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## Original Communications.

### PREFERABLE METHODS OF FIXATION IN THE TREATMENT OF SIMPLE AND OF COMPOUND FRACTURES OF THE LEG.\*

BY DR. N. A. POWELL,

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How to treat successfully a simple fracture of the leg is a mechanical problem which may be solved in numberless ways. Reduction secured and fixation maintained, consolidation almost uniformly follows. No one plan of treatment is so much better than all others yet advanced as to be the one first thought of by a majority of surgeons anywhere. If I attempt to classify a number of the methods now in use, to contrast their relative merits and deficiencies and to collect for your inspection a quantity of apparatus, it will not be because I have anything original or even new to present. Some, at least, of the appliances to which I shall call your attention are not heard of in practice here. There are those present who have had vastly more experience than myself in the use of certain other of the technical resources of surgical art here presented, and from them I hope to elicit such a practical discussion as shall more than make up for the defects in my own presentation of the subject. "Every surgeon," wrote Bell, in 1815, "sets a broken limb as he writes his name, after a fashion of his own."

We get our creeds in our cradles and our routine ways of immobilizing fractures from the offices and schools in which our student days are spent. Once in the rut it is easier to jog along than to make an effort to reach higher ground. Yet it is

\*Read before the Toronto Medical Society.

chiefly by the labors of those discontented ones, who are constantly striving to improve the means we have and to devise more perfect ones, that we make progress. The *unfittest* sometimes survives and the iconoclast is needed. To seek out and set in order the demerits of appliances which under the influence of certain great names have outlived their usefulness, is to do the surgical world a service which might rank equal with the services of those who have genius for construction rather than destruction.

I trust that both types are represented here tonight, and that the loose joints in this part of our surgical armour will be found and pierced, while at the same time we are strengthened by the free exchange of helpful suggestions. Young—that is very young—physicians are apt to have a special remedy for each disease or symptom, and to think they should have a special splint for each fracture. With ripening experience the tendency is to lessen the number of drugs used and to recognize that the essentials for fracture treatment are few and simple. An ample outfit, one with which many of us could get along very comfortably, need contain nothing ponderable beside thin basswood, mill-board, batting, bandages, cheese-cloth and plaster-of-Paris. The imponderable essentials are anatomical knowledge, the training of the hand, and what I once heard Mr. Erichsen call, "surgical horse-sense."

From my point of view it hardly seems that profitable discussion can be had regarding a choice of methods in the treatment of the later stages of simple fractures of the leg. There does not appear to be room for much divergence of opinion. The complete-encasement of the limb by plaster-of-Paris bandages is admitted to be the procedure which gives to both patient and surgeon the greatest degree of security and comfort. So well known has this method become that I shall refer to but a few points regarding it. It has seemed to me worth while to have the crinoline or cheese-cloth, from which the bandages are made, boiled in a solution of washing-soda and then in clear water. This makes it an absorbent gauze; it will sink at once if thrown into water, and plaster will set in its meshes as well as on its surface. Plaster dressings made with it wear out like felt, instead of scaling off and cracking. If a web of cheese-cloth be rolled tightly on a wooden cylinder and

this placed in a lathe, it can, as suggested by Martin, of Boston, be cut in a few moments into bandages of any desired width. The cutting is done by holding one corner of a broad chisel against the cylinder while it is in rapid motion. I have brought a roll so divided with me to show you; each section is fifty yards long by three inches wide. Cheese-cloth will not tear like thicker cotton, and life is too short to waste in cutting bandage material by hand. For crinoline, the bookbinder's knife has been suggested, and this machine will smoothly and rapidly divide the cloth into strips.

The earlier a plaster bandage is used the thicker should be, in my opinion, the layer of cotton under it. Batting makes the best padding while swelling exists and the patient is kept in bed. After all swelling has subsided and the patient is allowed to go around on crutches, padding by a single layer of old shrunk blanket has some advantages over that by batting or wadding. Abundant cotton padding allows the leg to telescope down into its case, while blanket padding will make the support more perfectly crustacean in type, and will correspondingly relieve the injured part of the skeleton from pressure when the patient is allowed to be up and about. Over the padding I always apply a firm dry flannel or cotton roller. It distributes the pressure evenly and lessens the risk of undue constriction.

There is no analogy between a bandage so used and a "primary roller," that is, one used under splints, applied to a part only of the circumference of a limb. While so good a surgery as that by Agnew advises the primary roller, and we continue to meet with physicians who employ it, I feel justified in asking for an expression of opinion from those present regarding this dangerous relic of the dark ages. In applying the plaster bandage so as to cover in the heel, if each turn be carried over the instep, there will be such a thickening at this part that slight pressure from the hands of the assistant making extension, or a slight change in the angle at which the foot and leg are being held, will lead to the formation of a ridge on the inner surface to groove the tissue on which it presses. To avoid this it is better to go back and forth over the heel from one malleolus to the other, binding all down smoothly by two or three final turns carried over the instep. The more

figures-of-eight we can put into a dressing of this kind the better will it be, and the more it is felted together and the air expelled from between its layers by rubbing with the hand the longer will it last. To strengthen it without increasing its bulk, the plan of interweaving two or more of the tin strips first advised by Dr. Fluhrer, is a good one. They should be cut from heavy tin plate, since common tin bends so easily as to be almost worthless. A single long strip crossing the sole and passing up to the knee on each side, gives the best support when the fracture is in the lower fourth of the limb. The strips should be perforated from each side and fixed to the limb by passing the bandage alternately over and under them.

Returning now to the treatment of the earlier stages of simple fracture of the leg, we find scope for endless differences of opinion and practice. What should the ideal dressing for a broken leg be and do? In answer to this question, permit me to quote from an address delivered by Dr. Gay, before the Massachusetts Medical Society: "It must be simple, comfortable, cheap, readily obtained, easily applied and removed, and must allow a frequent inspection of the limb without disturbing the patient. It must be applicable to all cases, capable of correcting any and all deformities and of retaining the fragments in their desired position for an indefinite length of time; not liable to produce abrasions or other mischief, and once properly adjusted it should require little attention during the progress of the case." Let us try by this standard some of the dressings in use here and elsewhere and note how far they fall short of our ideal appliance.

The support given may be by splints which are rigid or plastic, single or multiple. They may be applied to one or to more than one aspect of the limb, or the encasement may be complete.

*A Rigid Single Splint.*—The form known as Dupuytren's is capable of meeting the indications in a small proportion of cases of Potts' fracture. I should limit its employment to those instances in which we have to deal with marked and persistent outward displacement of the foot and but little backward displacement. A chief object of its use being to draw outward the upper end of the lower fragment of the fibula, it passes my comprehension why Erichsen and Stephen Smith should

figure its application with a bandage directly over the break. Hamilton and Druitt show it correctly. The wonder need not be great that students so often mis-apply this splint, when the teaching by illustration is in such marked contrast to the teaching in the text. The importance of keeping the lower bandage below the external malleolus, and of having the pad both firm and thick at a point just above the internal malleolus, are points long insisted upon but constantly needing to be emphasized.

Mr. Bryant figures and advises the application of a single straight wooden splint with foot-piece, for fractures of either one of the bones of the leg. Excepting as a temporary expedient, to be replaced as soon as possible by a more comfortable and efficient dressing, I am unable to endorse this plan.

Under the direction of Dr. Levis, of Philadelphia, a series of perforated and plated copper splints have been prepared and are largely sold in the U.S. Those for the leg are the least satisfactory in the entire set; they are posterior gutters which are apt to fit imperfectly in spite of moulding by the hands. My chief objections to them are, that they do not surround the limb sufficiently to maintain the apposition of fragments, and that they do not keep the foot at a fixed angle with the leg. I show you samples of the various sizes supplied. A series of lateral splints of the same material would be very much better, and could be moulded without difficulty.

*Rigid Splints, in pairs.* are usually applied laterally. Thin straight boards here seem to me inefficient means of support. They do not clasp the soft parts, and in spite of padding they are very apt to press hurtfully upon bony processes. The old and excellent plan of placing two thin boards at the opposite ends of a towel, rolling them in it toward the centre till a space is left between them corresponding to the width of the limb, placing the leg upon this web, stretched so as to form a posterior support, bringing up the sides and securing them after building a bird's nest of padding around each bony prominence, can be commended for temporary use. Folded newspapers do well for padding such splints. The toes can be kept from pointing by a strip of bandage passed around the ball of the foot and pinned to the splints upon each side. With such an apparel a patient can

often be moved home without the disaster of having his simple fracture converted, on the way, into a compound one. I should be sorry, however, to have one of my own legs, if fractured, left for even a week or two in such a crude and uncomfortable appliance. Once, in consultation, I saw a patient, who died from the effects of sloughing over one malleolus, produced by pressure of just such a pair of splints.

American surgical writers, as a rule, do not approve of carved wooden splints, while a goodly number of English surgeons endorse the kind known as Cline's. In America, Pratt's or Day's splints replace the English Cline model. Samples of each form are here presented. I must confess to an early prejudice against these splints derived from association with my old and greatly respected teacher, Frank H. Hamilton. With a considerable assortment of these appliances to choose from and with no hesitation in cutting them in order to secure a fit, one may make them serve useful purposes. On the other hand, if the physician thinks more of the splint than of the patient, he is better without the splint, or the patient is better without him. It must be admitted that a splint, even partly fitted, is better than straight board in the hands of a practitioner with whom the jack-knife is not an instrument of precision.

*Rigid Posterior and Lateral Supports.*—Under this head I mention fracture boxes and the iron splint used with lateral supports, and known in England as Arnold's or Neville's.

The common fracture box has always seemed to me to be a poor affair. When allowed to rest upon the bed it is especially objectionable. While it may be a safe and conservative practice to teach the average student to use it for the first week or ten days, until swelling has gone down, I should be sorry to have to use it very often myself.

In the old days, when the manufacture of pus, by compound fracture, was considered to be a laudable industry, the bran box had more uses than at present. Where its use is indicated I think it well to have at hand the most improved form.

The one I show you is more nearly like those figured in Wyeth's Surgery or in Stimson's work on Fractures, than any other, but seems to have some advantages over either of these. It was made from directions which I furnished, but for which I make no claim of originality. The idea of having

sides to let down in sections was suggested by John Neil, nearly forty years ago. The sliding floor by which the box may be adjusted to suit any length of leg is a real advantage. By means of Schede's adhesive plaster sling for the heel, the application of which I show you, the suffering of the patient from pressure upon this part of his limb can be relieved, and the risk of having that surgical disgrace, a bed sore over the *os calcis*, entirely obviated.

The iron back splint, with well fitted lateral supports, when suspended, is better than a box. It can be made by any blacksmith; should be  $2\frac{1}{2}$  to  $3\frac{1}{2}$  inches wide, provided with cross pieces by which it can be swung, cut out at a point opposite the heel, bent at right-angles for the foot, and at an angle of  $160^\circ$  for the knee, and should be of metal sufficiently strong to support the weight of the limb without bending.

This appliance meets the indications excellently well in the treatment of severe cases of fracture of both bones, with over-lapping and over-riding of the fragments. It is not as well known here as it deserves to be, and so I show you a sample.

Without a doubt the most important advance ever made in the treatment of simple fractures was the introduction of plastic material for splint making. As surgeons, we can well afford to toast the memory of that unknown benefactor of his race, who first padded a broken limb with moss and plastered it with clay.

Of plastic splints now in use we may make two divisions. The first of these will include all those softened by heat, or otherwise, and moulded to a part upon which they become firm and unyielding. The second division will include materials liquid at the time of application but subsequently hardening.

Gutta-percha is supplied in sheet form for splint making. I utter no malicious slander when I say that it is not eternal. With rubber goods generally most of us find this out to our cost. It is no better than other plastic material in any respect, and not so good in some. It is non-porous, expensive and short-lived. On the other hand, it can be moulded so as to perfectly fit any part, and no force need be used in shaping it.

Sole-leather, being inexpensive and easily obtained, is a favorite material with many. It should be slowly and perfectly softened in cool water,

with or without acetic acid, and can then be adapted to the inequalities of a part almost as perfectly as gutta-percha. One who has time at his disposal, and who by practice has gained some skill in working with leather, can make capital side splints from it. If it be imperfectly softened, the attempt to make it fit down to the exact shape of a limb may be the cause of new injury at the seat of fracture. Exceedingly bad splints are often the result of trying to economize time by using very hot water for the softening of leather.

Felt, and similar poro-plastic material, is supplied in sheets and in blocked forms. The English make is thicker and stronger than the American, and for the leg at least, the models adopted are decidedly the best. Softened by slightly moist heat, they are easily moulded and give sufficient support. I show you samples from leading manufacturers. These materials soon become soft and useless if dipped into hot water whenever a change of shape is required.

Kocker's adaptable splint seems to be a good form of shellac-stiffened cloth. It is, as you see, rather light for use upon heavy limbs.

Wire gauze has long been in use for splints. Its most distinguished advocate at present is Professor Jarvis S. Wight, of Brooklyn. He has been kind enough to send me samples of the best gauze for surgical uses.

The lighter variety has  $\frac{1}{4}$  inch meshes, is made of No. 20 iron wire, and is dipped into molten zinc, so that the wires are coated, and the points of intersection firmly soldered together. So made, the gauze is light, clean, cheap, strong and easily moulded to fit a part.

Mill-board is often referred to as though it is the same thing as, or is interchangeable with, paste-board or straw-board. It is really a great deal better than either, and is at once excellent for all its proper uses, easily obtained and cheap. It may be used as rigid as  $\frac{1}{4}$  inch deal, or as plastic as felt or gutta-percha. I am in the habit of advising students to stuff a long stocking with oakum and to use it as a model in making plaster dressings and in moulding mill-board. In my hearing, many old practitioners have expressed surprise at the really excellent quality of the splints which were made by moistening the mill-board just sufficiently with hot water, moulding and bandaging it upon the model, and allowing it to dry in position.

Additional strength and an elegant finish can be given to such splints by an outside coating of silicate of soda.

Practice of this kind wastes no time, since, so far as fractures are concerned, it helps to make us independent of the instrument maker.

In the second division, as starch dressings are practically obsolete, I shall consider only silicate of soda and plaster-of-Paris. The silicate I have used for a number of years. As it is not easily obtained here, and may not be familiar to all present, I place a sample before you. From it light, clean, strong and elegant splints can be made, but it is sticky to handle, and dries so slowly as not to give security against displacement by the time the physician is ready to leave the patient. It has been charged with causing extensive sloughing when allowed to remain in contact with the skin.

