

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

THE CANADIAN PRACTITIONER

EDITOR:

ADAM H. WRIGHT, B.A., M.D. Tor.

ASSOCIATE EDITORS:

JAMES F. W. ROSS, M.D. Tor. JOHN CAVEN, B.A., M.D. Tor.

EDMUND E. KING, M.D. Tor.

PUBLISHERS:

THE J. E. BRYANT COMPANY (Limited), 58 BAY STREET.

VOL. XVIII.]

MAY, 1893.

[No. 5.

Original Communications.

ALVEOLAR ABSCESS.*

BY E. HERBERT ADAMS, M.D., D.D.S.

ALVEOLAR abscess is a term applied to any abscess having its origin in the alveolar process of either of the maxillæ. It is generally due to a pericementitis occurring at the apex of the root of the tooth, and caused by the death of the dental pulp. The first pus is pent up in the apical space by bony walls, and the pressure being very great results in the rapid destruction of the surrounding osseous tissue. The pus burrows where there is least resistance, and on account of the cancellous nature of the bone surrounding the root, and the denser nature of the bone nearer the surface, a larger pus cavity is formed.

The pericemental membrane surrounding the apex of the tooth is even yet not perhaps destroyed; but its fibres become elongated and their meshes filled with pus; the swollen tissue forming the shreddy bag-like mass so often seen attached to the end of a root of an abscessed tooth after extraction.

Should the outer lamina of bone be perforated, the pus has then ready

*Read before the Toronto Medical Society.

exit through the soft tissues. The pain now lessens, and the symptoms abate somewhat. This may, however, be only a temporary cessation. The whole side of the face may swell up, the eye be distorted, or the jaws be so stiffened or swollen that they cannot be separated sufficiently for feeding purposes.

An examination will show a large swelling over the affected root. The swelling will usually show signs of fluctuation, and if left to itself will generally open just above the root. It is better, however, to anticipate nature by opening with a bistoury. After the discharge of pus, the swelling and pain usually subside.

Unless the affected tooth is removed, or the diseased pulp removed from the interior of the tooth by a dentist and the pulp cavity rendered aseptic a chronic source of irritation is kept up, and the abscess assumes the chronic type.

In acute alveolar abscess there may be seen, occasionally, a considerable elevation of temperature, even as high as 103° or 104° . During abscess formation, and before the pus has found exit, a peculiar dull, throbbing pain is often present, and the lymphatics at the angle of the jaw are sometimes sore and swollen.

An abscess, if left to itself, usually assumes the chronic form, the pus continuing to be discharged, but in lessened volume. In the chronic form of alveolar abscess the burrowing of pus may cause a fistulous opening in the cheek, chin, or neck, though the most usual place for the abscess to discharge is on the gum over the roof of the affected tooth.

Abscesses associated with the wisdom teeth, or third molars, sometimes pass in the direction of the parotid region. In these cases it is not uncommon to find the orifice of the fistula as low down as the clavicle. This is due to the unyielding character of the parotid fascia, which is a continuation of the deep cervical.

On account of the close relation of the roots of the teeth of the upper jaw to the antrum abscesses may open in the maxillary sinus, and thence be discharged through the nares. These cases are frequently mistaken for a diseased condition of the nasal passages, and treated accordingly, and, of course, invariably without success. The relation of the roots of teeth to the antrum is variable. In some cases the floor of the antrum is perforated by the first and second molars, so you can readily see how an abscess can open in this way.

The habit of applying hot fomentations, poultices, and counter-irritants to the cheek and face is often to blame for abscesses pointing on the face and neck.

One of the most common places for abscessed teeth of the upper jaw to open on the face is just beneath the malar bone, and just in front of the

anterior border of the of the masseter muscle. A disfiguring scar often results if the abscess is allowed to open in this or any other facial region. Such abscesses may discharge anywhere below the region of the eye.

Occasionally, abscesses of the superior incisors discharge directly into the nasal cavity, and an abscess of an anterior tooth has been known to pass back beneath the mucous membrane of the hard palate, and discharge at the junction of the hard and soft palate.

The greater number of abscesses discharging on the face are in the lower jaw. This is probably due to gravitation. Frequently these abscesses open first on the gum, but during the healing process this opening becomes closed. Little pus perhaps remains as the abscess becomes chronic, but the slow burrowing of this, according to the law of gravitation, causes it finally to find exit through the lower jaw. There may be no pain nor other symptoms until this opening has occurred, much to the surprise and annoyance of the patient ; the pus in some cases passing directly downward through the bone, but more frequently passing outward into the soft tissues, and then following these downward to point at the lower margin of the jaw.

Blind abscesses may occur, the pus being small in quantity, and being apparently absorbed without any external opening being formed for its exit.

Occasionally, alveolar abscesses have been known to cause extensive necrosis of the bones of the face. This is more especially the case in strumous or syphilitic patients.

Abscesses may also form osseous cysts on the side of the jaw. The pus, instead of being absorbed, is provided for by the expansion of the outer plate of the bone. These cysts form some what rapidly, and are sometimes half the size of a hazelnut. The rapid growth of these cysts is an important point in diagnosis.

In persons with an abnormally small jaw, the eruption of the wisdom teeth often causes severe inflammation and abscess, the jaw being too small to accommodate the new tooth. These abscesses generally discharge at the margin of the gum, but the swelling is often so severe as to cause almost complete immobility of the jaw. In a recent case where it was impossible to open the jaw sufficiently to extract the offending wisdom tooth, the second molar was removed, and of course the third molar had now a chance to come forward and the inflammation soon subsided.

Imprisoned teeth may be a cause of alveolar abscess. The diagnosis of these forms is rather obscure. A probe passed into the sinus, if one has been formed—if not, a bistoury passed through the softer parts and bone—will often assist in the diagnosis of such cases. Abscesses of temporary teeth require especial care, and if they are not readily amenable to treatment the diseased tooth should be extracted.

The *diagnosis* in most cases is comparatively simple; but from what has been said it will be seen that the diagnosis, of some forms at least, of alveolar abscess is not an easy matter for the general practitioner. And it is these unusual and anomalous cases that most frequently come under the observation of the physician and surgeon, and the ignorance displayed in treatment renders matters often uncomfortable for the patient, and not infrequently so for the surgeon.

A simple means of testing whether a tooth is abscessed is by rapping the tooth with an instrument. If it should prove tender on pressure, the apical pericemental membrane is inflamed, and the root of the tooth probably abscessed.

Abscesses most frequently occur on teeth with dead pulps. In such teeth the natural translucence of the tooth is gone, the dentinal tubuli being filled up with dead matter, due to the disintegration of the pulp. The dark color and opacity is often very marked, but is occasionally so slight as to escape notice. If, however, the patient is placed in the sunlight and the rays of light reflected on the teeth by means of a mirror, a slight opacity will be noticed.

The patient's notice is often directed to a painful tooth as a possible cause of the trouble, but it must be remembered that neither a decayed tooth nor pain need necessarily be present. The pulp may have died from some other cause, and the diagnosis can be made by the opacity of a tooth and its tenderness on pressure.

The following are some of the cases which have been recorded in dental and medical literature as cases of mistaken diagnosis :

Dr. Otto Arnold (*Dental Review*) mentions a case where a patient was confined to her bed by what her physician supposed to be diphtheria. After being treated for about a week, she began to suspect that her teeth were in some way implicated. The pharynx and tonsils were severely inflamed, but after some difficulty the diagnosis of an impacted wisdom tooth was made, and on its extraction she got well.

Dr. C. R. Butler (*Items of Interest*, 1891) mentions a case, diagnosed by the patient's physicians as carbuncles, but which proved to be due to alveolar abscesses from three dead teeth. On their extraction a cure was effected.

J. P. Wilson (*Items of Interest*, 1888) mentions a case of alveolar abscess of eight years' standing, where there was a fistulous opening over the clavicle, near the place of origin of the platysma myoides muscle. The disease had been pronounced by a council of physicians to be of a strumous character. He removed the roots of a diseased first molar and the discharge soon ceased, and the abscess healed without further treatment.

Dr. Tees (*Items of Interest*, 1886) mentions a case where death occurred

from a surgeon performing a surgical operation on a case of alveolar abscess with much facial swelling, the patient sinking gradually after the operation. He states that the abscess differed in no way from an ordinary alveolar abscess, the three roots of the first left superior molar being diseased, and the swelling of a sudden and recent nature.

A case recently occurred which had the following history: A boy had a swelling of the face. His family physician applied poultices and hot fomentations to the side of the face, and afterwards opened into the pus cavity with a lancet. A running ulcer formed, which lasted for about a year and three months. The school authorities refused to admit the boy to school during this time on account of the disease. The boy was examined by a couple of physicians from the civic health department, who also recommended his detention from school. He would probably be absent from school still and the abscess still discharging had not another physician made the diagnosis of an abscessed tooth. On the extraction of this tooth, the abscess healed readily, and the sinus closed of its own accord.

The *treatment* is comparatively simple in most cases, and consists in the evacuation of the contents of the pus cavity, and in injections of antiseptics until it is rendered thoroughly aseptic.

In the more simple cases this is readily accomplished by a dentist drilling through the root canal and thus allowing an exit for the pus, and an opening through which antiseptics can be injected. It is rare, indeed, that a skilled dentist cannot successfully treat even the worst cases by this means. Of course, if the offending tooth is for any reason considered of no value, the simplest method of cure is its removal, when the abscess will, as a rule, heal without any medication.

In some cases a simple way is to drill through the alveolus, just above the root of the tooth, and thus give an exit for the pus, and an opening for antiseptic medication. If it is desirable to keep this sinus open, a simple method is to place a pledget of cotton, soaked in a strong solution of carbolic acid, in the sinus.

In acute alveolar abscess where there is much swelling of the face, it is often well to endeavor to cause the abscess to point on the buccal surface of the gum over the root of the abscessed tooth. This can often be accomplished by the application of a counter-irritant, such as capsicum or cantharidine, to the gum overlying the root of the affected tooth. A roasted fig or raisin is said also to accomplish the same result.

All applications of hot fomentations, or poultices, or counter-irritants to the external surface of the face should be religiously avoided, and if the abscess seems to have a tendency to point externally a free incision for the pus should be made *in* the mouth, and the counter-irritants or other medica-

ments applied *in* the mouth. This will prevent many an opening on the face, and its consequent scar.

Constitutional treatment should not be neglected where indicated. A saline cathartic will often assist in hastening the removal of an acute abscess.

In those cases where there is a fistulous opening on the face, it is always well to direct, if possible, the discharge into the mouth. If this is done the sinus will heal of its own accord, and the abscess can then be treated in the usual manner. As a rule, the sinus needs little attention after the abscess has healed.

Often considerable disfigurement results from the scar due to a fistulous opening on the face. If under the chin the scar does not show much, and in a male can be covered by a beard. If on the neck it may be hidden by the clothing; but on the cheek, especially in a female, little can be done to hide the disfigurement.

And here let me give a note of warning. A great many cases have come under my observation where surgeons have made external facial incisions simply because the abscess showed a tendency to point on the face. In one case where the simple extraction of the tooth would have been all that was required to heal the abscess (though even that was not necessary), a prominent surgeon made a crucial incision in the cheek; thrust in a couple of his fingers as an exploratory procedure, and then ordered a lotion of ac. carbol., τ in 20 , to be applied externally.

It is needless to state that such treatment is very reprehensible. There are cases where an external incision is indicated, but these are the exception and not the rule. In such cases, if the knife is used in a conservative manner, the healing process is speedy on account of the vascularity of the facial tissues, and often no perceptible scar remains.

From an æsthetic point of view, the surgeon should always endeavor to give vent to the pus by an incision inside the mouth, and not by an incision on the surface of the face.

One of the hardest tests to which my powers of argument were ever put was in persuading a fellow practitioner from making a great gash in the cheek of a lady who had an alveolar abscess, which any good dentist could successfully treat by drilling through the root canal, and giving vent to the pus in that manner.

In regard to antiseptic medication any reliable antiseptic will do. Carbolic acid, peroxide of hydrogen, listerine, and campho-phenique are perhaps the favorites with dentists. Thymol, creasote, oil of cloves, oil of cinnamon, sanitas, salicylic acid, iodine, and various other antiseptics, all have their advocates.

In this paper I have purposely omitted going into the detail of treat-

ment of the simpler forms of alveolar abscesses, as they belong to the domain of the dentist and not of the surgeon. I would also strongly recommend that in all cases of doubtful diagnosis a competent dentist or oral specialist be called into consultation. These abscesses respond speedily to proper treatment, and the diagnosis, too, is, as a rule, simple to the dentist or oral specialist; and yet there are innumerable cases where the patient has been disfigured or inconvenienced for years by this disease simply through the ignorance of their family physician, who has failed to make a correct diagnosis. Later on, perhaps, a correct diagnosis is made by a dentist, or some one who is familiar with the disease, and the patient is cured in a few days or a week. Naturally, the patient is much embittered against the medical man whose ignorance allowed such a foul ulcer to remain on their face for such a long time.

Prophylaxis is of importance in the prevention of alveolar abscesses, but this belongs largely to the domain of the dentist. It should, however, be the duty of every physician, whenever he finds decayed or offensive teeth present in any patient, to impress on them the importance of visiting their dentist and having their teeth attended to.

RADICAL CURE OF STRICTURE OF THE NASAL DUCT.*

BY SAMUEL THEOBALD, M.D., BALTIMORE.

FIFTEEN years ago I called attention to the ineffectual use of small probes in the treatment of lachrymal stricture. Dr. Williams and Dr. Noyes also spoke about it at the same time. To-day, while using larger probes than formerly, the majority of the profession are not using as large ones as myself. Some of my first critics said that it was impracticable to insert such probes, and that I must have overlooked the anatomical arrangement of the canal. The fact was that anatomical observation was the foundation of my theory. I examined a number of skulls and cadavers, and I measured the duct by seeing how large a probe I could pass. In experiments on dry skulls I found that in 70 ducts probed, the average size was 4.7 mm. in diameter. I have in my hand a pamphlet of recent date, in which it is claimed that the probes cannot be passed even in the bony canals. As a matter of fact, it is really easier to pass the large probes on the cadaver, because there is more give to the tissues, and you can use more force than is possible in the dry skull without breaking the bones.

*Read at a meeting of the Clinical Society of Maryland, April 7.

Of ten subjects examined I found the average size of the duct to be 4.7 mm. in diameter, the largest being 7 mm., and the smallest 3 mm., which is equal to a No. 12 probe. Why should we use such large probes? Because the small ones will not produce permanent benefit. De Schweinitz, in his latest work ('92), speaks as if he still used Bowman's probes, but lays no stress upon the use of large ones, and gives a doubtful prognosis. Fuchs, in his new work ('92), does not go beyond a No. 6, and as to prognosis says: "Even in the most favorable cases treatment lasts for many weeks, and a recurrence is the rule." After an experience of fifteen years with their use, I can say that there is no class of cases which I approach with more confidence of a successful issue. Of course where we have to deal with a severe case of nasal catarrh or ozæna, we cannot expect the most marked success. Many of the cases I see have been treated before by small probes. I have watched this treatment for years, and have seen no relapses in patients who have been discharged as cured. I believe nearly all the relapses are in patients who have, for one reason or another, ceased before treatment was completed. I invariably endeavor to avoid beginning with the small probe, for it is so easy to produce with them a false passage. I prefer to begin with a No. 5 or a No. 6. There are three kinds of tissues in the duct—mucous membrane, periosteum, and bone. If the closure is due to simple hypertrophy of the membrane, it will probably be relieved by simple collyria. I have never met with blenorrhœa of the lachrymal sac caused by severe ophthalmia. It is almost invariably due to extension of catarrh from the nose. My method of operating is first to anæsthetize with cocaine and then pass a small probe, No. 2 usually, through the puncta, and canaliculus to look for, and, finding it, to overcome any stricture at the juncture of the canal and sac. This facilitates the entrance of the probe-pointed canaliculus knife into the sac. Having slit up the canal I then pass a No. 5 or No. 6 probe, or a smaller one if I fail with these. I anoint the probes with vaseline containing 10 per cent. of cocaine. Having surely entered the sac, we need not hesitate to use force in passing the stricture. I have never seen any serious consequences. Rarely I have had while using the small probes an ecchymosis of the lid, and once or twice slight inflammatory reaction. I do not think it advisable to probe daily unless compelled to do so for want of time. It may excite too much inflammation. Every other day is my custom. I increase by one number each time, skipping a number if very freely passed, or dropping back one if too tight. In two-thirds of all cases, including children, I have used a No. 16. Having reached the largest I intend to use, I then increase the intervals. The only objection I know to the treatment is that the duct may remain too pervious and air passes freely when the nose is blown; but such inconvenience is, I think, very small.

In addition to probing I always prescribe collyria to be used three times daily. The most useful one I have found to be a solution of bichloride of mercury 1-12000. Next to that I prefer solution of alum, 10 grs. to the ounce. I do not attack a fistula or carious bone; they soon take care of themselves if the passage is open. Patients may be taught to probe themselves with the larger probes. Stricturèotomy has never appealed to me as rational treatment, nor have I ever had any reason to destroy the lachrymal sac.

Selected Articles.

LECTURES ON THE CONDUCT OF MEDICAL LIFE.

BY S. WEIR MITCHELL, M.D., LL.D.

A GREAT soldier was asked in my presence what was, in warfare, the most interesting thing. He said, "Recruits going into their first battle." What he thought as to the young soldier I feel whenever it is my lot to see a mass of men about to turn from the training of the schools and to face the grim realities of the physician's life.

Here before me are some hundreds of men in the morning of existence. Where will the noonday find you? And the evening hour, when labor is over, and, looking back, the conscience, undisturbed by new ambitions, shall made up the ledger of a life—will it leave you weighted with the debts of wasted chances, or rich with the honest interest of accumulated character? That the veteran, like myself, should look with a certain sad curiosity at a group of young soldiers is not strange. Here are men of varied individuality, of unequal fortunes, of every condition of life—some for whom all their ways have been thus far made easy, some for whom life has been always hard. Here, at least, within these walls you have all had equality of opportunity. Let me hopefully presuppose you one and all to have used with diligence the precious years of training. You have thought, of course, of what you want to win. You vaguely call it success—success in life. That may mean many things you did not want or expect. You will fail where you least look for failure. You will win what you never dreamed of getting.

I shall try to remember only that you are all to be of the great army of medicine. First of all, I own for you the wish that in this vast organized

body you shall take honest pride. Through it you will earn your bread, and, I trust, much beside a mere living. That you may correctly estimate its splendid history, that you may fitly comprehend the opportunities it gives, let us look a little broadly for a time at some of its virtues and some of its values. I could wish that you were really taught something of the wonderful history of medicine. I have myself ancestral pride in the splendor of its conquests, the courage and heroism of its myriad dead. I am fond of saying it is a guild, a fellowship, a brotherhood, older than civilization. It had a creed of moral life antique when Christ was born. No other organization is like it. Customs, code, and creed separate the lawyer and clergyman of different lands; but we in all lands hold the same views, abide by the same moral law, have like ideas of duty and conduct. From Japan to London you may claim medical aid for self or wife or child, and find none willing to take a fee. There is something fine and gracious in this idea.

I once asked the care of a physician I never saw or heard of before in a German town. As I was about to pay him a card dropped from my pocketbook. He glanced at it, and said, "But you are a doctor; I can take nothing—nothing." I remonstrated in vain. "No," he said, "you will make it up to some other doctor." I believe that I have paid this debt and other like debts with interest. I hear now and then of men who break this beautiful rule which makes professional service given by one physician to another a friendly debt for which the whole brotherhood holds itself responsible. Doctors are said to differ, but these bonds of union and generous amity are mysteriously strong. Try to keep them so, and when you serve medical men go about it as if they were laymen. Put away all thought of wasted time, of the commercial values of what you give. The little biscuit you cast on the waters will come back a cheerful loaf. I consider it a glad privilege to help thus my brothers in medicine, and let me assure you few are more heavily taxed than I.

And there is another privilege your profession brings. From the time you graduate until you cease to work, whether in town or country, hospital or wretched homes, the poor will claim from you help in time of sickness. They will do it, too, with tranquil certainty of gracious service on your part.

The greatest of moralists has said, "The poor ye have always with you." I think He meant to speak of the poor as representing opportunities for self-sacrifice never absent. Of a certainty it applies to us. The poor we have always with us—the sick poor.

On every Friday I conduct the clinical out-service at the Infirmary for Nervous Disease. I never go through these long and tiresome hours of intense attention without feeling that it is needful to put some stress on my

self that I be not negligent or hasty, vexed or impatient, or fail as to some of the yet finer qualities of social conduct. I want you also to feel that such self-watchfulness is needed. These early years among the poor, or the class of uncertain debtors, are apt to make some men rude, and uncareful, and ill-tempered. Most honestly do I say that such work is what I may call an acute test of character.

A part of your life-work consists in giving of your best to those who cannot pay. A part consists in work for honest wages. I think you happy in that our work is not altogether paid labor, and not wholly work without pay. In both are chances which, rightly used, make the good better, the wise wiser; and there are many sides to it all.

I do not like to leave this subject without a living illustration. It is strange and interesting to see what our life does with different kinds of men.

I once went through a hospital ward in France watching the work of a great clinical teacher, long gray in the service of the sick. It was as pretty and gracious a thing as one could see. The examinations were swift, the questions few and ready. Clearly, he liked his work. A kindly word fell now and then; faces lit up as he came near. Now and then he answered a patient gravely and simply where there was real reason to do so, and twice I observed that when he did this he sat down as if in no haste—a nice trait of gentle manners. It was a ward of women, and he was very modest—a too rare thing in French hospitals in my student days. When he went away his interne told me that he had been very sharp with him for a piece of neglect, “but,” said the doctor, “he never says a word of blame at the bedside.” In fact, this great physician was a gentleman—a much-abused word—but think what that may fully mean; a man in the highest sense of manhood—so gentle (good old English word), that every little or large act of duty or social conduct is made gracious and beautiful because of the way of doing it.

