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A. H. WRIGHT, B.A., M.D. Toronto, M.R.C.S. England.

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Original Communications.

A CASE OF HEPATIC CIRRHOSIS.*

BY J. T. FOTHERINGHAM, B.A., M.B., M.D.C.M.,
Assistant Demonstrator of Anatomy, Toronto University.

The case which I am about to detail came under my notice during a few weeks as *locum tenens* in the Toronto General Hospital, and seemed to me so unusual a form of cirrhosis due to alcoholism as to be worthy of further record.

Specimens submitted: Gross, liver, hypertrophic cirrhosis, weight 76 oz. *Microscopic*, same, hardened in alcohol and in chromic acid, stained with alum-cochineal, and some counterstained with fuchsin.

History of Case: James McK—, æt. 38, patient in Ward 6, T.G.H., care of Dr. H. C. Burritt, admitted Aug. 29th, died Sept. 4th, 1891.

1. *Family History:* Good, father and mother both healthy and of advanced age.

2. *Personal History:* Occupation, shoemaker; native of North of Ireland; no history of venereal disease or syphilis. His own accounts of his habits as regards alcohol being unsatisfactory, enquiry of the tradesman for whom he had worked for the last ten years revealed the fact that he had, until within the past year, been using alcoholic stimulants to excess; for ten years past, being drunk at least once a week, and

within the past year, perhaps once a month, or on every holiday.

3. *Present Condition:* (a) A large well-formed man, nutrition good, appetite very fair; skin and conjunctivæ markedly icteric; very considerable ascitic distention of abdomen, not extreme, however; œdema of lower limbs, extreme at ankles, and pitting on pressure up to some inches above knees. Not so bad, he said, on admission as it had been. Jaundice was of ten months' standing, ascites and œdema of about three months'. Had been tapped in median line of abdomen some days before, and fistula had been established. House surgeon had sealed it by two fine skin sutures, one at right angles to the other, with iodoform and collodion dressing.

(b) *Nervous System:* Apparently normal; patient bright and talkative, and in good spirits; did not remain in bed till the last of the six days of his stay in the hospital, and then not all day. Even on the last day he was frequently up and at water closet, with strength apparently quite equal to the task.

(c) *Circulatory System:* No marked disturbance. Am not prepared to say that there was no hypertrophy of left heart, as *post mortem* was not allowed. No suspicion of immediate danger having been entertained, no certain account of the heart can be given. There were no valvular lesions.

(d) *Digestive System:* Appetite very fair; gastric digestion good; intestinal digestion impaired by lack of bile, as indicated by whitened

*Read before the Pathological Society of Toronto.

faeces, of which there was a history of ten months at least. Marked diarrhoea from use of saline and other hydragogue purgatives.

(e) *Urinary System*: Free diuresis from action of drugs; urine very dark-colored, containing very large quantity of bile pigment. The kidneys were found after death to be apparently normal in gross appearance, except for marked biliary staining. About the third day of his stay in hospital the scrotum and penis suddenly became very œdematous, but under increased purgation and diuresis the effusion largely disappeared in two days' time.

(f) *Respiratory System*: Normal; ascitic distention not enough to impede respiration much.

4. *History of Present Attack*: Patient noticed ten months before the paleness of stools and jaundice already mentioned, and for the past three months the ascites and œdema of lower extremities. Jaundice had thus preceded ascites by seven months. Was treated during all this time at the city dispensary and in private practice, with some temporary benefit at times. At the tapping already mentioned, two weeks before death, considerable fluid was removed; but no reliable data could be got as to quantity. What was oozing at the fistula spoken of was limpid, not viscid nor highly colored.

5. *Progress of Case—Treatment*:

(a) *Dietetic*: No fats, sugars, or alcohol were allowed; otherwise ordinary hospital fare—porridge and milk, meat, bread, rice, and vegetables. Ingestion of fluids limited so far as possible

(b) *Medicinal*: Salines were given copiously, pot. tart. acid; Guy's pills were ordered four in a day, then omitted for a day; then four more and two days omitted. Not more than eight, or at most ten, were taken in all. A tonic was also given of quinine, tincture of iron, chloride of ammonia, and the bichloride of mercury. Purgation was free, twelve to fifteen liquid stools in the twenty-four hours, and diuresis marked.

On his sixth day in hospital patient seemed less bright, but was still up and about at intervals, and at 10 p.m. was sleeping rather heavily, respirations not stertorous nor rapid. About 4 a.m. the house surgeon was called, and found him in a state of coma, insensible—extremities cold, heart feeble and rapid, pupils very much contracted, respiration regular, full, slightly

quickenened, and forced. Expiration was marked by loud monotonous groaning phonation without opening of lips; and inspiration was short, quick, and deep, with marked muscular effort, both acts nasal; pause marked, but not long, except occasionally, when it was followed by fuller respiratory cycles.

The diuretic treatment already pursued could not be further pushed, so that warmth and stimulants seemed the only available course; hot water cans, and ether and brandy hypodermically. Death ensued in a couple of hours, apparently from a variety of toxæmia from retained excrementitious substances. The pupil and respiration were much like those of uræmia, but there were at no time any convulsive seizures.

Permission to do a *post mortem* was not obtained, but the friends seemed pleased with the suggestion that the appearance of the remains would be improved by the removal of the ascitic fluid, and a small incision for that purpose was permitted, judicious enlargement of which allowed of the removal of the liver and kidneys.

The liver weighed 76 oz., instead of 52-56 oz. It was externally of pale green color, and on section quite yellow and bile stained. It was of density to the finger almost like that of well-soaked sole leather. Enlargement was not in any place localized, but evenly distributed cirrhosis was seen, almost perfectly unilobular; scarcely any groups of more than one or two lobules being found, and the uncut surface being consequently comparatively smooth. The kidneys, as already stated, were normal but for bile staining.

Microscopic Examination: The specimens submitted will be described under the four heads of:

1. *Cirrhosis* and other change in the *stroma*.
2. *Atrophy* and other change in the *parenchyma*.
3. *Pigmentation*.
4. *Pylephlebitis* and other *vascular* change.

1. *Cirrhosis*: Very marked increase in the amount of fibrous tissue; almost absolutely unilobular. In some lobules the cirrhotic tissue can be seen throwing partitions across and shaving off portions of the lobule, much as the similar process goes on in the plugged alveoli of the lung in fibroid phthisis. In such cases the

invading fibroid tissue is markedly cellular and nucleated. Between the lobules the new tissue is in places quite old and non-nucleated; elsewhere loose and very cellular. This distinction obtains especially when the median portion of any piece of cirrhotic tissue is compared with the lateral or *juxta-lobular* portion; the former being almost pure fibrous, the latter so filled with small-cell infiltration as to almost resemble lymphomatous tissue, and to suggest an exacerbation and increased rapidity of the morbid process towards the last. Another indication of recent rapid progress is the existence in the *juxta-lobular* portions of the cirrhotic tissue of liver cells, quite altered by pressure to oat-seed, crescentic, and similar shapes, but still persisting. The more persistent structures of course, such as bile ducts and other vessels, are seen in the proliferated Glisson's capsule, aggregated where lobules have disappeared. In places are seen patches of cirrhotic tissue which stain badly and seem to have undergone mucoid degeneration.

2. *Atrophy* and other *parenchyma* change: The lobules are found in all stages of atrophy, down to patches where the whole of the hepatic cells have been replaced by loose fibrous tissue so thickly infiltrated with small cells as to resemble closely under the low power a recent tubercle, the cirrhotic tissue being so delicate as form only a fine fibrillar stroma. As regards the individual hepatic cells they show pressure effects, especially at the periphery of the lobule, in the change of shape already mentioned, while in the more central parts the bile capillaries and ducts can be seen to be dilated. In places can be seen a marked increase in the number of bile ducts, which are aggregated in such a manner as to show actual increase in their number, the cells, as they proliferated, taking on the modified shape peculiar to those forming the duct wall, or rather *retaining* that form and taking that arrangement.

3. *Pigmentation*: Though properly to be mentioned under the last heading, is so marked a departure from the normal as to deserve special mention. It is especially marked at the periphery of the lobules, existing both as granules in the cells and as larger masses plugging the bile capillaries and ducts.

4. *Pylephlebitis* and other *vascular* change:

The radicles of the hepatic veins seem normal. The hepatic arterioles have not shared much in the changes that have occurred; but in addition to their being aggregated in spots where the parenchyma has disappeared, they at times are so dilated by obstruction at a point further on in their course as to form a kind of false aneurysmatous patch. The portal venous radicles show very marked pylephlebitis. Many of them are almost occluded, the lumen being occupied in five-sixths or nine-tenths of its area by new cell-growth, leaving only a chink or Y-shaped fissure in the centre. This is apparently of endothelial origin, and in some cases the cells are, in oblique or longitudinal section, markedly elongated spindle cells of the true scar tissue type. In cross section they show round outlines, and are arranged lengthwise with the vessel-wall. Other vessels in transverse section show short spindle cells standing on end, as it were, with ends projecting into the blood stream, and presenting for contact with it a rough quasi-villous surface.

INHALATIONS.

BY D. A. DOBIE, M.D., TORONTO.

There appeared in THE CANADIAN PRACTITIONER of September 16 an article upon this subject, selected from *The New York Medical Journal*, treating of inhalations as ordinarily given by means of sprays, or with inhalers in which air is made to pass through some medicated medium before inspiration.

I quite agree with the writer that, with the first-named method, the medicinal agents "are arrested often in the pharynx, oftener in the larynx, and never reach the seat of the disease." In the second method, "though the medicated atmosphere may reach the seat of the disease, its impregnation with carbolic acid, creosote, thymol, or other such agent, is so exceedingly feeble as to leave no solid ground for anticipating serious benefit from its use." The twelve cases he mentions, reported by Prof. Germain-See, treated upon a plan similar to the last, but with compressed air instead, certainly give grounds for hope, if they are not entirely satisfactory. The writer closes with the statement that if inhalation is ever to become a valuable agent in therapeutics, it will probably be by the adoption of some analogous plan.

The plan of inhalation, I believe, that offers the most reasonable hope is by first changing the drug to the gaseous state. A number of volatile drugs, particularly creosote, which, as the etymology of the word implies, has been long known to possess flesh-preserving properties, have been, as the result of certain satisfactory experiments, recommended in the treatment of pulmonary tuberculosis; and since then this drug has been given by the stomach *ad nauseam*. In advocating the inhalation of these drugs we are met by the following questions: Can drugs be absorbed by the respiratory tract? Has the direct local application of such drugs any advantages over their remote local action? What advantages does inhalation offer over the administration of drugs by the stomach?

Physicians, as a rule, are so conservative with respect to the employment of means not ordinarily in use, and the principal channel for the administration of drugs has so long been by the stomach that we seem to forget they enter the body through other absorbing surfaces. Though every medical man must be cognizant of the fact that absorption takes place by the lungs, this medium is very little utilized.