My personal experience with plaster-of-Paris, in the treatment of leg fractures, includes a series of thirty-eight consecutive cases, put up as soon as reduced, in one or other of the forms of splint presently to be described. I have never completely encased the limb in plaster bandages during the first week of treatment. In no instance was it thought necessary to wait and see if swelling would come on or for it to subside, and no increase in its amount was ever noted after the dressing was applied. The amount of ensheathing callus thrown out in these cases was surprisingly less than that which I have seen in cases treated by other methods. My three first cases were treated by the regular Bavarian splint, made by pouring plaster mud between two layers of flannel secured together down the back of the leg. Becoming dissatisfied with the weight and clumsy look of this dressing, I substituted, as many others have done, layers of cloth soaked in plaster for the plaster alone. Later, the doubled piece of flannel was omitted and layers of gauze or blanketting, cut by the measure of the patient's stocking and bandaged to the sides of the limb somewhat after the manner suggested by Mr. John Croft, became the favorite method. Finally I adopted, and have now used for four years, the plaster posterior splint, essentially, as it was perfected by my friend, Dr. Kingman, and others in the Boston city hospital. No new principle is involved in the making of this splint. It is not the posterior

splint described by Esmarch or by MacCormac. It is not the same thing as a plaster bandage with an inch-wide strip removed down its centre line in front. It differs from, and is better than either of these for the early treatment of simple fractures. I show you samples and photographs of the completed splint, and will now demonstrate the method by which it is made. The materials required are, cotton-wadding, cheese-cloth and plaster-of-Paris. I have lately been substituting scrim, a coarse and strong fabric, for the cheese-cloth as a less number of layers will give equal strength. I have this material here and also a splint made

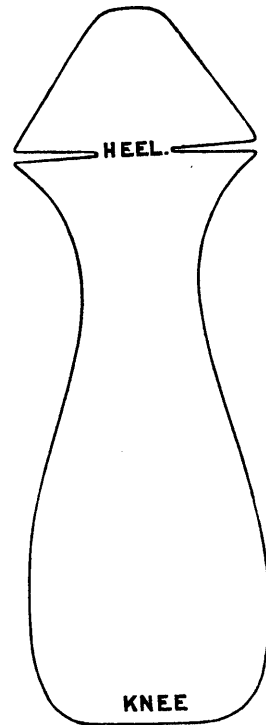


FIG. 1.

from it. The leg is to be bandaged with the batting, which, for the purpose, is torn into strips four inches wide and applied as a roller. Using the sound leg as a model, to save the injured one from movement, a pattern is cut which shall cover in all of the leg excepting a space an inch wide along its anterior aspect. Deep slashes opposite the heel allow the part for the sole of the foot to be brought into a right-angle with that for the leg without forming clumsy folds at the ankle. From this pattern four or five layers of scrim or from six to nine of cheese-cloth are cut. Then

with extension made and the foot properly held, the strips are to be saturated with a cream made by sifting—not stirring—plaster into warm water,

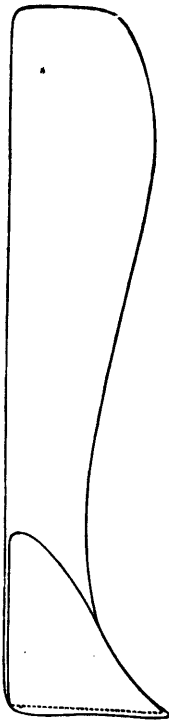


FIG. 2.

smoothed one upon another, applied to the posterior aspect of the limb, interleaved by the slashes at the ankle so as to hold the foot at right-angles with the leg, moulded to the part and then firmly bandaged to it with a cotton roller. He who is to be responsible for the result had better, as soon as this bandage is on, hold the limb in proper position till the plaster sets. To resign the duty into unskilled hands may mean either a deformity or the necessity for a new splint.

No more skill and no better judgment is called for in the use of this method than is needed for successful treatment by any other. A little practice will make almost anyone familiar with its essential details, and the result of its use may often become, as I can testify, a subject for the mutual gratulation of surgeon and patient.

This then is the dressing which I present to your notice as being more nearly the ideal one than any other yet proposed. Permit me to quote again from Dr. Gay: "Properly applied, it is comfortable and efficient, it is self-retaining, it

holds the fragments firmly in position, it allows the patient to be moved or to move himself without danger of disturbing the fracture, it permits the parts to be readily examined. Being opened throughout its entire length the bandage accommodates itself to the swelling of the limb without danger of strangulation, it can be applied immediately after the accident, there being no necessity for waiting until the inflammatory stage has subsided. It can be removed and re-adjusted with ease and can be worn indefinitely."

Any and every means by which displacement of the fragments is likely to be prevented, may properly be considered in discussing fixation. Position, suspension, extension and tenotomy become in this way possible factors in fixation. My own experience has been limited to the treatment of cases with the leg in the straight position, or at an angle of not more than  $160^\circ$  with the thigh. Reasoning from the ease with which reduction can at times be effected when the leg is flexed to a right-angle with the thigh, as well as from the comfort given the patient before his fracture is set, by flexing the



FIG. 3.

injured limb to relax the calf muscles and allowing it to rest upon its outer side, I am disposed to think

favorably of this position continued throughout the stage of consolidation in certain cases. I will leave it for those who have had experience in this matter, to define the cases which are suitable for such treatment. Theoretically, only fractures in the lower part of the leg should be put up with the knee unsecured.

Stanley Boyd, in his late and excellent revision of Druitt's Surgery, makes the curiously inaccurate statement, that in the United States fractures of the leg are usually treated by Buck's method—the American stirrup (meaning by these terms the weight and pulley extension), and that coaptation splints (Cline's) are also used when the fracture is oblique. It would be interesting to know in what small proportion of cases the members of this Society have used the weight and pulley for leg fractures, and in what still smaller proportion they succeeded in making this form of extension honestly efficient in overcoming deformity. It has appeared to me to be so difficult to obtain a purchase on the parts below the fracture for our extending force, without running the risk of ligating the limb or making injurious pressure upon parts like the instep, unfitted to sustain it, that I have not even made trial of this expedient. And before doing so, I shall certainly make trial of one or other of the two forms of double inclined plane which are here presented—the Liston's splint improved by McIntyre, or the wooden apparatus manufactured by Pratt & Son, of Bennington, Vt. When displacement is prevented by keeping the limb at a certain fixed angle, these appliances may prove useful.

*Suspension.*—I have seldom seen a broken leg doing so well without suspension, that it would not do better with it. One need not pay \$20 or \$30 for a Salter's swing, when any ordinary blacksmith, if shown how, can for \$4 or \$5, make one equally good. I show you one which is easily taken apart for convenience of carrying. This I have had in use for nearly ten years, and it has paid for itself many times over.

A simpler and quite familiar frame is this, which resembles two small window sash hinged together along one side. Simplicity and portability can go even further than this, and I show you here a bar of wood,  $1\frac{1}{2}$  inches square by 2 feet long. Into the upper surface of this and near each end, a screw hook is fixed, by which it may be suspended

over and parallel with the injured leg. Into its under surface three or four more screw hooks are fixed, and from them the leg is, by loops of bandage or otherwise, suspended. Dr. Walker, of Detroit, was the first, so far as I know, to describe the use of a bar like this. In practice, we often find that loops of bandage used for the suspension of limbs soon draw into ropes. Hamilton, to obviate this and to distribute the pressure along the limb, suggested the use of broad leather loops. As these are not always at hand, I have used instead starched linen cuffs, one cuff at the ankle and one below the knee, suspended by soft cord or bandage so as not to tear out the button-holes, will answer every purpose. In swinging a limb, it is good practice to have the knee slightly higher than the ankle. Motion at the point of fracture, muscular starting and pain from pressure on the heel, are almost if not entirely obviated by suspension, and yet I feel sure that no small number of limbs are kept lying upon the bed throughout the treatment.

The discussion of tenotomy of the tendo-achilles I leave to others, as I have had no practical experience with it. In very oblique fractures of the tibia, compound or threatening to become so, and in the V-shaped fractures first and best described by Gosselin, this procedure may well commend itself to our consideration.

*Compound Fractures of the Leg.*—Antiseptic surgery has revolutionized the treatment of this class of injuries and reduced the mortality of cases not demanding amputation, from over 30%, to practically no mortality at all. Volkmann, in 1876, startled the surgical world by reporting 75 consecutive recoveries. Dennis, in 1886, records 150 cases without a death due to septic causes. The very success we now attain brings to us new dangers. Men who formerly would have died now recover, and if not turned out models of manly symmetry, are very prone to listen to the suggestions of Ishmael and of Ananias, and to try and recover damages from those to whom they owe debts of gratitude for life prolonged. In selecting our methods of fixation for these cases, we should bear constantly in mind the fact that we may, within a few months, have to defend in the courts the procedures we adopt.

He who studies to be fertile in helpful resources will not be tied to any routine practice. After testing a considerable number of plans, such as



fenestrated and bracketed plaster splints, the bran box, etc., I have settled upon one method as being the best under all ordinary circumstances. The plan referred to is to make an anterior and a posterior splint, each of eight or ten layers of cheesecloth and each extending from the toes to the mid-thigh. The anterior one only needs to be removed for the renewal of the antiseptic dressing over the wound. MacCormac gives outlines of good patterns for these splints, and I present for your inspection a complete pair. The plaster posterior splint, described as best for simple fractures, I have used in but a single case of compound fracture. It gave satisfactory support, but not as free access to the wound as would have been required had the latter done badly from any cause.

In conclusion, permit me to submit the following propositions for your discussion:—

1. Plastic appliances are the best for the fixation of fractures of the leg in all their forms and at all stages of their treatment. Exception, certain cases of Potts' fracture.

2. For the early fixation of simple fractures, the plaster posterior splint is the best and safest appliance yet suggested.

3. Next to it should rank side splints made from plaster, soaked blanket, or open-meshed cotton, bandaged on so as to be hinged along the back.

4. In the later stages of all simple fractures of the leg, the complete encasement of the limb by plaster bandages is the preferable plan of treatment.

5. In treating compound fractures of the leg, posterior and anterior splints made of plaster-soaked gauze, are ordinarily the best for fixation. Exceptionally fenestrated or bracketed plaster splints may meet the indications more perfectly. Without considerable practice in the use of plaster, the fracture box suspended may be safer, both for the patient at the time and for the surgeon subsequently.

#### SOME FEW NOTES ON ABDOMINAL SURGERY.

BY J. ALGERNON TEMPLE, M.D., M.R.C.S., ENG.

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Altogether I have opened the peritoneal cavity for various diseased conditions sixty times, with forty-nine recoveries and eleven deaths:

	No. of Cases.	Recoveries.	Deaths.
Ovariectomy .....	47	41	6
Abdominal Hysterectomy .....	1	0	1
Removal of Uterine Appendages .....	7	5	2
Abdominal Section for Pelvic Abscess .....	3	1	2
Abdominal Section for Chronic Peritonitis, with Dropsy .....	2	2	0
Total Cases .....	60	49	11

It is not my intention to enter into a separate report in each individual case, but merely to make a few brief remarks on some of the more interesting ones. Many of these cases were both interesting and difficult from extensive adhesions.

They were nearly all private cases, though a large proportion were done in the pavilion of the Toronto General Hospital, a building, from its isolation and excellent sanitary arrangements, admirably adapted for such operations. Some were performed at their own homes in Toronto and some in the country. Of the six fatal cases following ovariectomy, the cause of death in two was shock. In both cases the women were old and much enfeebled from the long continuance of the disease, and the only reason I consented to operate at all was at their own earnest solicitation; one was aged 72 and the other 68. In both the adhesions were very extensive, and the tumors large. Both ovaries in each case had to be removed. Many ligatures had to be used, in consequence of the extensive adhesions, and the operations necessarily lasted a long time. In both cases the patients lived only two or three hours, the immediate cause of death being shock. I have concluded that in such cases, one had better not operate; the long duration of the disease, the age of the patient, the emaciated condition, and probably extensive adhesions, not being favorable conditions for recovery.

Two cases were sarcoma of the ovary. One patient lived two, and the other seven days. In regard to malignant disease of the ovary, no attempt at removal had better be made. Death follows rapidly in such cases. After the exploratory incision reveals the true nature of the disease, the wiser plan is to stitch up the wound and leave the case to nature.

One case died of acute peritonitis thirty-six hours after operation. It was a simple unilocular

cyst without a single adhesion. The operation was very easily performed and lasted but a short time. The gentleman who assisted me at this operation was at the time, though I did not know it, himself very sick and died within a few days after from typhoid pneumonia, in fact took to his bed immediately after the operation. How far such a condition of health in my assistant at the time of the operation favored development of peritonitis, I am not prepared to say. But I do think that no operator or assistant should undertake a case of laparotomy unless in perfect health at the time, and I don't think it is going too far to say, it would be advisable to take our own temperature on the day of the operation.

The sixth case lived fourteen days. The abdominal wound healed and no unfavorable symptoms showed themselves till the thirteenth day, when symptoms of septicæmia set in and the patient died of peritonitis. If I had an opportunity of going over the cases again, I would not have to record the first four deaths. Two were too old and feeble for operation, and in two the tumors were malignant—which had better have been let alone.

In one case, some two or three hours after the operation, the patient, during the absence of the nurse from the room for a few minutes, got out of bed, walked across the room and drank about eight ounces of lime-water which she found in a bottle, went back to her bed and never had a single bad symptom, though I certainly looked for nothing short of death. One case gave me a great deal of trouble, in consequence of the very soft and friable condition of the pedicle; I nearly lost her from hæmorrhage at the time of the operation. The ligature cut the pedicle completely through on three separate occasions, so that finally I had no pedicle left to ligate. I consequently stitched it with what sewing women call an "over-stitch" along the raw edge of the severed pedicle; the case made a good recovery.

The hysterectomy was for a large and rapidly-growing fibroid of the uterus, weighing twenty-two pounds when removed. I opened the abdominal cavity with the intention of removing the uterine appendages, but changed my mind and removed the uterus and tumor; the patient did remarkably well for eleven days, but died from peritonitis a few hours after its development. I have always

regretted that in this case I did not use a drainage-tube; the result might have been different.

The removal of the uterine appendages was in consequence of their diseased condition. Four of the cases proved to be double pyo-salpinx. Both the fatal cases died of peritonitis.

The three cases of pelvic abscess occurred in young unmarried women, under twenty years of age. The two fatal cases were unfavorable from the outset. They had been ill a long time and their constitutions were much impaired, as shown by their emaciation and debility. One lived three weeks, the other only three or four days, death being the result of exhaustion. Of course, in all three cases I used the drainage-tube and had the abscess-sac washed out several times a day with an antiseptic solution.