I saw a week later a great French surgeon in his clinic of women. The man was as swift and as skilful as could be. He was also ill-tempered, profane, abrupt, and brutally immodest—a strong, rough, coarse machine; and this was what the medical life had done with two men. With less intellect this rude nature must have altogether failed of success in life. He did not fail being a man of overwhelming force and really admirable mental organization; and so when you read of Abernethy's roughness and the like, pray understand that such great men as he win despite bad manners, and not because of them. There is no place where good breeding and social tact—in a word; habitual good manners—are so much in place as at the bedside or in the ward. When Sir Henry Sidney wrote a letter of advice to his son—the greater Sidney, Sir Philip, he said, “Have

good manners for men of all ranks ; there is no coin which buyeth so much at small cost."

A clever woman of the world once said to me: "I sent for Dr. A. yesterday, and by mistake the servant left the message with Dr. B. He came at once, and really he was so well-mannered and pleasant that I quite forgot what a fool he is."

I know men who have had large success in practice chiefly because of their gentleness and sweetness in all the relations of life. I know of far more able men who have found life hard and the winning of practice difficult simply because they lacked good manners or wanted tact. We began about the poor, and here we are discussing manners. I had not meant to say of it so much, but, on the whole, I am not sorry. Pray remember, finally, that neatness of dress and the extreme of personal cleanliness are, shall I say, a sort of physical good manners, and nowadays the last words of science are enforcing these as essential to surgical success.

There is a wise proverb of the east, "He who holds his tongue for a minute is wise with the wisdom of all time." I am fond of proverbs, and this is full of meaning, for really to refrain from instant speech when irritated is victory. An hour later you are sure to be silent enough. The temptation to speech is momentary. Above all, try not to talk of your patients—even with doctors. It is usually a bore to be told of cases, and we only stand it because we expect our own boring to be, in turn, endured. But my ideal doctor who reads, thinks, and has a hobby will not need to gossip about patients. He will have, I trust, nobler subjects of conversation. When I hear a young man talk cases or read them in societies with heavy detail of unimportant symptoms I feel like saying of him, as was once said in my presence of one who amply justified the prediction, "That man has a remarkably fine foundation for dullness in after life."

The methods of note-taking you are well taught, and, too, I hope, the best ways of examining your cases. As to this, circumstances must guide you. A patient is often a bad witness, and one man gets at the truth of his case—another does not.

As to acute cases, it is immensely valuable to learn through concentration of attention to be rapid without omissions. Dr. Edward Dalton is quoted as saying to his class, "After careful and repeated auscultation, percussion, palpation, and even succussion of your patient for twenty minutes, *you* may not be very tired. *He* is."

As you go on in practice you will get to be fond of certain drugs. Be a little careful of this habit, which has its reasonable side. Even the best of us fall into this therapeutic trap. I once met in consultation the late Prof. Blank, a delightful and most able physician. "As I came out of the house I fell upon his son, also a doctor. "Ah!" he said, "you have"

been meeting my father; I am sure he advised Plumer's pills"—an old mercurial preparation. It was true.

As I watch the better medical practice, I see a tendency to rely less upon mere drugs, and more and more sharply to question their value. The true middle course is to be skeptical as to new drugs, and to test them over and over before being mentally satisfied. Nor is it well to run into the extreme, which in our civil war caused an order forbidding the use of calomel because of the folly and indiscretion with which a few men had used it. After all, one of the most difficult things in ours, the most inexact of sciences, is to be sure of the value of a drug. When studying the poison of serpents, I found the most positive printed evidence of the certain value of at least forty antidotes. Not one of them was worth the slightest consideration. Such a fact as this makes one careful of crediting the endless cures to be read in the journals.

When you come to read over the works of the great masters, dead or living, and to see how Sydenham or Rush, Cardan or Bright, did their work, you will be struck, as I have been, with the great stress laid upon habits of living—what shall be eaten, diets, exercise, clothing, hours of work and rest. Curiously enough, these dicta are more often found in their records of cases than as positive theses; a proof that, in his practical work, a man may be better and wiser than in his generalizations. When, therefore, you come to deal with chronic conditions, be sure to learn all there is to learn as to the ways of men, their diet, clothing, sleep, work, play, wine, and tobacco. I like to make a man describe to me, with minute care, his average day. Then I consider, usually, how much of what is clearly wrong may be set right by a life on schedule. After that comes the considerate use of drugs.

The desire for drugs is a remainder from barbarous times. It is much in the way of what I call natural medicine. *Do* this and do *not* do that might cover a large amount of useful treatment if men would but consider the doctor as a wise despot to be implicitly obeyed. But just here I wish to add that the very men who are most chary as to drugs are those who, at times, win splendid therapeutic victories by exclusive diets, or heroic use of powerful medicines.

Much nonsense is talked about the injurious influence of drugs until, in the very word drug, there is a malignant sound. Men used to be overbled or salivated. This does not occur nowadays. And if I asked your whole faculty how many people they have seen permanently injured by mere medication, I fancy they might be puzzled to bring to mind illustrations of such mischief. The belief is another survival of conclusions founded on premises which perished long ago.

Men in our profession fail more often owing to want of care in investi-

gating cases than for lack of mental power. One man looks at the urine carefully once and decides; another looks once at the night and morning water and concludes; a third asks that there be made no change in diet or habits for a week, and examines the urine over and over, both the night and morning secretion. Of course, this is the only right way. Troublesome? Yes, very! If you do not want to practise medicine as it ought to be practised, better far to get some business which will permit of indolent intellectualization.

A friend of mine had a consultation in the country as to a case of great importance. The attendant fell ill and could not meet him. My friend went over the case with care. It was one of persistent headache. He took home urine of the night and morning, and wrote word that the patient had uræmic intoxication. The attendant said "No"; that neither casts nor albumin were in the urine which he had thrice examined. At last, puzzled, my friend asked if he had studied the night urine. He said "No." And here was the mischief.

I saw to-day a woman of wealth and social importance who, for years, suffered cruelly from headache. Now, as it always began after an hour of very acid vomiting, a dozen of the ablest men in Europe and America, who were led off by the vomiting, failed to take in the whole possibilities, and did not question the eyes. But a little country doctor did, and a tendon or two clipped put that woman back in a state of health. I was one of those who made the mistake, and yet I have written, was perhaps the first to write, on the eye as a cause of headaches of varied type. But to be constantly complete and exact in all examinations is, I admit, hard; nevertheless that way lies success.

And the like axiom applies to treatment. You are taught in acute disease to write your directions and to leave no possibility of change unprovided for. And the acutely ill are prisoners of our will. But how many men think it needful to write out a schedule of life, medicine, diet, exercise, rest for cases of chronic disorder—I do not say disease. I never tire of urging that in attention to minutiae lies the most uncertain success. A large practice is self-destructive. I mean that no over-busy man can continue to give always, unfailingly, the kind of care patients ought to have. But that is, as I said in my first lecture, a question of enduring energy, and of the firmly made habit of dissatisfaction with the incomplete. If medicine consisted only in mere intellectual endeavor; if to see, hear, feel, weigh, measure, in a word, know all there is to know of a case, were really all; if, then, we only had to say do this or that, one's life might be sufficiently easy.

In time of peril, or under stress of pain, any one, and always the great consultant, can secure absolute obedience. In the daily current of prac-

tice, fancy and unbelief, indolence, prejudice, and what not, stand in our way. Busy men, indulged children, hysterical women are your worst difficulties. Then come into play the moral qualities which, in union with educated intellect, make for the triumphs of the great healers of their kind. Are you gentle and yet firm? Have you the power of statement, which is so priceless a gift, the capacity to make the weak, the silly, the obstinate feel as you speak that your earnestness rests on foundations of kindness, and of thoughtful investigation of their needs? Can you, in a word, make people do what you want? Have you the patience to wait untroubled by the follies of the sick, to bide the hour when you can carry your point? Have you the art to convince the mother that the sick child is the last of all who should be left to the misery of self-indulgence? Can you sit by the bedside and gently satisfy some hysterical fool of her capacity to take up anew the reins of self-government? It demands earnestness. It means honest beliefs. It exacts such rule over your own temper; such good manners as few possess in their highest degrees of quality and quantity. Above all, it means that dislike of defeat which makes the great soldier.

A fine thing in our profession that mere hatred of defeat. As I came once out of a consultation with Prof. Gross, he said: "Don't you hate it, sir?" "Hate it; what?" I said. "Hate what?" "Oh, to spend a life like yours or mine, and be beaten—puzzled—licked, sir—by a miserable lump in a woman's breast." I always liked what General Sheridan said to me years ago. I asked how he accounted for his constant success in war. He hesitated, and then replied: "It was because I did so hate to be licked." No matter whence comes this feeling, it is valuable. Cherish it; never lose it. Find reason for disaster, but learn to loathe the result. I never see a death or a grave failure to cure that I am not personally hurt by it. I say, then, "A century hence this will be otherwise," for as I am proud of the past of this great guild, so am I full of glad hope for its future, when it shall have learned the conquest of cancer and tubercle.

I have come again half unexpectedly, as I draw to a close, upon this grave question of the moral qualities needed for the noblest success in medicine. It would lead me, and easily, to talk of the code, of your relations to the secrets of households, to the criminal law as to witnesses, of insurance cases, and the like; but all of this I must leave unsaid, and reject the pages in which I had said something of the ethics of our profession.

You have chosen a life inexorably hard in what it asks of soul and mind and body; but be that as it may, you have taken upon you, I surely think, the most entirely satisfactory of earthly pursuits. I have seen much of men and their ways, but nothing I have seen entitles me to think there is any truer, better way of serving God and man, and in this service making yourself what you ought to be.—*Abstracted from Univ. Med. Mag.*

NOTE ON A REMARKABLE HOUSE EPIDEMIC OF
TYPHOID FEVER.

BY WILLIAM OSLER, M.D.,

Professor of Medicine in the Johns Hopkins University.

House epidemics of typhoid fever, to the extent and severity of the one here noted, are very rare.

Nov. 26, 1892, I went near Darlington, above Havre de Grace, Md., to see a case in connection with which Dr. Sappington gave me the following remarkable history of a house epidemic of typhoid fever.

CASE 1. Wm. B., aged thirty-seven, had been ill early in August, at Ocean City, with what was supposed to be malaria. He returned to his home in Baltimore, August 8, and on the thirteenth came here to his mother's home, and was ill for six weeks with diarrhoea and delirium; and had, according to the doctor, a well-marked attack of typhoid fever. There had been no previous illness during the summer in the house, and it is perfectly clear that this, the first case, was imported.

CASE 2. His wife, A.B., aged thirty-four, was taken ill about the 29th of September with typhoid fever; well-marked case; fever 101° to 104° . At the end of four weeks she was better. She was moved, had hemorrhages, and again was ill six weeks, but ultimately recovered.

CASE 3. His sister, M.B., aged twenty-eight, was taken ill about the 29th of September, had a very bad attack, and gradually recovered.

CASE 4. J.B., a sister, aged twenty-one, was also taken ill about the third week in September, had fever, not very bad at first, and subsequently had severe hemorrhages, and died October 12th.

CASE 5. John B., aged three, son of Wm. B. (Case 1), came with his mother from Baltimore, and was taken ill about the third week in September. He had a mild attack, with fever, abdominal symptoms, and well-marked rose spots.

CASE 6. John B., aged thirty-five; fever began toward the end of September. He had headaches, diarrhoea, and a tolerably sharp attack. Convalescence began about October 17th; the temperature remained about normal until October 24th, then he had a definite relapse, with fever ranging to 104° and 105° . From November 8th until the 14th there was a period of apyrexia, and then the temperature rose again, and I saw him on the 26th in what appears to be a second relapse. The temperature has been up to 103° and 104° , and on several occasions 105° . On the 25th, for instance, temperature range was between 101° and 105° . He has been delirious, and has had several chills; great pain in his legs, and very great tenderness of feet, especially on the soles.

This case was away from the house at Annapolis a short time, and was the last to take the fever.

CASE 7. Nurse T., taken ill on the 17th of October, and was removed to the Homœopathic Hospital in Baltimore, where she had a well-characterized attack of typhoid fever, of which she died. She had been in the house forty-two days.

CASE 8. Colored nurse of child; was taken ill about the 10th of October, went to Baltimore, and had a definite attack of typhoid fever and died. She had been in the house twenty-six days.

CASE 9. Miss G., nurse, had been in the house forty-two days, and was taken to Philadelphia ill with typhoid fever, and died on the third week of the attack.

CASE 10. B.B., a sister, had also, according to the doctor's description, typhoid fever, but she kept about the house and would not go to bed for any length of time.

During the months of August, September, October, and November, there were ten cases and four deaths.

The house, a comfortable, old-fashioned, square stone building, is situated on a ridge in a beautiful rolling district of Hartford County, only a few miles from the Susquehanna River. In front of the house the ground slopes rapidly towards the roadway, which runs along a narrow valley. At the back of the house the land slopes more gradually. At a distance of about seventy-eight yards in front and to the left of the stone house, and about two-thirds of the way down the hill, is a comfortable frame house, occupied by the tenant, with a family of nine, of ages from fourteen to eighty-five. About seventy yards further down the valley, close to the roadway, is a spring of clear water, close to which is erected the "spring house" for dairy purposes.

Opening from the kitchen of Mr. B.'s house, which is a T-shaped extension, there is a covered stoop or porch, beneath the floor of which is a cistern, square, with a depth of nine feet, width of ten feet, the bottom of which is ten feet below the surface of the soil. It is cemented, and was last cleaned about May, 1892. This cistern collects the water from the roof, and at one time also received water from the spring, which was pumped up by a ram. This was abandoned years ago.

Immediately behind the kitchen, at a distance of about twenty feet, is a woodshed, and a privy, which is situated on the slope of ground behind the house. The bottom of the privy is on the level of the ground. The difference in level between the bottom of the cistern and the top of the privy is, Mr. B. thinks, about ten feet. This practically is the situation of the surroundings. The house itself inside is comfortable; the rooms are large and convenient. There is nothing whatever in their arrangement to call for special comment.

Dr. Sappington writes that "the household consisted of another brother, who did not go into the sick rooms, but ate the food and drank the water, as did also a colored boy aged fifteen, also the mother (Mrs. B.), also Dr. Sappington drank freely of the spring water, and often had his dinner at the house. A cook could be kept only a short time after the third week, and many things were supplied by their friends."

The source of infection in this epidemic is very difficult to trace. One thing only is certain, namely, that the spring water was not at fault, since living close by and using the water freely was the family of the tenant, every member of which escaped. Two alternatives remain, either the food supplied or the kitchen utensils were in some way infected from the first case, which seems to be by far the most likely view, or the disease was propagated by direct contagion, a view which Dr. Sappington holds very firmly, but which, though not impossible, does not seem to be very likely when one considers the extreme rarity of direct infection in this disease.

Though the surface slope is from the cistern, yet it is quite possible that it may have been contaminated; and if the water was used for washing the kitchen utensils (upon which point it is impossible to get positive information), this would be the most likely source of infection.—*University Medical Magazine.*

Clinical Notes.

COMPOUND COMMUNUTED FRACTURE IN THE NEIGHBORHOOD OF THE KNEE JOINT: RECOVERY, WITH MOVABLE JOINT.*

REPORTED BY J. N. E. BROWN, M.B.,
House-surgeon, Toronto General Hospital.

(Under the care of A. PRIMROSE, M.B., C.M. Edin., in the Toronto General Hospital.)

FRED. McCANN, æt. 12, was admitted to the Toronto General Hospital at 4 p.m., August 17th, 1892, suffering from a severe injury to the right thigh and knee. The following history was obtained: The boy had been running across the street-car track after a ball, and had not observed that a car was approaching; before the driver could bring the car to a standstill, the wheels had passed over the boy's thigh, immediately above the knee. He was at once taken to the hospital.

*Presented at the Toronto Medical Society.

On admission the patient was in a condition of profound collapse; his face was pale, lips blanched, extremities cold, and although not unconscious, yet he was apparently quite indifferent to what was going on around him; manipulation of the injured limb did not cause pain. The pulse was almost imperceptible; in fact, it was impossible to count it, and the respirations were shallow. On examination of the limb, a large lacerated wound was found on the inner side of the thigh, extending five inches above the knee joint and about two inches below. The edges of the wound were separated, so that a large raw surface was exposed. At the bottom of the wound the

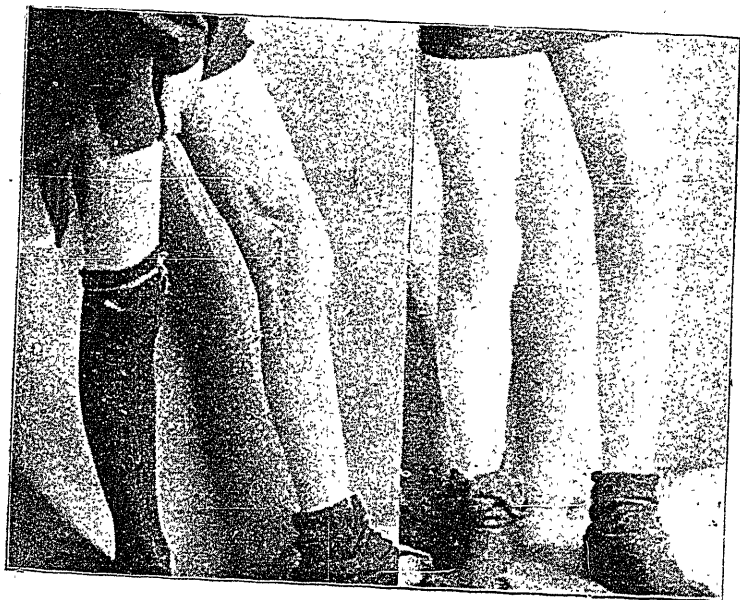


FIG. I.

FIG. II.

bone lay bare, and fractured at a point two inches above the knee joint immediately above the condyles; the bone was splintered at this point, and a fragment of considerable size was separated from the shaft; this, however, was not detached from the soft parts. The muscles and connective tissue behind the femur and in the vicinity of the fracture were severely crushed, particularly the lower third of the vastus internus, and the finger could be readily passed in and around the broken bone; the main vessels, however, had evidently escaped injury, as the circulation was well maintained in the limb beyond. A condition which must be considered very unusual, if not unique, was found on the anterior aspect of the bone; the lower

fragment was completely denuded of its periosteum in front and in its upper part, and along with the periosteum the upper part of the synovial sac of the joint was stripped off the bone; this was observed as a fluctuating sac lying in the wound. The synovial sac of the knee joint had, in fact, been detached from its moorings, and had been partially dislocated outwards. Firm pressure was made upon this, and it was concluded eventually that, in all probability, the joint cavity had not been opened, as the fluid contained (presumably blood and serum) did not leak at any point when pressure was applied. The knee joint was apparently unopened, and the circulation in the limb, beyond the injury, was well maintained; therefore it was determined that an attempt should be made to save the limb.

Treatment. The patient's head was lowered, hot bottles were applied about the body, and a hypodermic injection of m_3 liq. strychniæ was administered.

The wound (from which there was considerable venous oozing) was flushed out with hot water, and subsequently with 1-4000 bichloride of mercury; three large drainage tubes were inserted, and a few points of silk suture introduced. An antiseptic dressing, consisting of moist bichloride gauze with absorbent cotton, was applied. An interrupted long splint, extending from the axilla to the foot, was applied, with extension.

The patient suffered extremely from shock. Two hours after admission respirations were 44, pulse 128. The temperature was not recorded. At 2 a.m. (ten hours after admission) the temperature was 99°, respirations 46, pulse 130; the patient being delirious. The boy's condition remained very unsatisfactory for some hours; his pulse was extremely weak, delirium continued, the temperature remained about normal, whilst the pulse rate fluctuated between 104 and 128, averaging throughout the twenty-four hours 120. Free stimulation was employed, the stimulants used being brandy and strychnine. He was given

R. Brandy, \mathfrak{ss} .
 Liq. strychniæ, \mathfrak{m} i.
 Tinct. digitalis, \mathfrak{m} ijj.

administered every hour, and small quantities of milk at short intervals. The mixture of brandy, strychniæ, and digitalis was given hourly for the first eight hours, and subsequently every two hours. The temperature at 7 p.m. on the day after admission had risen to 100.4°, the pulse at that time being 124, and respirations 48. The strength of the pulse now began to improve, and the boy steadily regained strength. The wound was completely healed in a few weeks; the lacerated tissue came away as slough, and there was little or no suppuration. Firm union of the bone

was attained, and the boy left the hospital twelve weeks after admission, there being movement at the knee joint, but limited in degree.

The present condition of the limb (eight months after the injury) is as follows: The amount of shortening is barely one inch; flexion and extension are restricted, the maximum amount of movement being through an angle of about 10° ; when extended as far as possible, the limb is not quite straight, but is nearly so; an extensive cicatrix exists, marking the site of the original wound. This cicatrix measures seven and a half inches, extending upwards from a point two inches below the knee joint. At one point (two and a half inches above the joint), the cicatricial tissue is adherent to the bone beneath. The boy has no pain whatever, and walks well, though limping considerably, and still using a stick for support.

REMARKS BY DR. PRIMROSE The peculiar interest of this case exists in the remarkable manner in which the synovial sac of the knee remained unopened. The severe crush to which the limb was subjected, as evidenced by the lacerated condition of the tissues on the inner and back parts of the bone, and the examination of the bone itself, makes it seem almost incredible that the joint could have escaped injury. One is inclined to doubt the accuracy of the history obtained as to the statement that the car wheel passed *over* the limb. In all probability, the wheel did not pass completely over it, but simply ran up on to the anterior aspect of the limb and then slipped off. This is the only possible way of explaining the fact that the knee joint and the tissues at the outer side of the limb, as well as the great vessels, escaped injury. The wheel evidently had stripped the periosteum off the bone, torn the quadriceps extensor muscles transversely, and dislocated outwards the synovial sac, without having severed its connection with the periosteum.