The special function of the respiratory mucous membrane is the transference of oxygen to the blood from the air, and of carbon dioxide from the blood—in short, for the easy transfusion of gases. It is reasonable, therefore, to believe that the respiratory apparatus is, in anatomical construction, specially adapted for this function. Practically we know that many gases besides oxygen are absorbed through this channel, and produce their physiological effects more rapidly, and with less difficulty, than by any other mode of administration. Chloroform, ether, amylnitrite, ethyl-iodide, nitrous oxide, etc., are examples of such gases. We have other proofs of the absorption of gases in this way in the many unfortunate cases of gas poisoning, whether from manufactured illuminating gas, carbon monoxide, or sewer gas.

It follows, then, that absorption takes place by the lungs, when the drug is in the gaseous state, and it is therefore of primary importance for the successful inhalation of drugs that they be first volatilized. In the treatment of diseases affecting any particular organ, whether the application be made directly, as upon the skin, or remotely,

through the blood, the effect aimed at in many cases is local.

In a case of chronic bronchitis, for example, where we administer turpentine or some similar preparation by the stomach, we expect the drug to act beneficially, through its remote local action, being excreted, in part, by the respiratory mucous membrane, stimulating, disinfecting, and liquefying its secretions. But creosote, turpentine, and many other drugs so useful in the treatment of diseases of the respiratory organs, are not only nauseous and pungent to the taste and difficult to combine with other drugs, but by their immediate local effect upon the stomach they interfere with digestion, and, therefore, with nutrition; and whatever good their excretion by the lungs may effect is more than counterbalanced by such interference.

In such diseases as tuberculosis, where there is a struggle for existence between the bacilli and the cells of the structure they invade, we should attempt not only to destroy or retard the growth of the bacilli, but also to increase the vitality of the cells of the organism by nutrition, that they may offer a greater resistance to the progress of the disease. Since the drugs mentioned interfere with the nutrition of the patient, when given by the stomach, their administration by this channel is contra-indicated. Then, too, before entering the lungs such drugs must first pass through the liver—that wonderful chemical laboratory—and there they may undergo change.

Since, then, these drugs have a beneficial local effect upon the lungs, and such serious objections exist to their administration by the stomach, they should first be changed to gases and given by inhalation, leaving the stomach undisturbed for the digestion of such foods as will afford the best nourishment. Sprays, atomizers, or nebulizers, whether worked by compressed air or by steam, simply effect the division of the drug into minute liquid particles, which are dense, irritating, and non-diffusible, and the sensitive glottis closes against their entrance.

On the other hand, drugs in the gaseous state are light, uniform, non-irritating, and so diffusible that they are easily carried by the current of inspired air to every part of the lungs, thus coming into direct contact with their whole absorbing surface. Even if a finely divided spray reach the lungs, each drop of creosote contain-

ing about .0036 c. in., if divided into particles one-two thousand five-hundredths of an inch in diameter, would only come in contact with an absorbing surface of 9 sq. in., a very small proportion of the whole absorbing surface of the lungs.

The advantages of volatilization of the drug for inhalation over atomization is therefore apparent; and since absorption of such drugs takes place by inhalation, without interfering with nutrition, and since such interference occurs when they are given by the stomach, this method should be chosen for the administration of volatile drugs.

I have followed this practice for one year, and the results are quite up to my expectations. Among my cases I have one of tuberculosis, in which there were night sweats, much emaciation, cough, and copious expectoration. Bacilli were found in the sputa. One year ago she weighed 85 lbs., now she weighs 120 lbs. and has no evident signs of the disease. The instrument I find best adapted for this purpose is the Perfection Volatilizer.

Selections.

HEAD-NODDING AND HEAD-JERKING IN CHILDREN COMMONLY ASSOCIATED WITH NYSTAGMUS.

—Hadden, in the *Lancet*, discusses twelve cases of this affection. Full notes of five cases are given. This affection is usually confused in the text-books with a special variety of epilepsy. The author does not deny the possibility of an alliance with the latter disease. The cases are characterized by nodding or lateral movements of the head, either singly or associated with one another, or with movements of rotation. These movements may be almost constant or may occur more especially during efforts at fixation, or during excitement, always ceasing during sleep and when lying down. In most cases there is nystagmus of one or both, vertical, horizontal, or rotatory, often occurring simultaneously with the onset of the head symptoms, but sometimes preceding or following them. The nystagmus is much more rapid than the head movements, and has an independent rhythm; it is aggravated by fixation or by forcibly restraining the head, and may even be induced, when previously absent, by these means.

Case 1.—Nodding of head, with occasional lateral movement; vertical nystagmus of eye-balls and eyelids; attacks of unconsciousness, with deviation of eyes; throwing back of the head an early symptom. The patient was a female, *æt.* 7 months. The mother gave an account of a severe fright when six months pregnant. Family history was good; mother had had no miscarriages. The patient was the sixth child, and none of them had had convulsions. Labor was normal; though healthy when born, the mother said that the child used to throw back her head and look through the half-closed eyes. The eyes began to move at the age of six weeks, and the head movements came on when the child was two months old. There was no history of injury. The general condition of the child was excellent. For ten weeks there had been a yellowish discharge from the ears. There was no rickets. During the attacks it was observed that the eyes deviated strongly to the left, and downward, the head also turning in the same direction. An examination revealed pupils active to light; ocular excursions good; convergence also good. Ophthalmoscopically, both fundi normal. The child was treated with bromide of potassium and other drugs symptomatically. There was improvement in some symptoms during the year and a quarter that she was under observation.

Case 2.—Head-jerking, chiefly from side to side; horizontal nystagmus; attacks of unconsciousness with deviation of eyes; throwing back of the head to look at objects. The patient was a male, *æt.* 10 months. There was no history of neurosis in the family. Three months previously he fell, striking the back of his head, but the injury was probably trivial. The child had never suffered from convulsions and was not the subject of rickets. There was horizontal nystagmus of both eyes, constant in the left, exaggerated on extreme conjugate to left side, and least of all on conjugate deviation to right. Ophthalmoscopically, the fundi were healthy. During sleep the movements of the head and eyes ceased. The child recovered fully in about six months from the beginning of treatment, and remained well as long as a year and nine months after the first visit. The treatment consisted of bromide of potassium, and later iodide of potassium.

Case 3.—Side-to-side movements of head after head injury; subsequent occurrence of nystagmus, vertical in right, horizontal in left eye; peculiar method in looking at objects; rickets; convulsions; fits of laughter. The patient was a female, æt. 8 months. She was the tenth child. Four had had convulsions. She had never had convulsions or any attacks like *petit mal*. The child fell from a chair, striking the left side of her head, but did not seem to be much hurt. The movements began five or six days later. The child was good-tempered. There was some bending of the ribs. There were no teeth. The fontanelles were open. The nystagmus persisted when the head movements stopped; vision was good; the ordinary movements of the eyeballs unimpaired and the disks normal. She had several convulsions. She finally became free from these, but the head-jerking and nystagmus persisted.

Case 4.—Vertical nystagmus of one eye only following head injury; side-to-side movements of head four months later; peculiar method of looking at objects; two relapses following falls on the head. The patient was fourteen months old. There was a history of three severe falls. The movements of the eyes were noticed a week subsequent to the last fall. There was no history of fits. No evidence of rickets was found. About a month after he came under observation he suffered one evening from convulsions, with screaming. About this time he fell on the left side of the forehead. The next day he had some nystagmus, but it only lasted about five minutes. The treatment consisted of steel wine and cod liver oil. For a month he was treated with rhubarb and soda, and salt-and-water injections for thread worms. For a time he also had bromide of potassium.

Case 5.—Lateral nystagmus following a severe head injury; recurrence after a year with occasional head movements; peculiar method of looking at objects; convulsions; mental change. The patient was a boy, æt. 14 months. The child had fallen from a high chair to the floor, striking the left side of his head against the boards. Two weeks after the fall the movements of the eyes began. The movements ceased in a day or two and the child remained well for two months. He then had some fits at night, probably convulsive. No recurrence of the

nystagmus took place for a year. Six weeks later he had occasional head movements. Thirteen months after the injury all movements ceased and remained so as long as eighteen months. His disposition was changed. He became less intelligent; was forgetful and irritable. The treatment was bromide of potassium in six-grain doses.

The author next gives a detailed analysis regarding the head movements in eleven cases. In one the movements were purely nodding; in four lateral; in one a combination of lateral and rotatory; and in three a combination of nodding and shaking, or lateral movements. The muscles affected are, according to Henoch, the muscles which rotate the head as well as the sternomastoid. The nystagmus was rapid, four or six movements a second. It is often continuous, though aggravated by attention, by efforts at fixation, or by forcibly straining the head movements. Occasionally nystagmus will make its appearance when the head is held, though previously absent. Nystagmus is usually present in both eyes, but often one is more affected than the other. In three cases the movements were strictly unioocular. — *Weekly Medical News*.

AN UNUSUAL CASE OF APPENDICITIS.—At a recent meeting of the Society of the Alumni of Bellevue Hospital, the president, Dr. Charles Phelps, said that a little over a year ago he had been asked to see a case of appendicitis with a view to a possible operation. When they arrived at the house they had been astonished to find that the patient had suddenly passed into collapse and was absolutely pulseless. The abdomen had been so tympanitic that but little information could be obtained by examining it, and operation under these circumstances had been of course out of the question. Nevertheless, the patient had rallied, and about three months later, during the speaker's absence from the city, he had called upon Dr. Fluhrer, who had found a tumor in the region of the appendix, and had told the patient of the danger which menaced him. About three weeks ago he had returned to the speaker, and had said that he was suffering greatly from pain, which was increased by any slight indiscretion in diet. He had become greatly emaciated. A tumor had been found, but it had been situated more

in the lumbar than in the iliac region, and had appeared to be perinephritic. The speaker could not detect fluctuation, although one distinguished surgeon, who also examined the case, had been positive that he detected it. Operation had been advised, and about a week later, when it was about to be performed, no tumor could be found, although there was still considerable tenderness in the right iliac region. The man's general condition had seemed to indicate so clearly the existence of some pus formation that the lumbar incision had been made, and the region of the cæcum explored with the finger. No trace of inflammation could be found, so the wound had been drained. On dressing the wound three days later, the drainage tube had been found to be filled with extremely thick, foetid pus. There had evidently been a collection of pus deep down in the cæcal region. Two days after this he had said that he had felt a passage of gas through the tube under the dressings, and two days after this, after an enema of about a quart of soap and water, a considerable quantity of this had come through the drainage-tube. The speaker had advised the administration of another injection containing some coloring matter, but, before this could be done, some faecal matter had escaped through the wound, thus proving the existence of a perforation. During the past ten days there had been no discharge of faecal matter, and the pus was quite scanty. The drainage-tube had not been disturbed, the bowels were moving regularly, there was no elevation of temperature, and the patient's general condition was rapidly improving. The perforation must have occurred at the time of the collapse, but the general peritoneal cavity had escaped. The peculiar features connected with the tumor might be explained on the supposition that in consequence of the local irritation there might have been sufficient œdema of the cellular tissue to lead to the error regarding the existence of fluctuation.—*N. Y. Med. Jour.*

OPIUM ENEMATA IN THREATENED ABORTION.