The two cases I operated on for chronic encysted peritoneal dropsy, made good and perfect recoveries. After opening the abdominal cavity and removing the fluid, the peritoneum was found to be red, thickened and studded with little miliary-like bodies. I sponged out the cavity and thoroughly cleansed and washed the whole peritoneum, rubbing it all over with a sponge. Both cases made good recoveries. The result of these two cases has given me great encouragement regarding the treatment of such cases in the future, as I believe the method adopted, is the best known to surgical science to-day. In all cases I used the strictest antiseptic precautions. Too much care cannot be taken in this direction. The instruments, sponges, etc., should all be carefully cleansed and disinfected, as well as the operator and his assistants. In all cases the pedicle was ligatured with good stout silk ligature, which had been antiseptically prepared beforehand, and after ligation, dropped into the abdominal cavity.

Regarding the use of the drainage-tube, I think it ought to be used in all cases, where the adhesions have been numerous. Too much care cannot be taken to cleanse out the abdominal cavity before closing it up. I am in the habit of pouring in a pint or more of plain boiled water and removing it by sponges. Moderately hot water is not objectionable; indeed I have noticed that the introduction of hot water into the peritoneal cavity, in cases showing shock from length of operation, is decidedly beneficial to the patient. After the operation, should symptoms of peritonitis show

themselves, I think no time should be lost in re-opening the wound and introducing a glass drainage-tube and thoroughly washing out the cavity with boiled water moderately warm. I have seen the most beneficial results from this procedure, the active symptoms rapidly subsiding. I remove the abdominal sutures on the fourth or fifth day. The dressing of the abdominal wound should be as simple as possible, a little dry iodoform and a piece of antiseptic gauze and dry absorbent wool, and a flannel roller, is all I ever use.

Regarding the use of opium or morphia, I never administer either, unless the pain is so severe as to call for them, which is very seldom. For the first twenty-four hours after the operation I allow no nourishment of any sort, and to relieve thirst, which is as a rule very distressing, I find the injection into the rectum of one or two ounces of warm water, with a little salt in it, acts promptly, and the supervention of vomiting is avoided.

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### Correspondence.

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#### GONORRHOEAL OPHTHALMIA.

To the Editor of the CANADA LANCET.

SIR,—The manner in which one of my patients contracted this serious affection is worthy of some consideration. A young man came to my office some time ago with an acute gonorrhœa. I prescribed for him. Two days after he returned, the left side of his face being badly swollen, and the left eye almost closed, with a purulent yellow discharge exuding from between the lids, in fact with all the well-marked symptoms of gonorrhœal ophthalmia. Upon questioning him as to the manner in which he had been inoculated, he answered that he was in the habit of using his urine as an eye-wash—(easily procured if not efficient)—having had weak eyes for years. He fully recovered, with good sight in both eyes. Physicians should enjoin strict cleanliness on the part of patients affected with gonorrhœa; they should also caution them against putting their hands to their eyes except when thoroughly cleansed, a precaution which is often neglected or forgotten.

Yours, etc.,

J. M. SHAW.

Mallorytown, Jan. 3, 1889.

#### SOUTH WATERLOO MED. ASSOCIATION.

To the Editor of the CANADA LANCET.

SIR,—At the regular monthly meeting of South Waterloo Medical Association, held in Galt, Friday, January 5th, the following officers were appointed for the ensuing year:—President, Dr. Lovett, Ayr; Vice-President, Dr. Vardon, Galt; Treasurer, Dr. Sylvester, Galt; Corresponding Secretary, Dr. Hawk, Galt; Recording Secretary, Dr. Thompson, Galt. At this meeting the following resolution was passed: Moved by Dr. Sylvester, seconded by Dr. Vardon—

“That this Association cannot adjourn without expressing its sincere regrets at the departure of Dr. J. Price Brown, who has taken such an active part in the formation of this society, and who has so largely contributed by his culture and ability to promote its usefulness; and while this Association cherish the strongest fraternal feelings toward him, they are but exercising those principles of the golden rule which has been his invariable practice toward every member during his long residence in Galt. We, one and all, wish him the largest measure of success in that new and ample field of labour where his attainments so well fit him for extended usefulness.”

Dr. Brown left here about two months ago to study in Detroit, and intends moving to Toronto in a short time.

Yours, “GALT.”

Galt, Jan. 14th, 1889.

To the Editor of the CANADA LANCET.

SIR,—Your numerous readers would doubtless be pleased with your excellent wood-cut of Drs. W. S. and F. Black's combined cupping apparatus, breast pump and aspirator, which appeared in the last issue of the LANCET; and having for sometime had one of these instruments in use in connection with my own practice, I can fully endorse your criticism of it. Indeed, I regard the cupping apparatus alone as being an invaluable instrument, for it cannot be doubted by those who have fully tested the efficacy of cupping, that it presents a wider range of usefulness in the local treatment of disease than any other means known to the medical profession. Owing, however, to the trouble connected with its application, and the painful shock incidental to the operation, together with the greater or less danger of injury from the burning fluid, this useful means of treatment has, hitherto, possessed few attractions

for either physicians or their patients, and has therefore been too often only employed in cases of severe pain, when all other means of local treatment have failed to give relief.

Any apparatus, therefore, which eliminates from the cupping operation its only objectionable features places in the hands of the physician a means of affording relief from a host of neuralgic and rheumatic affections, and of applying the most rapid and effective counter-irritant, revulsant and depletant remedy in cases of internal congestions and inflammations.

As a counter-irritant it is more effective and less painful than blistering, and as a depletant, it presents many of the immediate advantages of general blood-letting, with none of the remote dangers connected with the latter, while it is applicable to the treatment of a vastly greater variety of cases. It may be employed with special advantage in congestion or inflammation of the kidneys, and in pneumonia and bronchitis in all their stages; and the nervous cough so often found in connection with the two latter diseases, which is so trying to the patient, and in which the cough is always out of all proportion to the amount of expectoration, can be readily controlled by a prompt and persistent use of the cups. With the advent of so efficient an instrument as that of Drs. Black, the use of cupping will, no doubt, be widely extended, and its efficacy more generally appreciated.

Yours, etc.,

Saintfield, Jan. '89.

JOHN PARK.

## ELECTROLYSIS IN URETHRAL STRICTURES.

To the Editor of the CANADA LANCET.

SIR,—In the January issue of the CANADA LANCET I note an editorial with the above heading, upon which I should like to make a few comments.

The *New England Med. Monthly*, for December, contained a communication from me, entitled, "Explanatory notes on Dr. Keyes' Investigation," the *N. Y. Med. Jour.* having declined to publish—as its editor expressed it—"one which savors of a spirit of depreciation," quite overlooking the fact that Dr. Keyes' article savored much more strongly of the aforesaid spirit than did my letter, to which I would refer those who are in a position to judge impartially.

If Dr. Keyes "says bluntly that the method is a failure," that is no reason why the results of other eminent men should be lightly set aside, particularly when Dr. Keyes cites eight unsuccessful against Dr. Newman's over two hundred successful cases, not to mention the very satisfactory results recently reported in England and Australia, as well as the United States and Canada.

As for Dr. Thomas' article, I would refer those who are interested, to Dr. Newman's reply in *Jour. of the Am. Med. Assoc'n* for September 8th last. Unfortunately for Dr. T., his battery was of a variety condemned by Dr. Newman for use in stricture cases, so his work was "Love's labor lost." He succeeds admirably also in being blunt as well as somewhat impertinent.

Nothing is to be gained, but very much lost by taking a one-sided view of this as of any other question. We all highly esteem Dr. Keyes for his labors in dermatology and genito-urinary affections, and are compelled to admire the very frank way in which he details his experience, first with the strong current, "galvano-casantique," then with the mild; but his failures, particularly in the latter case, serve a most useful end, for they demonstrate that to stand at the head of one's profession as a surgeon does not necessarily guarantee successful results with electrical methods.

Electricity will hardly reach its proper status till at least the present generation of reigning surgeons shall have passed away. To one prejudiced to the use of the quick sharp cut of the keen blade, the slow, cautious, gentle employment of the smooth-surfaced electrode is a weariness which it is much easier and far more popular at the present time to inveigh against than to endure. Each has its use, each its limitations.

If we are to reap the full benefits of electrical manipulation, the process of training must commence with the student whose mind is as yet unwarped. When he has obtained a comprehensive, intelligent grasp of the subject, he will be in a position to turn his theories to practical account, particularly if he possesses a good share of those inestimable blessings, common sense, patience and gentleness, without which his knowledge will prove unavailing; then we shall hear less of failures with electrolysis and electricity in general.

The sooner our medical schools awake to their responsibility in this direction the better will it be for our reputation as an enlightened, progressive, scientific profession.

C. R. DICKSON.

Kingston, Ont., Jan. '89

To the Editor of the CANADA LANCET.

SIR,—In order to render some little service to my fellow practitioners, as well as to elicit the reports of more extended experience in the matter, allow me to narrate, briefly, the results, in five cases, of a novel method of treatment of that intractable disease, whooping cough.

Dr. Keating says:—"As can readily be imagined, a disease which is so universal, so distressing, and at the same time so obscure in its pathology, as the one under consideration, would have in its literature a mass of recommendations for treatment from zealous advocates, based upon theory or experience, as numerous as the authors themselves."

In the face of such an assertion the advocate of another remedy must either have an abundance of "gall" or the endorsement of stubborn facts. However obscure the pathology may be, the history of the disease, in most of its aspects, is not out of harmony with its zymotic origin; although Dolan, in reporting the results of his investigations, asserts that no microbe essential to its existence has yet been discovered.

My own child, aged six, contracted the disease early this winter; for the first two weeks it ran the course of an ordinary attack; at the expiration of that time the symptoms became intensely aggravated. I ran the whole gamut of remedies acknowledged to mitigate the symptoms, but without avail. Atropine, to the verge of poisoning, had no effect; neither had opiates, pushed close on the heels of narcotism. Chloral hydrate, croton chloral, and the rest of them, were tried faithfully, and still the paroxysms increased in number and severity. As a last resort I determined to try the mode of treatment advocated by a French physician, and referred to in a former number of the CANADA LANCET, and that is to act directly on the specific germs in the respiratory tract by means of the fumes of sulphurous acid. At this time the cough occurred about thirty times in twenty-four hours, and was very severe, and the apnoea so prolonged that I feared the possible effects on the meningeal vessels. I selected an unoccupied room, and furnished it in the most sanitary manner possible—bare floor and walls, with nothing in the shape of furniture but a new cot and fresh bed-clothing. In this apartment I hung up her night dress. Early in the evening

I burned a good handful of common sulphur in this temporary bedroom; the fumes were confined for two hours, and then the room aired for an hour. At the expiration of this time, having had no treatment during the day, she entered the room naked and dressed in the disinfected clothing. This was repeated for three nights, and to my surprise, the following day she had but two paroxysms. The treatment was then discontinued, but in about thirty-six hours the cough re-appeared, but not quite so severe as at first. The sulphur applications were resumed for two nights, and after this there occurred in all but one or two mild paroxysms; she rapidly recovered her appetite, all the gastric symptoms having disappeared *pari passu* with the cough.

I could not conclude that the remedy and the abrupt cessation of the disease were only a coincidence; but for corroboration I determined to give it a further trial. In about a week I had a good opportunity, for I was then consulted regarding a family of four children suffering from the disease in a severe form. They were all pale and anæmic and pretty well exhausted. Internal medication I abstained from in order to make my conclusions more accurate, and confined myself to the use of the sulphurous acid. The bedroom was fumigated on four consecutive evenings, and, although the filthiness of the house was a first-class hot-bed for germination, in three cases a cure was effected, and the fourth child was much benefited,—a result that one could not fairly expect to follow any of the commonly used remedial agents.

It would be interesting to myself and many others, I am sure, to have reports from those who have tried the sulphur treatment.

Yours, WM. BRITTON.

Toronto, Jan. 23rd, 1889.

## OUR NEW YORK LETTER.

*From our own Correspondent.*

NEW YORK, Jan. 19th.

There has been a deal of discontent among the students of the University Medical College of the City of New York, about the appointment of a professor in anatomy. The students held meetings and drew up resolutions asking the faculty to appoint their choice to the chair. The faculty

had the vice-chancellor address the students, and explain that the students must leave such matters to the faculty, that they should appoint a man that would give entire satisfaction, and that in doing so they had the whole interest of the students at heart, that when a student entered the College he should trust to the faculty to provide him with the best instruction that could be obtained, and not with the idea that they give them certain lecturers; nor should the students dictate to the faculty. Many students threatened to leave the College, but I am glad to say that many have submitted to the faculty's judgment, and I am sure they will not have cause to regret it, for they have made an excellent appointment in Dr. George Woolsey. The students deserve a good deal of credit in their loyalty to a certain lecturer, and more could be said of their good behavior, when the new lecturer appeared before them.

Dr. J. Williston Wright has resigned from the chair of surgery, not on account of ill-health, as it was rumored, but to give more time to private practice.

Dr. Allen M. Thomas, Physician-in-Chief and Superintendent of the State Emigrant Hospital, has resigned after six and a-half years of faithful and valuable service to the institution. With the permission of the department, I am able to forward you an extract from his letter, not yet published, tendering his resignation to the Commissioners of Emigration, in which he reviews, in a general way, the statistics of the obstetrical department of the institution under his management. I do this as it appears to me a matter of great public, as well as professional, interest, since it shows so conclusively what may be achieved with proper care and wise management in this department of medicine: "The obstetric department has likewise been thoroughly renovated, notwithstanding the authorities at Washington have withheld a large amount of our funds. Unfortunately, the lack of sufficient money imposed upon us the practice of too rigid an economy in the performance of the work, and prevented that complete removal of old floors, plumbing, etc., which was desirable. Still we have done a very great deal, for we have practically succeeded in keeping the department in an excellent sanitary condition, and provided it with efficient service and every special arrangement necessary for its successful management. Being

located in one of the pavilions of the main hospital the health of the department is always *slightly menaced* by the unwholesome condition of the neighboring pavilions, but it is very satisfactory to report no appreciable contamination from that source during the past year. The new provision, which you have very recently allowed me to make, for the care of babies in a separate ward, adds greatly to the efficiency of this service, and amplifies still further our field for doing good.

