel.

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Send money by P. O., Money Order, or Registered Letter, AT OUR RISK. No goods sent C. O. D. unless at least \$5.00 accompanies the order. Address plainly,

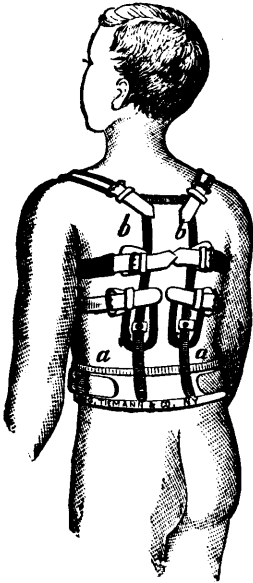
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- One beautiful Locket (engraved).
- One pair Band Bracelets.
- One Gent's Twist Link Vest Chain and Charm.
- One pair Onyx Sleeve Buttons.
- One set (3) Onyx Shirt Studs.
- One new improved Collar Button.
- One extra cut Cameo Seal Ring.
- One Arizona Solitaire Stud.
- One set Amethyst or Topaz Pin and Ear Drops.
- One Ladies' Chemise Button.
- One Plain Ring, stamped 18 K.

\$5.00 LOT.

- One Ladies' Opera Chain, with slide and tassel (retail price \$5.00.)
- One Gent's heavy Watch Chain, with Curb charm (retail price, \$5.00).
- One Ladies' heavy long Neck Chain.
- One elegant Chased Miniature Locket for above.
- One set Cameo Medallion Pin and Ear Drops.
- One pair (2) heavy Chased Band Bracelets.
- One Gent's Solitaire Diamond Stud.
- One Gent's Cluster Diamond Pin.
- One pair Amethyst or Onyx Sleeve Buttons.
- One set (3) Studs to match the above.
- One elegant heavy set Cameo Seal Ring.
- One Massive Band or Wedding Ring.
- One new "patent" Collar Button.
- One Ladies' Chemise Button.
- One Amethyst or Topaz Ring, (extra finish).



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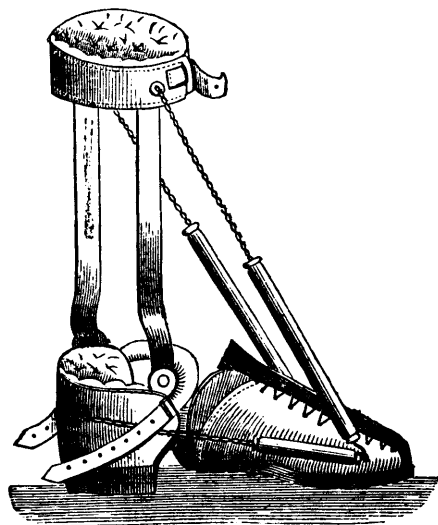
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| JOHN ORDRONAUX, M.D., LL.D., New York City, Emeritus Professor of Medical Jurisprudence. | JAMES L. LITTLE, M.D., New York City, Professor of the Principles and Practice of Surgery; Surgeon in Chief to Mary Fletcher Hospital. |
| WILLIAM DARLING, A.M., M.D., F.R.C.S., New York City, Professor of General and Special Anatomy. | GEORGE S. SMITH, Ph.D., University Professor of Chemistry and Toxicology. |

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| A. T. WOODWARD, M.D., Brandon, Vt., Professor of the Surgical Diseases of Women; Consulting Physician to Mary Fletcher Hospital. | EDWARD S. PECK, A.M., M.D., Burlington, Vt., Professor of Diseases of the Eye and Ear. |
| | LEROY N. BINGHAM, M.D., Burlington, Vt., Demonstrator of Anatomy; Attending Surgeon to Mary Fletcher Hospital. |

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| SURGICAL CLINIQUE , by Prof. LITTLE, every Saturday, from 9 to 12, during the last half of the session. | CLINIQUE FOR DISEASES OF SKIN , by Prof. TAYLOR, once a week during his course. |
| MEDICAL CLINIQUE , by Prof. CARPENTER, on Wednesday morning, during first half of the term. | CLINIQUE FOR DISEASES OF CHILDREN , by Prof. ROBERTS. |
| CLINIQUE FOR DISEASES OF EYE AND EAR , by Prof. PECK, once a week during his course of lectures. | CLINIQUE FOR DISEASES OF NERVOUS SYSTEM , by Prof. HAMMOND, during his course. |

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Students who have already attended two full courses of lectures in other regular schools are admitted on paying the matriculation fee and \$25.

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