—In the *Gazeta Lekarska*, No. 33, 1891, p. 657, Dr. Feliks Arnstein, of Kutno, Russian Poland, maintains that in cases of threatened abortion the practitioner is justified in accelerating and

terminating the process only when the interruption of gestation is induced by death of the fetus. "In all other cases," he says, "be the uterine pains of short or long standing, weak or strong; be flooding absent or present, scanty or profuse; be the cervix softened or not, and the os closed or widely gaping—in all alike treatment must consist in adopting all possible measures for retaining the ovum in the womb and arresting its threatened expulsion therefrom." As far as the writer's personal experience goes, the best way to accomplish this is the persevering administration of opium per rectum. As much as fifteen drops of simple tincture of opium, *Ph. Ross.* (containing one in ten of the drug), with two tablespoonfuls of lukewarm water, should be injected into the bowel every hour, the patient lying quietly in bed and taking occasionally some acid drink. Leaving out of consideration cases in which complete detachment of the ovum has already taken place, the treatment is said to be followed by the best possible results: "the uterine pains steadily and fairly quickly become less intense and less frequent, and ultimately cease altogether; hemorrhage becomes less and disappears; in some (occasionally twenty) hours the os is found to have contracted and the ovum to have receded." The author relates a case in which a fairly advanced abortion was controlled by the injection of 45 drops of the opium tincture. In some cases, however, the total quantity required for the purpose may amount to 80 or even 100 drops. Pregnant women are thought to tolerate opium much better than other persons, the toxic effects being usually limited to a heavy feeling about the head and drowsiness, which disappear in a day or so.—*British Medical Journal.*

ON THE LOCAL TREATMENT OF STRANGULATED HERNIA BY ETHER.—Dr. Finkelstein gave in 1882, from his own practice, 63 cases of strangulated hernia. Of these, five yielded to taxis. In 58 he employed "local etherization," taxis having failed, and of these 58 cases 54 proved successful. Of the four unsuccessful cases two underwent surgical operations and two died refusing operative treatment. The method is simplicity itself. The patient is placed on his back, with the hips slightly raised and legs flexed, and then every ten minutes or a quarter of an

hour a tablespoonful of sulphuric ether is poured on the hernia-ring and tumor. The application of ether is carried on for, as a rule, from three-quarters to three hours (or even four hours) until the tense tumor relaxes and lessens a little. As soon as this occurs, and if the strangulated bowel does not reduce itself, several slight efforts are made to reduce it, and almost "always" it slips with a gurgle and amazing ease into the belly cavity. If the omentum alone be strangulated, the ether method is absolutely useless. As the ether causes an after feeling of heat and burning on the penis, labia, etc., Dr. Koch (America) protects these and other sensitive parts by previously smearing them with olive oil, and, in addition, covering them with pledgets of cotton wadding. The ether seems to act thus. Richter, Velpeau, and others, hold that strangulation may in some cases be caused by spasm of the abdominal orifice. In these cases the ether may act by relaxing the spasm and thus reducing the bowel movable. That may be so, our author remarks, but he himself lays most stress on the property ether has of producing intense cold by rapid evaporation. The intense cold condenses the gas in the bowel, and by so doing diminishes its calibre. Possibly, also, the cold stimulates the peripheric nerves in the bowel sheath, and excites it to natural peristaltic action, which is more likely to empty it of gas, fluid and semifluid contents than the rude manipulations in taxis.—*Medical and Surgical Reporter*.

ARISTOL IN CANCER OF THE UTERINE CERVIX.—E. Arcoleo reports (*Rif. Med.*, October 10th, 1891) the results obtained by him with aristol in cases of cancer of the cervix. In the first case the disease had existed for about a year, and the patient complained of constant lancinating pain in the hypogastric region and loins, which hypodermic injections of morphine only slightly relieved; hemorrhage was frequent and abundant, and there was a copious, foul-smelling, ichorous discharge. The cervix was completely adherent, the anterior lip being entirely replaced by an ulcerated growth, which also involved one-half of the posterior lip. The curette and the thermo-cautery had been freely used without appreciably checking the progress of the disease. Aristol was insufflated through

a speculum, a small pledget of cotton-wool being afterwards left in the vagina. After the very first application the patient felt so much relieved that she was able to sleep at night, which the pain had previously prevented her from doing. A few days later the hemorrhage, which was rapidly exhausting her, ceased, and at the date of the report, forty days afterwards, it had not come on again. The discharge was also very markedly decreased and the general health improved. On examination after six weeks' treatment, it was seen that the limits of the malignant ulceration had not extended in the slightest degree; the ulcerated surface was shallower and in every way healthier looking. In several other cases the effects of insufflations of aristol were equally satisfactory. Arcoleo sums up its action as follows: (1) It relieves pain to a remarkable degree; (2) it stops bleeding; (3) it lessens the amount of discharge; and (4) it makes the latter comparatively inoffensive. The action of the drug is purely local; it is not absorbed, and therefore no toxic effects need be apprehended.—*British Medical Journal*.

BISMUTH SUBNITRATE AS A DRESSING FOR THE UMBILICAL CORD.—For several years I have used bismuth subnitrate as a dressing for the umbilical cord in the newborn. The method of application is as follows: Cut a piece of lint sufficiently large to fold over and prevent the bismuth from being dispersed. Through this a hole is made small enough to fit tightly about the cord and prevent dispersion at that point. The abdomen about the cord is dusted with the bismuth, the cord is passed through the hole in the lint, and the lint pushed well down upon the abdomen. Bismuth enough to completely bury the cord is applied, the lint is folded over smoothly, and the binder applied. The advantages I claim for this mode over all others are the following: (1) Convenience. It has to be applied only once, as the cord immediately dries up, and does not need to be disturbed until it has dropped off. (2) Cleanliness. There is absolutely no odor, and the addition, at the time of the bath, of a little bismuth to places showing evidences of moisture will keep everything dry and sweet. (3) Safety. Mothers and nurses are not meddling with the dressing, since everything goes on so satisfactorily. There is left no

sloughing, discharging stump to corrode the surrounding tissues and bring on hemorrhage or predispose to hernia. (4) The cord drops off sooner than by any other method. For small cords, three days; for large ones, five—rarely exceeding six—constitute the usual time. (5) A better and firmer cicatrix is left than by any other method known to me. Since I have been using the bismuth dressing I have had no accidents, and 100 per cent. of good results. Much depends upon the manner of dressing, and I have, therefore, somewhat minutely described its application.—George A. Stuart, M.D., of Wahu, China, in *Medical News*.

OXALURIA AND HÆMATURIA.—Of the clinical significance of the excretion of oxalate of lime in the urine, in the condition described as oxaluria, very little is known. Numerous cases of so-called cyclical albuminuria, accompanied by oxaluria, have been described in *The Lancet*, in which by some authors the albumen was ascribed to irritation of the kidneys by the crystals of oxalate of lime. That some of the albumen in those conditions is derived from the urinary tract is highly probable, but the following case seems to support the view that the excretion of crystals of oxalate of lime does irritate the kidneys in some cases.

Mrs. M—, a young woman of very rheumatic history, was taken ill during the night of July 20th with severe pain in the lumbar region. She likewise had headache and felt very feverish. Next morning the pain was easier, though the headache was still present, and she noticed that her urine had become of a bright-red color. There was no pain on micturition. I saw her on the following day; she was then complaining of headache. Pain in the back still present; no œdema. First sound of heart loud and accentuated. Pulse 100, full, and of rather high tension. Urine faintly acid, containing blood in large quantities and albumen. Under the microscope the deposit was seen to be composed of blood-corpuscles, crystals of oxalate of lime, and numerous tube casts containing epithelial and blood cells, oxalate as well as crystals. On inquiry I found that for three days before the attack the patient had been partaking largely of rhubarb, which she said she knew never suited her. She was directed to take nothing but milk,

to rest in bed, to keep the bowels freely open with Friedrichshall water, and nitro-hydrochloric acid was prescribed. On the following day there was marked improvement. The pain in the back was gone, the blood and casts were decidedly diminished, and urine was passed in larger quantity than formerly. The oxalates were still present. By July 26th the blood, albumen, and casts had entirely disappeared, and the patient was feeling quite well.

In the *Monthly Journal* for August, 1849, Begbie describes certain cases of what he terms the oxaluric diathesis, but in none of his cases, though there was pain in the back, does there seem to have been kidney irritation produced. The passage of the oxalates in the case above quoted differs from his, in that the oxalic acid seems to have been absorbed directly from the stomach, and not to have been produced during the process of digestion and assimilation. That there was in this case a true nephritis I think there can be no doubt from the presence of the casts, and the oxalate of lime crystals seem to be the cause, and not a mere concomitant.—Francis D. Boyd, M.B., M.R.C.P., in *The Lancet*.

SYPHILITIC INFECTION THROUGH SHAVING (*Allg. Med. Centralblt.*, 1890, 8).—In the *Berliner Dermatologischen Vereinigung*, Herr Oestreicher describes the case of a patient who contracted syphilis through a scratch he received in shaving. On the patient, a man about thirty years of age, a papulo-squamous rash was found, which, in addition to very pronounced polyadenitis, mucous patches on the soft palate, falling off of the hair, led to the diagnosis of syphilis. The patient did not remember even having had a sore on the genitals. In agreement with this, no scar could be found as the remains of a primary sore. After prolonged search, the author found on the left cheek, at the edge of the beard, a solitary scar-like thickening, which looked like a healed hard chancre; on this side of the head also the submaxillary glands were found much swollen. The patient remembered having been cut by the barber shaving him some weeks before, but could give no account of the further course of the disease.—*Medicisch Chirurgische Rundschau*, May 15, 1891.—G.A.F.

A NEW INDUSTRY.—To mention Upsal is to the majority of readers to recall Swedenborg to memory. But to the scientist, Upsal will ever be dear as the scene of Charles William Scheele's labors—labors great and numerous, any one of which would have shed lustre on his name, and all of which were completed prior to his premature death at forty-four years of age. One of the last of his works was the discovery and isolation of the sweet principle of oils and fats—glycerine—at first a mere chemical curiosity in the little laboratory of that far-off Norse town duly labelled and described by one who wore out his life in questioning Nature. But with what a result! How many thousands now enjoy wealth, and how many factories now raise their tall chimneys as monuments to the silent questioner, let one, and that one the least of his mighty works tell. The *Chemist and Druggist* informs us that the output of glycerine is 40,000 tons per annum. But this of itself is really nothing to the secondary results of the great chemist's discovery. He bestowed on the world cheap and good candle-light, and enabled manufacturers to produce a soap better and less expensive than was before known. Mining operations are rendered more easy by the glycerine compounds; smokeless powder makes a demand on it, and its use in pharmacy is daily becoming more essential. To write a list of the preparations into which glycerine enters, and of the method of its preparation, would be to give a summary of the majority of the domestic and scientific products that distinguish the civilization of the present from that of the past century.—*Med. Press and Cir.*

EXPERIMENTS IN GUNSHOT WOUNDS.—The army surgeons who have been attending the course of operations under the direction of Professor Kocher, of Berne, have just been studying at Thoun the destructive powers of the new Swiss rifle. In their presence have been practised several series of rifle shots, at ranges of from 60 to 600 metres, with bullets proportionately varying in velocity. Among the objects fired at were materials of various kinds, including osseous structures and pieces of wood filled with liquid, in order to take note, by way of analogy, of the effects of the bullet on the living subject. These experiments have amply

confirmed what has long been practically admitted, that at high velocities the bullet discharged from small-bore firearms produces effects analogous to those of an explosive projectile.—*London Lancet.*

THE Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS
OF THE MEDICAL SCIENCES.