"At this juncture, let me call your attention to the results of our obstetrical service from the time of its final re-organization, in properly renovated wards, five and a-half years ago. It bears very forcibly upon this question of bettering the sanitary condition of the hospital, and will give you some substantial evidence of the great good that has been done in return for the considerable outlay of time and money you have, from time to time, so wisely made in this department. As these improvements have been more radical and complete than those made elsewhere in the hospital, permit me to suggest, in passing, that the evidence deducted from the facts I shall bring to your notice should be an additional stimulus to you to push forward, as speedily as possible, the similar outlay required to keep up the best possible condition of the other departments. The conditions under which our obstetrical department existed in former years were more or less unavoidably opposed to the obtaining of the best results. For the two or three years prior to 1883, improvements were made in this department as rapidly as the time and circumstances would allow, until, in the latter half of 1883, it reached its complete organization, under the new regime of a physician in charge: a complete and efficient corps of nurses, properly arranged wards, and isolating rooms, and excellent supplies; each for the exclusive use of this service, and all working together harmoniously under an established system of procedure: Before the fulfilment of these conditions, and so far back as I have been able to get accurate knowledge of it from your reports, the rate of mortality of women delivered, varied from 4% to 8% annually, and of still-births, from 5% to 12%. Since August, 1883, we have delivered 544 of 550 children. We have a total of only 17 still-births, and 3 deaths of women, as follows: In 1884, one woman died of exhaustion shortly after confinement, the result of

an advanced disease of lungs, from which she was suffering for a long time previous to her admission. In 1885 and 1886 there were no deaths. In 1887, we had 2 deaths, one from puerperal convulsions and one from puerperal fever, rheumatism and Bright's disease. This case of fever is the *only* death from infectious puerperal disease that has occurred during the past five and a-half years. She came to the maternity ward from one of our medical wards, where she had been under treatment for two months, suffering from rheumatism, pericarditis and acute forms of Bright's disease. At the time her labor began she had a high fever, which was supplemented by all the subjective symptoms of a severe form of puerperal sepsis, of which she died on the fourth day of her lying-in period. During the past year of 1888, we have again had no death. This one case of fever, with all its serious complications, seems scarcely chargeable to any faulty condition of the department. If we had excluded it from our statistics, it would have left us with an absolute freedom of deaths from preventable puerperal cause. The death from consumption and the one from convulsions are so-called accidental or unavoidable cases, which no efforts on our part could avert. After charging the total number of three deaths, as I have done in making up these statistics for the last five and a-half years, it gives the very low mortality rate of only a trifle over  $\frac{1}{2}$  of one per cent. of the 544 women delivered. This is in striking contrast to the average 6% mortality rate of previous years. Concerning the record of still-births, which reflects, more or less, directly upon the manual dexterity and special judgment of the medical attendant, there has been a similarly good result achieved. The percentages of still-births for the entire 550 births which we have had, being 3%, in contrast to the average rate of 9% of previous years, when the service was almost entirely in the hands of a midwife."

This is surely a record of which we may be justly proud and of which no degree of modesty forbids a boast. The *Medical Record* published in their last issue the statistics of the maternity division of the Charity Hospital for the last year, which are as follows: 349 confinements, with 3 deaths of mothers or  $\frac{1}{100}$  per cent.; 13 babies died, 37 still-births.

AJAX.

## Reports of Societies.

### REPORT OF THE NEW YORK SURGICAL SOCIETY.

REGULAR MEETING, HELD JAN. 14TH, THE PRESIDENT, DR. STIMSON, IN THE CHAIR.

(From Our Own Correspondent.)

#### PRESENTATION OF CASES.

Dr. Hartley presented a case showing ulceration and necrosis of the last phalanx of the thumb, and loss of the third phalanges of the little and middle fingers. Patient had had the affection for twenty-three years, and began as a bulbous eruption which gradually had gone on to necrosis of the phalanges. Dr. Star had kindly examined the case and found some anæsthesia of the median and ulnar nerves, and some vaso-motor changes. They both came to the conclusion that the case was one of syringomyelitis, situated at about the seventh cervical or first dorsal vertebræ, and involving the posterior horns and only sufficient of the anterior horns to cause the atrophy. Dr. Lange stated that he had seen two cases of a similar nature, one in which the toes had been involved, and Chopart's operation had been performed with a good result. The other in which the phalanges of the hand were amputated without an anæsthetic.

#### NEPHRECTOMY.

Dr. Lange exhibited a man in whom he had successfully removed the left kidney for suppurative nephritis on November 21st. The result was especially gratifying, as the patient had been in a very weak condition before the operation. The wound was very large and had now healed except a small superficial granulating surface; it had purposely been kept open and only allowed to unite at the corners. In operating, he always placed the patient on his stomach, and had one assistant hold the pelvis while another made traction on the arm in order to secure more room. In addition to the usual incision along the crest of the ilium, he made one over the tenth rib, and recommended excision of the eleventh rib to facilitate matters. He had not seen anything of the pedicle after the operation, and thought it had been absorbed and vascularized again.

Dr. Abbe remarked that in a case of suppurative nephritis, in which he had removed the

kidney, the pedicle included a portion of the suppurating kidney, he had simply washed it with antiseptic solution and returned it. The patient died in forty-eight hours, of uræmia, and the autopsy showed that the pedicle had become vascularized.

#### SEPARATION OF HUMERAL EPIPHYSIS.

Dr. Murray presented a case of a boy, aged 11, who had fallen the distance of twenty feet, and, with extended arm, endeavored to save himself. When seen fourteen days after the accident, the shoulder was much swollen and very painful; the axis of the arm was directed more downwards and outwards than normal. A tumor was felt under the coracoid process, and on rotating the elbow it moved with it. There was shortening as compared with the opposite arm. Diagnosis of separation of epiphysis was made, and a fracture of the external condyle and upper third of the radius was also discovered. All attempts at reduction failed, so an incision was made over the lower fragment, and the lower fibres of the deltoid were found intervening between the fragments. These were divided and about  $\frac{3}{4}$  of an inch of the epiphysis excised. The arm was then easily reduced, the wound dressed antiseptically, and position maintained by means of a plaster-Paris bandage. Good union was obtained, and movement is now very fair, although there are  $1\frac{1}{2}$  inches shortening. Dr. Lange stated that he had recently had a similar case where the same difficulty existed, and he had been obliged to cut down and divide the fibres of the deltoid, and that position had been maintained by abduction and extension of the arm.

Dr. Abbe then read the paper of the evening on a case of colo-Colostomy, with remarks on the use of Dr. Senn's plates. He began by paying a glowing tribute to Dr. Senn for his original experiments and investigation in the field of abdominal surgery. Now operations, which formerly occupied over two hours, could be completed in from fifteen minutes to half-an-hour, and the result of this, in the prevention of shock alone, was invaluable. The principle of Dr. Senn's method was to do away with intestinal resections in suitable cases, and to substitute an anastomosis of the intestine above and below the seat of stricture or obstruction, and to secure union by means of his decalcified bone plates. The patient was a man,

aged 60 years. In November, 1887, he had been operated on for hæmorrhoids, and four months after the operation he began to complain of intestinal hæmorrhage, severe abdominal pain and cramps. In April he entered St. Luke's Hospital for obstinate constipation; a large fæcal mass could be felt in the region of the cæcum, movements took place every five days. Discharged in June, and again entered the hospital in September. No purgative action could be obtained except by the use of enemas, patient became weaker and weaker and subject to attacks of syncope. Under cocaine anaesthesia an incision was made four inches above the pubes, eleven pints of ascitic fluid escaped from abdominal cavity, and on introducing the finger, a large fæcal mass could be felt, which proved to be in the distended cæcum and ascending colon; two silk sutures were passed through the mass, and it was brought up to the abdominal incision and an opening made into it, when about twenty pounds of fæces, oakum, reeds and other foreign material escaped. After the mass was thoroughly cleaned out, the edges were stitched to the abdominal wound, and an artificial anus established. Patient improved rapidly for two weeks, then three quarts of milk were injected into the rectum, and no trace of it could be observed at the fistula; only three pints could be injected at the fistula, and the diagnosis was made that the obstruction was situated at the hepatic flexure of the colon. Six weeks after the operation the patient was anaesthetized, the fistula plugged, and an incision made over the right hypochondriac region. Openings were then made in the transverse and ascending colon by an incision across the transverse muscular fibres of the colon, above and below the seat of obstruction, and Dr. Senn's decalcified bone plates were introduced; the sutures passed through the intestinal wall, and the peritoneal surfaces of the colons brought together; this was further reinforced by the use of several Lembert sutures. On the third day flatus was passed; fourth day some fæces; on ninth, fair movement, and in two weeks a good movement was obtained, and artificial anus was plugged. Patient has steadily improved ever since, and the intention is to shortly close the fistula. Dr. Abbe then stated that the objection to Dr. Senn's plate was that they only allowed an opening the length of one and a-half inches, and that furthermore



they could not at all times be readily obtained ; to obviate this he proposed substituting rings made of five strands of heavy No. 7 catgut ; these could be made any desired size at a moment's notice. Dr. Abbe then gave some account of his experiments on dogs, in which he had used his rings in place of bone plates, and had obtained good results in all cases. In six to eight hours good plastic union took place, and in forty-eight hours very firm union.

In the discussion which followed, Dr. Meyer stated that he had been present at the operation and remarked at the rapidity with which it had been performed, as the old method of operating took at least two hours. He had recently performed a case of gastro-enterostomy, the operation was long and tedious, the patient died of peritonitis. At that time he did not know of Dr. Abbe's rings.

Dr. Lange gave an account of two cases of gastro-enterostomy and one of colo-colostomy in which he thought the rings would have been applicable. He considered Dr. Abbe's rings a great improvement on Dr. Senn's plates, as the latter were difficult to obtain, but that they might be open to the objection of not holding sufficient peritoneal surface together.

Dr. Abbe in closing the discussion, showed that the rings held together at least a  $\frac{1}{4}$  to  $\frac{1}{2}$  inch of peritoneum, and when this was reinforced by several Lembert sutures the amount brought together was surprising.

#### PRESENTATION OF SPECIMENS.

Dr. Stimson presented the following :

CASE I. — Gunshot wound of brachial artery, which resulted in a traumatic aneurism and necessitated ligature of the brachial.

CASE II. — Carcinoma of uterus in which abdominal hysterectomy had been performed, after previous ligation of the uterine and ovarian arteries. He specially referred to the value of atropia sulphate, 1-75 gr., as preventive of shock. This he had first brought to the notice of the profession some five years ago and attributed its action to a paralyzing effect on the inhibitory nerve. The patient had been subjected to previous etherization for examination purposes and the resulting shock was almost fatal. Before the operation, 1-75 grs.

of atropia was administered and the patient recovered from the operation with little or no shock.

CASE III. — Two specimens in which gastrotomy had been performed for carcinoma ; in both these cases the stomach had been drawn up to the incision and fixed there in order to secure union of the peritoneum and the following day the stomach was opened. Both patients had died as a result of their disease.

#### NOTES.

For angina pectoris and coronary degeneration Prof. Janeway recommends the following :

R.—Glonoïn 1 % - - - - - m. j.  
Kali iodidi, - - - - - grs. x.  
Spts. am. aromat., - - - - - ʒ ss.  
Spts. ether co., - - - - - ʒj.

Sig.—t. i. d.

The beginning of this year has seen the establishment of the Bellevue Training School for male nurses. A magnificent building has been donated for this purpose, by the Hon. D. O. Mills. The institution is probably the first of its kind in America, and is intended to train male nurses in a somewhat similar manner as the females are now trained. The term of service is two years ; during that time the pupils receive free board and washing and a salary of \$15 per month. Their work in the wards is supervised by experienced female nurses, who are graduates, and besides the training they receive in the hospital, they are compelled to attend a full course of lectures on the various subjects. At the end of their service, if proficient, they receive a diploma, and efforts will be made to keep them supplied with private cases. From all accounts the experiment is, so far, a decided success ; the necessary number of applicants have been secured, and the condition of the wards of the hospital has been much improved. As yet it is in its incipiency, but if successful, it will doubtless be followed by similar institutions throughout the country.

Prof. Lusk recently performed cesarean section for rachitic pelvis, the outlet of which was so narrow that it was with difficulty that a vaginal examination could be made. The child was saved, but the mother, after lingering for about a week, died of asthenia. The autopsy showed that the uterine incision was perfectly healed and no evidences of septicæmia could be observed. Prof.

Lusk has now performed four cæsarean sections, with the record of three recoveries and one death.

For the relief of lumbago, Prof. Janeway, in a recent clinic, advised the use of antipyrine in 10 gr. doses, or 5 grs of antifebrine three times a day, and from the use of these remedies he had obtained the best results. If there was a gouty history in connection with the case, he combined them with colchicum; if rheumatic, with the salicylates.

For the disinfection of suppurating wounds of all kinds, Prof. Phelps uses a saturated solution of hydrogen peroxide. A piece of absorbent cotton is dipped in the solution and then laid on the sloughing surface; this is repeated three times a day until the pus disappears. The peroxide has the advantage, besides being an excellent antiseptic, of being entirely innocuous.

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### Selected Articles.

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#### B-NAPHTHOL IN ENTERIC FEVER.

In B-naphthol we have found a substance very insoluble, and having at the same time sustained and powerful antiseptic properties. Moreover, it is only toxic in large doses—about eight ounces in the twenty-four hours for an adult of average weight—while forty grains distributed over the twenty-four hours are sufficient to keep the intestinal contents aseptic. But whilst giving naphthol it is also advisable to control the pyrexia that necessarily occurs in the course of typhoid, and so prevent the damaging effects on the tissues and organs of the body of a long-continued high temperature; we should therefore together with naphthol administer an antipyretic, preferably perhaps antifebrin or phenacetin, whenever the temperature rises beyond a certain height, say 102° F.

The drug is given suspended in milk, and a small quantity of pure milk is taken after the dose. The doses must be administered frequently in order to keep up a constant effect, and small doses have also the advantage of not giving rise to the pungent after-taste in the throat that naphthol is apt to produce. To adults it may be administered in gelatine capsules, or the following formula, which seems the most satisfactory after several trials, may be made use of: R—B-naphthol gr. xx., Tr. aurantii ℥ ij, Syr. limonis ℥ss, Mucilaginis tragacanthi ℥ iij, Aq. ad ℥ vj. Dose, ℥ j.

Taste, however, is practically abolished in most cases of enteric fever, and the patients to whom I gave it in milk make no complaint on this score.