The condition of the boy's limb on admission to the hospital was one which presented considerable difficulty in determining the proper course of procedure in treatment; amputation had already been advised by two surgeons, both of them being men of good judgment. The reasons for the course adopted are stated in the history given above.

A CASE OF PNEUMO-HÆMATOTHORAX WITH PRESENTATION OF THE PATIENT.

BY WILLIAM OLDRIGHT, M.A., M.D.

IT is not my intention to present notes of this case from day to day, but to give a summary of the clinical history. E.J., aged 51, while stepping from one grain bin to another on the 29th of March, slipped, over-balanced, and fell about three feet, striking his side against the corner of a post, the point of contact being three and one-half inches below and posterior to the left nipple.

He came under my care on the 1st of April. His symptoms were pain and a feeling of distress in the left side, so increased by lying down that he had passed his nights in an armchair. Pulse about 100; temperature, 101°; respirations 28, and shallow; great weakness, œdema of the feet, urine not albuminous, sp. gr. 1020, violaceous odor, probably from diuretics, taken before I saw him. I examined the ribs; no crepitus, no pain on pressing dorsal and sternal extremities towards each other.

There has been swelling on the left side of the thorax, obliterating the intercostal depressions. Percussion from time to time has revealed patches of dullness extending generally as high as two or three inches above the nipple line; somewhat higher at first, especially anteriorly, than it is now. There is a space of about three inches square, the centre being three inches below and posterior to the nipple, over which hyper-resonance existed, especially when lying down. This varied at different times; sometimes the resonance could be produced whilst the patient was either upright or recumbent on the right side; at others only in the latter position. To-day it was more expansive, especially on deep percussion.

The respiratory murmur has always been audible, though faint. The movements of the left thoracic wall were somewhat lessened.

The apex beat of the heart was at first loudest about one and one-half inches farther to the right than it normally should be, but this was only for a few days. The respirations have not exceeded 28.

The chief reasons for the diagnosis of hæmatothorax are the irregularity of the dullness, the presence of respiratory murmur, the fact that the apex beat has been for the greater portion of the time in the normal position, the infrequency of respirations, and, we may add, the weakness. The resonance was at one time so circumscribed and so superficial, especially when the chest wall was uppermost, as to lead to the conclusion that

there was a slight wound of the visceral pleura¹ covering admitting air, as well as causing hemorrhage.

To-day I introduced a hypodermic needle in the postero-lateral line, between the eighth and ninth ribs, and withdrew a few drops of sanguinous serum, which was aspirated with difficulty. Fine bubbles of air came with it. The length of the needle from the cutis inwards was one and one-fourth inches, so that it could not, I should judge, be more than one-half inch internal to the parietal pleura.

CASE OF PLACENTA PREVIA WITH TENDENCY TO POST-PARTUM HEMORRHAGE.

BY WILLIAM CRAWFORD, M.B.,
Burk's Falls, Ont.

MRS. A—, mother of three healthy children, born at full term. I was called on the morning of March 23rd, 1893, and arrived about noon, and found her resting quietly and without pain. She told me that she would not have sent for me so early but that about 4 a.m. she noticed a considerable hemorrhage without any pain, and as that was unusual she sent for me. The hemorrhage had been repeated several times, but had then ceased. Friends informed me that her previous labors had always been hard ones, and followed by severe after-pains and excessive discharge.

I made an examination and found the os patulous, and about the size of a silver dollar. I found that occiput presented in first position. On introducing index finger of right hand into cervix, I found a marginal placenta previa, having lower margin detached, and placenta attached to posterior wall of uterus. Pregnancy being at full term, I thought it best to wait a while for labor to come on, since no active symptoms demanded interference, and I was ten miles from home, so could not leave. She had several weak and irregular pains in the afternoon, but at about 8 p.m. pains became more frequent and severe, and the hemorrhage commenced again. I still thought it best to wait a little, hoping that the head, by coming down, would lessen the hemorrhage; but by 9 p.m., hemorrhage becoming profuse and pains irregular and severe, I ruptured the membranes and exerted pressure on fundus with the left hand. This succeeded in stopping the hemorrhage, and increasing frequency and strength of pains. Labor now progressed normally, and a strong, healthy child was delivered at 11 p.m. If that had not stopped hemorrhage, I intended to separate placenta over area of unavoidable separation, after the method of Dr. Barnes. As is my custom, I kept my left hand on fundus, and as placenta did not come

away I expressed it by Cr  d  's method in half an hour. Membranes were partly adherent; but by allowing them to come away of themselves and exerting no traction, the uterus was completely emptied. I still retained my hand on the uterus, to obtain good contraction before applying a bandage; but on lessening pressure I found, to my surprise, that the uterus enlarged under my hand, and the next pain expelled a considerable amount of bright red blood. I at once gave $\bar{\text{v}}i. \text{ fl. ext. ergot}$, and ordered $\text{m}x.$ every hour, and got assistants and continued pressure on uterus, which would enlarge under any relaxation of pressure. I remained till 7 a.m. the following morning, and then found the uterus would remain contracted without pressure. Patient was then suffering from less pain and discharge than after any of her former labors.

Before leaving I put on a bandage, and underneath it an inverted saucer over the uterus, which was left there till next day.

Patient was very weak for a few days, but with stimulants and judicious nourishment she gradually made a good recovery, without any rise of temperature or other bad symptom. It seems to me that the cause in this case must have been either subinvolution of uterus, or chronic endometritis when pregnancy took place.

Such cases being rare, I hope it will be interesting to many of the readers of your valuable journal.

A CASE OF PURPURA FULMINARIS.

REPORTED BY R. B. NEVITT, B.A., M.D.

THE rarity of these dreadful cases of purpura, in which the disease pursues its fatal course with such fearful rapidity, induces me to relate the following brief history:

A.T., a healthy, rosy, round-cheeked boy eight months old, was full of life and activity, taking his food well, and enjoying the best of health. The father is now in good health, but some years ago had an extensive operation on the nasal bones successfully performed. The mother has always been in good health. The child is the youngest of six children, who have all been well with the exception of the various exanthemata. About two months ago one of the elder children had diphtheria.

The child had been well until 9 a.m., when it became dull and drowsy, and was evidently so sick that the mother, dreading an attack of diphtheria, sent for me. The drowsiness continued, the breathing became rapid, the skin cyanosed, the extremities cold. About eleven o'clock purpuric spots began to appear on the feet, wrists, and upper part of the

thighs; later, they appeared on the forehead and scalp; some also were situated on the fingers and on the back between the shoulders. The spots were the usual dark purpuric spots, irregular in shape and size, not disappearing on pressure. There was one spot on the side of the tongue, one or two on the lips, and one on the palpebral conjunctiva.

The spots continued to appear in the various localities named, and some few on the chest and abdomen. The child continued to try to nurse; but was prevented by weakness and growing restlessness from sucking more than a short time. The cyanosis deepened, the breathlessness increased, and the child died at 2 p.m., after an illness of only five hours.

At the examination held twenty-four hours after death, the head was not examined. The thoracic and abdominal viscera appeared healthy and normal, with the exception of the kidneys, which had purpuric spots under the capsule, not in the gland tissue. The right suprarenal gland contained a large black clot of blood, which distended the hat-shaped gland. The bladder contained about two ounces of clear, limpid urine. The spleen was healthy and normal in appearance and size. There was a small supernumerary spleen dangling at the end of a long pedicle.

Progress of Medicine.

MEDICINE

IN CHARGE OF

W. P. CAVEN, M.B. Tor.,

Lecturer in Clinical Medicine in the University of Toronto; Physician to
Home for Incurables.

THE TREATMENT OF MYXŒDEMA.

At a recent meeting of the Clinical Society of London, Dr. Arthur Davies, Dr. Calvert, and Dr. Pasteur presented several patients who had been treated by internal administration of the thyroid gland itself, or by an extract made therefrom. The patients exhibited had, previous to treatment, presented all the characteristics and symptoms, physical as well as mental, of typical myxœdema. The improvement manifested in each case might fairly be called marvellous.

Within a short time of the commencement of treatment, the patients begin to lose the characteristic phenomena of the disease. The features lose their puffy and mask-like appearance, the hair begins to grow, the

skin becomes soft and smooth, and the intellect brightens. These obvious indications of improved nutrition are accompanied by an increased discharge of urea, a very marked and often rapid loss of weight, and a general sense of improved health. The improvement is manifested with striking constancy whatever method of administration is adopted, whether by subcutaneous injection, as advocated by Murray of Newcastle; by feeding with the raw gland, as recommended by Dr. Hector Mackenzie; or by taking the freshly prepared extract of the gland by the mouth, as in the case of Dr. Pasteur's patient. Equally good results were also obtained by Dr. Calvert by giving the gland lightly fried. In all cases the result was the same, and the conclusion seems irresistible that the thyroid gland does impart to the blood something which neutralizes the tendency to myxœdematous degeneration, and even removes the latter when it is present.

It would appear that it is not so much the rapidity of the changes effected in the body as the quantity of the substance administered that is open to risk. In Dr. Pasteur's patient alarming symptoms of cardiac enfeeblement, with syncopal attacks and dyspnoea, were directly attributable to an overdose (a whole sheep's thyroid) on two or three occasions, and did not reproduce themselves after the dose had been sensibly diminished (20 to 30 minims of freshly prepared extract in infusion of cloves every third day). Dr. Ord referred to a case in which similar alarming symptoms had occurred as the result of overdosing.

On the whole, the most convenient form of administration is in the form of powders (prepared by desiccating a glycerin extract of the gland), or by giving the fresh extract by the mouth.—*American Journal of the Medical Sciences.*

PIPERAZINE IN THE TREATMENT OF STONE IN THE KIDNEY.

Dr. David D. Stewart, in *Therapeutic Gazette*, reports three cases in his usually careful manner. The urate of piperazine, which is said to be a neutral salt, is seven times more soluble than is the corresponding salt of lithium. Despite the affinity of this remedy for uric acid, and the extreme solubility of its urate, little can be expected from it in uratic chronic multiple arthritic enlargements, at least in the doses generally administered—fifteen grains daily. In much larger amounts, such as a drachm or two daily, exhibited over a continuous time, more promising results may be anticipated; whether, however, such doses will be tolerated without injury is yet to be determined. The present unfortunately high price of the drug prevents the determination of the question. In the first case, gravel, which had been a persistent and troublesome symptom for months,

permanently disappeared. In the second case, which was one of undoubted pyelitis, the pus has almost entirely disappeared from the urine, being only ascertained by microscopic examination. In the third case, that of probable mulberry calculus, no benefit has been obtained—which fact is in accordance with what might be anticipated from the behaviour of this remedy with this salt of calcium, upon which it has no solvent action. The precise mode of action of piperazine is still obscure, although it is certain that it is beneficial in cases of gravel and stone.—*American Journal of the Medical Sciences.*

THE USE OF BENZOSOL IN DIABETES MELLITUS.

Benzosol or benzoyl-guaiacol, which has lately been introduced by Dr. Bougarts as a substitute for creasote and guaiacol, has recently been recommended at a very useful remedy in diabetes mellitus by Dr. Piatkowsky, of Cracow. It is administered in doses of one to three grammes per diem. According to a recent communication, at a meeting of the physicians at Prague, by Professor Jaksch, the sugar disappeared from the urine after the administration of benzosol for eight days in the case of a female patient aged fifty-six, who had 5-7 per cent. of sugar, but the patient died in consequence of a toxic enteritis with grave jaundice, which was attributed to the use of the remedy. On the other hand, it has been pointed out by a Vienna chemist that caution must be exercised with regard to the polarimetric examination of the urine in cases where benzosol has been administered, as the urine of persons who have taken this drug polarizes to the left, and therefore the polarimetric examinations of the urine of such persons, when it contains sugar, are misleading.—*The Lancet.*

A SUCCESSFUL CASE OF PNEUMONECTOMY.

Dr. Lawson, of Hull, recently operated on a case of tuberculous disease of the lung by removing the right apex, to which the disease was limited. The patient bore the operation well, and was able to get up for a short time in the third week; she was then eating well and had no pain. The operation was commenced by the removal of the anterior third of the second and third ribs, the parietal layer of the pleura was opened, and the apex of the lung was pulled out after separating a number of extensive adhesions; the diseased apex was then transfixed with a needle and strong silk, firmly tied, and removed. The sudden development of pneumothorax gave very little trouble, and oxygen, which was at hand, was not needed. The respirations were never more than 44, and dropped in a day or two to 32, and soon after to 24; the pulse showed a similar elevation

and decline. The highest temperature was 101.8° F.; this occurred in the second week, and lasted five or six days, with complete morning remissions. The wound was quite healed by the end of the third week. The after-history of this patient will be watched with much interest.—*British Medical Journal*.

DIABETES FOLLOWING INFLUENZA.

Drs. Hetherington and Brown record the case of a boy of fifteen who had influenza one month previously. For three weeks he had suffered from thirst, which became distressing, and was associated with the passage of large quantities of urine. He rapidly lost flesh and strength, and when seen presented an aspect suggestive of diabetes. The urine was typically diabetic, loaded with sugar, and of a specific gravity of 1040. He improved rapidly under strict dieting and half-grain doses of codeine. Nine days from commencement of treatment all sugar had disappeared from the urine. A similar case was reported in the *Lancet* for April, 1892—*Lancet*.

BROMIDE OF STRONTIUM IN VOMITING.

Coronedi, according to the *Repertorie de Pharmacie*, October 10, 1892, has used this agent with great success for the relief of vomiting from various causes. Fifteen grains, before meals, relieve nausea more or less promptly; and this dose—thirty or forty-five grains a day—is efficacious even in the obstinate vomiting of pregnancy.

THERAPEUTICS

IN CHARGE OF

O. R. AVISON, M.D., Tor.,

Demonstrator of Materia Medica and Elementary Therapeutics in the
University of Toronto.

AND

GRAHAM CHAMBERS, B.A., M.B., Tor.,

Professor of Analytical and Toxicology, Ontario College of Pharmacy; Lecturer
in Organic Chemistry and Toxicology, Woman's Medical College.

TROPACOCAINE AS A LOCAL ANÆSTHETIC.

Dr. Hugenschmidt (*La Semaine Médicale*, February 3, 1893), confirms the results of Chadbourne's experiments with tropacocaine. The ingestion of one-third or two-thirds of a grain produced no appreciable effect on an adult. When two-thirds of a grain were injected rapidly into the region of the lower maxilla, vertigo, uneasiness about the heart, and a marked

fall of blood pressure were observed within three minutes. The effect was transient, and in ten minutes the pulse returned to normal. Doses of one-third to two-thirds of a grain do not affect respiration, whereas it is easily affected by full doses of cocaine. The above doses produce no effect on the nervous system, whereas similar doses of cocaine often produce marked symptoms of cerebral anæmia. Tropacocaine exerts no influence on the vaso-motor system. Dr. Hugenschmidt believes that tropacocaine is likely to prove of great value as a local anæsthetic. He employed it as such in thirty-seven cases, never exceeding five-twelfths of a grain, usually in the following solution :

R. Tropacocaine.....gr. ij.
Distilled water.....ʒj.

SIG.—Ten minims for an injection.

It is of the greatest importance that the injection should be made slowly. One-third of a grain was found sufficient to produce anæsthesia when the injection occupied fully one minute. With this dose no toxic symptoms were observed in the thirty-seven cases.

Dr. Hugenschmidt claims for tropacocaine the following advantages over cocaine :

(1) Being prepared synthetically, it is less liable to variation than cocaine which is obtained directly from the plant.

(2) In equal doses, consistent with the production of anæsthesia, tropacocaine is less toxic than cocaine, and exerts very little influence on the vital functions of the organism.

(3) Local anæsthesia is produced more rapidly with tropacocaine, and lasts the same time as that produced by cocaine.

(4) Tropacocaine being antiseptic, its solution can be kept unaltered for months, whereas solutions of cocaine have a tendency to undergo decomposition and lose their analgesic properties after four or five days.—

University Medical Magazine.

SALOL IN THE STOMACH AND INTESTINE.

Dr. Paul Cornet (*Le Progrès Médical*, 1892, No. 44) performed a series of experiments on dogs to ascertain the changes which salol undergoes in the alimentary canal. He found that in an hour the decomposition of the drug was exclusively in the intestine, but this was not the case at the end of two and a half to three and a quarter hours after the ingestion of thirty or forty-five grains of salol. Lépine, by the microscope, and the author by analysis, both detected undecomposed salol in the fæces and in the intestine. The detection of salicylic acid in the stomach, and the arguments of Papuli, Renzi, Réale, and Gley, weaken the theory that the

decomposition of salol is effected entirely by the pancreatic juice. The slow decomposition of salol in the stomach impairs its value in determining the motor power of the stomach, as suggested by Sievers and Ewald.

The author draws the following conclusions from his experiments: (1) Salol is at first decomposed in the intestine. (2) Salicylic acid is found in the stomach two or three hours after the ingestion of thirty to forty-five grains. (3) Salol is not completely decomposed in the intestine, for some is detected in the fæces.—*University Medical Magazine*.

RULES FOR THE ADMINISTRATION OF COCAINE.

Dr. Magitot, in the *Repertoire de Pharmacie*, formulates the following rules which should govern the employment of cocaine as an anæsthetic:

(1) The dose of cocaine injected should be appropriate to the extent of the surface desired to render insensitve. It should not exceed in any case one grain to one and three-quarter grains. Each dose should be restricted in large surfaces.

(2) Cocaine should never be employed in cases of heart disease, in chronic affections of the respiratory apparatus, or in nervous subjects; and this exclusion applies also to other anæsthetics.

(3) Cocaine should be injected into the interior and not under the derm of the mucous membrane of the skin. This is the intradermic method of reclus, which should be substituted for the hypodermic method. By this means the introduction of a substance into the vein is avoided, and the risk of accidents minimized.

(4) The injections should always be practised upon the subject in a recumbent position, and he should only be raised when the operation is to be performed upon the head and mouth, and then only after anæsthesia is complete.

(5) The cocaine should be absolutely pure, since, as pointed out by Laborde, its mixture with other alkalies forms highly poisonous compounds.

(6) Cocaine should be injected in divided doses, with a few minutes' interval. This method of "fractional injection" renders it possible to guard against the production of sudden symptoms of poisoning.—*New York Medical Times*.

STERILIZATION OF HYPODERMIC SOLUTIONS.

D. Marinucci has found large numbers of living germs, some of a harmful nature, in freshly prepared hypodermic solutions of strychnine sulphate, morphine hydrochlorate, atropine sulphate, eserine, etc. Steri-

lization by heat did not affect the therapeutic value of strychnine and quinine, but partly checked the action of morphine and atropine. Eserine and atropine solutions are said to be best prepared with a solution of corrosive subimate (1 in 1,000), which renders them aseptic without modifying their therapeutic properties. Morphine solution could not be sterilized without injuriously affecting the properties of the alkaloid. It is suggested that all such solutions should be renewed every fourteen days.—*Cent. f. Bakt.*, xii., 282, through *Pharm. Journal*.

ANTISPASMIN.

This is a preparation consisting of one molecule narceine sodium combined with three molecules sodium salicylate. Merck describes it as a whitish, slightly hygroscopic powder, readily soluble in water. It contains about 50 per cent. narceine, has an alkaline reaction, and absorbs carbonic acid from the air, with partial separation of narceine. It is considered that the purity of the narceine in this preparation and its solubility will remove some of the chief objections to the use of narceine in medicine, and admit of the favorable results expected by Bernard (*Compt. Rend.*, 1862, 406) being realized. It has been tried at Berne by the late Professor Demme, who considered it to be an excellent hypnotic and sedative, especially suited for the relief of cramp, and hence the name adopted for it. It may be administered without danger in doses of $\frac{1}{10}$ grain to 1.5 grains, and appears to be well adapted for use in the treatment of diseases in children.—*Bericht*, 1892, p. 40.

THE TREATMENT OF RAYNAUD'S DISEASE BY INJECTION OF NITRO-GLYCERINE.

M. Cates treated a patient suffering from Raynaud's disease when there was ulceration of the fingers, elbows, and insteps. He injected, to commence with, $\frac{1}{100}$ of a grain of nitro-glycerine three times a day, and gradually went up to $\frac{1}{50}$ of a grain three times a day. Relief was rapid. The ulcers healed; the pains, which had been severe, disappeared; and the patient was soon able to sleep, something he had not previously been able to do.—*University Medical Magazine*.

THE TREATMENT OF THE GREEN DIARRHŒA OF CHILDREN.

Ernest Luton, in *La Revue Mensuelle des Maladies de L'Enfance*, recommends very highly the method of treatment known as the water

diet. It consists in the cutting off of all forms of diet, and the replacing of the milk in the bottle with boiled water. This treatment gives the most gratifying results.—*Bulletin Général de Thérapeutique.* J.A.A.

TREATMENT FOR THE ITCHING OF URTICARIA.

Dr. Bourdeaux has used equal parts of liquor calcis, aqua laurocerasi, and glycerini with great success in the treatment of the itching of urticaria, and even of the itching of other skin disorders. He sops the itching parts well with it, then covers with absorbent cotton, without wiping. The relief is almost immediate.—*Rev. de Clin. et de Thér.* J.A.A.

AN AGREEABLE PURGATIVE FOR CHILDREN.

The following purgative is to be taken in teaspoonful doses: Emulsionize 15 grammes of castor oil with the yolk of one egg; add to this 60 grammes of an infusion of coffee and 20 grammes of sugar.—*Bulletin Général de Thérapeutique.* J.A.A.

NITRO-GLYCERINE.