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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TORONTO, JANUARY 1, 1892.

THE ELECTION PROTEST FOR THE BURLINGTON AND HOME DIVISION.

It will be remembered that at the last general election for the Ontario Medical Council, Dr. George Shaw was declared duly elected, and acted as the representative for the Burlington and Home Division for one session. A protest was entered, and the matter came before the Committee on Credentials, who were thus called upon to act in a judicial capacity. After a consideration of various questions which were raised, it was found that the members of the committee were unable to agree, and, as a consequence, a majority and a minority report were submitted, the result being that the report of the majority was accepted and Dr. Shaw was unseated.

We publish in this issue a letter from Dr. Shaw on the subject. We do not propose at this time to discuss the details of the points at issue. From what we could learn at the time the decision was reached, we were inclined to think that Dr. Shaw was rather harshly treated. From what we have heard since the meeting of the council, we believe there is a pretty general consensus of opinion among those who have carefully considered the matter that the minority report was the one which, in justice, should have been accepted by the council. The Committee

on Credentials may be a very good one in a way, but as a court of appeal—perhaps the less said about it the better.

DR. CANNIFF'S NEW WORK: "THE
MEDICAL PROFESSION IN
UPPER CANADA."

We are glad to learn that this work will shortly be published. We understand it will be illustrated by a considerable number of portraits of physicians, among whom are Drs. Widmer, Rolph, and Workman. There will also be a picture of the first medical school building in Upper Canada, erected for the medical department of King's College. We quote as follows from Mr. G. Mercer Adam's expressed opinion of the work:

"The historical narrative-treating of the medical men in Upper Canada from the foundation of the Province, which Dr. William Canniff, of Toronto, is now passing through the press, ought to be hailed with satisfaction, if not with delight. The beginnings of the professions in Upper Canada necessarily introduce to us many of the men who were the makers of the Province. Of these, the physicians and army surgeons who settled in Upper Canada after the Revolutionary War form no inconsiderable portion of that element in the community which gave substance to the national fabric and contributed to its integrity and stability. It adds no little to present-day interest in these early medical practitioners to know that not a few of them were U. E. Loyalists, and identified with the cause which led many of the then inhabitants of the Province to sacrifice their all for the sake of living under the grand old Red Cross banner of Britain. Coming from the pen of so devoted a student of Canadian history and enthusiastic member of the medical profession as Dr. Canniff, the subscription list should be eagerly filled, and the work thereby hastened in its appearance. A youthful community like Canada owes too much, in many ways, to its medical men of a past generation to be indifferent to their fame or heedless to their memory."

We regret that we have not space for the list of physicians to whom reference is made in the work, but it includes all the prominent doctors of the past and many of the present generation.

DANGERS OF TURKISH BATHS.

Two deaths which have recently occurred in Turkish bathing establishments in New York city have impelled *The Medical News* to give a word of caution on the subject. In one case a young man died in convulsions in the hot room;

in the other the bather died suddenly after coming from the plunge bath. There appears to be no certainty as to the exact cause of death in either instance; but the results are not a great surprise to those who have any knowledge of the workings of such institutions in recent years.

Such baths are undoubtedly useful from a hygienic and therapeutic point of view, but are quite unsuitable for many, and positively dangerous for a few. *The News* well expresses the position in saying: "There can be little doubt that in certain forms of cardiac, arterial, and cerebral disease, the bather should act upon the advice of his physician, and there can also be little doubt that every bathing establishment should see that supervision and guidance are exercised over the bathers. The pulse rate is immensely quickened in the hot air, and a too protracted stay has probably in many cases proved injurious."

PAN-AMERICAN MEDICAL CONGRESS.

The arrangements for the meeting of the congress in '93 are being rapidly pushed. For a time it was expected that the preliminary publications would be printed in English and Spanish only. It has been decided, however, by the executive committee, to use the Portuguese also, out of consideration for the large number of distinguished physicians in South America who speak this tongue, and have promised their cordial support towards the success of the undertaking.

Meeting of Medical Societies.

TORONTO MEDICAL SOCIETY.

November 18th, 1891.

The president, Dr. A. A. Macdonald, in the chair.

Dr. A. H. Wright read a paper on

THE TREATMENT OF PLACENTA PRÆVIA.

As a rule the first symptom which calls our attention is a hemorrhage, coming on suddenly without any known cause. Not infrequently there has been comparatively little bleeding, which may have ceased entirely before the physician has seen the patient. Under such circumstances there is a great temptation to temporize. We should ever bear in mind that the life of a woman with placenta prævia is in constant danger until the uterus is emptied. Whether the placenta just reaches the internal os,

or covers it, there exists the grave danger of a hemorrhage which may cause death before the doctor can reach the bedside. The safest procedure for the mother is, therefore, the immediate induction of labor. There is, however, a serious objection to such an action when the fœtus is alive, but not viable. While I would not sacrifice the life of a mother for such a consideration, I would be willing to assume certain risks in the interests of the unborn babe. I would say in a general way: Keep your patient quiet; if possible, have with her a trained nurse capable of acting promptly in case of alarming hemorrhage; as to yourself, keep as close as possible to the handle of your patient's front door, armed with your best-filled obstetric satchel. When the fœtus is dead our rule should be to induce labor at once.

When pregnancy has advanced to the end of the seventh month, we have to consider the safety of both mother and child—the welfare of the mother being the more important consideration with most of us. Fortunately, in the majority of cases the induction of premature labor is safer for both mother and babe. At this stage the child is viable, and under a policy of non-interference its chances in utero are somewhat precarious. The partial detachments of the placenta, which are apt to occur, and which cause the hemorrhages, tend to produce asphyxia in the child. If, on the contrary, no hemorrhages occur up to the time of labor, and only slight ones then, the mother is comparatively safe, and the newborn babe is likely to be strong and vigorous. Such happy but exceptional histories should no influence us in the direction of a do-nothing policy, or what is called the expectant plan of treatment. Under such circumstances it is decidedly better for the mother, and certainly as well if not better for the child, that premature labor should be induced.

Barnes' hydrostatic dilators are considered by the majority of authors the best means of dilating the cervix and producing labor pains. I am not a great admirer of these dilators. Rubber is a most unreliable material in this changeable climate of ours. After having kept the bags for a few months, we are apt to find them utterly useless when we want them. They are not easy to use in all cases, as they are prone to slip in too far, or suddenly pop out of the cervical canal as we are filling them. In injecting them with water it is hard to know when they are properly filled. If we inject too little they are not of much use, and if we inject too much they may burst. However, they are sometimes very useful, and it is well to have them at hand.

There is another dilator, somewhat old-fashioned, in disgrace in certain quarters, viz., the clean fingertip, or a combination of two or three fingers. Put intelligent eyes into your finger ends, proceed cautiously and carefully in stretching the cervical canal with them, and you can frequently, if not generally, do good work. In a large proportion of these cases the cervix is soft and easily dilatable and, under such conditions a judicious use of the fingers can accomplish much. The finger dilation may, however, do much harm if accompanied by undue force, in consequence of the development of large blood vessels in the cervical region through the faulty position of the placenta.

Another method, rather old, and vigorously condemned by some of our ablest obstetrical authori-

ties, is the vaginal tampon. Braxton Hicks, in the discussion on placenta prævia at the British Medical Association, August, 1889, speaking of the stoppage of hemorrhage, says: "With regard to the pressure by the tampon, I believe that the general consensus in British midwifery is against its use, and with this I am in accord—partly because, unless perfectly done, and this is difficult, it is of no use; and if perfectly done, it is very distressing to the patient, especially if it be necessary, which it often is, to renew it to avoid septic generation. Still it has some advantages, because, by distending the roof of the vagina, we also dilate the os, and provoke uterine action. But its action is tedious, and lacks the precision afforded us by the more recent methods." On the other hand, so high an authority as Dr. More Madden stated that after trying various plans he had found nothing superior to the tampon, "the introduction of which is followed by labor, and then effecting delivery by version."

In considering so vital a question as the treatment of placenta prævia, I am anxious to choose a method not only efficient, but always available. Barnes' bags are excellent things in their way, but very unreliable. Any practitioner, though he own a dozen of them, may be caught in an emergency when the bags are not at hand. The materials for a plug are always easy to get. You can get clean cotton, hot water, and soap in any house. You will probably have some antiseptic with you; if not, your soap and hot water will clean the fingers, with the aid of a penknife, and your hot water will render aseptic anything like ordinarily clean cotton. If you are attending a case of placenta prævia, with a dead fœtus or viable child, where there is hemorrhage with an undilated os, your aim should be to stop the hemorrhage and at the same time dilate the os and bring on labor as soon as possible, and for that purpose I contend that one of the most easily available and most efficacious procedures is the introduction of a vaginal tampon. Dr. Hicks thinks that unless it is perfectly done it is of no use. Certainly! I agree with him, but it ought to be perfectly done. He also objects because it is very distressing to the patient "if perfectly done." My opinion is that if it is perfectly done it is not, as a rule, very distressing. Dr. Hicks admits that it has some advantages in distending the roof of the vagina and thus dilating the os and provoking uterine contractions.

This leads to the question: What may we expect from the tampon? (1) It helps to prevent hemorrhage in two ways; first, by direct pressure; second, by irritating the nerve ganglia in the upper portion of vagina and thereby causing uterine contractions. These uterine contractions tend to close the bleeding vessels by the direct pressure, and also by forcing the fœtus against them. (2) It helps to dilate the os in the majority of cases. (3) It excites the uterine contractions, and thus, together with the dilatation of the os, precipitates labor.

For material I prefer old soft cotton torn into strips not more than an inch and a half wide. I generally have these strips stitched together so as to have one continuous piece, which is very easy to remove. I saw this plan carried out by the late Dr. Taylor, of New York, about twenty years ago, and I have seen no improvement on it since, excepting the additional antiseptic precautions. Dr. Taylor used the cotton in the form of an ordinary

roller bandage, but I prefer to leave it loose in a basin of bichloride solution, 1-5000, and draw it from the antiseptic solution as I place it in the vagina. Iodoform gauze torn into strips in the same way answers admirably for the same purpose. Although not absolutely necessary, it is a great convenience to have a Sims' speculum. It is very important to pack the upper part of the vagina carefully and systematically, first surrounding the cervix and then putting the cotton within the os if possible. It is not well to distend the vulva very much because it causes great pain, and it is not necessary, as pads carefully placed over the vulva, and properly retained there, will exert all the pressure needed.