Out of seven cases, four, of whom two were boys of twelve, took the drug in doses of 3½ grains every two hours during the whole course of the disease, until the temperature remained normal for five or six days: one boy aged ten took gr. iss instead of gr. iij doses. In two cases the naphthol had to be discontinued before the termination of the fever. In addition antifebrin or phenacetin was administered in the manner stated above. The patients' ages varied from ten to thirty-two years. Taking first the five cases in which naphthol was given throughout the illness, the average duration of fever, reckoned from the first appearance of spots to defervescence, was thirteen days. Diarrhœa was in all slight, and the stools became at once very much less offensive than before naphthol was given, though still retaining the characteristic appearances and alkaline reaction of typhoid evacuations; there was never more than a moderate degree of abdominal distension, this symptom, when in marked degree on admission, showing diminution in a few days. The tongue cleaned early, and there was not the usual degree of dryness of the lips and mouth, nor of the dirty brown fur so often found on the tongue towards the end of the second week and succeeding the period of fever. Enlargement of the spleen was not detected in four of the cases, and only in slight degree in one. There was certainly less pain and tenderness in the abdomen than is generally found, and no albumen was present in the urine.

As to temperature, it followed the usual course, the highest range being from 103.5°–104.8° F. There was a varying amount of bronchitis. One of the boys complained in the third week of the disease of pain in the stomach after his milk, so the naphthol was stopped for two days, and was then continued without further trouble.

It might certainly be anticipated that naphthol in checking the abnormal fermentations taking place in the alimentary canal, would also hinder the normal fermentative process of digestion, and give rise to dyspeptic disturbance. Although I believe that this does not occur in the majority of cases, in the two following instances the use of the drug was stopped on this account. The first patient, a girl of twenty-three, was admitted with irregular rises of temperature ranging from 101°–103.4°, but with no spots or other symptoms of enteric fever. The stools, dark, liquid, and offensive, were rendered at once almost odorless by the administration of naphthol. After eight days she improved, and the temperature became normal during the two following days; it then began to rise, and the typical symptoms of an attack of typhoid developed themselves, the spots appearing on the seventh day from the commencement of the rise of temperature; on the fifth day of this period the naphthol, which had been steadily taken from

the day of admission, was discontinued on account of its exciting pain and vomiting. The vomit consisted of a large amount of very firm hard curd, barely corroded by the gastric juice, indicating perhaps that the action of pepsin was interfered with.

In the second case a relapse occurred eleven days after defervescence from a mild first attack; the patient had been taking naphthol during the whole twenty-three days occupied by the first attack and subsequent apyrexial period, and appeared to be convalescent, until a severe relapse occurred lasting four weeks and nearly proving fatal. On the sixth day of the relapse there was much pain in the lower part of the abdomen, considerable distention and vomiting; naphthol was therefore stopped, and the pain and distention became less, whilst the vomiting ceased on the following evening. The stools became very much more offensive after the drug was discontinued. In these two cases naphthol certainly seemed to excite gastric disturbance; if it had been discontinued for a day or two, it might perhaps again have been given without further trouble, as in the case of the boy mentioned above; but one did not like to run the risk of exciting a return of the sickness. Both these patients made a good recovery. It was disappointing to see in the first case a typical attack of enteric fever developing, and in the second a relapse occurring, in these patients who had been taking naphthol regularly for some time previously, for on the theory on which its use is based, relapse especially should be prevented. The aim of the plan of treatment being to put a stop to the growth and further multiplication of the virus in the alimentary canal, and in this way to prevent constant fresh supplies of toxic material—whether actual micro-organisms or the poisonous products of their life-action—passing into the general circulation and maintaining the morbid process, one chief test of the practical value of the method would be the non-occurrence of a recrudescence of the disease. In these two instances, in spite of the administration of naphthol, the bacillus appears to have maintained its injurious activity unimpaired.

One point came out prominently, namely, that convalescence was more rapid than usual, and that the patients were less reduced in strength than is generally the case. I should like also to call attention to the absence of albuminuria, of any but the slightest degree of splenic enlargement, and of secondary complications. The disinfection of the stools, as shown by loss or reduction of offensive odor, might also reduce the risk of propagation of the disease to nurses or attendants. The author concludes:

(1) That the production of intestinal antiseptics is a rational mode of treatment of enteric fever, and that B-naphthol is a safe and tolerably efficient

agent for this end. (2) That by its use in the above cases the duration of the disease was shortened, and the intensity of the symptoms directly arising from profound disturbance in the alimentary canal was lessened. (3) That the tendency to the occurrence of splenic enlargement, albuminuria, and of secondary complications such as boils, abscesses, etc., of purulent infective origin, is diminished. (4) That complete convalescence is more speedily and satisfactorily attained: and that there is less risk of a propagation of the disease to others. Finally we must bear in mind that in some patients naphthol may excite so much gastric disturbance as to prevent its use.—J. M. Clark, in *Practitioner*.

#### ANTIPYRINE DURING THE FIRST STAGE OF LABOR.

In an article published in this Journal for July 14, 1888, Dr. Egbert H. Grandin, visiting surgeon to the Maternity Hospital, called attention to the use of antipyrine in the first stage of labor. He stated that he had used it for the past year with gratifying results, and that the pains were rendered much less severe, while at the same time the progress of the labor was not interfered with.

In accordance with Dr. Grandin's suggestion, and during his term of service, Dr. T. H. Rockwell, house surgeon at the Maternity Hospital, used it in each case of labor where applicable. The first dose was given when the os was about one-third dilated, except in cases where the pains were very severe from the outset, when it was ordered earlier. Antipyrine, gr. xv, and spt. ammon. aromat., ℥ xxx, were administered every two hours during the first stage for three doses. The temperature and the pulse were noted at the time the first dose was administered, and every hour thereafter until dilatation was complete.

In almost every instance the patient said she felt greatly relieved, and this was evident from her behaviour. In some cases the patient would fall asleep for an hour or so after the first or second dose. These observations were all the more important since the class of patients delivered in the hospital includes many nationalities and social conditions, conspicuous among them being many Polish Jewesses and Bohemians, who, as a rule, are very restless and demonstrative during confinement, and the effect on these was quite noticeable.

Incidentally it was observed that generally the temperature fell from half a degree to a degree and a-half F. The pulse became somewhat more frequent and the respiration slightly increased. Occasionally, if the pulse was rather rapid before administering the drug, it decreased in frequency. Thus an ordinary case taken from the history-book shows:

At 4.45 a.m., patient's temperature was 98.6° F., pulse 100; 5 a.m., patient was given antipyrine, gr. xv, spt. ammon. aromat., ℥ xx; 6 a.m., temperature 98.2°, pulse 68; 7 a.m., temperature 98.2°, pulse 68. Patient was given antipyrine, gr. xv, spt. ammon. aromat., ℥ xxx. 9 a.m., temperature 99°, pulse 64; 10 a.m., temperature 98°, pulse 80.

CASE II.—1 p.m., antipyrine, gr. xv, spt. ammon. aromat., ℥ xxx; 1.20 p.m., temperature 98°, pulse 64, respiration 20; 3 p.m., antipyrine, etc., repeated; temperature 97.4°, pulse 66, respiration 19; 4 p.m., temperature 97.4°, pulse 70, respiration 19; 5 p.m., temperature 97.2°, pulse 68, respiration 22.

In order to ascertain the effect of antipyrine in decreasing or lessening the duration of labor, comparative statistics were taken where the drug was not and where it was used. Comparing a number of consecutive cases (of primiparæ) where the drug was administered with a similar number of same cases where it was not, we obtain the following data:

*Primiparæ with Antipyrine.*

First stage.	Second stage.	Operation.
Hrs. min.	Hrs. min.	
12 20	35	
18 55	1 35	
8 30	2 40	Low forceps.
17 30	45	
6 40	2 45	Low forceps.
16 50	1 40	
10 45	2 45	Low forceps.
5 30	30	
17 00	2 10	Low forceps.
11 55	30	
15 00	50	
10 00	1 35	
8 00	2 00	
Ave. 12 13	1 34	Forceps, 4.

*Primiparæ without Antipyrine.*

First stage.	Second stage.	Operation.
Hrs. min.	Hrs. min.	
10 00	3 25	Low forceps.
25 15	15	
9 35	10	
9 00	3 00	Low forceps.
11 45	1 15	
20 00	2 35	
12 40	1 50	
3 20	1 10	
15 45	1 20	
3 05	1 05	
26 40	30	High forceps.
11 25	2 45	Low forceps.
6 50	45	
Ave. 12 43	1 33	Forceps, 4.

From the preceding data it is apparent that antipyrine does not increase the duration of labor, but, on the contrary, tends to lessen this stage on an average of about half an hour, while the second stage remains practically the same, and in no case was there any injury done the mother or child.

Thus we see that the results of carefully kept statistics go to substantiate the statement made by Dr. Grandin, namely, that antipyrine very materially lessens the severity of the pains during the first stage without increasing the duration of the labor and without in any way injuring either the mother or child. The drug has never given rise to alarming symptoms, and this immunity is doubtless due to the fact that we have always associated it with a stimulant, and further to the fact that during labor there exists a physiological stimulation of the heart's action.—Dr. Van Winkle, in *N. Y. Med. Jour.*

**THE DISINFECTATION OF PHYSICIANS' CLOTHING.**—A simple, ready method is needed—and an inexpensive one as well. The man busy in practice will shirk cumbrous devices. If he has but to hang his suit on a hook, touch a light to a dash of alcohol, and close a door, he is altogether likely to carry out his good resolutions, and sterilize his clothing after each exposure. The galvanized iron closet devised by Dr. Chas. Jewett, which I have used for some months with much satisfaction, meets these indications. Certain modifications suggested by experience are added in this description. Few houses have spare closets which can be kept empty for this purpose, or so placed that fumes escaping would not greatly inconvenience the occupants of the remainder of the floor. But the metal box may be placed in any desired position, as in the yard or under the front steps. The disinfectant used is sulphur. The employment of dry heat at 230° Fahrenheit for one or two hours is impracticable by any simple method which does not require watching. Steam saturates, and might cause shrinking. Chlorine acts only in the presence of moisture, under which condition the colors and texture of fabrics will be affected. Sulphuric acid gas is efficient, inexpensive, and easily produced. It is endorsed by the writers on hygiene, by the national and local health boards, and by the Committee on Disinfectants of the American Public Health Association in their exhaustive report (Dr. Sternberg, Chairman, in *Phil. Med. News.*) Half an ounce is all that is required by the cubic air space of this closet, but I usually throw half a pound into the bowl to ensure the most complete saturation, and to allow of some leakage. An ounce of alcohol ignites the sulphur readily. More than a small quantity of alcohol should not be used, for fear of the flames leaping up high—although danger of igniting the clothes is obviated by the screen.

The closet should be six feet high, two feet wide, and eighteen inches deep. A shorter closet brings the clothing down on the screen. The screen is made of ordinary mosquito wire gauze. The openings are kept as small as they conveniently may be. Should the upper door not close tightly, a piece of cloth larger than the door can be placed on its inner side and lapped back over its edges, although this has not been found at all necessary in practice. Four hours' exposure of the clothing in this closet is probably sufficient, but the suit may well be hung up in the evening and left over night. It may be worn again in the morning without needing to be aired; in such cases the wearer scents sulphur faintly for some hours, but no one else is conscious of the odor. The cost of this closet is about \$13.—Dr. Dickinson, in *Brooklyn Med. Jour.*

**SHOCK.**—Dr. Cheever first describes this surgical condition, and then continues contrasting primary and secondary shock as follows:

Primary shock; reaction early and perfect, or slow and imperfect. Secondary shock: prostration, nausea, excitement, collapse. Loss of blood from accident or operation, adds to the shock, or complicates its symptoms.

Jar, crushing, mutilation, pain, cutting, bleeding, chilling, all act on the nervous system; react on the ganglia, the heart, the power of breathing, the temperature, the consciousness, the life.

Given then the problem and the phenomena of shock, what particular influences have the operative procedures of modern surgery upon them?

They may be summed up in three points:

1. The effects of anæsthetics.
2. The effects of the operations.
3. The effects of the dressings.

These all belong together and affect each other. Anæsthetics annul pain, but end in nausea.

Operations under anæsthetics are needlessly prolonged and exhausting.

Modern dressings are tedious and chilling

Have we lessened or added to shock by modern surgery?

Pain and bleeding are less. Slow cutting, nausea, exposure, low temperature are more. Primary shock is diminished; secondary shock is increased.

He then asks and answers the following question:

What can we do to prevent or diminish shock?

- (1) Wait for reaction.
- (2) Never neglect to calm those suffering mental shock by a cheerful word and personal presence.
- (3) Give alcohol, either spirits or wine, a quarter of an hour before the anæsthetic.
- (4) Make the anæsthesia short; never begin it until everything is ready; suspend it during less painful dressings. Consciousness returns tardily.

We keep up the anæsthetic longer than is necessary.

(5) As rapid an operation as can prudently be done.

(6) As short a dressing as is practicable.

(7) As a cardinal point, avoid chilling the patient.

To promote reaction after the operation:

(1) Persistent and carefully applied dry heat. (Be over-careful about accidental burns.)

(2) Liquid nourishment, combined with a stimulant and a little laudanum, by enema.

(3) Subcutaneous injection of brandy.

(4) Aromatic spirits of ammonia by the mouth. Champagne is sometimes retained when other things are rejected.

(5) Black coffee and brandy, the stimulant *par excellence*, when it can be retained on the stomach.

(6) Quiet: a horizontal, or more than horizontal position; sleep; assurance that all is over, and doing well.

Modern surgery has won three great triumphs:

It substitutes sleep for pain.

It averts secondary hæmorrhage by the animal ligature.

It prevents fermentation by germicidal applications.

Can we add a fourth by stilling the nervous system, and averting, or diminishing secondary shock?