In certain conditions the action of nitro-glycerine or glonoin is marvellous. When a powerful stimulant is indicated, its universality of action distinguishes it from all others; and if given more freely than is necessary for the exertion of its influence in this way, it not only operates on the brain especially, but does so with great energy. In favor of nitro-glycerine is its smallness of bulk; and as an anti-spasmodic and nervous stimulant, it has no peer amongst medicines of that class. In a case of emergency, one drop of a one per cent. solution may be placed on the tongue or inside the upper lip when the patient is in an unconscious condition. Its effects are immediately observed, by its property of relieving spasm, which it certainly does to a remarkable degree. Its effects are immediately manifested by the capillaries carrying more blood than they had done before its administration; the radial pulsation grows fuller, freer, and more rapid; and there appears an increased warmth of the extremities. An overdose of it produces giddiness, weakened vision, headache, with throbbing in the temples, a sense of weariness, sleepiness, and severe pain in the cardiac region, with unusual trembling. Since the introduction of nitro-glycerine in therapeutics, I have not had an opportunity of testing its virtues in puerperal eclampsia; although my observations of its *modus operandi* as a nervous stimulant and a remedy in some other affections, especially those of a spasmodic character, have been quite satisfactory.—*Times and Register.*

OBSTETRICS

IN CHARGE OF

ADAM H. WRIGHT, B.A., M.D. Tor.,

Professor of Obstetrics in the University of Toronto; Obstetrician to
the Toronto General Hospital.HYSTERECTOMY PERFORMED FIVE DAYS AFTER LABOR FOR PUERPERAL
METRITIS.

I offer the following contribution under the conviction that a certain percentage of cases of "puerperal fever" tending to run a fatal course could be rescued by a timely radical operation, cleansing the peritoneum, removing ovaries and tubes or uterus; in other words, wherever a local septic focus exists which cannot be reached *per vaginam*, attacking it *per abdomen*.

My patient, Mrs. S., came to term, giving birth to a normal healthy living boy, December 8, 1891. She was a primipara, aged thirty-four, in excellent health. The labor was natural, and but few examinations were made, and each time after scrubbing hands and nails, both before and after the examination. There was no hemorrhage, the placenta came away under gentle expression in about fifteen minutes, and I could detect no tear on careful inspection of the genitals within as well as outside. Her condition remained normal until seventy-two hours after labor, when when she was seized with a severe chill, lasting over an hour. I saw her between three and four hours later, when the temperature was 104.5° F. and the pulse 120; she had an anxious, collapsed expression. There was no abdominal pain or nausea, but much headache; the abdomen was flat. The lochia was suppressed to a slight foul, odorous discharge. Tenderness on pressure was marked; she screamed upon pressure on the uterus. My first efforts at treatment were directed toward washing out the uterus with the long point of an alpha syringe, using warm carbolyzed water. I also ordered at once large doses of sulphate of quinine, forty grains in the day, and phenacetine in ten-grain doses every few hours, as soon as the temperature rose above 103° F. I hastened, in addition, to evacuate the intestinal tract by giving her five grains of calomel and soda. Hot mush poultices were kept constantly on the abdomen. In this way I secured some temporary relief, but, as I now fear, at the expense of masking some of the important symptoms necessary to a correct estimate of her condition.

On the following day (Sunday, the fourth day), Dr. T. B. Steele was called in consultation. The general condition was manifestly worse, the uterus furnishing a scant, fetid, black discharge, and the tenderness in-

creased. Specular examination showed a large, congested, blackish-blue cervix covered with grayish, diphtheritic exudate, closely adherent; this could not be detached *en masse*, but broke off, leaving a bleeding surface; this deposit extended down into the vagina and involved the labia. The temperature was 105°, pulse 130, prostration extreme, facies anxious and drawn, tongue coated and dry, thirst intense, abdomen tympanitic, no vomiting, frequent urination. She had had several copious evacuations from the calomel. The diphtheritic masses were removed with peroxide of hydrogen applied within the uterus as well as in the vagina, and the uterus was again washed out with warm carbolized water, and phenacetine was continued. A fatal issue seemed certain under the present condition, and we therefore decided, on account of her rapidly failing condition, to telegraph for Dr. H. A. Kelly, of the Johns Hopkins Hospital, to come prepared to perform a hysterectomy.

Dr. Kelly responded at once, arriving the following day (Monday) at one o'clock, and, finding her condition as described, in addition to a septic pleurisy under way, while the patient appeared to be approaching collapse, performed abdominal hysterectomy.

Operation. An incision was made in the linea alba fifteen centimetres (six inches) in length, and the distended intestines, which were embarrassing throughout the operation, were held to one side by pieces of sterilized gauze, while the large, softish, putty-like, deeply injected uterus was lifted out of the abdomen and a temporary rubber ligature thrown around its cervical end, and the uterus and ovaries and tubes were at once cut away above the ligature, thus removing the whole septic body with the enlarged ovaries and tubes. Extreme care was taken to prevent any fluid from the uterus escaping on to the peritoneum while cutting the organ away. The stump of the cervix was thoroughly burned out with a Paquelin cautery managed by Dr. Steele, and then sewed together in two layers—a lower of buried sutures and an upper of symperitoneal silk sutures; this stump was then suspended in the lower angle between the lips of the incision where the parietal peritoneum on all sides was attached to the peritoneum of the stump, thus secluding it from the abdominal cavity, closed down to the stump without drainage, and avoiding the more dangerous method of leaving the constricting ligature on the stump to slough off later.

The symperitoneal ligatures were left long for the purpose of suspending the stump, and avoiding a tendency to drag back into the abdomen.

A small opening was left in the lower angle of the skin wound leading down to the stump, and was packed with iodoform gauze. There was no peritonitis and there were no adhesions; the right ligament was distended by bright red cords, looking like lymph vessels, as large as the little finger.

Both ovaries were swollen. The uterus was large and everywhere infiltrated, containing necrotic areas in its substance where the muscular tissue was disintegrated.

After the operation. Following the removal of this great septic focus, there was an immediate marked improvement; the temperature became normal within an hour, and the pulse dropped to 120. The pulse varied from 120 to 130 for three days, and the temperature 100° to 102.5°.

Subsequently there was no vomiting, no tympany, and no pain; there were no chills until five days after operation, when a stitch-hole abscess formed, with severe local pain and elevation of temperature and pulse (150); this discharged on the eighth day, with relief of the symptoms. At this time all abdominal stitches were removed. Her subsequent recovery was interrupted in the fourth week by phlebitis, beginning in the left ankle, extending up to the body, involving the right leg on the following day. In three to four weeks the suspensory ligature came away, and without any further drawbacks she recovered complete health and resumed all household duties in four months. To-day, just a year after the operation, she is in the best of health, with no sequel save a small abscess which formed in the abdominal cavity and healed.—*Dr. Goldsborough in N. Y. Medical Journal.*

SYMPHYSIOTOMY.

Pinard, of Paris, furnishes one of the most interesting contributions on this subject. During a clinical lecture, delivered Dec. 7th, 1892, he presented thirteen patients on whom he had performed the operation during the previous year (*London Lancet*). The thirteen mothers, representing all his cases, were well. They had no urinary troubles, nor any difficulty in standing. All the children were born alive, but three died subsequently on the first, second, and third days respectively.

Pinard's method of operating is somewhat different from that of Morisani, described in the February number of *THE PRACTITIONER*. The Italian school (including Morisani) use a very small incision, and make a subcutaneous division of the symphysis with a Galbiati knife. Pinard, on the other hand, makes a free median incision 8 cm. (3.15 inches) long, stopping immediately above the clitoris. He then separates the recti muscles, and pushes the index finger into the præ-vesical cavity in order to protect the bladder by its dorsal aspect. He then divides the symphysis from above downwards and before backwards. In doing this he cuts through all the fibres of the subpubic ligament, the index finger in the præ-vesical cavity being the guide from the time that the probe point of the bistoury strikes it above until the last fibres of the subpubic ligament are

divided. Before this ligament is divided he takes the precaution to introduce a sound into the urethra, so as to push it downward and laterally out of the way of injury. He then attacks the ligament "by small cuts, as if cutting it fibre by fibre." This ought to allow a separation of 4 cm. ($1\frac{1}{2}$ inches) when the thighs are carefully abducted. During the extraction of the child the separation at the symphysis may reach, but should not exceed, 7 cm. ($2\frac{3}{4}$ inches). After the delivery of the placenta the symphyses are brought together; four deep and four superficial sutures are used, and left in for eight days. An ordinary binder very firm on the pelvic region, or a plaster bandage, should then be applied. Pinard, in his hospital practice, uses a special bed. Full particulars of Pinard's methods may be found in the *London Lancet*, Feb. 18, 1893.

THE EFFECT OF PURGATIVES ADMINISTERED TO THE MOTHER UPON THE NURSING INFANT.

At a recent meeting of the Toronto Medical Society, Dr. Oldright referred to the effects of such purgatives as sulphate of magnesium on nursing infants when administered to mothers. In the English *Practitioner* for March, 1893, Gow reports his experience in connection with such use of purgatives. The drugs used were aloes, senna, cascara sagrada, and sulphate of magnesium. He did not find that senna, cascara, or aloes, when given to the mother, had any effect upon the infant; but the sulphate of magnesium frequently caused looseness of the bowels in the babe. The editor of the *American Journal of the Medical Sciences*, in commenting, says that, according to his experience, the salts will sometimes act more promptly on the intestines of the child than on those of the mother. He has, however, had a similar experience with other drugs, notably aloes. In my practice, I have frequently found that the mag-sulph. acts on the child; but when I think watery catharsis is urgently needed by the mother, I do not withhold the salts on that account. In obstinate constipation, I have found rhubarb and salts act on the child before they affected the mother; but aloes has seemed to me much less likely to affect the child, while it is probably the best remedy for this condition during the puerperal period, especially when there is a sluggishness of the rectum, with a tendency to hemorrhoids.—A.H.W.

SORE NIPPLES.

Ichthyol, 50 per cent. in lanolin, is said to be a good application.—Hermann (*Centralblatt für Gynakologie*).—*American Journal of the Medical Sciences*.

THE TREATMENT OF ALBUMINURIA GRAVIDARUM.

Jaccoud, of Paris (*La Semaine Médicale*, February 10th, 1893), places pregnant women, as soon as they have shown signs of albuminuria, upon an exclusive milk diet, and continues it until labor has taken place, even though the albumin disappears from the urine. He examines the urine at least once a week. If it shows no other change than the presence of a certain quantity of albumin, he prescribes the daily inhalation of oxygen, using at least thirty litres in the twenty-four hours. If the urea excreted is below normal, the quantity of oxygen is increased to twice or three times this amount. The patient should be carefully protected from cold, and should uræmic symptoms appear he resorts to phlebotomy.

Jaccoud further insists on the systematic use of milk by all pregnant women to prevent the occurrence of albuminuria. He directs them to commence with two pints a day, gradually increasing to three pints, until the end of the sixth month, after which two quarts daily should be taken. After labor the quantity is gradually decreased during the following six weeks.—*University Medical Magazine*.

THE USE OF PURGATIVES IN NURSING WOMEN.

In the March number of the *Practitioner*, Dr. William J. Gow alludes to a popular impression that purgatives administered to a nursing woman often lead to disturbances of the suckling's bowels, gives a condensed account of his own experiments with several of the ordinary purgatives, and expresses his conclusion that magnesium sulphate administered to a nursing woman frequently causes looseness in the child, while senna, cascara sagrada, and aloes rarely have that effect.—*New York Medical Journal*.

INTRA-UTERINE INJECTIONS OF TINCTURE OF IRON.

Eichhalz (*Der Frauenarzt*) makes some remarks upon the fatal case of Dr. Pletzer, following intra-uterine injections of tincture of iron. He condemns the method in general, but more especially when so dangerous a drug as tincture of iron is used. Chrobak alone has collected eighteen cases of death resulting from the injection of this agent.—*Alloway, in Montreal Medical Journal*.

GYNECOLOGY

IN CHARGE OF

JAMES F. W. ROSS, M.D. Tor.,

Lecturer in Gynecology in the Woman's Medical College; Gynecologist to St. John's Hospital, Toronto General Hospital, and St. Michael's Hospital.

TWO FŒTUSES REMOVED FROM THE PERITONEAL CAVITY AT ONE OPERATION.

Truth is stranger than fiction. I have here two fœtuses at about the same stage of extra-uterine development, removed from the abdomen by one operation. They were apparently about four months old when they perished. The condition was complicated by a right hæmatosalpinx and a left hydrosalpinx.

Mrs. P.G., aged 42, married 25 years, 8 children, youngest 12 years.

Seven years ago went two weeks over her time; then, October 23rd, 1885, had a slight flow of blood, and was taken with most severe cramp-pains in the lower abdomen, recurring again and again. Was in bed until December 10th; then got up and went to the office of Dr. W. H. Byford, who sent her back to bed for two weeks longer. Called on Dr. King, who prescribed ergot, and caused the expulsion of something from the uterus.

Five years ago had a similar attack, commencing with cramps and fainting. The late Dr. J. S. Knox diagnosed a pelvic hæmatocele. Has been treating for diseased appendages almost ever since. Three months ago she had an attack of pelvic peritonitis, with bulging in the cul-de-sac of Douglas. I apparently cured the attack by drawing off about five ounces of serum from the cul-de-sac.

Abdominal section, February 21st, 1893, at the Woman's Hospital, assisted by Drs. T. J. Binkley and Marie White. Found the uterus and appendages matted together in a conglomerated mass the size of two large fists, with intestines adherent over them. Came first upon a hæmatosalpinx on the right side, which burst and let out about four ounces of a bloody fluid. I then came upon a membranous sac adherent in the pelvis, containing a fœtus with bones well preserved. After tying off this side I found almost exactly the same thing on the left side, except that the tube contained a watery fluid. The adhesions were so firm that a portion of the cyst of the right ovary had to be left on an adherent loop of intestine, and the fœtal sac of the right side had to be ligatured, and a portion left on the rectum to which it was adherent. No definite placenta was found. The operation was quite a bloody one throughout. Drainage for 36 hours. Unusually smooth recovery, temperature remaining below 100° F.

throughout, excepting a temporary rise during the second week from a superficial stitch hole abscess in the unusually fat abdominal walls.

This is another of the many cases that are being discovered in which extra-uterine pregnancy has not killed the patient. It is the second patient I have had with two tubal pregnancies, none of which produced any apparent dangerous symptoms. The condition has by no means the mortality attached to it that many eminent surgeons would have us believe. I know of no other case in which both tubes, each with a fœtus, have been removed at the same operation. The history, together with the mummified appearance of the fœtuses, would make it quite probable that one of the conceptions occurred seven years ago, and the other five years ago, that each had caused a pelvic hæmatocele, had become encysted, and remained to trouble the patient ever since, but not to kill her.—*Henry J. Byford, in the Chicago Clinical Review.*

CONSTIPATION AND ITS TREATMENT BY LARGE ENEMATA OF OIL.

Prof. Heiner, in an article in the *Beliner Medicinische Wochenschrift*, discusses this question, and recommends the large enemata of oil as the curative agent in such cases. He divided constipation into two classes, the "atonic" and the "spastic." The first he considered to be the result of insufficient and slow peristalsis, but the latter he considered to be due to spastic contraction of the colon. This condition he considered most frequently found in nervous persons, neurasthenics, hypochondriacs, and women with pelvic troubles. Firm masses of fæces are kept back by sections of intestine that remain in a state of firm contraction, and hinder the onward movement of the fæces. The evacuations in such cases are characteristic. They are thin, of small calibre, and of moderate quantity. Sometimes the fæcal matter is small and knobbed. He considered massage in spastic constipation as useless, and he also considered faradization and drastic purgatives as equally useless. For such cases he advised, as the best treatment, a large enemata of oil. With the patient in the dorsal position, twelve to fifteen ounces of oil is injected. The pelvis should be raised as high as convenient; the oil should be warmed and emptied into the bowel. The administration should occupy about fifteen minutes. The enemata should be repeated daily until a favorable result is obtained. After this a smaller quantity of oil will be sufficient.

Sometimes the oil produces an irritation at the sphincter. If the best olive oil is used, however, this is not likely to occur. The oil is supposed to act by softening and loosening fæcal masses, by soothing and diminishing irritation, by exciting peristaltic action, by preventing reabsorption of fæcal constituents and all their decomposition products.—*Medical Press and Circular.*

CANCER OF THE BREAST IN A MALE.

Though not strictly gynecological, the following case is one of interest: A man aged sixty was admitted into the Sheffield Infirmary, under the care of Mr. Arthur Jackson. Three sisters had swellings in the neck and arms; one sister had her right arm amputated for bone disease; another died of phthisis at the age of eighteen. Both parents lived to old age. Twelve months ago detected hard tumor in the right breast, free from pain, even on pressure, and movable. It increased in size. Tumors in the axilla began to develop, and they were also noticed under the right clavicle. Loss of appetite and emaciation, together with pains in the head, now set in. At the last report there was a tumor about the size of an orange in the right mammary region, nodulated on the surface; hard and movable glands in the axilla were enlarged, and under the lower border of the pectoralis major muscle and right clavicle enlarged glands were to be found. No operative treatment was advised owing to the evident extension of the disease.

INJECTION OF SALT SOLUTION INTO THE VEINS FOR SEVERE HEMORRHAGE.

At an operation in Guy's Hospital recently, while Mr. Davie Colley was performing the operation of amputation of the hip-joint, a branch of the profunda artery, or perhaps the profunda itself, bled freely, and the patient lost a great deal of blood. Mr. Colley's house surgeon injected into the median cephalic vein of the patient's right arm thirty ounces of a solution of common salt, sixty grains to the ounce. About two inches of the vein was at first exposed, a ligature placed around the lower part of the piece exposed, while a hollow needle attached to a tube was introduced into the vessel and tied in, and the injection gradually given.

In this case the procedure seemed to have a very good effect. A procedure that can be rapidly applied without too much danger to cases of excessive loss of blood during the removal of adherent abdominal tumors should be kept in mind by the abdominal surgeon. Many of these cases after the complete removal of a tumor, the pedicle of which can only be reached near the end of the operation, if they can be kept alive by such a ready method as that offered by the injection of salt into the veins, would be likely to make a permanent recovery.—*British Medical Journal*.

CANCER OF THE COLON REMOVED IN COLOTOMY.

Mr. Herbert Allingham read notes of a case suffering from cancer of the colon. The abdomen was much distended; no growth could be felt in the rectum. The incision made was that made for left inguino-colotomy, but obstruction was found to be due to a malignant stricture of the sigmoid

flexure. The growth, with about fifteen inches of the intestine, was pulled through the inguino-incision and fixed outside the abdomen; the intestine was then incised. Ten days later the author's spike clamp was applied to the protruding intestine and the cancer and the mass were removed, weighing, in all, fourteen and one-half ounces. The clamp was left on for thirty-six hours, and was then removed. There was not the slightest bleeding. All was healed in about fourteen days, and there was no prolapse through the incision. Although the sigmoid flexure was twisted, the two sides of the bowel above and below the growth looked exactly the same size, owing, no doubt, to the emptying of the intestine by its traction through the walls of the incision. It was difficult to tell which was the upper end. Resection was considered inadvisable, owing to the unfavorable condition of the patient.—*British Medical Journal*.

ABSCESS BENEATH DIAPHRAGM WITH GASTRIC ULCER.

At a meeting of the Clinical Society of London, held on the 13th of January, 1893, Drs. Penrose and Dickinson reported a case of abscess beneath the diaphragm in connection with perforating gastric ulcer.

The paper was based upon the notes of ten cases in which perforation of the stomach had resulted in the formation of an abscess confined to the upper part of the abdominal cavity. Most of the cases gave hyper-resonance on percussion, amphoric breathing, and the bell-note over an area more or less confined to the epigastrium and the left hypochondrium. There was evidence of compression, either with or without pleural effusion, at the base of the left lung. The heart's apex was generally, to a slight extent, displaced. The diagnosis of the cases was usually not very difficult; but certain thoracic complications, such as empyema, pyo-pneumothorax, or pulmonary abscess, were liable to arise, and might be very misleading. The limits of the cavity were generally found to be above the arch of the diaphragm; on the right, the falciform ligament of the liver; on the left, the cardiac end of the stomach, the spleen, and the diaphragm, with a deep pocket of the abscess extending backwards between these organs; in front, the anterior abdominal wall; behind and below, the left lobe of the liver.

In the discussion, the question came up as to whether any case of perforation had been noted in which an abscess had formed and a subsequent perforation and evacuation of the abscess contents back into the stomach had taken place and been followed by recovery. If so, cases of peritonitis with this termination could be readily understood.

Dr. West reported a case in which the symptoms pointed to pleurisy. The patient, however, referred the pain to the abdomen. The case was supposed to be one of empyema, but it proved to be an abscess consequent on the rupture of the gastric ulcer. There had been no symptoms

at all to point to the presence of a gastric ulcer until the fatal pain and suppuration came on. He referred to the case of a man who was admitted with a swelling in the left loin; it was elastic and tense, without resonance. It was opened and contained a large amount of fæcal pus. The patient died unrelieved by the operation, and at the *post mortem* the abscess was found to originate in the perforation of a gastric ulcer.

Dr. Dickinson, in reply, stated that he could not admit that the diagnosis was as difficult as some of the speakers led them to suppose. A sudden attack of peritonitis in a chlorotic girl was almost certain to be consecutive to rupture of a gastric ulcer, and laparotomy ought to be resorted to at once unless there was reason to suppose that the peritonitis was circumscribed.—*Medical Press and Circular*.

HEMORRHAGE FROM UTERUS.