During the progress of labor, while the os is dilating, the great danger is from hemorrhage. If we can manage to control the hemorrhage, as a general rule we have nothing else to do. Formerly it was considered all-important to complete the delivery as soon as possible, and hence arose the procedure known as "accouchement forcé," which is now so generally condemned. In the early stage, when there is only slight dilatation of the os, I would rely chiefly upon the tampon introduced into the vagina in the manner indicated. After the os is dilated so that the fingers can be introduced we should still check hemorrhage, and the best way to accomplish that is to cause pressure on the bleeding vessels by means of the fetus.

I have never seen a case in which the placenta could not be pushed to one side of the internal os. As soon as one or two fingers can be passed this should be done and the membranes ruptured; then try to bring the head or breech of the child against the placenta. In some cases the forceps may be applied to the presenting head, which may then be brought down until it presses on placenta. Here it may be left, especially if the cervix is not fully dilated, and the labor finished in the normal way.

It occasionally happens in central placenta prævia that the edge of the placenta cannot be reached, even when the finger is introduced within the os and swept in every direction, separating the placenta from uterine tissue; and in such cases it is sometimes necessary to push the finger through the placental mass before the membranes can be ruptured, or the manipulations of the fetus can be accomplished.

In the great majority of cases there is a definite line of treatment which should be adopted after the os is wholly or partially dilated, *i. e.*, the treatment recommended by Dr. Braxton Hicks: turn by the combined or bimanual method and pull down the leg until the breech presses against the placental vessels. As soon as the hemorrhage ceases, stop pulling on the leg and leave the case to nature. If bleeding recurs, pull again on the leg until the breech is brought against the placenta with sufficient force to act as an efficient tampon. Turning by Hick's method can frequently be performed when the os is sufficiently dilated to allow only one finger to pass through it.

I would summarize as follows:

(1) If hemorrhage occurs before child is viable, wait and watch carefully, unless the bleeding is copious.

(2) In all cases where the child is dead or, being alive, is viable, induce premature labor at once.

(3) In doing this use first the vaginal tampon,

and complete the dilatation of the os with the fingers or Barnes' dilators.

(4) When the os is wholly or partially dilated, try to bring the head or breech in a position to act as a tampon on the bleeding vessels.

(5) In the majority of cases rupture the membranes, turn by the combined method, and pull the leg until the breech acts as a plug; then leave the case to nature, unless a necessity for interference arises.

Dr. Britton had seen four cases, of which two had been fatal. One is very apt to overlook slight hemorrhages as due to tears of small cervical vessels; but when sudden severe, perhaps fatal, hemorrhage sets in, the true cause of the trouble becomes apparent. His first case was a multipara. Os was partly dilated; some slight hemorrhage. Suddenly severe hemorrhage set in; os was dilated and a marginal placenta prævia found. Delivery was effected with forceps. Half an hour after delivery fatal post-partum hemorrhage occurred. Had the slight initial hemorrhage led to a careful vaginal examination, the fatal result might possibly have been averted.

In another case a placenta prævia was found partly covering the os; the placenta was separated at one side, membranes ruptured and version done. In this case also there was violent post-partum hemorrhage. The inside of the uterus was swabbed out with cotton soaked in tinct. ferri mur. Violent tonic contraction ensued and the case went on to recovery.

Slow delivery is not always safe. In a case of placenta prævia where hemorrhage had been so severe that sighing and complaint of constriction around the chest were marked symptoms, the os was dilated with the fingers and version done. In spite of the feet and the hips being brought down and left, very severe bleeding kept up, probably from laceration of some large cervical vessel during dilatation. In such a case speedy delivery is certainly indicated. Shortly after delivery profuse post-partum hemorrhage occurred, although it had been anticipated and every precaution observed. This bleeding lasted for an hour; seven hours afterwards death occurred from a convulsion.

Astringents might be of some use. In a multipara with central placenta prævia, the os was found to admit two fingers. The finger was swept around and then warm liq. ferri persulph., 1 in 5, injected, controlling the bleeding. This process was repeated until the edge of the placenta was reached, when delivery was effected by version.

Post-partum hemorrhage is frequent in placenta prævia because of the weakening of the patient by previous loss of blood, and because from the abnormal position of the placenta there is but little uterine tissue to contract around it, and so check hemorrhage. If the foetus is dead the placenta is contracted; there is less circulation in the part and less danger of hemorrhage. The tampon he had used but once for placenta prævia. Hemorrhage may occur in spite of the tampon if the uterine contraction be not very strong.

In the way of prevention something might be done. Most cases occur in multiparæ who have chronic endometritis. Naturally, no doubt, the ovum adheres to the first convenient place. Owing to the endometritis, the ovum falls lower down because the normal preparation for the ovum by hy-

peritrophy of the mucous membrane has not been so complete. Uterine tumors, by altering the shape of the uterus, predispose to placenta prævia. It should be a rule of practice to examine the uterus a month or six weeks after placenta prævia, in order to find the cause of the condition.

Dr. Powell had seen three cases successfully treated by means of the vaginal tampon.

Dr. Cameron had seen but one case, and in it Barnes' method followed by version had been used. Forceps were needed to deliver the after-coming head. The placenta was adherent and had to be stripped off piecemeal. Post-partum hemorrhage followed and was successfully dealt with. Carbolic acid injections were ordered, but the nurse injected the fluid into the rectum and carbolic acid poisoning followed. The solution of bichloride proposed was too strong, for the vaginal mucosa may be irritated by even 1 in 5000. Creolin or carbolic acid are better.

Dr. Machell thought that too much stress could not be laid on the fact that if the child was viable, and there was any hemorrhage, interference should be immediate.

Pathology.

THE DISSEMINATION OF TUBERCULOSIS BY PASSENGER TRAFFIC ON RAILWAYS (Prausnitz, *Central. für Bakt. u. Parasit.*, Sept. 18, 1891).—Incited thereto by Cornet's investigations, Prausnitz investigated the dust taken from passenger trains for the bacillus tuberculosis. He chose for his experiments through-going cars, which were most used by consumptives. After the arrival of the train from Berlin in Munich, he swept up the dust collected underneath the compartment carpets of the selected cars and mixed it up in a sterilized porcelain capsule, mixed a part of it in sterilized distilled water, and injected it into the peritoneal cavity of guinea-pigs. In this way twenty guinea-pigs were injected with the dust taken from ten compartments of four cars on five days. Of these twenty guinea-pigs, five developed tuberculosis. The dust used in these five cases all came from two cars. The experiments showed that the dust of railway cars, in which one would presume that large numbers of tubercle bacilli might be present, for the most part contains none of these germs, and even in the cars which are longest on the road the dust contains but few. "The ordinary method of cleaning out railway passenger cars suffices to keep them so free of tubercle germs that danger to the travelling public in this respect seems to be excluded."—J.C.

SUPPURATION COMPLICATING TYPHOID FEVER (*Centralb. für Bakt. u. Parasit.*, Nov. 7, 1891).

—Dèstrée made bacteriological investigations in the case of a number of patients ill of enteric fever, in the clinic of Prof. Stienou, and with the following results: In four cases of abscess in different locations (viz., right and left mammae, left axilla, region of sacrum), only the staphylococcus pyogenus aureus could be found. In a fifth case, in which there appeared a left-sided acute purulent ostitis in the convalescence stage, Eberth's bacillus alone was discovered. The investigator concludes that whilst the typhoid germ may excite suppuration, in most cases the ordinary pyogenic forms are the cause.—J.C.

Correspondence.

Editor of THE CANADIAN PRACTITIONER:

SIR,—With your permission I desire to point out an apparent defect in the Ontario Medical Act which should be remedied before the next elections in 1895, and in doing so I shall refer to the recent Burlington and Home protested election, which was decided at the last session of the Medical Council, and to which you referred in your issue of July 1st. It will be remembered that I was elected, and that my opponent, Dr. Miller, entered a protest, with the result that the Committee on Credentials gave him the seat by a majority of two. In doing so they allowed Dr. Cattermole's vote for my opponent and disallowed the votes of Drs. O'Reilly, Ranney, Robinson, and Lafferty (the returning officer), who had voted for me. Firm in the belief that I did not receive justice at the hands of the committee, I submitted all the facts in connection with the protest to Mr. A. B. Aylesworth, Q.C., Toronto, with the view of appealing from the decision of the council.

Re the vote of Dr. Lafferty, Mr. Aylesworth says: "In the absence of any legislation depriving the returning officer of his vote at an election for member to the council, I can see no reason why such returning officer (if otherwise qualified to vote at any such election) could not validly cast his ballot with precisely the same right as any other elector. I think, therefore, that, unless there is some legislation in the council by-laws declaring that the returning officer is

not entitled to vote at the election in his division, he is so entitled, and his ballot ought to be counted."

Mr. Aylesworth again says: "As to the votes of Drs. O'Reilly and Ranney, I do not see how there can be any question, if they were at the time duly registered practitioners."

I might add that after the council adjourned, Drs. Bray, Campbell, and myself met Mr. W. R. Meredith, Q.C., and Dr. Bray, who was a member of the Committee on Credentials, stated to him the case of the returning officer's vote, and Mr. Meredith took precisely the same view as given above by Mr. Aylesworth. I might say further that the returning officer had written instructions from Dr. Pyne that it was proper for him to cast his ballot; also that returning officers had voted at such elections in the past, and that the returning officer's vote had been allowed by the council in a former protested election case, which facts were known to the committee when they disallowed the returning officer's vote cast for me. So far the opinion of my counsel is quite satisfactory, because, without going further, it would give me the seat. But now comes the disappointment, for again Mr. Aylesworth says: "Section 10 of the statute provides for the case of disputed elections, empowering the council to hold an enquiry and decide who is the legally elected member; and the section goes on to declare that the person whom they decide to have been elected shall be, and be deemed to be, the member duly elected, and the question is whether, in view of this enactment, there is any other remedy open to a dissatisfied candidate than this section provides. . . . The general rule is that where a new right is given in a statute, accompanied by specific remedies, the remedy is confined to those specifically given." After reciting precedents, etc., he says: "On the whole, therefore, the best opinion I can form in the matter is that there would be great doubt as to the jurisdiction of the court to entertain the matter at all, and the gravest reason to fear that the only safe course of procedure (if proceedings are taken) to adopt, viz., by *quo warranto*, would be so tedious, expensive, and uncertain, one would hesitate before advising a client upon such a line of litigation. . . . I have known several cases in which such pro-

ceedings were instituted and carried on some distance, but I have not met in my practice with any case in which a proceeding of this character has been carried to a termination."