—Dr. Cheever, *Boston Med. and Surg. Jour.*

#### THE PATHOLOGY OF PERNICIOUS ANÆMIA.—

The article is a *resume* of a recent contribution by Dr. Wm. Hunter to the *Lancet*. Space is wanting for more than a summary of the results of the investigations, and some short comment upon them. In the first place, he concludes, pernicious anæmia is to be regarded as a special disease, both clinically and pathologically. It constitutes a distinct variety of idiopathic anæmia. 2. Its essential pathological feature is an excessive destruction of blood. 3. The most important pathological change to be found is the presence of a large excess of iron in the liver. 4. This condition of the liver serves at once to distinguish pernicious anæmia, post-mortem, from all varieties of symptomatic anæmia, as also from the anæmia resulting from the loss of blood. 5. The blood-destruction characteristic of this form of anæmia differs both in its nature and its seats from that found in malaria, in paroxysmal hæmoglobinuria, and other forms of hæmoglobinuria. 6. The view can no longer be held that the occurrence of hæmoglobinuria simply depends on the quantity of hæmoglobin set free. 7. On the contrary, the seat of the destruction and the form assumed by the hæmoglobin on being set free, are important conditions regulating the presence or absence of hæmoglobinuria in any case in which an excessive disintegration of corpuscles has occurred. 8. In

paroxysmal hæmoglobinuria the disintegration of corpuscles occurs in the general circulation, and is due to the rapid dissolution of the red corpuscles. 9. In pernicious anæmia the seat of disintegration is chiefly the portal circulation, more especially that portion of it contained within the spleen and liver, and the destruction is affected by the action of certain poisonous agents, probably of a cadaveric nature, absorbed from the intestinal tract.—*Ed. Jour. Am. Med. Assoc.*

**THE USE OF TEREbene.**—In the *N. Y. Med. Jour.*, Dr. D. M. Cammann reports a number of cases of bronchitis and other lung affections treated by the use of terebene, from 15 grains to  $\frac{1}{2}$  drachm being given three times daily. Of these cases thirteen were of bronchitis, most with more or less pleuritic adhesions. Three were acute bronchitis, ten emphysema, two asthma and bronchitis, ten phthisis, one pleurisy, and one of the third stage of pleuro-pneumonia. Two of these—both cases of acute bronchitis—were cured, one in four and the other in eleven days. Thirty-three cases were improved, most of them markedly, but a few only to a slight degree. Five were unimproved, two of the patients being obliged to discontinue the drug after two or three days, as it produced vomiting. The shortest time the treatment was continued in any case was four days, the longest time six months. The average length of treatment was a little over twenty-six days. Most of the patients took 15 minims, and some as much as  $\frac{1}{2}$  drachm, in a mucilaginous mixture, four times daily. In all except three the cough was improved, becoming softer and less frequent. In twenty-six the quantity of the expectoration was lessened, in four it was unchanged, and in two it was increased. The latter were under treatment only one week, and it was found in some of the other cases that the expectoration was increased for the first few days and afterwards diminished. In seventeen cases the expectoration became thinner and more watery; in six it was no thinner. In the other cases no note was kept in regard to this point. In those troubled with dyspnoea it was diminished in eight. The patients noticed an increase in the urine in nine cases; no increase was noticed in fifteen. In many of the cases the appetite improved. In two cases the terebene caused vomiting, in two nausea, in one dizziness and nausea, and in two dizziness. These symptoms usually disappeared when the dose was reduced. It is beneficial in affections of the bronchial mucous membrane, both acute and chronic. It relieves the dyspnoea of emphysema, it is readily borne by the stomach, and it seems to have a resolvent action on pleuritic adhesions.—*Therap. Gaz.*

**TREATMENT OF POST-PARTUM HÆMORRHAGE**—In the presence of sudden and abundant hæmorrhage

*post-partum*, Dr. Ségournet administers powdered ergot, freshly prepared, introduces the carefully disinfected hand quickly into the uterus and compresses the aorta (which is easily recognized by its pulsations) between the fingers and the vertebral column. The hæmorrhage is arrested at once. Pressure is maintained as long as possible, and is not relaxed until an aid compresses the aorta through the abdominal walls and shuts off the circulation below. If hæmorrhage does not recur the hand is not introduced into the uterus again, but the compression of the aorta through the abdominal walls is maintained for some time, occasionally even an hour or more. The advantages of this method are that it requires no instruments, which are so likely either not to be at hand or to be out of order, and that it is easily and quickly applied, and perfectly trustworthy.—*An. de Gynéc.*

**COCOANUT AS A VERMIFUGE.**—Referring to the recent statement of Professor Pariso as to the vermifuge properties of the cocoanut (*Pharm. Journ.*), a correspondent of the *Times of India* writes that the cocoanut has been used as a vermifuge in India for probably forty generations by the beef-eaters of the country, and is so well known there as a means of expelling the fat worm that he cannot conceive how information of this fact has not reached England before. When properly prepared and intelligently administered, so says this writer, the cocoanut is equally efficacious with male fern oil, koussou, pomegranate-root, or turpentine, while it is as pleasant to the palate as they are offensive. He is of the opinion that this is only one of the many valuable Indian remedies that would become better known to the European practitioner if an edition of the *Pharmacopœia of India* were published, properly brought up to date.—*Pharm. Journ.*, 1888.

**ALBUMINURIA IN RELATION TO LIFE INSURANCE.**—At the recent annual meeting of the Association of American Physicians, held at Washington, the subject of renal disease was dealt with by several members from various points of view. One of the most practically interesting papers was read by Dr. James Tyson, of Philadelphia, and referred to the significance of albuminuria in respect to life insurance. The writer pointed out that in certain cases candidates presenting this symptom might be accepted, although he would draw the line rigidly at those who, in their general health, in the fact that no casts accompany the albumen, in the small quantity of the latter, and the high specific gravity of the urine, present no evidence of structural kidney disease. When the specific gravity is above 1020, the assumption is that the albuminuria is functional; if it be 1010, it would be hazardous to accept such a case, however good his health may be, even in the absence of casts.

Of course, evidence of cardiac hypertrophy with albuminuria would suffice to exclude the candidate; nor if a patient suffering from albuminuria were over forty years of age should he be accepted unless he has long been under observation. The subjects of true gout were also recommended as unfit, seeing their liability to renal disease.—*Lancet*.

**THE DIETARY OF ASTHMATICS.**—Asthmatics, from necessity, become spare feeders, and are often very thin. In so many cases a heavy meat meal is followed by an attack that a restricted dietary is inevitable. To certain asthmatics certain articles are specially injurious, while to others they are not so.

The dietary which suits most asthmatics best is that which limits them to two meat meals, viz., breakfast and lunch or early dinner, and restricts their food for the rest of the day to liquids, with only bread, toast, or biscuits as solids; the great principle being that the asthmatic should retire to bed with gastric digestion quite complete, and thus preclude any pressure upward against the diaphragm from flatulent accumulations in the stomach. Where there is much dyspepsia, and especially where flatulency occurs immediately after meals, it is advisable to omit sugar and starch from the dietary and to avoid potatoes, and in these cases a little alcohol in the form of whiskey, or brandy and water, should be taken with lunch or dinner. Coffee is generally a suitable beverage, and should be taken at least once a day, black, as it distinctly lessens the spasm without rendering the patient sleepless, whereas tea, though it is a product of the same natural order of plants, acts in a different way and often increases the neurosis. Various extracts, such as Brand's and Valentine's, and strong beef-tea, especially when taken warm, are excellent, as they are easily assimilated, and enable the patient to get over the asthmatic attack without great prostration.

It need hardly be added that all articles of food which are in themselves more or less indigestible, such as pastry, pickles, uncooked vegetables, salads, garlic, and fruit, except when perfectly ripe, and we may add cheese in its various forms, and richly dressed or highly flavored dishes, are to be strictly avoided.—*Dietetic Gaz.*

**TREATMENT OF PNEUMONIA BY DIGITALIS.**—M. Petresco has treated a large number of cases of acute pneumonia with great success by the administration of four grams of digitalis leaves in infusion every half hour, by mouth. The infusion is prepared with 4 grams of digitalis leaves to 200 grams of water and 40 grams of syrup. The disease is generally checked in three days. The fever and all the physical phenomena, local as well as general, disappear rapidly. In spite of the large doses he has never seen poisonous effects,

tolerance having been incontestably proved by 577 observations. By this treatment it is claimed that the mortality of pneumonia has been reduced to 1.22 per cent.—*Lyon Med.*

**CAPILLARY ASPIRATION OF THE BLADDER.**—This was one of the subjects brought before the Society of Naturalists, at Cologne, by Drs. Rosenberger, of Wurzburg, and English, of Vienna. The first speaker remarked it was a procedure warmly recommended by Lücke, and he wondered that it was so little practised. The operation was easily performed. Any kind of aspirator could be used, and a fine needle no thicker than an ordinary knitting needle passed into the bladder above the symphysis in the *linea alba*. When all the fluid was evacuated the canula should be removed, with a sudden jerk. By this means no bleeding took place, especially if care was taken to keep the sides of the canal together until they adhered. Of course all antiseptic precautions should be made use of. In old people it was sometimes necessary and frequently useful. It often happened that when aspiration had been performed two or three times the patient could micturate naturally, or a catheter could be introduced, when before such a thing was impossible. It was a procedure generally indicated in retention of a passing character, and when catheterization set up violent hæmorrhage from the urethra. The pain from the operation was slight, frequently less than was caused by introduction of a catheter. Dr. English, of Vienna, said he had never practised capillary aspiration of the bladder, and criticised the procedure adversely as both unnecessary and dangerous.—*Med. Press and Circular.*

**TANNIN IN PHTHISIS.**—Dr. de Viti Demarco, of Otranto, has found that large doses of tannin will reduce the temperature of phthisis, and will sometimes produce a most beneficial effect on the course of the disease. He prescribes it in the form of a pill, to be taken every two hours. Each pill contains seven grains and a half of tannin, with a quarter of a drop of creasote. In one case, where there were cavities in the left apex, the whole of the lung being affected, the temperature rising as high as 40° C. at night, apyrexia was obtained in twelve days, and at the end of three months the general condition was much improved, the cough and expectoration being greatly lessened, the weight having increased, and there being an entire absence of fever. Notwithstanding the prolonged use of the tannin, no unpleasant symptoms were produced by it.—*Lancet.*

**ERGOT IN INCONTINENCE OF URINE IN CHILDREN.**—A writer in the *Medical Analectic* says that he has been using for many years the fluid extract of ergot in the treatment of incontinence

of urine in infants and children, and almost regards it as a specific for the disease. He prefers to give it simply, and to treat separately any conditions of the patients that may require therapeutical aid to correct those states of physical debility which either predispose to incontinence of urine or aggravate its presence. He gives to an infant from one to three years old, five to ten drops; and to a patient from three to ten years, ten to twenty drops every three hours. Few children object to its taste, and it should be continued uninterruptedly for two or three weeks, and resumed if the disease should return, in which case the doses ought to be gradually increased.—*Med. Rec.*

**PUERPERAL ANÆMIA, AND ITS TREATMENT WITH ARSENIC.**—After a brief reference to the literature of the subject, the writer gives in full the history of a case which did well under the plan of treatment indicated. He then continues:—To Bramwell, of Edinburgh, the profession is indebted for pointing out the almost specific action of this drug in certain cases of pernicious anæmia. The statistics collected by Padley a few years ago, show forty-eight cases treated without arsenic, of which forty-two died. Of twenty-two cases treated with arsenic, sixteen recovered, four died, and two improved. Within the past few years, numerous observations have shown the powerful effect of arsenic in certain cases. Unfortunately, we do not yet fully understand why, in some instances, the drug should be well borne and prove successful, while in others the patient continues in the progressively downward course. That the cases which we group as pernicious anæmia are very varied is now recognized by all writers on the subject. It is not to be expected that when the gastric tubules are atrophied, arsenic can be curative. We need a careful study of those instances in which the drug has proved successful and of those in which it has failed. To judge from therapeutic test alone there must be a very deep-seated difference between the two classes. I know of nothing more remarkable in practical therapeutics, nothing so resembling specific action (unless we except iron in chlorosis and quinine in ague) than the rapid recovery of profound anæmia under this drug. As a rule it is well borne, and should be given, as Bramwell advises, in increasing doses, beginning with five minims, and rising gradually to twenty or thirty, three times a day. Puffiness of the eyelids, œdema above the eyebrows, vomiting or diarrhœa, indicate that the drug should be suspended for a time, or the dose reduced. It is interesting to note that the existence of vomiting or diarrhœa does not, however, contraindicate the employment of the medicine, as in the case here reported. These symptoms seemed to improve, for a time at least, when the arsenic was first given. If the Fowler's solution disagrees, arsenic

acid may be tried. I have known it to be well borne when the liquor arsenicalis disturbed the stomach. The drug may be given hypodermically, but in these instances of profound anæmia the tendency to hæmorrhage is so marked that the punctures may become hæmorrhagic. I have known considerable subcutaneous extravasation follow an injection. The point of the greatest importance is the fact that the medicine must be given in increasing doses, and for prolonged periods. I find practitioners express great surprise when they hear of doses of Fowler's solution, of fifteen, twenty, and twenty-five drops three times a day. There is, I think, but one rule in the matter; give the drug cautiously until physiological effects are produced. The tolerance of the system for arsenic is well known. I have never seen serious consequences from its careful administration. Young persons, as a rule, take it better than adults. In an instance of pernicious anæmia which I reported a few years ago, the patient took twenty minims of Fowler's solution three times a day for weeks, with the most satisfactory results. In post-partum cases recovery is always slow. It may be many months before perfect health is restored. It is well to intermit arsenic for a few weeks; but the drug should be given at intervals for many months, even when the health is apparently re-established, as there is a well-recognized tendency in these cases to relapse.—Prof. Osler, in *Bost. Med. and Surg. Jour.*

**THE DIRECT APPLICATION OF COPAIBA IN GONORRHŒA.**—Having read, some time ago, a short article by Dr. I. H. Stearns, of Mansfield, Mass., on The Abortive Treatment of Gonorrhœa, in which he advised the direct application of copaiba balsam, I decided to act upon his suggestion. Hence, the first case that presented itself to me was subjected to that treatment. It was a young man, who, six days previously, had been exposed to contagion. On the evening before I saw him he had noticed slight burning on urinating, and the next morning the burning had increased, and a thin, yellowish discharge had appeared. On examination, I found the meatus reddened. I smeared a No. 23 steel bougie with balsam of copaiba and introduced it down as far as the membranous portion of the urethra, and allowed it to remain for six or eight minutes. At noon of the same day he noticed that the scalding, on making water, had diminished, and on the following morning there was no trace of a discharge. The second morning I again introduced the balsam-smeared bougie. A third application was made on the fourth day, although he considered himself cured. Four or five weeks after he called on me about another matter, and assured me that no symptom of gonorrhœa had appeared since. I have tried the above plan of treatment since in eight cases



of gonorrhœa in the first stage, and in all but one obtained like results. The exceptional case was that of a young man, who insisted upon drinking large quantities of beer and having intercourse with his mistress on the second night after beginning treatment. In gleet I have obtained no beneficial results at all. This I attributed to the fact that, in the majority of cases, a gleet is kept up by a stricture. When the stricture is cured the gleet disappears; all other treatment is but palliative. It seems but natural that copaiba would manifest its curative properties to more advantage when applied directly, than when compelled to travel through the system first; for, when taken by the stomach, the volatile oil passes off by the lungs, while the copaivic acid is excreted by the kidneys. There is usually a slight burning sensation experienced immediately after the passage of the bougie, but this passes off in a few minutes. Of course the ordinary restrictions in eating and drinking must be observed.—Dr. Rively, in *Med. Reg.*

**TUBERCLE BACILLI IN THE SWEAT OF PHTHISICAL PERSONS.**—Dr. Eugenio di Mattei reports, in the *Archive prio le Scienze Mediche*, a number of experiments made to determine the possibility of transmitting tuberculosis through the medium of the sweat. In the first series, in which the sweat was taken from the skin without any precautions, numbers of tubercle bacilli were found. In the second series the author cleaned carefully a portion of the integument, covering it subsequently with a glass to prevent possible contamination from the air, and then examined the sweat excreted on this part. Here no bacilli were found, showing that the micro-organisms found in the first instance were deposited upon the skin from the surrounding atmosphere, and that none passed through the sweat-glands.—*Med. Rec.*

**INCONTINENCE OF URINE IN CHILDREN.**—Dr. J. E. Clark, one of Brooklyn's most celebrated physicians, and President of the Medical Board of St. Peter's Hospital, stated to us recently, that he had been almost universally successful in treating this unfortunate malady by dilating, once in a while, the urethral canal with the ordinary sound. Our experience has convinced us of the value of this method.—*Am. Med. Dig.*

**DR. ESGUIVE**, Colonization physician to the Paris-Lyons-Mediterranean Railway, Bon-Medja, France, March 28, 1887, says: "I tried BROMIDIA (Battle) on two cases of insomnia, which I had already treated for some time, with a mixture of equal parts of bromide of potassium and chloral. I noticed that hypnotic results were produced with much smaller doses of BROMIDIA than of the mixture of bromide and chloral. In a large

number of cases it is important not to push too far the quantity of bromide of potassium. On this account I believe BROMIDIA is destined to be of real value, particularly in insomnia of cardiac origin, and I deem it vastly superior to the simple mixture of bromide of potassium and chloral."