At the meeting of the British Gynecological Society, Dr. Savage read a paper on hemorrhage from the uterus. He divided the subject into two classes; first, those in which the hemorrhage was associated directly with the uterus itself; and, secondly, those in which the hemorrhage was associated with some condition outside the uterus. In speaking of myomata and the various remedies in vogue, he considered electrolysis a dream of the past. He thought operative interference for hemorrhage, namely, the operation of laparotomy, was the best operation. Should this fail, hysterectomy would become necessary. In the second class of cases above mentioned, he considered the causes external to the uterus, such as the presence of cystomata, dermoids, extra-uterine gestation, chronic inflammatory diseases of the appendages.—*Medical Press*.

SURGERY

IN CHARGE OF

L. M. SWEETNAM, M.B. Tor.,

Lecturer on Therapeutics in the Woman's Medical College; Surgeon to the Outdoor Clinic, Toronto General Hospital; Surgeon to St. Michael's Hospital.

DUPUYTREN'S FINGER CONTRACTION.

The accepted theory of the cause of Dupuytren's contraction is that it is of constitutional origin; and while gout and rheumatism are the essential elements in many persons who suffer deformity from disease of the palmar fascia, I am impressed with the belief that syphilis may act as a primary cause also.

I am driven to this opinion by one case which was recently under my care; and, while one swallow doesn't make a summer, the evidence in this

instance is *prima facie*, and I trust that I may make it convincing to you. In the family to which this lady belonged, as far back as history goes, there has never been a case of gouty diathesis or rheumatic fever. I mean that neither disease with these folk is hereditary. It has been supposed hitherto that women were exempt from contractura palmaris; however, as there are exceptions to all rules, so it is on this occasion. The lady was of good social grade, sixty-seven years of age; and when I saw her first her fingers were permanently bent. I was consulted with reference to her general health, and also if it were possible to remedy the existing deformity. While there was no pain connected with the contraction, she was annoyed and depressed by constantly recurring inconveniences. To comb the hair, to change the dress, to lift a weight, to write—in fact, to perform any manual duty—was a burden, if not an impossibility. The thumb on the right hand was drawn to the middle of the palm; motion was only possible between the first and second phalanges.

The fascia of the palm and the fibrous tissue of the inside of the fingers of this hand were diseased in a somewhat higher degree than on the left. But she was bad enough off in both members, so that life was hardly worth living. She frequently wished the Gordian knot might be cut, and her desires were gratified in less than a couple of moons after my first visit by an attack of acute pneumonitis, which quickly did the work for her.

The disease began in the thumb and extended gradually. After a varying interval, the precise time she couldn't remember, the disease attacked the little finger of her left hand, and by degrees the ring and other fingers became involved. This patient in her earlier years enjoyed robust health; was never troubled with either rheumatism or gout. As a widow she had a small estate, which was inducement enough to attract a progressive gentleman many years her junior. He informed me that in an immoral moment he contracted syphilis, and, as he expressed it, "burnt the old woman." Treatment was given her by the family-physician in complete ignorance to her of the real nature of the malady. She passed through the several stages, the disease being pretty well kept in abeyance. Seven years were passed from the initial lesion of the syphilis before the least sign of contraction of the palmar fascia became manifest.

The morbid process, as before remarked, began in the thumb by a little weakness, which was rapidly followed by bending in all the fingers of the right hand.

This malady being of obscure etiology, can we not make a diagnosis as to cause by exclusion? She had no gouty process, no rheumatic diathesis. She did not remember ever to have had an inflammation, either acute or chronic, in the palmar aspect of the hand, and it was only after the nutritive processes were much interfered with, and sequently the nervous system, by the "lues venerea" that contraction began to exhibit itself.

Processes to a certain extent may be described, but ultimate causes are sometimes beyond the reach of the subtlest intellect; and, as the problem of palmaris contractura has not been settled, we may reasonably suppose that the specific effects of syphilis may be a factor, just as that which has been attributed to gout and rheumatism. I cannot divine any other solution. The case is novel: first, in its occurring in a female, which is rare; secondly, that the thumbs were contracted. Both Dupuytren and Malgaigne say they never saw contraction of the thumb.

A moderate permanent bending of the fingers of both hands is frequently seen in many old persons, men and women, especially laborers; they are unable to extend the fingers completely.

With advancing age the adipose masses between the linea mensalis and the flexion-furrow, corresponding to the metacarpal articulations of the fingers, disappear regularly, and contraction of the palmar fascia results; but to these folk it is of little moment, and they plod on till the millennium without asking for relief.

Contraction in these instances may be due to shrinking of the surface of the aponeurosis palmaris; but to make a distinction between this and of the fibres that ascend from it to the integument is subtle and useless. It is evident that even in cases where the "brides" first begin to shrink, the permanent bent state of the hand will be followed by shortening of the palmar fascia itself.

My object is merely to bring forward, as possible, another etiological factor for Dupuytren's finger contraction, apart from gout and rheumatism, which have always been considered and doubtless are the fount and origin of the malady with the majority of the unfortunates.

Syphilis, which is the most striking illustration of a cachexia, was outwardly apparent, and as empiricism has declared that it is useless to treat syphilitic sequelæ without directly treating the syphilis my therapeutics were tied to hæmatics and mercurials, with the belief that by curing the anæmia she might bear surgical interference for the relief of deformity after the manner of Madelung, of Bonn, with whose operation you may be familiar.—*Steele Bailey, M.D., in American Practitioner and News.*

TREPHINING FOR INTRACRANIAL HEMORRHAGE.

Elliot (*Boston Medical and Surgical Journal*, cxxviii., No. 6, p. 137) has reported a case of hemorrhage from the middle meningeal artery and one of subdural hemorrhage, in both of which relief was afforded by trephining, controlling the bleeding and removing the clots. In the first case, the patient had fallen a distance of twelve feet upon his head. Consciousness was lost and the pulse became abnormally slow. The pupils failed to

respond to light, and the right was dilated. Convulsive movements occurred, and coma set in, with stertorous breathing. No fracture of the skull was appreciable until the scalp had been reflected, when a linear fracture was found, extending from the parietal eminence down to the base of the skull. On trephining, without anæsthesia, an extra-dural clot, as large as a small fist, was found, and the meningeal artery was seen spurting in the trephine opening. The vessel was ligated by passing a curved needle through the dura, and the clot was removed. There was a deep indentation in the brain, in which the blood rapidly accumulated until it was packed with gauze. The frequency of the pulse increased from 40 to 100 during the course of the operation, and the patient became sensitive to pain, and moved his arms and legs. On the second day intelligence began to return. The wound healed rapidly and recovery was complete. The second patient was kicked by a horse, and was unconscious for about ten minutes. When seen, three hours later, consciousness had returned, but there was difficulty in speech. The protruded tongue deviated to the left. There was a compound fracture of the skull, two and a half inches above the ear, running upward and backward for two and a quarter inches. The depression was an inch wide and three-quarters of an inch deep. The skull was trephined, and the depressed fragments of bone removed. The dura appeared white and uninjured, but bulged into the wound and did not pulsate. Distinct fluctuation indicated the presence of fluid beneath. The dura was incised, and a quantity of blood was found in the arachnoid space. The hemorrhage continued until controlled by a deep packing of gauze. The patient made a prompt recovery. During convalescence there was slight paresis of the upper lip, and for several weeks the tongue deviated to the left.

APPENDICITIS.

As the relation of this disease to peritonitis becomes more generally and thoroughly appreciated, any information which assists us in recognizing it and treating it successfully becomes more and more welcome. Dr. H. H. Mudd (St. Louis Medical College), in a recent lecture, reported in the *International Clinics*, says: "The great majority of the cases which have come under our observation at the clinic have been during the presence of an acute attack, and have been operated upon, where operation was needed, during the acute process. The great majority of these cases have had a circumscribed pus cavity in the peritoneum. The experience of the past few years has taught me how to open these abscesses to a better purpose than formerly. I confess to have opened many abscesses in the right iliac fossa, in my earlier experience, without recog-

nizing what I believe now to have been the true source of the abscess, viz., a suppurating appendix. We can open such abscesses by the ordinary incision for the removal of the appendix. Great care should be exercised not to break up the circumscribed adhesions which limit the pus cavity. If the general peritoneal cavity is opened, it should be carefully guarded, by sponges and by cleanliness, from infection. In all cases where the pus has been in any considerable quantity, I pack the cavity with iodoform gauze and establish free drainage through the external wound. The removal of the appendix becomes an incident in the operation for the relief of the abscess and the proper cleansing of the cavity. Unfortunately, the great majority of these cases still come to the surgeon after an abscess cavity has formed. It is then too late to make a clean and perfect laparotomy and close the wound for primary union. It is true that many cases of appendicitis recover without operative measures, the necessary treatment being rest in bed, attention to the bowels, and moderate diet—the abscess, if there be one, opening into the bowel and discharging through the intestine. Induration and thickening about the head of the colon do not necessarily imply suppuration, for not infrequently the inflammation subsides without the formation of an abscess. It must be admitted, even by the most conservative, that operative interference in these cases is very generally judicious, conservative, and efficient.

COCAINE IN THE TREATMENT OF ACUTE INFLAMMATION OF THE MIDDLE EAR.

An unusually large proportion of the cases of la grippe occurring during the past few months have been complicated by middle ear trouble.

Dr. Wolfenstein, of Cleveland, has treated about one hundred cases of acute otitis media by instillations of a 5 per cent. cocaine solution. In an article which appeared several months ago, the *New York Medical Journal* says: Ninety-five per cent. of all his cases have escaped suppurative inflammation. His plan is to instil 5 or 6 drops of the cocaine solution as often as the pain returns. A single medication, the meatus being closed afterward with cotton, will, it is stated, cause pain to cease within ten or fifteen minutes, and the patient will be free from pain for several hours.

Ordinary cases of acute otitis media will subside under two or three days of treatment, the drops being instilled four or five times daily.

Inflammation of the naso-pharynx must be treated also.

The writer believes that hearing returns more rapidly, and that tinnitus is greatly diminished and ceases more promptly, after this cocaine treatment than after any other procedure. Excellent results have been

obtained in cases of otitis media complicating scarlatina and diphtheria. Merck's crystallized hydrochloride of cocaine has been found most reliable. The author has never seen any toxic effects result from this method, although he has sometimes used much stronger solutions of cocaine.

TREATMENT OF COMPOUND FRACTURES.

The views held by prominent surgeons upon this subject have always special interest for the general practitioner, whether he is located in town or country.

Tréves (*Annals of Surgery*) expresses a preference for the following as a treatment for this class of fractures :

On admission the limb is covered with lint soaked in carbolic lotion, and is then cleaned with the greatest care ; protruding bone is removed, and the broken ends are adjusted as soon as possible.

(1) Ordinary well-padded wooden splints are used, but under no circumstances is the limb secured to them by strapping. Instead of plaster he uses fine webbing and buckles. No bandages are ever applied.

(2) The limb is kept throughout in the open air. (3) The wound itself is covered by a heap of antiseptic powder—iodoform or creolin, preferably the latter. This covering of powder keeps out bacteria without hindering the free escape of discharges, which form with the protecting powders a harmless scab or crust. The advantages claimed are : (1) Simplicity.

(2) Avoidance of "meddling." (3) The damaged part is open to view.—*British Medical Journal*.

VOMITING IN CHLOROFORM ANÆSTHESIA.

Passet (*Münch med. Woch.*, June 7, 1892) says that the chloroform vapor acting on the mucous membrane of the mouth produces a flow of saliva. This saliva is swallowed, and a certain part of the chloroform is thus conveyed into the stomach. The gastric mucous membrane is in this way irritated, and vomiting is set up. This increased flow of saliva at the beginning of the administration may be seen in animals, especially in cats, as well as in the human subject. For some time after the anæsthesia chloroform is exhaled with the breath, and even this may irritate the mucous membrane of the mouth in the same way, and with the same result. The action of chloroform upon the stomach varies in different individuals. The author adds that the only rational way of preventing the vomiting is to avoid the swallowing of chloroform, and that this may be done more easily than might appear by directing the patient to spit out the abundantly secreted saliva.—*British Medical Journal*.

LOSOPHAN.

Losophan may be looked upon as a tri-iodide of cresol. It contains eighty per cent. of iodine, and is soluble in alcohol and readily taken up by fatty substances. Dr. Saalfeld finds a one per cent. ointment valuable in skin diseases due either to vegetable or animal parasites, as tinea tonsurans and pityriasis versicolor; for pediculi capitis and pubis twenty-five per cent. of vinegar is added to the ointment; and in the case of scabies a stronger preparation is employed, containing two or three per cent. of losophan. In chronic skin infiltrations an ointment of the strength of one or two per cent. was useful, but in acute eczema it appeared to be irritating. In prurigo, sycosis vulgaris, acne vulgaris and rosacea, and in puritus, it was very effectual. It appears to be of little use, however, in psoriasis or urticaria, and is contraindicated in acute inflammations of the skin.—*Medical Record.*

GENITO-URINARY AND RECTAL SURGERY

IN CHARGE OF

EDMUND E. KING, M.D. Tor., L.R.C.P. Lond.

Surgeon to St. Michael's Hospital; Physician to House of
Providence and Home for Incurables.

HOW TO OPERATE FOR HEMORRHOIDS.

Dr. Charles B. Kelsey, in a lecture delivered in the New York Post-Graduate Hospital, and published in the *Therapeutic Gazette*, April 15th, 1893, after graphically describing the clamp and cautery, and the ligature methods of operating, goes on to say the following about the injection of carbolic acid as a means of cure, which we quote in full. Our experience has been very similar:

So much for the radical cure of hemorrhoids. But the average man only wants his hemorrhoids cured when he is suffering pain; that is, if they are to be cured by an operation. And as the pain of the disease is very intermittent, and, as a general rule, he suffers only a certain amount of annoyance and discomfort from them, it follows that he will seek relief in many ways, and, if he does not find it, will carry his piles with him through a long life down to the grave. It is, therefore, a very desirable thing to be able to do something for these patients that will satisfy them—something that will stop the bleeding and protrusion, and yet shall not be “an operation” that will compel them to be laid up. The knife they fear, ether carries with it a great dread, and the ligature is not pleasant to contemplate.

Can we meet this legitimate want on the part of the public? In a measure, yes. We can by several means arrest bleeding. By more serious measures we can reduce the size of the tumors till they shall no longer protrude at stool. The relief will probably not be permanent; the pain may be considerable; it is, in fact, the old story of cutting off the dog's tail by inches to avoid hurting him; but if the patient prefers that kind of surgery, after it has been explained to him, there are ways of doing it without any special danger, and the practitioner is justified in using them. It is true that only enough of the caudal appendage will probably be removed to make a very unsatisfactory stump in the eyes of the surgeon; but if the patient wishes it done, I hold that, as long as no false promises are made, it is a justifiable concession to his fears and desires.

The best known, but I think not the most desirable, method of accomplishing this is by the injection of carbolic acid into the tumors. With a fine and clean hypodermic syringe inject from 5 to 10 drops of a ten per cent. solution of carbolic acid, in a menstruum of equal parts of glycerine and water, into the centre of each hemorrhoid. When it works nicely, there will be a little smarting only at the time and soreness for a few days after, and the foreign substance will set up just sufficient irritation to cause some consolidation around it, and hence decrease in the vascular supply, with decrease in size and in the amount of bleeding. After all of the piles have been injected—some once, others several times—the patient will consider himself cured. The tumors will no longer bleed or protrude at stool, and he is very grateful. The relief will probably last three or four years in a favorable case, and then he will return, and you will find a decided change. The tumors now are harder and firmer to the touch, and the skin of the margin of the anus is more involved in them. They are, in fact, covered by muco-cutaneous tissue instead of velvety mucous membrane, and they are much less amenable to a second course of the same treatment than they were to the first.

This is the course of a favorable case, but all cases do not act in this way by any means. The variations from it are manifold.

Some day you will make the usual injection, as you have done dozens of times before, and your patient will suffer great shock. Exactly why it is hard to tell, but he will either faint on the table or will get cold; his pulse will become weak; you will think he is about to faint—as, indeed, he is—and you will rush for stimulants. After an hour or so he will probably be able to leave the office and go about his business, but it will be many days before you will cease to wonder what was the matter with him. Finally, you will call it a nervous shock, but you will not be anxious to inject him again. On that score, if your experience is like mine, you need

not have any uneasiness. He will not come back. You have lost your patient.

In another case, after the injection, your patient goes out of the office with only the usual smarting and pain ; but instead of subsiding, it goes on increasing, and after a few hours you will get an urgent request to come to him at once. In fact, you may get a telegram, as I once did, saying that the patient is suffering the "torments of the damned." You go with a hypodermic syringe in your pocket, and as soon as you arrive you use it—this time for morphine, however. After a while the pain is overcome, but again you don't know what has happened. The man is all right after a day or two, but he never has another injection, and again you have lost your patient.

In another case the history will be as follows : After the usual glowing prognosis of no pain, no interference with business, etc., you make an injection, and tell your patient to come again in a few days. At the end of a week he appears. Perhaps he has been in the house since the last visit, and perhaps he has dragged around at his business, but he has certainly had a good deal of pain. On examination you find quite a deep slough, the size of a silver quarter, covering the point of injection. That particular hemorrhoid, you may be sure, is in a fair way to be cured, and you inject another one. The same result follows, and after four or five weeks of pain and partial disability, if the sloughs heal kindly, the patient is discharged from treatment. He has had rather a hard time—much harder than either of the radical operations would have caused him; but still he will not be troubled again for some years, and, if he is satisfied, perhaps you may be. I have noticed also that after three or four years, when these patients come around again to talk about having something done for their piles, they do not take kindly to the idea of a second course of treatment by injection.

Exactly why sloughing will result in one patient with weak solutions, and will not in another, though much stronger solutions are used, it is not easy to say. Such, however, is the clinical fact.

Another class of cases will give you still more trouble. After the first injection, or perhaps not until after the second or third, the patient will go to bed and send for you on account of his pain. You find on examination a painful tumor at the verge of the anus, the size of the end of the thumb, covered partly by skin and partly by tense mucous membrane. This is a marginal abscess. It means much pain and confinement to bed for several days. Then it bursts, generally on the skin, and again on the mucous surface, and a short fistulous track half an inch or an inch in length is left between the two openings. This may heal spontaneously, or may have to be cut. In any event, the patient has carried the treatment as far as he will, and you will get no credit.

In another class of cases you will be surprised at the powerful effect of your remedy, and you will get a partial cure from a single injection, but not much to your gratification.

On the day after the injection the patient will send for you, and you will find not only the pile you injected, but all his piles, inflamed, prolapsed, and strangulated. You will be surprised to find how much more hemorrhoidal disease he has than you supposed when you made your injection. You keep the man in bed, apply poultices and anodynes, give a cathartic to act on the portal circulation, and leave the case to nature. Part of the protrusion will slough off, and when the inflammation has subsided and the protruded mass returned the patient will be partially cured.

But these are not all the complications. There is a peculiar blind, internal, submucous fistula which often owes its origin to an injection of carbolic acid. The piles may be cured as far as the patient knows, but, instead of being well, he has a new symptom—a sense of discomfort, often of actual pain, in the rectum, back, legs, and urinary organs. He goes from doctor to doctor, and nothing is found, till finally some diagnostician more thorough than the others finds a drop of pus coming out of the mucous membrane, just above the internal sphincter, and a small probe passed into the point from which the pus exudes will follow a submucous fistulous track for an inch or more. The injection did not cause a slough over its point of deposit and allow of the escape of matter in that way; but the pus, when formed, followed the course of the needle and escaped at the point of puncture. The same patient may have two, three, or even more of these fistulæ—one, in fact, for each injection.

These are the minor accidents and complications of this method of treatment. There are graver ones—large abscesses, deep and extensive perirectal inflammations resulting in bad fistulæ or dangerous illness, and ending in permanent disability or death. More fatal results have been reported in this country from carbolic-acid injections in the last ten years than from all of the radical operations combined. A fatal result I have never seen, but all of the other accidents have happened to me personally, and, combined, constitute a perfectly satisfactory reason for your not seeing me use the treatment here. Almost every week you see me operate with the clamp and cautery, and during the three years of this clinic you have never seen a failure to cure, and never any complications such as have been described. Therefore, I say to you, if you want to cure your patients and sleep comfortably yourself, use one of the radical operations. If you want to try palliative treatment, go very gently. Carbolic acid is only a palliative at best.

THE TREATMENT OF BUBO.

Dr. F. Sedgewick Watson, in the *Journal of Cutaneous and Genito-Urinary Diseases*, Feb., 1893, advocates the excision of buboes, and an attempt to secure union by first intention of the wound. He relates twenty-two buboes operated on, with perfect union by first intention. In ten the cases were not picked, but taken as they presented themselves in his clinic. The operation was practically the same in all cases, the only difference being in modifications of the incision. The skin was inflamed over the bubo in all but four cases, and in some was more or less necrotic. In every case suppuration of the glandular structure had gone on to a greater or less degree.

He uses one of two incisions in all cases when there is no necrosis of the skin. The one parallel to Poupart's ligament across the middle of the bubo, dissecting the skin up and down, thus exposing the glands, removing all diseased tissue, and uniting the wound with buried or ordinary sutures. The other, a crescentic cut, with the concavity upward, the base line being above Poupart's ligament and extending well down below the bubo into healthy skin; this flap is dissected up, the gland exposed, and thoroughly removed. The flap is then turned back and sutured. In some cases he drains by means of sterilized strands of silk through an opening made below the lines of incision. Where there is necrosis of the skin he uses the first cut, but modifies it by dividing it toward the middle, so as to form an ellipse which includes the necrosed area, and then removing it.

He warns against wounding the spermatic cord and femoral vessels, and to proceed with great caution in dissecting around the vaginal ring, lest an unsuspected hernia be present—the writer having found one, and narrowly escaped wounding the gut.

He draws particular attention to the tying of the ends of all lymph vessels that have been divided. If these are not ligated, a large quantity of fluid may exude and fill the wound, militating against primary union.

He could not draw any conclusion as to the results from these cases, as some that were expected to heal by first intention did not, and others that did not seem so favorable at the time of operation healed perfectly. In all cases the average duration in hospital was much less than by the old method of treatment by poultice and incision.