You will agree with me that Mr. Aylesworth's opinion is second to none in Ontario; and while from a counsel of such high standing it will be seen that I was entitled to the seat, yet, owing to the wording of section 10, I was practically debarred from bringing the matter into court. It seems to me, therefore, that a change should be made in the statute governing elections whereby they would not come before the council at all, but that instead they should be taken before a judge in the territory in which the election is held, which would not only be simple, but would materially reduce the cost, to be paid by the candidate or candidates, as the court may direct. It is a well known fact that when parliament dealt with protested elections to the House of Commons, the member opposed to the government of the day almost invariably lost his cause, which led to the radical changes which have been made in the procedure in connection with such cases.

The Medical Council this year was divided into two opposing factions over the proposed changes in the curriculum; one determined to carry certain clauses, the other equally determined to prevent the same. I voted with the minority, and, figuratively speaking, against the government. It is notorious, too, that in former protests the decisions of the council have not given unmixed satisfaction; for instance, Quinte and Cataraqui, of some years ago; Malahide and Tecumseh, in 1890; Miller v. Russell, the same year, in reference to which the petitioner stated that he had been "snuffed out" by the council. My suggestion would relieve the council of all trouble. There would be no chance for unfavorable comment upon its ruling, as there has been in the present instance, not only by my own supporters, but by some who voted against me, by others not residing in this division, and by yourself in your editorial on the subject in your issue of July 1st. It would also be a safeguard against the minority candidate getting the seat.

Following are the reports of the Committee on Credentials under date of June 13, 1891

"The committee to whom was referred the protest against the election of Dr. Shaw for the Burlington and Home Division beg leave to report that they considered the objection to certain votes; and after a careful scrutiny of all the votes, find that Dr. Miller has been duly elected."

Dr. Bergin, Chairman.

D. L. Philip, Secretary.

To the President and Members of the Council of the College of Physicians and Surgeons of Ontario:

Gentlemen,—I beg as a member of the Committee on Credentials to present the following minority report:

1. I think the vote of the returning officer should have been allowed.
2. I think the vote of Dr. Ranney should not have been disallowed.
3. I think the vote of Dr. Cattermole should have been disallowed.
4. I think the vote of Dr. O'Reilly should have been allowed.
5. I think Dr. Shaw should have been allowed the vote of the returning officer, that of Dr. Ranney, and also that of Dr. O'Reilly, which would give him fifty-eight votes, and that the vote of Dr. Cattermole should have been disallowed to Dr. Miller, which would have given him fifty-six votes.
6. It is my opinion that seat No. 6. Burlington and Home Division properly belongs to Dr. Shaw.

All of which is respectfully submitted.

Henry W. Day.

(The Committee on Credentials was composed of Drs. Bergin (Chairman), Moore, Bray, Philip, Day, and Fenwick.)

Since the publication of the council proceedings, in which the minority report gives me the seat by two votes (see announcement pp. 221-2), my friends cannot understand why a majority of the Committee on Credentials thought, or rather reported, differently; and, at the risk of trespassing on your space, I shall endeavor to throw a little light upon the matter. The report of the Educational Committee this year was a bone of contention in the council, as will be seen by reference to its proceedings, and a very strong feeling existed in the council over the proposed changes. The chairman of the Committee on Credentials was determined to carry through some of the proposed changes, and to this end not a little canvassing was done, with the result that some of the members of the council voted one way, though, it has been stated, they promised the opposite. The test of strength was over the clause extending the student's period of study from four years to five,

which has for some time, I believe, been a hobby of Dr. Bergin, chairman of the Educational Committee, as well as of the Committee on Credentials. Now, while I was in favor of raising the standard, I was opposed to the five-year clause, and so voted; but it was carried by the casting vote of the chairman when in Committee of the Whole. The protest was heard on Thursday afternoon, and the committee adjourned till 8 p.m. the same evening, but did not meet owing to the reported indisposition of the chairman, though he was apparently quite restored next morning at 9 a.m. Please notice that it had been arranged that the report of the Educational Committee was to come before the council on Friday, and Friday evening at 7.30 was appointed for the Credential Committee to meet again, but again the appointment was not kept—can any one surmise why? Was it because Dr. Bergin's pet scheme was not finally disposed of in the council, as was expected, and that it was thought best to hold the lash over me a little longer in the hope that it might influence my vote? Will some one tell me why, when the changes in the curriculum had been finally disposed of, and after the hardest and longest day's work of the session, the Committee on Credentials cheerfully met as late as 11 p.m. and remained till midnight, allowing votes against me which some of its members, unsolicited, had early in the week stated to me were, in their opinion, properly disallowed by the returning officer? I may say that at least one member of the committee, after the council adjourned, had the boldness to state that they looked upon my course (as a new man) in voting against the Educational Committee's report as a want of confidence in that committee, and intimated that I should be treated accordingly. Before I left Toronto a member of the council said to me: "Well, Shaw, I'm very sorry about this, but I told you yesterday you were voting with the wrong crowd," thus plainly conveying the information that I had been condemned on account of my vote on the Educational Committee's report. To those familiar with all the facts, it is now an open secret why the protest went against me. The committee presented its report at the close of the session after some members had gone and when others were anxious to get away to catch

the trains for home, and it was received without the council having time to inquire into its merits. Had it been presented earlier in the session, I do not doubt that the council would have done me justice, because I believe it contains many capable, honest, and faithful representatives, true to the trust committed to them. I have always been, and am yet, a strong supporter of the council, and believe it has been of great benefit to the profession; but I think there is great danger of a legislative body of its character becoming arbitrary in its enactments, and its methods assuming too much of the style of a modern "star chamber." No man can complain of being fairly and squarely defeated; but to feel that you have honestly won and then be deprived of your victory without any means of redress is, indeed, as you say in your editorial, "hard luck."

GEO. M. SHAW.

Hamilton, Dec., 1891

Book Notices.

Transactions of the Southern Surgical and Gynecological Association. Volume III. Third Session, held at Atlanta, Georgia, 1890.

This vigorous young society is doing excellent work. We understand that that high-minded and distinguished son of the "Sunny South," Dr. W. E. B. Davis, of Birmingham, Alabama, conceived the idea of such an organization, and its pronounced success is largely due to his indefatigable efforts. This third volume of its transactions contains many good papers and discussions. Among the authors are many of the brightest lights in America, such as McMurry, Joseph Price, Warren Potter, Charles A. L. Reed, Reamy, Howard Kelly, Engelmann, Maury, Gaston, and others. This young association promises to do great things in the future for the "New South." We congratulate its able and large-hearted enthusiasts upon the brilliant success that has already crowned their efforts.

Elements of Practical Medicine. By Alfred H. Carter, M.D., London. Sixth edition. London: H. K. Lewis, 136 Gower Street, W.C., 1891.

This book, the constant friend of the English medical student, deserves to be better known

on this side of the ocean. Nowhere else within the same compass will be found such broad, truthful sketches of the various types of disease. What Walsham's work is to surgery, Carter's is to medicine.

Manual of Physical Diagnosis for the use of Students and Physicians. By James Tyson, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Philadelphia: P. Blakiston, Son & Co., 1891.

Dr. Tyson, so well known by his manual on the examination of urine, offers this little work on physical diagnosis, *not* to fill a long-felt want, but simply as the outcome of his teaching of the subject to students. It certainly can be recommended to students, combining, as it does, conciseness with sufficiency.

The Physician's Visiting List. Lindsay & Blakiston, for 1892. Forty-first year of its publication. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street.

This is an admirable little pocket-book, well arranged, and very convenient in size and shape.

Book Reviews.

Surgery: Its Theory and Practice. By William Johnson Walsham, F.R.C.S., Assistant Surgeon to St. Bartholomew's Hospital, Surgeon to the Metropolitan Free Hospital, London, etc. Third edition, revised and enlarged, with 318 illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut St., 1891. Toronto: J. A. Carveth & Co.

The third edition, revised and enlarged, of "Walsham's Practical Surgery, 1891," has been placed in our hands, and, after a careful perusal of it, we do not hesitate to say that it ranks high among manuals, as well as many larger and more pretentious works. The book, on the whole, is fairly well up to the times, but on closing it the reviewer cannot help wishing that its pages were more abreast of the period. We shall briefly refer to a few practical points throughout the work, as examples of how we think it might be improved. In the well-written article on brain surgery, why refer to the crucial incision? It has nothing to commend it, whereas the verdict seems unanimous in favor of the semi-circular one. A favorable

reference might have been made to the use of the chisel, out of respect to a large number of surgeons, especially the Germans. In the chapter on dislocations, the author could well have made room for a little modern material by leaving out the description for reducing dislocations by means of pulleys and the accompanying diagrams. It is rare, indeed, that the practitioner of to-day meets with a dislocation requiring the use of so much brute force as is recommended in these pages. A little further on we come to the reduction of Colles' fracture, which is dismissed in these words: "After reducing the fracture as thoroughly as possible." What practitioner or student could have any idea of the proper manipulations for the reduction of this fracture, as taught by such surgeons as Moore and Pilcher? It is only too well known that without a good knowledge of the difficulties met with in this fracture, and the way to overcome them, the results have been frequently lamentable failures. Again, what surgeon who is at all familiar with spinal surgery will be satisfied with the treatment of spina bifida? The success that has followed the ligature in these cases, using the precautions taught by Abbé and others, is somewhat dazzling, and surely merits a little attention in a standard work. Again, the reference to appendicitis is somewhat disappointing. When so much has been written on this subject of late years, it seems that any work of the present day should give the student a good insight into the various forms of this trouble and the means of relief. The chapter, an important one, on amputations is relegated to an appendix. So far as it goes, this part is made very plain; but there are many interesting points in connection with the subject that the student, if he wants to have a good mastery of it, must look for elsewhere, or draw too largely upon his common sense. There are numerous other practical points that might be referred to in a somewhat similar way throughout the work, did space permit; but sufficient has been noticed to give the reader an idea of what he will be required to fill in from other sources. It does seem a waste of time, however, for any author to give an incomplete description of any well-recognized operation; it is certainly a waste of time and money to the reader. The work of the specialist is not to be expected

in a manual, but we do think that on subjects which interest and belong to the general practitioner writers of manuals should write to the times and make their productions so clear and complete that they will be useful guides to plodding ones. The work, on the whole, is so well handled by the writer, and contains so much that it will compare favorably with many high-priced works, that we cannot help thinking that, so long as manuals are found useful, this one will be in demand.

A Clinical Text-book of Medical Diagnosis for Physicians and Students, based on the most recent methods of examination. By O. Vierordt, M.D., Prof. of Med. at University of Heidelberg, formerly of Leipzig, and of Jena. Authorized translation of the second (latest) German edition, by F. H. Stuart, A.M., M.D., Brooklyn, N.Y. Cloth, \$4.00; sheep, \$5.00; pp. 700. Philadelphia: W. B. Saunders, 913 Walnut St., 1891; Toronto: J. A. Carveth & Co.