**LEUCORRHOEA IN CHILDREN.**—In cases of leucorrhœa in children, where injections cannot be used, Professor Parvin recommended pencils of iodoform (containing three or four grains each), to be introduced into the vagina, or—R. Argenti nitratis, gr. v; aquæ, f ʒ j. M. Sig.—To be dropped between the labia.

## HEADACHE.

FORM	TREATMENT SUGGESTED.
1. Anemic.	Amyl., Bella., Fe., Menthol, Quin.
2. Biliary.	Ammon. Chl., Hg., Mag. Sulph., Podoph.
3. Cardiac.	Cactus. Dig., Glonoin., Strophanth.
4. Catarrhal	Acon., Potas. Iod., Puls., Duboisine.
5. Cerebral Softening.	Anodyne, Ergot.
6. Cerebral Tumor.	Ergot. Potass. Iod.
7. Cinchonism.	Bromides, Iodides.
8. Congestive, active.	Acon., Erg., Morph., Pod., Salines.
9. Congestive, passive.	Aq. ferv., Dig., Potass. Acetat.
10. Climateric.	Cimicif., Ver. Vir., Sulphur.
11. Constipation.	Aloin. Cascara, Hg., Nux Vom., Pod.
12. Diabetic.	Potass. Brom., Valerian.
13. Dyspeptic.	Bryon., Guarana, Nux Vom., Sod. Salicyl.
14. Fevers.	Acon., Antipy., Did., Gels., Ver. Vir.
15. Gouty.	Colch., Salicyl.
16. Hemicrania.	Antipy., As., Can. Ind., Dig., Gels.
17. Hemorrhoidal.	Cascara, Sulphur.
18. Hysterical.	Asaf., Camph., Hyos., Val. of Zn.
19. Idiopathic.	Caffeine, Guarana, Bromides.
20. Inebriate.	Bromides, Camph. Monobrom., Chloral, Hyos., Pilocarp.
21. Migraine.	Antip., Brom., Ergot, Glonoin. Menthol.
22. Meningeal.	As. et Op., Frigus Gels.
23. Menstrual.	Am. Mur., Antipy., Gels., Pierot., Viburn.
24. Malarial.	Ars. et Bell., Gels., Quin., Am. Picr.
25. Nervous.	Bromides, Gels., Guarana, Strych., Zinc.
26. Neuralgic.	Antipy., Caffein., Gels., Phosp., Quin.
27. Optical.	Correct the vision. Rest.
28. Ovarian.	Am. Mur. Gels., Viburn.
29. Periosteal.	Potass. Iod.
30. Periodical.	Ars., Can. Ind., Gels., Quin.
31. Plethoric.	Alkalies, laxatives.
32. Rheumatic.	Colch., Pot. Iod., Salicyl.
33. Sick.	Caff. Citrat., Guarana, Nux Vom., Sod. Phosph.
34. Syphilitic.	Hg., Pot. Iod., Stillingia.
35. Toxemic.	p. r. n.
36. Uremic.	Elater., Morph., Pilocarp., Podoph.
37. Uterine.	Bella., Cimicif., Viburn.
38. Worms.	Salicyl., Vermicides, Vermifuges.
39. Zymotic.	p. r. n.

BENJ. EDSON, M.D., in *Medical World*.

# THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science  
Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Address, DR. J. L. DAVISON, 12 Charles St., Toronto.

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*The LANCET has the largest circulation of any Medical Journal in Canada.*

## DIDACTIC LECTURES.

Our valued contemporary, the *Canadian Practitioner*, in the January number, is "surprised" at the course taken by this journal, in opposing very strongly any reduction in the full course of didactic lectures, now, as we think very wisely, required by the Medical Council of Ontario, on the principal subjects, primary and final. We would be even more "surprised" could we, for any reason whatever, advocate the slightest abridgment of this very essential part of medical study. Our contemporary asks, "Shall students be compelled to listen twice to the same set of didactic lectures?" We answer without the least hesitation, and we believe that the vast majority of both good students and teachers will endorse our answer, that two courses are not too many on any important subject; and further, we add, that no good teacher gives just the same set of lectures twice. They are, or should be, so modified and improved every year, as to be full of interest. And we venture the opinion, that nine out of every ten lecturers, whose teaching powers amount to anything worthy the name, will bear out the general opinion of teachers and students, that the first course is of far less value to the student than the second, for the first only lets him know how to profit fully by the second course. And that after having attended both he can read at home, and receive clinical instruction at the hospital to advantage, for he

knows how to read with profit, and can understand the cases he sees. We care not how much the practical instruction given is extended—the more of this the better—but we feel convinced, and that from an experience of over sixteen years, actual teaching in Toronto, that any curtailment in the number of lectures now given in all the important subjects, would be a step in the wrong direction. Believing this, we can never advocate the views advanced by our esteemed contemporary, and again repeat, that it would be an evil day for medical education in Canada if such change should by any possibility be made.

We had almost omitted to correct an error into which the *Canadian Practitioner* has fallen, in quoting "McGill University" as in favor of reducing didactic lectures to a single course on each subject. We have it on authority, that whatever may have fallen from any individual member of the Faculty, in giving his own views, the Faculty, as such, has not only come to no decision, but has not, as yet, even considered the matter.

## TREATMENT OF PRURITUS.

There is no more troublesome disease, or rather symptom, for the general practitioner than pruritus. Correspondents to the *Lancet* send the following suggestions, which will be interesting and useful to our readers:—

H. W. J. suggests that an undiscovered diabetic or inflammatory or cystic disorder of the cervix uteri will often render a pruritus vulvæ intractable. Barring these important causes, he should try the fifty per cent. ointment of ichthyol with lanoline. Surgeon, presuming there is no gout or uterine disease, recommends a mixture containing sod. bicarb., mag. sulph., and inf. gent., to be taken three times a day in sufficient quantities to keep the bowels moderately open. Also the following lotion, to be applied on linen cloths three or four times a day:—R Liq. plumbi, 1 drachm; pulv. boracis, 3 drachms; zinci. oxid., 2 drachms; glycerine, 2 ounces; water to sixteen ounces. No alcoholic drink to be taken. Mr. Henry Ryley (West Brompton) has during a practice of thirty years found the disease yield to an outward application of the following:—Liq. plumbi, liq. op. sed. (Battley), ung. cetacei, and pure cream from the cow, of each one ounce. The ingredients must be well

mixed and dispensed in a wide-mouthed bottle, to admit the fingers. Mr. J. F. Briscot suggests a systematic examination of the external and internal organs of generation for tinea, animal or vegetable, vascular caruncle, and other possible sources of irritation within the vagina or rectum, and an examination of the rectum. Dr. Thursfield (Leamington) asks if cocaine, either as a lotion or an ointment, has been tried. He suggests that the condition of the os and cervix uteri be ascertained, and that coffee be forbidden. Mr. J. C. Balfour (Redbourne) suggests that relief may be obtained by bathing the parts with a solution of boracic acid in water, or a lotion composed of hydrochlorate of morphia, hydrocyanic acid, and water. Bromide of ammonium given at night as a sedative has also been found useful. Mr. H. E. Rowell (East Rudham) suggests, if no cause for the disease can be found, great cleanliness, and a lotion containing glycer. boracis, 2 ounces; water to 6 ounces. He also observes that in the 1888 edition of the "Univesal Merdical Sciences" a sitz bath of hot salt water (from one to five per cent.) just before retiring and an ointment of cocaine oleate and lanoline to be applied twice a day, are recommended by Piffard. Mr. Percy Newell (Ipswich) recommends a careful regulation of the diet and the use of vinolia. The following lotion is, he says, recommended by Dr. Atthill, in his work on "Diseases of Women":—Acid. carbol., 20 grains; tinct. opii, 4 drachms; acid hydrocyan. dil., 2 drachms; glycerine, 4 drachms; water to 4 ounces. Mr. J. Wrixon (Watford) says that he has found the following prescription effectual:—Ung. plumb. hyd. nit. ox., and acid. borac., of each 2 drachms; cocaine (1 to 30),  $\frac{1}{2}$  ounce; ft. ung. This is to be gently rubbed on night and morning for a month, and the parts bathed in a lotion composed of two teaspoonfuls of borax to a pint of cold water. A strong infusion of green tea is also useful. R. W. W. suggests a trial of the following lotion:—Liq. ammon. acet., 1 drachm; acid. hydrocyan. dil.,  $\frac{1}{2}$  drachm; inf. tabaci to 8 ounces. The parts subject to irritation to be bathed two or three times a day. The inf. tabaci to be made by infusing sixty grains of bird's-eye tobacco in boiling water for a quarter of an hour. Ixion recommends vinolia, which, he thinks, will allay the irritation at once. The preparation is said to consist of zinc, antiseptics, etc.

## TESTS FOR HYDROCHLORIC ACID IN THE GASTRIC JUICE.

Not long ago we called attention in an editorial note to the fact, then said to be established, that the gastric juice of persons suffering from cancer of the stomach contains no hydrochloric acid. This conclusion was arrived at by many competent observers, especially among the Germans. It has been lately confirmed by M. Labord, Vechaeiff, of St. Petersburg, (*Jour. de Méd. de Paris*) has decided that the absence of the acid in the stomach and œsophagus in cases of cancer is the rule and that its presence is the exception. He used a number of tests, some of which we give, hoping they may prove of value to those of our readers who may be in doubt as to cases of gastric trouble, as well as to the most approved recent methods of testing for Hcl.

1. Aqueous solution of tropeoline. This solution, which is yellow, becomes dark cherry-red when in contact with a liquid containing  $\frac{1}{1000}$  part of hydrochloric acid.
2. Methyl violet. This becomes blue with a solution containing  $\frac{1}{1000}$  part of Hcl.
3. Congo paper. This also becomes blue when immersed in a solution of Hcl similar to the preceding.
4. A mixture of three drops of a saturated aqueous solution of carbolic acid. This mixture takes a yellow color with lactic acid, but becomes colorless in the presence of free hydrochloric acid.
5. Günzburg proposes the following, which must be preserved in the dark:

Vanilline . . . . .	1 gram.
Phloroglucine . . . . .	2 "
Alcohol. . . . .	30 "

By gently warming the liquid to which the reagent is added, a crimson red color is produced if the liquid contains Hcl, even in the most minute quantity, no change is produced by the presence of lactic acid. Germain Sée speaks very highly of this last test, while M. Laborde thinks the Methyl violet is equally as reliable as this last.

## RICH DISPENSARY PATIENTS.

A note to the *Br. Med. Journal* gives the case of a man, who, "owner of twenty cabs, four vans, a greengrocer's and dairy combined, has had his

medicines from a dispensary at sixpence per bottle for several months past." This condition of affairs is not, by any means, confined to London, or the old-world cities. Here in Toronto, patients come to the extern at the General Hospital for free advice and medicine, who, if we may judge by their appearance, are well able to pay for both. Females, who would be indignant if not called "ladies," clad in furs, neither scant nor inexpensive, with nodding ostrich plumes, silks and satins even, present themselves unblushingly, while many a poor wretch, having still pride enough to abhor the position of a mendicant, shuns the hospital and dispensary, and thus wants the much-needed advice and medicine for which he is truly unable to pay. It seems to us that a little judicious discrimination by members of the extern staff would be conducive to a better state of things in this department of the hospital. In only one case do we remember having seen the doctor question a patient's ability to pay, and when it was found that said patient was by no means a pauper, he was very properly sent for advice where he would have to pay for it. If patients can afford to wear ostrich feathers and gold bracelets, they can assuredly afford to pay for the services of a profession which does more charity work than any other body of men in the world.

#### PRIVATE HOSPITAL.

We are pleased to be able to announce that Dr. Temple is about to open a private hospital for the treatment of medical and surgical diseases of women. This is a want long felt in both the City of Toronto and throughout the Province of Ontario. When we regard the great success that has attended such institutions in England, in the hands of such men as Mr. Lawson Tait and others, we feel it but right they should be encouraged. Many patients, especially among the better classes, are averse to entering a general hospital although the department for diseases of women is entirely separate. To the profession must be apparent the great advantages and better prospects which the private hospital affords the patient. The doctor has secured a comfortable building and fitted it up with all modern improvements and the best of sanitary arrangements. He has also secured, as matron, a very competent nurse, a graduate of the Nurses' Training School, Toronto, and who has been for a

long time in the Woman's Hospital, New York, and we are sure patients coming from a distance will find in the institution every home comfort. From the doctor's past experience in the treatment of the various diseases of women, and his long connection as Professor of Gynæcology in Trinity Medical College, he has had abundant opportunities of perfecting himself in this special department. It is expected this institution will be open for the reception of patients by the 1st February, and with Dr. Temple as its head, with his able assistants, we may confidently expect good work. We wish the enterprise every success.