In all cases the following rules were strictly adhered to:

(1) To remove thoroughly all diseased tissue, and to leave, as far as possible, a perfectly healthy surface in every part of the wound. (To secure this it is always necessary to carry the dissection down to the fascia covering the abdominal muscles; sometimes to expose the femoral vessels, and generally the external inguinal ring.)

(2) To excise such portion of the skin as threatened to become necrotic, or had already become so.

(3) To curette the under surface of the skin flaps.

(4) To thoroughly swab the whole wound with drained sterilized gauze sponge, or sponge wet with a solution of cor. sub. 1-4000.

The writer also advises against using stronger solutions in cleansing the wound cavity. Have the wound as dry as possible before closing, and dress with large pads of sterilized gauze.

THE TREATMENT OF GONORRHOEA WITH ICHTHYOL.

Jadassohn (*Deutsche Medicinische Wochenschrift*) gives the results of his treatment of 106 cases of gonorrhœa with ichthyol. They were of both sexes. In the male cases examinations were made twice a week to determine the presence of gonococcus, the secretion examined being obtained from the deep portion of the urethra. In the female cases the cervix uteri and urethra were both examined. The ichthyol was used in a one to five per cent. solution in the anterior portion of the urethra, and one to ten per cent. in the posterior portion of the male urethra and the cervical canal in females. A one per cent. solution produces a burning sensation in the anterior urethra, but tolerance is soon established. A one per cent. solution has a marked anti-gonorrhœal action, the gonococci disappearing rapidly. In a certain number of the cases there was a return of the trouble, but the ichthyol rapidly changes the secretion from a purulent to a watery one. The use of ichthyol is strongly recommended as one of the best means of treating gonorrhœa.—*University Medical Magazine*.

[We have used ichthyol in from one to three per cent. solution, and have found most favorable results. It is not irritating, nor in any way disagreeable.—E.E.K.]

PEDIATRICS

IN CHARGE OF

W. B. THISTLE, M.D., L.R.C.P. Lond.,

Assistant Demonstrator of Anatomy, University of Toronto; Physician to Victoria Hospital for Sick Children; Clinical Lecturer on Diseases of Children in the Woman's Medical College.

DISCUSSION ON PNEUMONIA IN SECTION OF PEDIATRICS, NEW YORK ACADEMY OF MEDICINE.

In the report of the March meeting of the New York Academy of Medicine, section on Pediatrics, there appears an extremely interesting discussion on pneumonia.

Dr. William L. Stowell related a case in which empyema followed pneumonia, and due to the same cause, the pneumococcus, which was demonstrated to be present.

Dr. Koplik discussed the bacteriology and epidemiology of pneumonia in children. Broncho-pneumonia in catarrhal pneumonia might occur as a primary or secondary disease. The author accepted the view that broncho-pneumonia was peculiarly a disease of childhood, in which the bronchi, their walls, and neighboring structures were the seat of inflammation.

Pneumonia as it occurred in childhood had been regarded as an acute infectious disease by Jurgenson in 1883. His conclusions are of interest even to-day, namely, that it was an acute infectious disease of bacteriological origin. In 1884, the investigations of Fraenkel led him to the conclusion that pneumonia in the adult was the result of infection by a micro-organism, which he named *diplococcus pneumoniae*. Fraenkel asserted that the diplococcus was the cause of pneumonia in the adult, but denied its presence in broncho-pneumonia. Weichselbaum contended that the diplococcus was also present in broncho-pneumonia. The views of the latter are borne out by many investigations since.

The streptococcus of Fraenkel was tenacious of life, and might not only cause pneumonia, but also pleurisy, meningitis, peritonitis; and Netler's investigations tended to show that in the second period of childhood it might cause empyema, broncho-pneumonia, otitis, meningitis, lobar pneumonia, purulent arthritis, and hepatic abscess.

Infection of children occurred chiefly through the nose and upper respiratory passages, while in the adult it occurred most frequently in the lungs and upper respiratory passages. The bacteria might remain local or invade every organ in the body, causing a species of septicæmia.

Regarding the secondary pneumonia, there is no constant factor in causation.

Discussing epidemiology, the author said that pneumonia could be communicated from one person to another through the medium of the sputum. This point had been established upon bacteriological data. The organisms in the sputum of pneumonia are very tenacious of life. The dried particles containing the virus were carried into the atmosphere, and spread the disease to others.

Dr. Keelafeld agreed with Dr. Koplik that there was no difference in the bacteriology of broncho-pneumonia and lobar pneumonia, the primary form in each being caused by the pneumococcus. Secondary broncho-pneumonia more frequently showed the streptococcus, less frequently some other micro-organisms. The same was true of secondary lobar pneumonia. We had to admit, then, that the cause of broncho-pneumonia and lobar pneumonia was the same. We had to ask ourselves, then, why it was that children exposed to the same causes regularly had broncho-pneumonia, adolescents either lobar or broncho-pneumonia, while adults regularly had lobar pneumonia. The only explanation the speaker could offer was the age of the patient, and consequent difference in the structure of the lungs.

REFLEX ECZEMA IN BABIES AND YOUNG CHILDREN.

Dr. George T. Elliot (New York) says: It is a reflex neurotic eczema occurring in babies and young infants, and is met with often in the first month of life, at times in the first week, and occasionally not until the first or second year.

One of its especial features is its localization; it is always symmetrical, and primarily situated over both cheeks, the forehead comes next in point of frequency, and occasionally the scalp. It may, however, extend over the extensor surfaces of the extremities—not the flexor—especially about the wrists, knees, and ankles. The trunk was exceptionally implicated.

The cause depends upon pathological conditions, which are internal in nature, or which can act only in a reflex manner, and gastric and gastrointestinal disturbances occupy the first place. These, operating both as primary causes and as determinative of relapses, may be catarrhal or fermentative or irritative in nature, or there may only be constipation present or some other functional trouble. Diet plays an important rôle. Other causes are detention, slight or grave cystitis, intestinal worms, oxyuris vermicularis, and particularly an adherent prepuce.

The first indication is to remove the reflex cause, and therefrom the remedies or drugs called for are precisely and absolutely the same as would be indicated were there no eczema present. While the removal of the exciting cause is the absolute *sine qua non* in the treatment of these cases, yet the local remedies should not be neglected. They do not act in a

curative manner, but simply as adjuvants, protecting the diseased surfaces, relieving the subjective symptoms, and thus preventing the production of secondary irritative outbreaks by the scratching. The following is as good as any other :

R.—Acidi salicylici.....gr. x.
 Ung. aq. rosæ..... $\bar{3}$ i.
 Zinci ox..... $\bar{3}$ ss.
 M.

Still great benefit will be obtained oftentimes by the addition of ichthyol (two or three per cent.) to the same ointment, or a half a drachm to one drachm of the fluid extract of ergot. When the skin is considerably thickened and infiltrated, and the inflammatory and exudative symptoms are not of a high grade, tar will be more useful.—*International Medical Magazine*.

PURPURA FULMINARIS IN CHILDREN.

Dr. Clara E. Dercum, in the *Medical and Surgical Reporter* for November, 1892, publishes a paper on the remarkable and fatal affection, purpura fulminaris. She gives a description of a case coming under her own observation, and has collected twenty additional cases from various sources. In the reported case, a little boy of four years, the subcutaneous hemorrhages were very extensive. There was epistaxis, but no loss from the mucous membranes. Death resulted on the eighth day. Of the twenty collected cases, nineteen occurred in young children, and one in a pregnant woman. Eighteen of these cases resulted fatally, three recovered. In fourteen cases there had been preceding illness, two followed pneumonia, three after scarlet fever, one after measles, one after whooping-cough, two during attacks of impetigo, nine after gastro-enteritis, and one was preceded by malaise. In one case the cow from which the child received its food had an abscess of the udder. The pus was noticed in milk, and no other food was given to the child. In one case a micrococcus was obtained from pure cultures from the affected tissues of the body, which reproduced the disease in rabbits.

The writer gives the results of an investigation regarding the etiology of purpura by Latzerich. This investigator had six cases under his immediate care. He revealed a bacillus from pure cultures from these patients, which when injected into rabbits caused purpura. While making these investigations Letzerich in some way became infected, and suffered from three successive attacks. During these attacks he had hemorrhage from gums, pharynx, nares, bronchial tubes, and intestines. There was very great enlargement of the liver and spleen, and purpuric spots on the skin.

and buccal mucous membrane. During these attacks he obtained from these purpuric spots the same bacillus obtained from culture experiments. He also obtained pure cultures from the spots, and reproduced purpura each time in rabbits. He infers from these experiments that purpura in all its forms is due to this bacillus, and that the different varieties depend upon the intensity of the poison and the resistance of the individual. (See page 344 in this issue—Dr. R. B. Nevitt's case of above disease.)

DIURETIN IN THE TREATMENT OF SCARLATINAL NEPHRITIS.

Demme (*Journal de Médecine de Paris*, 1892, No. 20, p. 241) states that diuretin is contraindicated in infants under one year of age, with whom its administration is often followed by irritation of the gastrointestinal mucous membrane. To older children, two to five years, he gives 7 to 22 grains daily, increasing this to 45 grains in children from six to ten years old. He has employed this drug in 11 cases: in 4 of which there was anasarca; in 3, mitral insufficiency, with insufficient diuresis, despite the restoration of compensation by digitalis; in 2, chronic peritonitis with ascites; and in 2, pleurisy with effusion. Diuretin he finds to be an efficient diuretic, acting directly upon the epithelium of the kidney. It is still impossible to pronounce upon its influence over the circulation, but it seems to be of little moment. In scarlatinal nephritis it is very energetic, the ascites disappearing more rapidly than under the action of any other diuretic. It is important, however, to describe it only after the end of the first stage of the inflammation. The anasarca and ascites following upon mitral lesions should be first treated by digitalis until compensation has been secured, and then submitted to diuretin. Under these conditions all dropsy rapidly disappears.—*American Journal of the Medical Sciences*.

ULCERATION OF SUPPURATING BRONCHIAL GLAND.

J. W. Smith showed before the Manchester Pathological Society the preparation from a case in which suffocation had resulted from ulceration of a suppurating bronchial gland into the right bronchus. The patient, a girl of three, who was supposed to be choking from a piece of coffee, was brought to the Manchester Royal Infirmary in a moribund condition. Tracheotomy and artificial respiration were performed without success. At the necropsy an oval ulcer with ragged edges was found on the outer and posterior wall of the right bronchus. It communicated with the cavity of a caseous bronchial gland. A flocculent slough the size of a horse-bean lay at the bifurcation of the trachea. Caseous nodules were scattered through both lungs.—*The Lancet*.

HERPETIC AFFECTIONS OF THE MOUTH AND PHARYNX IN CHILDREN.

Dessau, S. Henry (*Int. Med. Mag.*), says: No better treatment in herpetic affections of the mouth and pharynx in children can be found than fractional doses of calomel, given in the form of the tablet triturate, one-twentieth to one-tenth grain each, every two or three hours. In such doses calomel acts as an undoubted stimulant of the liver, one of the five functions of which organ is to destroy the poisons formed in the process of both normal and abnormal digestion of food, and so prevent their entrance into the general circulation of the blood.—*Archives of Pediatrics*.

MENSTRUATION IN AN INFANT.

O. E. Tchernomordik, of Tschashniki, relates (*Vratch*, No. 4, 1892) the case of a normally developed and generally healthy girl who has been regularly menstruating since February, 1891, when she was not quite one year old. The hemorrhage recurs every four weeks, lasting on each occasion four or five days, and being accompanied by occasional pain about the hypogastrium. The first menstruation was preceded by some fever, an urticaria-like rash over the whole body, and general restlessness lasting for three days. The symptoms subsided with the appearance of the bleeding. The girl's mother is somewhat nervous, but otherwise healthy. She began to menstruate at about the age of fifteen.—*Archives of Gynecology*.

PATHOLOGY

IN CHARGE OF

JOHN CAVEN, B.A., M.D., L.R.C.P. Lond.,

Professor of Pathology, University of Toronto and Ontario Veterinary College; Pathologist to Toronto General Hospital and Home for Incurables.

THE CAUSATIVE FACTORS IN WHOOPING-COUGH.

Ritter (*Münch. Med. Woch.*, Nov. 8th, 1892) refers to the failures to isolate the actual cause of this disease until it was borne in mind that the chief changes lie in the lower third of the trachea—the larynx and rest of the trachea showing no marked catarrhal changes.

Special attention was then given to the bronchial secretion, which is of a blackish-yellow color. From the lenticular masses of sputum cultures of a very small diplococcus were almost always obtained, and the author looks upon it as the cause of whooping-cough. This micro-organism is

strongly aerobic, grows best on agar-agar, and between 36° and 38° C. These diplococci may be arranged in straight or clustered chains.

The author points out the many and unmistakable distinctions from other micro-organisms found in catarrhal sputum.

His experiments on animals are not as yet concluded. In dogs he has been able to produce the disease; but the introduction of various agents into the dog's neck has been found capable of setting up typical whooping-cough.—*British Medical Journal*.

DETECTION OF TUBERCLE BACILLI IN SPUTUM AND URINE.

Van Ketel recommends that in cases where tubercle bacilli are so few in number as to render their detection in sputa difficult carbolic acid should be made use of, since it separates the epithelial cells and increases the fluidity of mucus, and thus enables the bacilli to fall more readily. His method is as follows: 6 c.c.'s of carbolic acid, 10 c.c.'s of water, and 15 c.c.'s of suspected sputa are mixed and thoroughly shaken up together. The mixture is allowed to stand in a conical glass for from 12 to 24 hours, and cover-glass preparations then made from the sediment. Jolles suggests a modification of this method for use in the examination of urine where tubercle of the urinary tract is suspected. To 100 c.c.'s of sediment containing urine add 6 c.c.'s of a saturated solution of carbolic acid in water. Shake up together and let sit in a conical glass for 24 hours; decant off the fluid, and prepare cover glasses from the sediment. After such treatment bacilli tuberculosis are not only more likely to be found in the sediment, but staining is accomplished more easily than would otherwise be the case.

LAVÉLAN'S MALARIA GERM.

In the March number of the *Southern California Practitioner* appears an article by C. Schwalbe, M.D., of Los Angeles, Cal., which calls in question the microbic character of Laveran's "plasmodium malariae." The writer asserts that by the injection of certain chemical agents into the blood of animals one can produce the same changes and appearances as malaria gives rise to in human beings. Amongst the animals experimented upon were guinea-pigs, cats, dogs, and rabbits—the last most frequently. After using subcutaneous injections of acetylphenyl hydrazin (1 c.c. of a 1-100 watery solution) all the forms of "plasmodium malariae" excepting the "sunflower" were found. The *post-mortem* examination of a rabbit which had received numerous injections during the period of time embraced between November 29th, 1892, and January 31st, 1893, showed

that the spleen was enormously enlarged and contained much black pigment; the medulla of the bones was deeply pigmented, and the urine in the bladder contained pigment. The plasmodia-like bodies are the result of degenerative processes in the blood corpuscles, and there can be no *microscopic* evidence sufficient to show that those seen in malaria are protozoan any more than are those produced experimentally. Schwalbe takes exception to Gerhardt's proof of the germ origin of malaria by injections of blood from malarious patients into supposedly sound ones for two reasons. First, that the soundness (*i.e.*, as far as malaria was concerned) of those experimented on was not established; and, second, the degenerated blood of malarious patients is *in itself* quite able to cause changes in the blood of sound people and give rise to the formation of the so-called plasmodia.

THE PRESENCE OF TUBERCLE BACILLI IN THE LYMPHATIC GLANDS OF NON-TUBERCULAR SUBJECTS.

Primary tuberculosis of the lymphatic glands, although a rare condition, has been fairly well investigated, and its pathology is now tolerably well known. It is not in this direction, therefore, that Dr. Pizzini (*Zeitsch. f. klin. Med.*, xxi, 3-4, 1892) has directed his researches. He has endeavored to ascertain by systematic investigation whether the lymphatic glands of non-tubercular individuals who die of some other disease than tuberculosis contain any tubercle bacilli, and his experiments have disclosed some very interesting facts.

He inoculated guinea pigs with the bronchial, mesenteric, and cervical glands of thirty adults free from tuberculosis, and in whom death was due to acute disease or accident. Twelve out of the thirty guinea pigs inoculated rapidly developed tuberculosis, from which it may be inferred that Koch's tubercle bacilli may be present in the body of perfectly healthy individuals without giving rise to any perceptible lesions.

But tubercle bacilli were not found indiscriminately in the various groups of glands experimented with. One would *a priori* expect to find them more frequently in the bronchial glands. The correctness of this assumption is clearly demonstrated by Dr. Pizzini's experiments, which also disclose the important fact that in not one of the thirty guinea pigs was tuberculosis produced by inoculation with the mesenteric glands. This leads us to the equally to be anticipated conclusion that the disease is much more frequently acquired through the lungs than through the alimentary canal. Introduced into the trachea and large bronchi, the bacilli are deposited on the surface of the mucous membrane through which they pass, whether it is healthy or the seat of catarrhal inflammation, and thus find their way to the bronchial glands which are connected with the respi-

ratory mucous membrane by means of the very numerous lymphatics. There they remain dormant, but still retain their vitality (as is readily shown by inoculation), until for some cause or other they are aroused again to activity.

The fact that virulent tubercle bacilli are found in the glands in such a large proportion, 40 per cent., of healthy individuals, without giving rise to any manifestation, enables us to understand the anomalies which are sometimes present in certain clinical varieties of pulmonary phthisis. In presence of these results, the question might also be asked whether there is any hope of success in the attempt to effectually prevent ourselves by prophylactic measures against such a widely distributed organism. Ought we not to consider the part played by certain conditions of *milieu*, and by secondary causes of greater importance than the actual introduction of the bacilli into the system?

The occurrence of certain acute forms of tuberculosis, of miliary tuberculosis in particular, is perhaps to be explained by the presence of living tubercle bacilli in apparently healthy glands, ready to spring into activity again and to infect the whole organism on the first favorable opportunity. This is usually afforded them by the occurrence of such diseases as diabetes, measles, etc., which favor their growth and development.—*The Medical Week.*

THE DIAGNOSIS BETWEEN TUBERCULAR AND NON-TUBERCULAR PUS.

[E. Debraye and E. Legrain, *Rev. Med. de L'Est.*, Oct., 1892; abstract from *Rev. Internat. de Bibliog. Med.*, Jan., 1893.]

D. and L. have conducted experiments to determine whether tubercular and non-tubercular pus might be easily differentiated by chemical reaction. They conclude that pus containing only tubercle bacilli, and which has not been contaminated with ordinary pyogenic organisms, gives when diluted in the proportion of two or three drops of pus to two or three c.c.'s of distilled water, to which a small piece of caustic soda or potash has been added, the *violet color* due to albumins on the addition, drop by drop, of an almost colorless solution of sulphate of copper. Pus from an ordinary abscess, on the other hand, when treated in the same way, presents the *rose color* characteristic of peptones. One is not entitled, however, to absolutely exclude tuberculosis by the peptone reaction, since pus microbes invading softening tubercular foci peptonize the products, and the violet coloration is lost.

Editorials.

SPECIALISM IN MEDICINE.

THE growth of specialism in medicine in recent years, especially in the United States, has been almost marvellous. Whether we like it or not matters but little; we may as well recognize the fact that it is "here to stay." Dr. Osler, of Baltimore, who was president of the American Pediatric Society last year, took as his text for his address at the annual meeting the subject of specialism. The existence and prosperity of this young and vigorous society furnish one of the many examples of the growth and strength of specialism at the present time. This, however, is only one out of more than a dozen societies organized for the study of particular diseases which now exist and hold annual meetings in the United States. The union of these special societies in a triennial congress is well known, and generally recognized as a marked success.

Dr. Osler, in the address referred to, discussed, in his usual clear style, the advantages and disadvantages of specialism. He takes it for granted that the rapid increase of knowledge has made concentration in work a necessity, and then contends that the earnest workers in different branches of medicine have contributed largely to inculcate the idea of thoroughness and produce better work all along the line. He says a shallow diffuseness has given place to the clearness and definiteness which comes from accurate study in a limited field. The advantages of a division of labor are fully recognized and highly appreciated by the public, who exhibit such a desire for expert knowledge that there has arisen a grave danger that the family doctor will become a relic of the past.

In reference to the disadvantages, the doctor expresses himself somewhat as follows: A radical error is the failure to recognize that the results of specialized observation are only partial truths. The various organs, whose diseases are subdivided, are not isolated, but complex parts of a complex whole, and experience proves that "when one member suffers all the members suffer with it." A serious danger is the attempt to manufacture rapidly a highly complex structure from ill-seasoned material. A reference is also made to the mistake of entering on special lines without a sufficient knowledge of physiology and pathology. The enthusiastic student who is almost born a specialist is not commended. The cultivation of a speciality as an *art* tends to develop a narrow and pedantic spirit.

Dr. Osler's views on the education of students in medicine are fairly well known. He is, and always has been, opposed to the short and superficial courses which, in the past, have been sad blots in the history of medical education in the United States. He says it is impossible, in three sessions, to bring men beyond the superficial routine; but in a more prolonged course the student can be taught practically, in the wards and dispensaries, enough of the technique of the specialist to give, at least, a foundation on which to work.

THE ONTARIO MEDICAL ASSOCIATION.

WE have received from Dr. Wishart, the secretary, the announcement of the Ontario Medical Association, giving lists of its officers and members, together with certain information respecting its formation and progress. It was organized in the year 1880. In October of that year a meeting of the profession was held at the Canadian Institute, Toronto, when a committee of Toronto physicians was appointed to take charge of the matter. Dr. Wishart's announcement omits to mention the fact that a committee of Hamilton physicians was appointed to co-operate with the Toronto committee. A meeting of the two committees was held in the Rossin House, Toronto, in the latter part of the year 1880, when the final arrangements for the first meeting were completed.