A review of a translation necessarily calls for treatment under the three heads of the work done by the publisher, by the translator, and by the author. Arranging them thus in the inverse order of their importance, the work done by the publisher can fairly be very highly spoken of. The type is of good size and plain, the paper and binding excellent, and the illustrations, 178 in number, particularly good, the colored microscopic fields being worthy of a special treatise upon microscopy. The translator's task is always a particularly difficult one, as the temptation to lapse into the idiom of the original is ever present, and tells seriously upon his style as a writer of his own language. This, and the other pitfalls of the translator, Dr. Stuart has fairly well avoided, though his mode of expressing himself is in some places open to criticism that is not hypercriticism. The author's work is particularly well done. This is the best text-book we have seen, regarding it both in the light of scientific classification, comprehensive arrangement, perspicuity, and suggestiveness of treatment of each subject, and, finally, modernness of method. The references to chemical and microscopical examination as a means of diagnosis in disorders of the blood and of the digestive, respiratory, and urinary systems are very acceptable, and the draw-

ings of microscopic specimens excellently done, most of them in colors. The work is done in three parts. Parts I. and II. are introductory and general; Part III. is devoted to the special consideration of the various systems of the body, respiratory, circulatory, digestive, urinary, and nervous; and with the true scientific tendency to generalizing, each "system" is treated of in the most systematic and uniform manner. The anatomy, structural and topographical, of each region is touched upon briefly but most effectively, as a "refresher," before entering upon medical diagnosis proper, and the chapter ends with the microscopic and chemical means of diagnosis now at our disposal. The only point at which, as it seems to us, the due balance of parts is not preserved is in the pages devoted to the consideration of nervous disturbances, 131 in number, most valuable to the general practitioner, but, perhaps, from the student's point of view, too long. The book should be in use in all our medical schools as soon as possible. The favor with which it is regarded is proven by the fact that, though the first German edition appeared only in 1888, a second was necessary in 1889, and that it has been translated already into English, Italian, and Russian.

A System of Practical Therapeutics, by American and foreign authors. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Phila., Secretary of the Convention for the Revision of the U.S. Pharmacopœia of 1890, Physician to St. Agnes' Hospital, Phila., etc.; assisted by Walter Christie, M.D., formerly Instructor in Physical Diagnosis in the University of Pennsylvania, and Physician to St. Clement's Hospital, Philadelphia. In a series of contributions by seventy-eight eminent authorities. In three large octavo volumes of about 1000 pages each, with illustrations. Price per volume: Cloth, \$6; leather, \$7; half Russia, \$8. Toronto: J. A. Carveth & Co.

It is scarcely necessary to dilate on the vast importance of practical therapeutics in the practice of medicine, as the fact is generally appreciated by intelligent physicians. A large and complete work like this, published by such a company as Lea Brothers & Co., will be examined with interest by the majority of practition-

ers who have the opportunity of seeing it. The publishers, thinking that the subject is so broad that no one man can be fully conversant with all its divisions, have endeavored to secure the co-operation of a number of collaborators having special fitness in the various departments. We know of no better way of giving our readers an idea of their success in this direction than by furnishing a partial list of the contributors to Vol. I., with subjects treated, as follows: General Therapeutic Considerations, by Horatio C. Wood, M.D., LL.D.; Prescription Writing, by Joseph P. Remington, Phar. D.; Electricity, by A. D. Rockwell, M.D.; Rest-Cure and Neurasthenia, by John K. Mitchell, M.D.; Massage, Swedish Movements, by Benjamin Lee, A.M., M.D., Ph.D.; General Exercise, by Edward Murray Hartwell, Ph.D., M.D.; Climate, by S. Edwin Solly, M.R.C.S., L.S.A. London; Hydrotherapy, including Baths and Mineral Springs, by Simon Baruch, M.D.; General Sanitation, by Henry B. Baker, M.D.; Disinfection, by George M. Sternberg, M.D.; Antisepsis and Asepsis, by J. William White, M.D.; Nutrition and Foods, including Obesity and Leanness, by I. Burney Yeo, M.D., F.R.C.P.; Tuberculosis, by Solomon Solis-Cohen, M.D.; Scrofulosis and Rachitis, by Walter Chrystie, M.D.; Acute and Chronic Rheumatism, Rheumatoid Arthritis and Gout, by James Stewart, M.D.; Scurvy, by John B. Hamilton, M.D.; Diabetes Mellitus, by Frederick A. Packard, M.D. Judging from the character of the first volume, we have no hesitation in saying that the complete work will be one of the most interesting and valuable which has ever been offered to general practitioners.

Annual of the Universal Medical Sciences, Vol. IV. Edited by Sajous. Toronto: J. A. Carveth & Co.

This book is eminently calculated to interest specialists rather than general practitioners, though the latter, too, may find profit from its perusal. As an attempt at *précis* writing, the object being to get a bird's-eye view of the enormous and ever-widening field of medical literature, the work seems a success. The character of the volume may be judged partly from a partial list of its contents:—Diseases of the skin; ophthalmology; otology; diseases of

the nose and accessory cavities; diseases of the pharynx, tonsils, and soft palate; diseases of the larynx, trachea, and œsophagus; intubation of the larynx; diseases of the thyroid gland; inebriety, morphinism, and kindred diseases; legal medicine and toxicology; medical demography; histology and microscopical technology; bacteriology. The letter-press is very good, the bibliography and references very full, though so introduced as to economize room to the utmost, and the illustrations excellent and not few. Two very good chromo-lithographs are given in the chapter on diseases of the skin of Mr. Treves' famous "Elephant Man," with a synopsis of his account of his unfortunate patient in the *British Medical Journal*. The article on bacteriology by Ernst and Jackson contains much interesting information, in short space, on the work more recently done in tuberculosis (in which of course Koch's name occurs often), in typhoid, anthrax, carcinoma, rodent ulcer, cow-pox, diphtheria, distemper in dogs, hog cholera, malaria, meningitis. In a paragraph on parasitic and pathogenic protozoa, psorospermes, the name of Professor Ramsay Wright, and the paper he read at the opening of the Biological Department, are prominently mentioned.

Pamphlets Received.

The Work of Medicine for the Weal of the World.
By C. H. Hughes, M.D., St. Louis. Advance reprint from *Alienist and Neurologist*.

Personal.

DR. STEPHEN LETT, of Guelph, was rather seriously ill early in December from the effects of exposure and cold in consequence of his brave act in rescuing a couple of children from drowning during the first cold wave which appeared during the latter part of November. The little ones were playing on the ice of the River Speed, when they broke through, and after struggling in the water for a time were rescued with great difficulty by Dr. Lett, who managed to carry both to the shore. The doctor, as well as the children, had been in the water for some time, and all were more or less affected; but

the former in looking after the latter forgot his own condition for a considerable period, and suffered seriously for over a week thereafter. Even now he has not quite recovered, although he is gradually improving, and we hope that ere long he will be entirely restored to health.

THE following officers were elected at the annual meeting of the New York Obstetrical Society: President, Dr. Clement, Cleveland; 1st vice-president, Dr. Malcolm McLean; 2nd vice-president, Dr. W. Gill Wylie; recording secretary, Dr. Arthur M. Jacobus; assistant recording secretary, Dr. Goffe; corresponding secretary, Dr. J. Boldt; treasurer, Dr. Morrill; pathologist, Dr. J. H. Gunning.

DR. T. S. CULLEN (Tor. 1890), who has been in Baltimore for some months, paid a short visit to Toronto last month. He has returned to Johns Hopkins Hospital, where he will act for one or two years as resident-assistant in the gynecological department under Dr. Howard Kelly.

DR. L. F. BARKER (Tor. 1890) spent the summer in a hospital for sick children in the suburbs of Baltimore. He is now resident-assistant in Johns Hopkins in the medical department under Dr. Osler.

DR. JAMES F. GOODHART delivered the Harveian Lectures November 19, 26, and December 3, on the subject, "Common Neuroses, the Neurotic Element in Disease, and its Natural Treatment."

DR. W. H. HINGSTON, of Montreal, has been invited to deliver an address at the next meeting of the British Medical Association, which will be held in London.

DR. GRANVILLE BANTOCK, of London, was elected a corresponding member of the Obstetrical Society of Leipsig on the occasion of the celebration of its 400th meeting.

THOMAS WHARTON JONES, F.R.S., F.R.C.S., Professor of Ophthalmic Medicine and Surgery at University College, London, for thirty years, died in November at the age of 84.

PROF. MOSELEY, F.R.S., the distinguished zoologist of Oxford, died in November from pneumonia. He had been for some time suffering from an incurable mental disease.

DR. GOOD, of Winnipeg, according to *The Toronto Mail* of Dec. 7th, was suffering from typhoid, but on the 19th was said to be recovering.

DR. W. H. B. AIKINS went to Winnipeg, Dec. 9th, on account of the illness of his brother, Mr. J. A. M. Aikins.

DR. BUCKE, the superintendent of the Asylum for Insane, London, went to Philadelphia to see his old friend, Walt Whitman.

DR. STEINTHAL, the Dean of the Medical Faculty of Berlin, is 93 years of age. He has been in practice for seventy years.

SIR JAMES RISDON BENNETT, of London, England, died December 16.

DR. W. BURT, of Paris, who has been ill since September, is recovering.

Therapeutic Notes.

GLYCO-GELATINE IN SKIN DISEASES.—In recent years no more useful advance has been made in the treatment of skin diseases than the adoption by Unna of a compound of glycerine and gelatine (glyco-gelatine). The best basis for the incorporation of all other drugs appears to be the zinc oxide of glyco-gelatine, of which there are two forms (A soft, B hard), composed as follows:

	A (SOFT).	
Zinc oxide,	.	15 parts.
Gelatine,	.	15 "
Glycerine,	.	25 "
Water,	.	45 "
	B (HARD).	
Zinc oxide,	.	10 "
Gelatine,	.	30 "
Glycerine,	.	30 "
Water,	.	30 "

Iodide of lead, precipitate, chrysarobin, sulphur, and iodoform, are all miscible in any proportion—5 to 10 per cent. is a suitable pro-

portion for the first three mentioned, 20 to 30 per cent. for the last two. Carbolic acid, salicylic acid, resorcin, naphthol, creasote, exercise an inhibitory action on the setting of the gelatine, and should only be incorporated with the hard variety up to 10 per cent. Fats, balsams, tars, and ichthyol have a diluting and loosening effect, and should be prescribed with the hard variety, and not in larger proportion than 33 per cent. Substances in powder form may be used, but never in greater quantity than the proportion of gelatine. Camphor and chloral may be incorporated up to 2 per cent., ext. cannabis indica to 5 per cent., hydrarg. perchlor. up to 3 per cent.

The method of application is excessively simple. The solid glyco-gelatine is melted in a hot-water bath. It is then applied with a paintbrush to the affected region and dabbed over immediately afterwards with a roll of absorbent cotton wool; thus a sort of skin is formed, which acts as a protector and as a medium by which the medicaments may be kept in constant contact with the skin. Besides this, it acts beneficially by its slight compressing effects, producing a localized anæmia, also favoring the absorption of inflammatory products.