This meeting was held in Toronto, June, 1881, under the presidency of our distinguished and beloved Nestor, Dr. Joseph Workman. Since that time the presidents have been successively: Drs. C. W. Covernton, Toronto; J. D. Macdonald, Hamilton; D. Clark, Toronto; A. Worthington, Clinton; G. A. Tye, Chatham; J. H. Richardson, Toronto; J. W. Rosebrugh, Hamilton; W. H. Henderson, Kingston; J. Algernon Temple, Toronto; W. H. Moorehouse, London; R. A. Reeve, Toronto; and R. W. Hillary, Aurora. Of these, three are dead—Drs. Worthington, Tye, and Henderson.

The meetings have been held in Toronto, excepting those of 1884 and 1885, which were held in Hamilton and London. There were 132 present at the first meeting. During the last few years there has been an attendance of about 200 or more. In 1890 there were present 233; last year, 218. The membership is now 700.

The association has been remarkably successful since its organization, and the prospects in the future are of the brightest sort. It is expected the coming meeting will be fully up to the standard attained during recent years. The time fixed by by-law is the first Wednesday and Thursday of

June ; but, on account of certain meetings and excursions to the Chicago Fair, it was decided to change the date this year. As will be seen in our advertising columns, the meeting will be held on Wednesday and Thursday, June 21st and 22nd. Physicians who are willing to read papers or present cases are requested to notify the secretary as soon as possible. Parties wishing to join the association may obtain blank forms from the secretary.

TYPHLITIS.

THE question of typhlitis is one of such importance to the profession in general that we feel that the stand taken by Mr. Frederic Treeves in his paper on "Relapsing Typhlitis," read before the Harveian Society, and published in the *British Medical Journal*, April 22nd, 1893, should not go unchallenged.

There are few questions that arise in general practice that require more serious consideration than that of deciding at just what moment we should operate in case of typhlitis. Often we hesitate until it is too late. It is better to operate a day too soon than an hour too late. The mortality of cases operated on is greatly augmented by delayed operation. Many patients who are rendered chronic invalids from frequent relapses might be saved from such by early operations. They are allowed to run all the dangers attendant on each succeeding relapse, simply because it is impossible to say that any one attack may not be the last. It often is, in more senses than one. It is from these few uncertainties that we take exception to Mr. Treeves' position. The appendix is the most frequent source of trouble in a great majority of all cases. In the relapsing form Mr. Treeves says that in "90 or 95 per cent. it is due to mischief in the appendix." We do not know what percentage of all cases can be considered as relapsing. Fitz places the *mortality* of cases treated medically at 11 per cent.; then the relapsing cases are made up of a proportion of the surviving 89 per cent. It would be exceedingly difficult to arrive at the percentage, but we can infer from experience that it is large. Cases in which the appendix has been the source of the trouble are liable to relapse.

Mr. Treeves is aware of many cases in which a patient has had three or more attacks of typhlitis, and has then ceased to be troubled with further attacks; but to what dangers was the patient exposed during these subsequent attacks, that might have been avoided by surgical interference, say, after the second attack? How are we to distinguish the last attack from

which recovery will be made by medical treatment alone? He may be classed amongst recoveries from the second attack, and relieved from the possibility of a third by operation; but from a third he may furnish material for *post-mortem* discussion. Mr. Treeves mentions: "Case 2, nineteen relapses in six years, patient a chronic invalid; operation; recovery." "Case 4, eleven relapses in three years; operation; recovery." "Case 3, thirteen relapses in four years; operation; recovery," and several other instances like the above." These show that the system will become tolerant to relapses without necessarily being fatal to the patient, and allows the surgeon plenty of time to make up his mind as to relapse limit. A great many surgeons would feel that they had been very derelict in their duty, and that they had allowed their patients to expose themselves to repeated dangers unnecessarily, if they had not operated sooner; at any rate, in this country that would be the feeling. Mr. Treeves further says: "I have never operated in any case in which I have not been able to make out the enlarged appendix still in evidence after the acute symptoms have passed away." Possibly this will account for the frequent relapses in the cases cited. It is not always an easy matter to distinguish the enlarged appendix. It is frequently bound down, or curled up by adhesions in such positions that it is impossible to feel it. It is not essential before deciding to operate that the appendix be felt; yet there might be other sufficient evidence to warrant the operation.

The appendix is of no physiological use, and the same cry cannot be raised against its removal that can be against the removal of appendages with known physiological uses. Man would be less liable to typhlitis if he had no appendix. The mortality from early operative interference, as we have said, is very low.

Whatever doubts there may be as to operation in first attacks, we think that in relapsing cases it is always quite justifiable, and, after a second relapse, advisable. The patient has demonstrated his weakness; and simply because cases have made perfect recovery after three or more attacks, it is not right to suppose that all will. In the same issue of the *British Medical Journal*, page 841, Gilbert Barling says of relapsing cases: "Does every (relapsing) such case call for operation? Personally, I should wait for a second relapse before resorting to operation, unless the symptoms in the first relapse were of a severe kind." We agree with Mr. Barling in the premises. The mortality of Fitz should be reduced by a combined medical and surgical treatment, and, notwithstanding Mr. Treeves' opinions, we think that relapses should not be allowed to continue indefinitely.

THE PAN-AMERICAN MEDICAL CONGRESS.

WE publish in this issue (page 394) the official circular from the Secretary-General, Dr. Charles A. L. Reed, giving valuable information with reference to the first Pan-American Medical Congress, which will be opened, September 5th, at Washington, under the presidency of Dr. William Pepper, the distinguished provost of the University of Pennsylvania. An immense amount of energy has been expended by the able and indefatigable general secretary and his confrères in making satisfactory arrangements for this congress, and the prospects for a successful gathering appear at present to be very bright.

The preliminary announcement, which was issued some months ago, contained lists of the officers of the different sections, and the members of the various committees of the different countries of North and South America, outside the United States, as well as those in the several states of the Union. Canada has received very cordial invitations to co-operate with our cousins south of us, and many of her physicians have been selected as officers in the various sections and members of committees.

Some of the Canadian officers have shown much vigor in entering upon their duties; but have not, in many instances, received as much encouragement as they desired. Dr. Walter H. Moorehouse, of London, Ontario, the Canadian secretary of the section in general medicine, writes to say that he finds it a very difficult matter to get general practitioners to consent to write papers for the congress. We hope the profession in Canada will take a live interest in this great undertaking. There is plenty of time between now and next September to prepare papers. Our friends in the United States want to see us at the congress; they also want to hear us at the same. Let us give a hearty response to their kind and cordial invitations.

UNIVERSITY OF QUEEN'S COLLEGE.

AT the recent convocation of this university, held April 25, the post of honor was assigned to John L. Bray, of Chatham, who delivered an address to the graduates and students of the new Medical Faculty. He gave good advice to the new graduates, related interesting reminiscences, and referred to the positions of honor and trust which had been or are now held by his fellow-graduates. The doctor graduated in Queen's thirty years ago. Of the twenty-four in his class, only eight are now living. Of the professors of that time only two are left, Rev. Dr. Williamson (Arts and Divinity) and Dr. Fowler, the present Dean of the Medical Faculty. He

called attention to the success of Queen's graduates in all parts of the world. The first president of the Ontario Medical Council (1866-7) was the late Dr. John R. Dickson, at that time Professor of Surgery in Queen's. Since the formation of the Medical Council, seven of Queen's graduates have filled the same position. The address was well received, and highly complimented by Principal Grant. While we have pleasure in congratulating Dr. Bray, we think it not wise to tell the public that he graduated thirty years ago. Those who watch him on the cricket field, or on the ice when he "pits the stane" after the sturdy curler's fashion, might either doubt his veracity or think that he graduated before he was born.

UNIVERSITY OF TORONTO.

A SPECIAL convocation for conferring degrees in medicine and dentistry was held in the hall of the School of Practical Science on Friday, May 5th. Mr. William Mulock, the vice-chancellor, presided. The president, Professor Loudon, the dean, Dr. U. Ogden, many members of the various faculties, a large audience composed mostly of ladies, and the students of medicine were present. Full lists of the graduates of the various universities of Canada and the successful candidates at the examinations of the Medical Council will be given in our next issue.

Correspondence.

ARTIFICIAL RESPIRATION IN ASPHYXIA NEONATARUM.

Editor of THE CANADIAN PRACTITIONER:

SIR,—I am pleased to see a communication on page 280 of your most valuable medical journal on the above subject from the pen of Dr. A. T. Rice, of Woodstock, Ont.

Several years since the late lamented Dr. John Ross, of Toronto, kindly asked me to see with him a restored infant, at which he had labored most of one night and next day till about noon, somewhat in the manner Dr. Rice describes.

A point, however, which Dr. Rice omits to mention, but which I have no doubt he very carefully attended to, is closing the nostrils with the finger and thumb clasped on the nose, while forcing air, freshly inhaled as possible, very gently into the infant's lungs.

In several instances I have adopted the method Dr. Rice mentions, with the most satisfactory results. In a case of breech presentation, the length of time elapsing before the head could be delivered rendered it altogether likely that the birth would be "still." So still was it that the cord was pulseless, and the action of the heart imperceptible, and the little stranger a deep blue color, and as limp as a rag. But for the hope rested upon Dr. Rice's method, I should have laid the body by as lifeless. Persisting for half an hour with scarcely a ray of encouragement, so far as signs of life could encourage, I at length saw a change in color; and soon came a gasp for breath. With what exultation that gasp was witnessed none can judge but him who has been called upon to deliver into proper hands, and abounding in life, the budding hope of awaiting and anxious parents.

The attendant at the lying-in once having carefully and judiciously practised the method of restoration Dr. Rice has so well called attention to will never again be found resorting to the barbarous method of dashing cold water upon the steaming form that should especially be kept snugly warm.

CHARLES H. LUSK, M.D.

Oakville, Ont.

Book Reviews.

MEDICAL AND SURGICAL GYNECOLOGY. By S. Pozzi, surgeon to the Lourcine-Pascal Hospital, Paris. Translated from the French edition under the supervision of and with additions by Brook H. Wells, M.D., Lecturer on Gynecology at the New York Polyclinic. Volume II., with 174 wood engravings and nine full-page plates in color. William Wood & Company, 1892.

It is with pleasure that we review the second volume of this admirable work. The second volume begins with inflammation of the uterine appendages, and it is here that the author has given very decided views, with which we agree in the main. The author gives all the latest views bearing upon this subject, and the opinions expressed are very moderate. We might make a suggestion that we would like to see carried out, and that is that this valuable work, taking into consideration both the first and the second volumes, might be put into better shape for the use of the student of medicine. As it is, it is suited for the practitioner. To make it more suitable for the student it would require condensing, and perhaps some alteration in the classification and nomenclature. In places we notice some repetition that might be avoided; this occurs chiefly in connection with the pathology. The nomenclature is more correct than that usually adopted, but we notice one error that is carried through the work.

namely, the word salpingotomy. If the removal of the tubes is meant, salpingectomy should be the word used.

We are sorry to see that the author has not taken a more decided stand against the use of pelvic massage, a procedure that should be heartily condemned. We have often wondered if advocates of this treatment would submit their own wives or sisters to it.

We cannot agree with the author's views regarding the value of electricity in certain cases of salpingitis. We do not believe that these cases recover on account of the special virtue of the electricity, but on account of the natural resolution that takes place. In one paragraph the author makes a happy comparison between the swelling of the cheek accompanying dental neuralgia (that is, of course, septic in its origin) and the pelvic œdema accompanying catarrhal salpingitis. We do not use electricity to cure the cheek, but the cheek, by virtue of the natural processes going on in the body, rapidly recovers its swollen condition; and surely the pelvic tissues may do likewise.

Here and there through the work the old-time gynecology that we thought almost buried crops to the surface, but only as landmarks of the limit between the old thought and the new. In the future, we hope to see these landmarks entirely disappear.

We are sorry to see the author collecting statistics without going more fully into the details of the cases. This is hardly fair to operators who report their cases, because erroneous conclusions are arrived at. The work is, however, freer from statistics than most works on this subject. It is pleasant to hear an author state his views in the following positive tone. For instance, on page 43 we find the following: "Is it permissible to make an exploratory puncture for the sake of clearing up a diagnosis? It seems to me a dangerous procedure, however far the tumor may be from the point of puncture. Whether it be abdominal or vaginal, this exploration, which seems so trifling to the patient and her friends, is, in reality, much more serious than an incision under antiseptic conditions." Again, we find another valuable paragraph: "An examination of the inflamed organs is difficult in acute tubo-ovariitis, because of the pain which it causes. If there be any doubt as to the diagnosis and a decision be imperative, the patient should be anæsthetized. I hardly know how to protest with sufficient energy against the systematic neglect of this valuable auxiliary to investigation, and against the substitution for it of an inquiry into the anatomical condition of the parts by one means of diagnosis only, namely, localized pain. This neglect is an excellent method of multiplying exploratory laparotomies." The author might also have said, "And of leaving unperformed operations that are necessary to effect the cure of the patient." How many of the old-time "fiddlers" ever gave an anæsthetic to aid them in making a diagnosis?

The chapter on the pathology of ovarian cysts is good, and sufficient for a work such as the one under review. It is hardly suited for the medical student, as a certain amount of knowledge is already taken for granted, an amount of knowledge not likely to be possessed by a medical student.

Extra-uterine pregnancy has more space given to it than is usual in works on gynecology. Genital and peritoneal tuberculosis is also given room.

The translation might, in places, be somewhat improved. On page 280 we find "A case of generalized peritonitis reported by Welander *concerns* a little girl of five years." We are willing to admit the great difficulties encountered by a translator, and consider the translation, in the main; excellent.

In some future edition of the work, we hope the author will spend more time on the treatment of various diseases. Take, for instance, vaginismus, one of the most troublesome affections met with. The treatment is not of sufficient definiteness. One would like to have the author's own experience recorded in treating such cases.

At the last of the work are added chapters on disorders of the urinary tract and diseases of the rectum, thus making the work one of the most complete on the subject of medical and surgical gynecology. The plates in Volume II, as in Volume I., are excellent.

TUBERCULOSIS OF BONES AND JOINTS. By N. Senn, M.D., Ph.D., Professor of Practice of Surgery in Rush Medical College; Professor of Surgery in the Chicago Polyclinic; Attending Surgeon Presbyterian Hospital; Surgeon-in-Chief, St. Joseph's Hospital; President of the American Surgical Association; President of the Association of Military Surgeons of the National Guard of the United States; Permanent Member of the German Congress of Surgeons, etc. Illustrated with 107 engravings (seven of them colored). In one handsome royal octavo volume, 520 pages. Extra cloth, \$4.00 net; sheep, \$5.00 net; half-Russia, \$5.00 net. Philadelphia: The F. A. Davis Co., publishers, 1231 Filbert Street.

The subject of this book is one of the most profound interest, not only to the surgeon, but also to the physician. The fact that the majority of bone affections are of a tuberculous nature renders a proper understanding of their pathology and treatment of great consequence to both patient and attendant. It should be a cause of satisfaction, therefore, to the medical profession at large that one so well qualified to handle the subject as Dr. Senn has taken it up and dealt so exhaustively with it. Surveying the field as he does, historically, pathologically, and therapeutically, we have nothing but commendation to write of the book as a whole. On looking closely into it there are flaws discoverable, as in every such work, which will no doubt be removed in time. We will merely instance one or two of these as an indication of the direction in which, as it seems to us, improvement can be made. Would it not be well that Dr. Senn should set an example with regard to the *proper* use of certain terms which at present are used loosely and in a way likely ultimately to cause confusion? We have in mind just now the word "ptomaine," which is constantly put in the place of "toxin." Surely "ptomaine" ought to be reserved for certain results of germ life in the *dead* body, not the living? Again, we do not like to see the word "specification" applied as on page 46, where caseation is said to depend upon "specification of the bacillus of tuberculosis or its ptomaines." We doubt if such a use of the term be justifiable. There are other instances which we might give of similar faults, but repetition is unnecessary. With the form and style of the book we are not highly impressed; it is not worthy of the matter. The print is large and clear, but the cuts are, many of them, very poor.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONERS' INDEX FOR 1893. Edited by a corps of thirty-eight department editors—European and American—specialists in their several departments. P. W. Williams, M.D., Secretary of Staff. 626 octavo pages. Illustrated. \$2.75. E. B. Treat, publisher, 5 Cooper Union, New York.

The eleventh yearly issue of this valuable one-volume reference work is to hand, and it richly deserves the reputation which its predecessors have made, for selection of material, accuracy of statement, and great usefulness. The corps of department editors is representative in every respect. Numerous illustrations—many of which are in colors—make the "Annual" more than ever welcome to the profession, as providing, at a reasonable outlay, an excellent *résumé* of medical progress.

Part I. comprises the new remedies, together with a review of the therapeutic progress of the year.

Part II., comprising the major portion of the book, is given to the consideration of new treatments.

Part III. is made up of miscellaneous articles, such as "Recent Advances in Sanitary Science," "Improvements in Pharmacy," "New Inventions in Instruments and Appliances," "Books of the Year," etc.

The arrangement of the work is alphabetical, and, with its complete index, makes it a reference book of rare worth. Price, the same as in previous years, \$2.75.

PSYCHOPATHIA SEXUALIS, with especial reference to contrary sexual instinct. A medico-legal study. By Dr. R. von Krafft-Ebing, Professor of Psychiatry and Neurology, University of Vienna. Authorized translation of the seventh, enlarged and revised, German edition. By Charles Gilbert Chaddock, M.D., Professor of Nervous and Mental Diseases, Marion-Sims College of Medicine, St. Louis; Fellow of the Chicago Academy of Medicine; Corresponding Member of the Detroit Academy of Medicine; Associate Member of the American Medico-Psychological Association, etc. In one royal octavo volume, 436 pages, extra cloth, \$3.00 net; sheep, \$4.00 net. Sold only by subscription. Philadelphia: The F. A. Davis Company, publishers, 1914 and 1916 Cherry Street.

The above work is a valuable addition to medical jurisprudence. It has already gone through seven editions in the German language. The subject is treated of very fully indeed. The work is well worth reading. The typography and binding are in keeping with the general good work of the publishers.

TWO LECTURES ON THE CONDUCT OF THE MEDICAL LIFE. By S. Weir Mitchell, M.D., LL.D., Harv. Philadelphia: University of Pennsylvania Press, 1893.

These lectures, which appear as a supplement to the *University Magazine*, May, 1893, were originally addressed to the students of the University of Pennsylvania. By invitation, Dr. Mitchell repeated them before the students of the Jefferson Medical College. On account of similar invitations received from other schools, and also owing to repeated requests, they have been published in a neat little volume of fifty-one pages.

The book is bound in boards, and is sold at twenty-five cents. It may be obtained from the University of Pennsylvania Press, 1516 Chestnut Street, Philadelphia.

The profits derived from the sale of this book will be donated by the author and the publishers to the fund for the Students' Club House at the university.

We publish an abstract of these lectures in this issue (see page 329.)

DIET FOR THE SICK. By Miss E. Hibbard, Principal of Nurses Training School, Grace Hospital, Detroit, and Mrs. Emma Drant, Matron of Michigan College of Medicine Hospital, Detroit; to which has been added **COMPLETE DIET TABLES** for various diseases and conditions, as given by the highest authorities. Detroit, Mich.: The Illustrated Medical Journal Co., publishers. Paper, 74 pages. Price, postpaid, 25 cents; 6 for \$1.00.

This little book is a worthy supplement to any cook book, as it deals only with the dishes suitable for the sick and convalescent, the recipes being favorite ones in use daily in the hospitals wherein the authors employed. To this has been added the various authorized Diet Tables for use in anæmia, Bright's disease, calculus, cancer, chlorosis, etc. It also gives various nutritive enemata.

PHYSIOLOGY (Students' Quiz Series). By Fred. A. Manning, M.D. Lea Bros. & Co., publishers.

This manual, arranged in the form of questions and answers, is one of a series which we cannot recommend students to make use of. Everything that a student finds here he can also find in better form and with proper context in some of the recognized text-books. Such compends encourage superficial work for examination purposes, and are of little use, even for such purposes, where examiners are physiologists.

The following pamphlets and reprints have been received :

TRANSACTIONS OF THE AMERICAN PEDIATRIC SOCIETY. Vol. IV., 1892.

REPORT OF SURGICAL CASES. By Donald Maclean, M.D. Reprinted from Proceedings of Michigan State Medical Society.

BONELESS AMPUTATION AT THE HIP JOINT BY A NEW METHOD. By Nicholas Senn, M.D., Ph.D. Reprinted from *The Chicago Clinical Review*.

SURGICAL THERAPY OF RECTAL CANCER. By Thos. H. Manley, M.D. Reprinted from *Merck's Bulletin*.

FIXATION AFTER EXCISION OF THE KNEE. By H. Augustus Wilson, M.D. Reprinted from *The American Journal of the Medical Sciences*.

THE VALUE OF JAVAL'S OPHTHALMOMETER FOR THE CORRECTION OF ASLIGMALISM WHERE MARKED AMBLYOPIA IS PRESENT. By A. Britton Deyward, M.D. Reprinted from *The Post-Graduate*.

Medical Items.

MR. LAWSON TAIT contemplates removing from Birmingham to London.

DR. HERBERT J. HAMILTON, of Woodville, sailed for Europe, May 6th.

DR. ROBERT ARMSTRONG ROSS died in Barrie, April 27th, at the age of 42.

DR. W. HARLEY SMITH, of Spadina Avenue, is attending the convention of Y.M.C.A. secretaries at Minneapolis, Minn.

MR. GEOFFREY BOYD (Tor., '91) has been appointed surgeon to the Canada Pacific Railway's s.s. Empress of China.

DR. PEPPLER, of Queen street west, has gone to Johns Hopkins to take a special course in pathology under Dr. Welch.