Indications for application:

- (1) Pruritus, both simple and senile, if uncomplicated.
- (2) Artificial dermatitis, produced by free use of mercurial ointments, alcoholic inunctions, irritation from chrysarobin, salicylic acid, resorcin, etc.
- (3) Erythema and rhagades, which disappear very quickly.
- (4) Acute and localized eczema, when not weeping.
- (5) Pruritic eczemas (the ichthyol 2 per cent. or cannabis indica 5 per cent., zinc glyco-gelatine).
- (6) Inflammatory acne. (In some cases a 20 per cent. sulphur, or 5 to 10 per cent. resorcin, zinc gelatine acts admirably.)

Besides the above indications, zinc glyco-gelatine is very useful as an adjuvant in the treatment of lupus, tinea tonsurans, etc. For efficacy, cleanliness, and comfort, glyco-gelatines can not in selected cases be equalled by any other method of topical application.—NOVÈS, *Med. and Surg. Reporter*

TREATMENT OF A "BAD COLD."—Dr. John Auld, of Philadelphia, speaks as follows (*Med. Record*) about the treatment of a "bad cold": "For the benefit of those members of the profession who are on the outlook for improvements upon the methods of bygone days, I venture to offer a single remedy for the treatment of a 'bad cold' that is far superior to all others. Gelsemium is not only useful in those cases which would recover without medication, but is also efficient when formidable symptoms are present, and, judiciously employed, may be the means of averting an attack of pneumonia, pleuropneumonia, pleurisy, or other serious disease beginning in the form of a bad cold. Gelsemium arrests profuse nasal secretions, quiets headache and neuralgia, subdues cough and pain, favors a re-establishment of the secretions, through its influence upon the skin, kidneys, and gastro-intestinal tract. It reduces temperature and pulse rate, promotes sleep, and creates a feeling of comfort and well-being without in any way approaching narcosis or destroying the oxygen-carrying capacity of the blood-corpuscles. By the use of this single remedy, much discomfort to the patient is avoided, digestion remains undisturbed, nauseating draughts are banished, the necessity for purgatives precluded, and all dangers of subsequent relapse practically eliminated; while recovery is prompt, perfect, and satisfactory in every particular. Ten drops of a reliable fluid extract (assayed) are dissolved in three ounces of water, and of this mixture the patient takes a teaspoonful every ten or fifteen minutes for an hour, then at less frequent intervals, according to the effects produced. The plan is simple, the medicine harmless in the dosage recommended, and not at all unpalatable, and the claims for it can be verified almost any day of the week, at this season of the year, by submitting the remedy to the crucial test of clinical experience."

THE TREATMENT OF TYPHOID FEVER BY PERCHLORIDE OF IRON.—I have intended making a communication on this subject to the *British Medical Journal* for some time, but the present moment seems favorable to a brief statement of a mode of treating typhoid fever which I have already more fully described in a thesis to Edinburgh University, and which has

had very remarkable results in my hands, no case of typhoid having died for several years where the treatment has been begun before essentially fatal conditions had arisen, such as perforation.

The treatment consists in administering a full dose of the liq. ferri perchloridi fort., namely, 5 minims (for an adult) every hour of the day and night, until a week has elapsed from the complete subsidence of the fever. To enable the patient to take this, the dose is combined with half a drachm of glycerine or one drachm of simple syrup, and a few drops of tinct. zingib. fort., and diluted in a tumblerful of water. If sickness is caused, 5 grains of bismuthi subnit. are given ten minutes before each dose of the medicine until nausea ceases to be produced. In a few days the diarrhoea will be arrested, and thereafter a mild aperient must be given daily as long as the medicine is continued.

In a moderately severe case not brought under this treatment until the end of the first week of fever, it will take ten days to reduce the temperature to normal. If the medicine is not given every hour night and day, it will take a little longer; if begun within two or three days of onset of fever, the latter will be gone in about five days. The patient sleeps in the intervals between the doses at night, and of all the serious symptoms of typhoid most never appear, and any present at first disappear rapidly.—J. W. Anderson, M.A., M.D., Edin., in *British Medical Journal*.

NUTRITIVE ENEMATA.—M. Ewald, in his researches on nutritive enemata, arrived at the unexpected conclusion that, even when not peptonized, eggs are partly absorbed by the mucous membrane of the rectum.

A Swiss *confrère*, Dr. Huber, having lately taken up these researches of Ewald in the medical clinic of Professor Eichhorst, at Zurich, found that the absorption of eggs by the rectal mucous membrane was considerably increased, to the extent of becoming almost equal to that of peptonized eggs, by adding to the enema one gramme of chloride of sodium for each egg. The addition of common salt in the quantity mentioned is well borne, and ordinarily produces no irritation of the intestine.

It appears established, then, that for the

present, at least, the best nutritive enema is one composed solely of raw eggs beaten up with common salt. M. Huber advises that two or three eggs, with the addition of two or three grammes of salt, be used for one enema. It should be introduced slowly by means of a Hegar's funnel, and a soft rubber tube passed up the bowel as far as possible.

The patient receives three such enemata every day. An hour before each nutritive enema his bowels are evacuated by means of an enema of water.—*Mercredi Medical*, April 1st, 1891.—*Lyon Medical*, May 3rd, 1891.—G.A.F.

STITES' TEST FOR CARCINOMA.—In the *Medical News* Dr. Brinton, gives a description of this new test. He says: The new method of examination was that furnished me by Professor Chiene, of Edinburgh, which I give in his own words: (1) Excise the mamma. (2) Wash thoroughly in water to remove the blood. (3) Place in a 5 per cent. solution of nitric acid (B.P.) for ten minutes. (4) Wash in cold water for five minutes. By the time these procedures are executed, the axilla is cleaned out, and the vessels tied. The mamma is now examined; the carcinomatous structure appears a dull white, like the eye of a boiled fish, the healthy tissue translucent. When any such reaction is seen, additional tissue should be removed at the corresponding point. In removing the carcinomatous breast, Professor Chiene directs that its relations to the circumferential tissues should be marked by the knife, so that after the test has been applied to the mass excised the situation of any outlying unremoved diseased areas can be fixed.

TREATMENT OF EARACHE.—The acute pain accompanying otitis is often relieved by the following mixture:

Chloroform 1 gr.
Olive Oil 8 grs.

Twenty to forty drops to be poured into the auditory canal, which is then closed by a little plug of cotton wool.

In cases of pain due to furuncle of the auditory canal, the relief is even more complete and immediate if, for the previous liquid, the following is substituted:

Menthol 1 gr.
Olive Oil 20 grs.

—*Medical Record*.—*Gazette des Hopitaux*, Oct. 22nd, 1891.—G.A.F.

THE TREATMENT OF THREAD-WORMS BY NAPHTHALINE.—Minerbi has used naphthaline in the treatment of thread-worms. Eleven children infected with this parasite were cured by its use in less than eight days. The formula employed was the following:

Naphthaline 1 gr. to 1 gr. 50.
Olive Oil 40 to 60 grs.

For one enema.

In the adult larger doses must be used.

Naphthaline 5 to 6 grs.
Olive Oil 60 to 80 grs.

For one enema.

—*Médecine Moderne*, April 2nd, 1891. *Lyon Medical*, May 3rd, 1891.—G.A.F.

TREATMENT OF ECZEMA OF THE VULVA.—Lusch (*Journ. des Sages Femmes*, 1891) recommends the following treatment for vulvar eczema. A lotion is made, consisting of bicarbonate of soda, 8 parts, by weight; bicarbonate of potash, 4 parts; glycerine, 6 parts; tinct. opii (French, *Codex*, 1 grain of extract of opium in 12 minims), 8 parts; and water, 250 parts. This lotion is applied night and morning to the vulva. After each application the parts should be dusted with a mixture consisting of powdered starch, 98 parts, and pulverized camphor, 2 parts.—*British Medical Journal*.

FOR the relief of nausea and vomiting consequent on etherization, one of the best remedies is chloroform gtt. iv. or v. with gtt. ii. or iii. of vinegar of opium, given two or three times a day. A hypodermic of morphine, gr. $\frac{1}{6}$, after the operation, controls the nausea, puts the patient to sleep, giving the stomach and nervous system time to recover themselves.—Brinton, in *Times and Register*.

DRYDALE recommends exercise in the open air for diabetics. Walking or riding for several hours daily are excellent remedies. The patient

should take to gardening and pass much of the day out of doors, whilst for rainy days carpentering is most beneficial.

LEUCORRHEA is, according to Dr. Louis Bauer, often due solely to constipation, hence clearance of the bowels of their faecal contents is in many cases the chief and most effective treatment of that troublesome disorder.—*Med. Record.*

THE free use of pine-apple juice is recommended to dissolve the membrane of diphtheria. It contains a vegetable pepsin analogous to papoid.

Miscellaneous.

ANTI-KAMNIA.—Dr. W. Thornton Parker, of Manchester-by-the-Sea, Mass., thus writes of this remedy: *Gentlemen*,—Antikamnia is no longer a stranger to the medical profession, but is daily winning laurels in its mission as “opposed to pain.” Briefly stated, it is indicated in cephalalgia, neuralgia, attacks of acute rheu-

matism, locomotor ataxia, sciatica, and the disorders of menstruation accompanied by pain. Dr. Holland, in *The Medical Summary* of May, describes an interesting case of dysmenorrhœa promptly relieved by its use. My own experience confirms this. I believe it to be one of the best remedies for the relief of pain in this disease. So far as my experience goes, we need not anticipate unfavorable after-effects; its action is soothing, tranquilizing, and diminishes the tendency of a rise of the bodily temperature. It is best exhibited in doses of from three to ten grains every three or four hours, in powder or tablet form, taken in water or wine.

BOVININE is being highly recommended by medical practitioners. Dr. G. H. Price, in the *New England Medical Monthly*, says of it: “There are certain cases where this blood renewer (for such it is, pure and simple) can have its place taken by nothing else. It is not a medicine *per se*; it is a food; even more, it is, as Prof. Waugh, of Philadelphia, asserts, “one step beyond a food; it has received the finishing touches and has become the *vital fluid itself*.”

:: Physicians' Supplies ::

Antipyrine	per ounce	\$ 1.00
Aristol	“	1.75
Blaud's Pills S. C., in bottles of 5 pounds,	per pound	80
Chloral Hydrate	“	1.00
Chloroform D. & F., pure	“	1.70
Fluid Extract Ergot, P. D. & Co.	“ net	1.50
Salicylate Soda	“	1.90
Sulfonal Bayer	per ounce	40
Phenacétine Bayer	“	60
Pil. Cath. Co., P. D. & Co., S. C.	per pound	1.15
Quinine Pills, in bottles of 1000, gr. 2..	per bottle	2.50
Iodoform	“	70
Antiseptic Tablets, in bottles of 100 .	“	70
Absorbent Cotton	per pound	40
Mead's Adhesive Plasters, on cylinders,		
1 in. x 10 yds.	each	35
Hypodermic Needles	“	35

...STUART W. JOHNSTON...

—TORONTO.—