DR. A. B. ANDERSON (Trinity, '92), late of house staff, Toronto General Hospital, has sailed for England to take a special course in pathology.

DR. J. E. GRAHAM, of Toronto, sailed for Europe, May 6th. He will spend three or four months on the continent.

DR. JAS. GRANT, jr., of Ottawa, left for England, May 5th. He expects to return in about two months.

AT the annual meeting of the Medical Faculty of the University of Toronto, held in April, Dr. Uzziel Ogden was elected Dean.

DR. CHARLES TEMPLE, who has been abroad for two years, is now in Toronto.

DR. ROBERT BARTHOLOW, who was seriously ill for some time, has recovered and resumed practice.

DR. WILLIAM SMITH, for many years a resident of Toronto, died recently in Hamilton, at the age of 93.

DR. H. A. BRUCE (Tor., '93), late of the house staff, Toronto General Hospital, has been appointed surgeon on the Canadian Pacific Railway's s.s. Empress of India.

DR. J. H. MCCASEY (Victoria, 1887) has been appointed Chief Superintendent of the Asylum for the Insane of the State of Kansas, at a salary of \$3,500 per annum.

DR. J. J. CASSIDY, of Toronto, Chairman of Ontario Board of Health, has been made an Honorary Councillor of the British Empire for the International Congress of Hygiene and Demography.

DR. HIRAM A. WRIGHT (Vict., '85), of Detroit, Mich., paid a short visit to Toronto early this month. Dr. Wright holds the appointment of Inspector of Immigrants at the port of Detroit under the government of Uncle Sam.

THE staff of the Home for Incurables was considerably changed at the last annual meeting. Drs. Bruce Riordan and W. H. B. Aikins resigned from the active, and were placed on the consulting staff. Drs. Primrose and Acheson also resigned. The four vacancies on the active staff were filled by the election of Drs. J. E. Elliott, W. Lehmann, R. A. McArthur, and J. S. Hart.

DR. O. R. AVISON, who has been associated in the Department of Therapeutics in THE PRACTITIONER since January, has left for Seoul, Korea, where he has entered the mission fields under the American Presbyterian Mission of New York. He has promised to let us hear of the medical and surgical diseases that are prevalent in Korea. He was accompanied by his family. We wish them all Godspeed and good health.

OFFICIAL BULLETIN OF THE PAN-AMERICAN MEDICAL CONGRESS.

The Executive Committee of the First Pan-American Medical Congress promulgates the following information :

(1) The First Pan-American Medical Congress will be opened under the presidency of Prof. William Pepper, M.D., LL.D., President of the University of Pennsylvania, at Washington, D.C., September 5th, and will adjourn September 8th, 1893.

(2) The countries officially participating in the congress are restricted to the Argentine Republic, Bolivia, Brazil, British North America, British West Indies (including B. Honduras), Chili, Dominican Republic, Honduras (Sp.), Mexico, Nicaragua, Paraguay, Peru, Salvador, Republic of Colombia, Republic of Costa Rica, Ecuador, Guatemala, Hayti, Kingdom of Hawaii, Spanish West Indies, United States, Uruguay, Venezuela, Danish, Dutch, and French West Indies.

Distinguished representatives of the profession from other countries are expected to be present as guests and to participate in the proceedings.

(3) The general sessions will be limited in number, one for opening and one for closing the congress, being all that will be held unless some necessity arises for a change in this particular. This arrangement will permit members to employ all of the time in the scientific work of the sections, which are as follows :

(1) General Medicine, (2) General Surgery, (3) Military Medicine and Surgery, (4) Obstetrics, (5) Gynecology and Abdominal Surgery, (6) Therapeutics, (7) Anatomy, (8) Physiology, (9) Diseases of Children, (10) Pathology, (11) Ophthalmology, (12) Laryngology and Rhinology, (13) Otology, (14) Dermatology and Syphilography, (15) General Hygiene and Demography, (16) Marine Hygiene and Quarantine, (17) Orthopædic Surgery, (18) Diseases of the Mind and Nervous System, (19) Oral and Dental Surgery, (20) Medical Pedagogics, (21) Medical Jurisprudence, (22) Railway Surgery.

The evenings will be devoted entirely to social features, the detailed announcements of which will be made by the Committee of Arrangements.

(4) Membership is limited to the members of medical profession of the western hemisphere, including the West Indies and Hawaii, who shall either register at the meeting or shall serve the congress in the capacity of foreign officers. No membership fee will be accepted from any member residing outside the United States. The membership fee for residents of the United States is ten dollars. All registered members will receive a copy of the transactions. Prominent students of the allied sciences will be cordially received as guests and as contributors to the proceedings upon invitation by the executive presidents of sections. Ladies' tickets will be issued upon application to registered members only, and will entitle the holders to reduced fare and to admission to all entertainments. Physicians of the United States should register at once, by remitting \$10.00 to Dr. A. M. Owen, Treasurer, Evansville Indiana.

(5) Papers are solicited, the hope being entertained that the programme will be largely taken up with contributions from outside the United States. Papers may be read in any language, but a copy must be furnished for publication in either Spanish, Portuguese, French, or English, and must not occupy more than twenty minutes in reading. An abstract not exceeding six hundred words must be furnished the Secretary-General in one of the above four languages by not later than July 10th. Abstracts will then be translated by the literary bureau into the three remaining languages, and will be published in book form before the meeting of the congress.

(6) The Congress of the United States has adopted a joint resolution whereby all the governments of the western hemisphere have been invited by the President to send delegates to the First Pan-American Medical Congress, and has appropriated a liberal sum for the purposes of entertainment.

(7) The reduced fare offered by all transportation companies on the occasion of the World's Columbian Exposition to be held in Chicago will be open to all persons attending the Pan-American Medical Congress. The Committee of Arrangements will endeavor to secure still greater reduction to members travelling between Chicago and Washington, and an effort will be made to arrange either excursions or circular tours for those who may desire to visit the great universities of the United States. All such arrangements are open to subsequent announcement.

(8) By arrangement with the committee at Rome, the date of the Eleventh International Medical Congress has been so appointed that those who attend the meeting of the Pan-American Medical Congress may subsequently attend the former. The Pan-American Medical Congress will adjourn on the afternoon of September 8th; a steamship will sail from New York on the following day, going by the Azores and Gibraltar, and enabling the tourist to reach Rome on the morning of September 20th, where the Eleventh International Congress will be opened on the afternoon of September 24th. It will thus be seen at a glance that in the period usually allotted to a summer vacation the medical tourist may spend a week at the World's Columbian Exposition, the next week at the Pan-American Medical Congress, the next week and a half with delightful companions in a voyage to the Mediterranean, the next few days in

witnessing the sights of Rome, and the following week at the Eleventh International Medical Congress. Special reduced rates for members and their families are given both ways on the trip to Rome, particulars of which will be furnished on application to the Secretary-General, 311 Elm Street, Cincinnati, Ohio, who is also a member of the American Committee of the Eleventh International Congress.

(9) The best possible arrangements will be made with the excellent hotels with which the national capital is abundantly supplied. The Committee of Arrangements will do its utmost to secure desirable rates and locations for members and their families. The headquarters of the Committee of Arrangements is at the Arlington Hotel, where communications may be addressed either to Dr. Samuel S. Adams, Chairman, or Dr. J. R. Wellington, Secretary.

(10) Copies of the official announcement of the congress, containing the regulations and the names of all officers and committeemen of the general congress and of the various sections, and residing in the various countries, may be obtained upon application to the Secretary-General, or to either of the members of the International Executive Committee, as follows:

Argentine Republic, Dr. Pedro Lagleyze, Calle Artes 46, Buenos Ayres; Bolivia, Dr. Emilio di Tomassi, Calle Ayacucho 26, La Paz; British West Indies, Dr. James A. de Wolf, Port of Spain; British North America, Dr. James F. W. Ross, 481 Sherbourne St., Toronto; Chili, Dr. Moises Amaral, Facultad de Medicina, Santiago; Costa Rica, Dr. Daniel Nunez, San José; Dominican Republic, Dr. Julio Leon, Santo Domingo; Ecuador, Dr. Ricardo Cucionalon, Guayaquil; Guatemala, Dr. José Monteros, Avenida Sur No. 8, Guatemala City; Hayti, Dr. T. Lamothe, Rue du Centre, Port au Prince; Hawaii, Dr. John A. McGrew, Honolulu; Honduras (Spanish), Dr. Geo. Bernhardt, Tegucigalpa; Mexico, Dr. Tomas Noriega, Hospital de Jesus, Mexico; Nicaragua, Dr. J. I. Urtecho, Calle Real, Granada; Paraguay—; Peru, Dr. Manuel C. Barrios, Facultad de Medicina, Lima; Republic of Colombia, Dr. P. M. Ibanez, Calle 5a Numero 99, Bogota; Salvador, Dr. David J. Guzman, San Salvador; Spanish West Indies, Dr. Juan Santos Fernandez, Calle Reina No. 92, Havana; United States of America, Dr. A. Vander Veer, 28 Eagle street, Albany, N.Y.; United States of Brazil, Dr. Carlos Costa, Rua Largo da Misericordia 7, Rio de Janeiro; Uruguay, Dr. Jacinto de Leon, Calle de Florida No. 65, Montevideo; Venezuela, Dr. Elias Rodriguez, Caraccas.

CHARLES A. L. REED, *Secretary-General*.

Cincinnati, April 2, 1893.

THE PAN-AMERICAN MEDICAL CONGRESS.—The Section in Marine Hygiene and Quarantine has been organized as follows:—Honorary presidents: Dr. Lino Alarco, Lima, Peru; Dr. Henry B. Baker, Lansing, Mich.; Dr. Cardenas, Managua, Nicaragua; Dr. J. J. Cornilliac, St. Pierre, Martinique, F.W.I.; Dr. Felix Formento, New Orleans; Dr. H. B. Horlbeck, Charleston; Lieutenant-Colonel Amalio Lorenz, Sub-inspector of second-class Spanish Navy, Havana; Dr. F. Montizambert, Quebec, Canada; Dr. Francisco Nunez, St. Tecla, Salvador; Dr. Juan Ortego, Guatemala, Guatemala; Dr. Joseph Y. Porter, Jacksonville, Fla.; Dr. John Pringle, Kingston, Jamaica; Dr. Juan J.

Unoa, San José, Costa Rica ; Dr. J. Mills Browne, Surgeon-General United States Navy. Executive president: Dr. Walter Wyman, Surgeon-General United States Marine Hospital Service, Washington. Secretaries : Dr. S. T. Armstrong (English speaking), 166 West Fifty-fourth Street, New York ; Dr. G. M. Guitéras (Spanish speaking), United States Marine Hospital Service, Washington. The executive president desires to call the attention of all members of the medical profession interested in the topics pertaining to this section to the regulation of the congress that contributors are required to forward, not later than July 1st, to the secretary of the section, abstracts, not to exceed six hundred words each, of the papers they propose to present before the section. The topics that will be considered by this section are as follows: (1) The hygiene of vessels, commercial or naval, including the questions of ventilation, heating, sanitary arrangements, the disposal of cargo so as to facilitate disinfection, food supply, etc. (2) The medical officers of passenger vessels ; methods for their selection, duties, etc. (3) The vital statistics of seamen and firemen ; the question of the medical examination of crews preparatory to shipping. (4) The supervision of vessels by government medical inspectors at ports of arrival and of departure ; code of rules for handling an epidemic disease that breaks out on shipboard ; disinfection of passengers and crew during a voyage ; location and arrangement of ships' hospitals. (5) Epidemic or exotic diseases propagated by shipping ; what diseases should be quarantined ; responsibility of nations for epidemics, India for cholera, South America for yellow fever ; can a feasible plan be devised to totally exterminate cholera ? ; international intervention to prevent the propagation of cholera or other epidemic diseases by pilgrimages or immigration. (6) International uniformity in quarantine regulations ; should quarantine officers be notaries public ? (7) Arrangement of detail and equipment of quarantine stations : *a*, inspection stations ; *b*, local quarantine stations ; *c*, refuge stations ; methods of handling infected or suspected vessels ; interstate and inland quarantine : sanitary cordons, camps of refuge, camps of probation ; recent improvements in hospitals for infectious diseases ; railroad inspection and quarantine ; length of time vessels should be held in quarantine ; conditions that should determine proclamation of quarantine against a country ; under what requirements may passenger traffic be carried on between a port infected with yellow fever and a southern port of the United States during the summer with the least obstruction to such traffic ? ; what merchandise should be considered as requiring treatment if shipped from a port or place infected with cholera, yellow fever, or smallpox. (8) Methods of disinfection : *a*, persons ; *b*, baggage ; *c*, cargoes ; *d*, vessels ; recent improvements in quarantine appliances, steam chambers, sulphur furnaces ; liquid sulphur dioxide as a disinfectant ; treatment of ballast, water, solid ; what time should an infected vessel be detained in quarantine ? : *a*, for cholera ; *b*, for smallpox ; *c*, for typhus fever ; *d*, for plague ; *e*, for yellow fever ; methods of disposal of the bodies of those that die while in quarantine.

THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS will hold its sixth annual meeting at the Russell House, Detroit, Mich., on

Thursday, Friday, and Saturday, June 1, 2, and 3, 1893, under the presidency of Dr. Lewis S. McMurtry, of Louisville.

The following is the preliminary programme as far as titles are announced:

1. The President's Address : The Present Position of Pelvic Surgery.
Dr. L. S. McMurtry, Louisville.
2. Abdominal Fixation Dr. Florian Krug, New York.
3. Endoscopic Tubes for Direct Examination of the Interior of the Uterus
and Bladder Dr. Robert T. Morris, New York.
4. Placenta Previa Dr. Wm. H. Wenning, Cincinnati.
5. What are the Indications for Abdominal Section in Intra-Pelvic Hemorrhage?
. Dr. M. Rosenwasser, Cleveland.
6. Treatment of Metritis Dr. E. Pietranera, Cordova, A.R.
7. A Plea for Better Surgery in the Closure of the Abdominal Incision.
Dr. H. W. Longyear, Detroit.
8. Remarks on the Treatment after Abdominal Section.
Dr. C. C. Frederick, Buffalo.
9. The Management of the Abdominal Incision.
Dr. Chas. A. L. Reed, Cincinnati.
10. Dilatation of the Cervix for Dysmenorrhœa.
Dr. E. M. Pond, Rutland.
11. Intra-Uterine Pregnancy, with Report of Cases.
Dr. George S. Peck, Youngstown.
12. A Contribution to the Study of Ectopic Gestation.
Dr. E. Arnold Praeger, Nanaimo.
13. A Few Practical Notes on the Establishment of Anastomosis between the
Gall-Bladder and Intestine for Obstruction of the Common Duct, with
the Relation of a case of Obstruction of the Common Duct by Small
Growth Dr. James F. W. Ross, Toronto.
14. Vaginal Hysterectomy for Malignant Disease.
Dr. Rufus B. Hall, Cincinnati.
15. The Care of Pregnant Women Dr. John Milton Duff, Pittsburg.
16. A Contribution to the Pathology of Surgical Disease of the Gall-Bladder.
Dr. Walter P. Manton, Detroit.
17. The Legal Questions in Gynecological Operations on the Insane.
Dr. Walter P. Manton, Detroit.
18. Pelvic Abscess Dr. I. S. Stone, Washington.
19. Central Rupture of the Perineum, its Causation and Prevention.
Dr. John C. Sexton, Rushville.
20. A Case of Myomectomy with Extra-Peritoneal Treatment of the Pedicle,
followed by Pregnancy, and Complicated by Hemorrhages through
the Abdominal Cicatrix Dr. X. O. Werder, Pittsburg.
21. Anatomy and Surgical Importance of the Peri-Renal Cellulo-Adipose
Tissue Dr. L. H. Dunning, Indianapolis.
22. Report of Cases from Practice, with Remarks on the Same.
Dr. A. Vander Veer, Albany.
23. Further Observation on the Relation of Pelvic Disease and Psychological
Disturbances in Women Dr. George H. Rohé, Catonsville.

A cordial invitation is extended to the members of the medical profession interested in the work of the association to attend its several sessions.

By order of the Executive Council.

WILLIAM WARREN POTTER, *Secretary.*

THE CHICAGO WORLD'S FAIR.—At a meeting of the joint committee of the Chicago medical profession on the World's Fair entertainment, held at the Sherman House in November, 1892, the establishment of a bureau of information and service was delegated, with approval and indorsement, to Charles Truax, Greene & Co., the committee reserving to itself the duty of such social entertainment of visiting physicians during the continuance of the exposition as might seem desirable. This action was confirmed at the final meeting of the joint committee on February 25, 1893, and, on application of the Practitioners' Club and the South Side Medical Club, the matter of social entertainment was delegated to them, with full authority to act in the capacity of entertaining bodies, with the retention of the chairman and its American and foreign secretaries already appointed: Chairman, Dr. C. Warrington Earle; American Secretaries, Dr. Archibald Church, Dr. G. Henry Cleveland, Dr. John C. Cook, Dr. J. C. Culbertson; British, Dr. Sanger Brown; German, Dr. F. C. Hotz; French, Dr. Fernand Henrotin; Spanish, Dr. E. J. Gardiner; Italian, Dr. A. Lagario; Swedish, Dr. K. Sandberg; Canadian, Dr. R. D. McArthur.—*N. Y. Medical Journal.*

At a largely-attended meeting of the Brant County Medical Association, held at the John H. Stratford Hospital on Wednesday, March 8th, 1893, the following resolution, moved by Dr. U. M. Stanley, Brantford, and seconded by Dr. Addison, St. George, was unanimously adopted, viz.: "That this association desires to place on record its strong disapproval of the methods adopted by an association called the Medical Defence Association in its attack upon the Medical Council; and whilst believing that grounds may exist for difference of opinion as to the advisability of certain acts of the council, nevertheless it has secured for the profession a very complete and solid organization, which is the admiration of the other provinces and states upon this continent; that this association trusts that the legislature will be slow to make any very radical alterations in the constitution or government of the council, believing that if the changes set forth in a circular note of the Medical Defence Association, dated January, 1893, or any considerable number of them, should be adopted, it would be detrimental to the best interests of the profession and the public, and materially hamper the usefulness of the council and destroy the object for which it was first instituted." M. J. KEANE, M.B., Secretary Brant County Medical Association.

DR. J. HERSCHBERG, of Berlin, in a series of letters which appeared in the *Deutsche Medizinische Wochenschrift*, in describing a trip around the world, makes the following allusion to Toronto: "I crossed the North American continent this time by a different route from that taken on a previous occasion, namely, a fourth by water over the great inland lakes, and then by the Canadian Pacific Railway to Vancouver. I remained some days in Toronto. Here is a state university, with magnificent buildings. Canada has in the last few years made great progress in all directions. In the biological laboratory of the university I found German apparatus for the study of bacteriology, and even German microscopes. We at home consider Canada to be cold and in-

hospitable. The course of the Canadian Pacific Railway, however, is about in the same latitude as Wiesbaden. It is certainly quite cold in winter in Canada, but very hot in summer."

A LITTLE English lord went over to hunt with the good old Ward hounds (I know every dog of them) this season. He did it, not from love of hunting, but because his doctor told him that the finest thing for the inside of a man was the outside of a horse. So fox-hunting the little lord would go. The fox went a rattling spin from Tara to Dunshaughlin, and the little fellow held on bravely, telling himself "it is the pace that kills," though whether he meant that for the fox or himself isn't quite clear. Anyhow he was the last of the field, except Lady Hasketh, who, on entering a stiff bit of field, found the little man sitting under a hedge, holding his head and groaning dismally. His gallant hunter had started off after the brush, and left him lamenting. "Dear, dear!" cried the lady, reining in as she anxiously enquired, "Have you hurt your head?" "My head? Thanks, no," replied the little man, "quite the reverse!"—*Toronto Mail*.

MR. GLADSTONE ON MEDICAL FEES.—There seems to be no end to Mr. Gladstone's feats. He has favored the public with another great speech—that on bi-metallism, in the course of which he remarked that many things had risen in value in late years. Oddly enough, among the few things he instanced was the remuneration of medical men. "No one is aware of the increase of fees in the medical profession, and I am bound to say that there are none more nobly earned in the world."—*Medical Record*.

THE KANSAS WAY.—The following appears at the foot of a bill-head of a Kansas physician. It is unique, original, and pointed, and, we presume, effective: "A prompt settlement of this bill is requested. If bills are paid monthly, a discount of ten per cent. is given. Bills not paid promptly will be passed to my attorney for collection. If you pay your physician promptly he will attend you promptly, night or day, rain or shine, while your slow neighbor suffers and waits, as he made the doctor wait, and while he is waiting the angels gather him in."—*Kansas Medical Journal*.

BANDAGING THE EXTREMITIES IN COLLAPSE.—Many regard the procedure of bandaging the extremities in collapse as a modern procedure. But Alexander of Tralles advised ligatures to the arms and hands for the relief of purging, and Garcia d'Orta, in his work on the simple drugs of India (printed in 1563), states that the Hindoo treatment for the cramps and purging of cholera was to put a tight band around the head and to bandage the legs very tightly.—*N. Y. Medical Journal*.

A CHILD SWALLOWING A LOCOMOTIVE.—A mother brought in her arms a beautiful infant of ten months, telling me it had swallowed a steam-engine. The patient sat in her arms sucking its fingers and smiling at me, while the mother told of the tragic occurrence. "What, wheels, funnels, and all?" I asked. "Yes," added the mother. "Well, madam, it seems to have agreed with it up till now; keep a good lookout." In a few days she brought the engine in triumph. It was like the image that Nebuchadnezzar set up in the plain of Dura, all of gold and had running wheels. I said, "Madam, that is fortunate, for that locomotive has passed safely through a long, dark tunnel, and has not left a tender behind."—*Birmingham Medical Review*.