#### PORTRAIT OF DR. JOSEPH WORKMAN.

One of the most pleasing events which have ever marked the history of the Toronto Medical Society, took place at a recent meeting of that body, when the members presented Dr. Joseph Workman his portrait. The venerable Dr. has the admiration, and we might almost say love, of all who know him. No man perhaps, in the profession to-day, stands so high in the esteem of his brethren. His great attainments and the noble career he has so long pursued are well known, not only to the profession of which he has been for so protracted a period, an ornament, but also to the laity generally. We heartily wish the veteran Dr. God-speed and trust that his valuable life yet may be spared for years, to continue the grand work in which his energies have never flagged, nor his devotion grown cold.

ON THE NECESSITY OF STERILIZING THE URINE OF TYPHOID PATIENTS.—It is a matter of great importance, and one which is perhaps not sufficiently attended to, that the urine of patients suffering from enteric fever should be disinfected, as well as the excreta. Many observers have doubted the presence of the bacilli in the urine, but the following, by Dr. Konyaeff (*Lancet*), goes to show the absolute certainty of the presence of these bodies in the kidneys, in not a few cases, at any rate, of typhoid. The Dr., with the aid of Dr. Uskoff, has made researches "on the microscopic structure of some little nodules found in the kidneys of typhoid-fever patients, in twenty-one cases out of 120 *post-mortem* examinations of bodies dead of this disease, in the Alexandroff Hospital in St. Peters-

burg, during the year 1887. The preparations were stained with a solution of methyl in dilute spirit and fuchsine in a 5-per-cent. solution of carbolic acid. In all the cases examined there were found in the centre of the nodules colonies of slightly colored bacilli precisely like those of typhoid. No others were seen. In two cases these were successfully sown in nutrient jelly, and from them a double kind of colony was developed exactly like typhoid colonies. Potato cultivations were also reared, and the microscopical examination of these left no doubt that the jelly cultivations were cultivations of true typhoid bacilli."

COMPRESSED TABLET TRITURATES.—The advantages of prescribing such powerful remedies as aconite, morphia, arsenic, etc., in the form of triturates, are becoming more obvious, now that physicians have had some experience in administering medicines in this way. We have no faith in the potency, homœopathically speaking, of triturates, yet we can readily appreciate the benefits to the patient of giving medicines in a state of minute subdivision. Their accuracy and convenience in administration, coupled with the absolute freedom from danger in prescribing, always attending to a greater or less extent, the dispensing of dangerous drugs, in the form of powders, drops, or large doses in solutions, is one sufficient reason for their popularity. We have, for some time, used the tablets prepared by John Wyeth & Bro., of Philadelphia, and can vouch for their efficacy and convenience. They are, we believe, absolutely exact, and will keep indefinitely with little or no danger of loss; they can be readily swallowed with a mouthful of water; or, if smaller doses be required for infants, the tablets can be reduced to a fine powder, by simply crushing with a knife or the thumb nail.

ANTIPYRIN IN MENSTRUAL COLIC.—Dr. Windelschmidt, *Med. Chir. Rundschau*, states that thirty grains of antipyrin administered as an enema proves an excellent sedative in menstrual colic, its action ordinarily occurring within half an hour, although in some cases the injection had to be repeated after twelve hours. In two cases where, after nearly every well-known method of treatment had failed, to prevent most violent pains and colic lasting through eight days of menstruation, injections of antipyrin in the morning and evening

produced the most wonderful success; usually this relief was accompanied by narcotic effects, the patients falling asleep, and waking entirely free from pain; no unfavorable symptoms occurred, with the exception of profuse sweating and frequently slight ischuria. For prevention of collapse a glass of wine is ordinarily administered.

DEAFNESS.—Kent O. Foltz, M.D., in an article on Otolology (*Am. Med. Jour.*), draws attention to the use of the tuning-fork as a means of differentiating between deafness caused by disease of the external or the middle ear, and that caused by disease of the internal ear. Strike the fork on some non-resonant body, and hold it close to the external and auditory meatus. The vibrations are scarcely perceptible. Strike it again, and hold the end of the handle on the mastoid process, when the vibrations are distinctly heard. Therefore the disease is in either the outer or the middle ear. If the outer ear is healthy, then the middle ear must be examined. If the patient is deaf, and hears the tuning fork better by ærial than by bone conduction, the difficulty is almost always in the inner ear or labyrinth.

ASPHYXIATION BY ILLUMINATING GAS.—The following rules were given at a recent meeting of the American Gas Light Association, of Toronto, for the treatment of persons overcome by gas:

1. Take the man at once into fresh air. *Don't* crowd around him.
2. Keep him on his back. *Don't* raise his head, or turn him on his side.
3. Loosen his clothing at his neck and waist.
4. Give a little brandy and water—not more than four tablespoonfuls of brandy in all. Give the ammonia mixture (one part aromatic ammonia to sixteen parts water) in small quantities, at short intervals—a teaspoonful every two or three minutes.
5. Slap the face and chest with the wet end of a towel.
6. Apply warmth and friction if the body and limbs are cold.
7. If the breathing is feeble or irregular, artificial respiration should be used and kept up until there is no doubt that it can no longer be of use.
8. Administer oxygen.

THE ILL-EFFECTS OF PROLONGED HIGH TEMPERATURE.—The saying, that "prolonged high temperature kills" has been denied by Professor Pott, of Halle, who, at a recent meeting of Ger-

man naturalists and physicians, held at Cologne, said that high temperatures do not constitute a permanent danger to patients, and that he is inclined to consider a considerable degree of fevers is beneficial rather than otherwise. He believed that the pyrexia killed the microbes if long enough continued. He did not believe in antipyretics in eruptive fever and pneumonia, and would give baths only so far as was necessary to promote the functions of the skin.

**UTERINE HÆMORRHAGE.**—Dr. Scudder, in his work on Diseases of Women, says:—"In passive uterine hæmorrhage I have placed more dependence upon *carbo. veg.*, 2d dec. trituration, than upon any other remedy, though, of course, it is not adapted to all cases. I give it in grain doses every one to four hours, and usually follow it with the tincture of *cuprum* as a blood-maker." No experimenter has ever discovered a solvent for this drug, hence we cannot account for its probable action in such a manner.

**GONORRHOEA.**—Dr. McPherson (*Am. Med. Jour.*) has had great success in treating gonorrhœa in the male by injecting a 1% solution of muriate of cocaine every three hours, which is held in the urethra for a few minutes each time, the canal being will cleansed before its use by injections of tepid water. He also gives internally:

R.—Mag. Sulph., . . . . . ʒij.  
Pulv. cubebæ, . . . . . ʒij.—M.

Sig.—ʒj. morning and evening in a wineglass of water. This is to keep the bowels open and the urine bland, thereby preventing constipation with pelvic congestion.

**SIMPLE TEST FOR ARSENIC.**—The following is simple and reliable, *Am. Jour. Pharm.*:—"To the suspected liquid is added, in a test tube, a solution of caustic potash or soda, and then a fragment of aluminium. The mouth of the tube is then closed with a paper moistened with a solution of nitrate of silver. If arsenic be present, the paper turns black. Aluminium is preferable to zinc, for the latter may contain arsenic, whilst aluminium is always free from it.

**TUBERCULOSIS FROM COWS.**—The report of the Sub-Committee, appointed by the Dominion Parliament, to inquire into the possibility of the com-

munication of tuberculosis from animals, has been handed in. It goes to show that the opinion of prominent medical men is that the disease may be communicated to man through the flesh and milk of cows. It is now in order that legislative precautionary measures be taken.

**THALLIN IN GONORRHOEA.**—This remedy is an antiseptic as well as an antipyretic. It has been successfully used by the Germans in the treatment of gonorrhœa. An injection of the strength of 1 or 2% of the tartrate is used once a day. It may be used from the very commencement of the attack, but should be continued some time after the discharge has ceased.

**TERPIN IN BRONCHITIS.**—The following formula by Chéron (*Monde Pharm.*) is spoken highly of as not producing gastric disturbance if given after meals:

R.—Terpin . . . . . 75 grains.  
Glycerin . . . . . }  
Alcohol (of 95 per cent) . . . . . } āā 2-2½ ounces.  
Syrup of honey . . . . . }  
Vanillin . . . . . 4 grains.—M.

One tablespoonful contains about seven grains of terpin. Two tablespoonfuls are given daily to loosen and finally diminish expectoration.

**FOR UTERINE HÆMORRHAGE.**—The *Rev. Therap.* gives (*Med. News*) the following formula for uterine hæmorrhage:

R.—Extract of Indian hemp . . . 7½ grs.  
Fluid extract of ergot . . . . . 1 drachm.  
Fluid extract of hamamelis,  
Tr. of cinnamon . . . . . āā ½ ounce.—M.

Sig.—One teaspoonful three times daily.

**HEADACHE.**—Dr. Bringier (*Med. Surg. Rep.*) says that the following prescription is valuable:

R.—Antipyrin, . . . . . gr. xv.  
Pot. Bromidi, . . . . . gr. xv.  
Tr. Digitalis, . . . . . gtt. vij.  
Aq. ad. . . . . ʒ ss. M.

Sig.—Take at once.

This is the adult dose. It is adapted to headaches of fevers, cerebral congestion, migraine, and headaches of hysterical women.

**GLANDULAR AFFECTIONS.**—S. J. Mays, M.D., in the *Am. Med. Jour.* speaks very highly of the use of calcium chloride in glandular affections of the neck. The dose is from two to four grains for

children, and from ten to twenty grains for adults, the best vehicle being the syrup of sarsaparilla.

THE "OCCIDENTAL MEDICAL TIMES" is the new title of the journal hitherto known as the "Sacramento Medical Times." The journal has been enlarged to fifty-six pages and the subscription price is to be reduced to \$2 per annum, beginning with the number for January, 1889.

ELECTION OF MEMBERS TO THE HAMILTON HOSPITAL BOARD.—Drs. Miller and Malloch were recently elected to the acting staff of the above hospital, and Drs. McKelcan and McCargow as members of the consulting staff.

FOR FRECKLES.—The *Ph. Post* gives the following:

White precipitate,  
Bismuth subnitrate,  
Ointment glycerine, equal parts.  
Use thrice daily.

TOOTHACHE.—The *Jour. de Med. de Paris* gives the following as useful:

R.—Acetate of morphia, . . .  $\frac{3}{4}$  grs.  
Essence of peppermint, . . . 4 drops.  
Phenic acid (pure), . . . 20 "  
Collodion q. s. to make, . . . 1 drachm.  
Apply with cotton.

TOXIC ACTION OF ANTIPYRIN WHEN PRESCRIBED WITH NITROUS ETHER.—A suit for malpractice against Dr. Castleman of Houston, Tex., is pending. Two or three other cases have been reported. Experiments by Dr. Ludwig Bremer and others fail to demonstrate the toxicity of the compound.

ALOPECIA IS CONTAGIOUS.—The report of the committee appointed by the Academy of Medicine, in Paris, to consider the question of the contagiousness of alopecia is such as to leave no doubt that they believe it is a contagious disease.

*Rev. Therap.* gives the following formula for constipation with hæmorrhoids:

R.—Glycerine, . . . . . 60 parts.  
Soap, . . . . . 10 "  
Fl. ext. of rhubarb, . . . . . 40 "  
Ess. of chamomile, . . . . . 10 drops. M.  
S.—Use as an enema three times daily.

FOR MIGRAINE.—Dr. Little (*Dub. Med. Science*) says he has had good results from twenty grains of salicylate of sodium in a wineglassful of water, made effervescent by the addition of a dessert-spoonful of effervescent granular citrate of caffeine. He has not found the latter alone efficient.

ARSENIC IN LEUCOCYTHÆMIA.—This remedy has been shown to increase the relative and absolute number of red corpuscles (*Lancet*) in a case of leucocythæmia. The remedy was employed in large doses, as much as one grain of the arsenious acid having been administered in twenty-four hours.

FOR THRUSH AND STOMATITIS.—The following is recommended (*Med. Brief*) for thrush and stomatitis:

R.—Acidi boracic. . . . . gr. x.  
Listerine, . . . . .  $\zeta$ jss.  
Glycerine, . . . . .  $\zeta$ ijss.—M.

S.—Use as a wash for the mouth every hour or two.

PERSONAL.—Dr. Price Brown has opened an office at the corner of College Street and Spadina Avenue, for the treatment of diseases of the nose, throat and lungs, exclusively.

PETERBOROUGH MEDICAL ASSOCIATION.—At the regular meeting of the Peterborough Medical Association, held on Thursday, January 3rd, Dr. J. H. Fife was elected President, and Dr. Fred. H. Brennan, Sec.-Treas., for the ensuing term.

APPOINTMENTS.—Dr. S. M. Henry has been appointed Associate Coroner for the County of Waterloo.

Dr. P. N. Davey, of Duart, has been appointed Associate Coroner for the County of Kent.

ANOTHER USE FOR ETHER DURING ANÆSTHESIA.—Dr. Hare writes to the *Univ. Med. Mag.* that if, during anæsthesia, respiration stops, he has found that in a large number of instances, both in man and in the lower animals, the free use of ether poured upon the belly causes so great a shock, by the cold produced by its evaporation, as to cause a very deep inspiration, which is often followed by the normal respiratory movements.

#### THE GASTRIC JUICE IN ACUTE FEBRILE DISEASES.

—Regarding the importance of feeding in acute infectious diseases, Dr. Gluzinski, of Cracow, has come to the following conclusions, *Deutscher Archiv of Klin. Med.*, as to the value of the gastric juice in such cases:—1. During the whole course of the fever (except in the final stage of typhoid fever) the gastric juice contains no hydrochloric acid. 2. The gastric juice digests neither in the organism—since it contains no pepsin—nor outside the organism. 3. This gastric juice digests very well, artificially, after the addition of the proper quantity of hydrochloric acid, which shows that it contains pepsin, and that the impossibility of digestion is due solely to the absence of hydrochloric acid. 4. With the disappearance of the fever, or somewhat later, the gastric juice becomes capable of digestion both within and outside the organism. In regard to the chronic febrile diseases, normal, digesting gastric juice exists during the fever.

Other things being equal, the nature of the gastric juice in febrile diseases is influenced more by the nature of the infection than by the high temperature. The possibility of a secretion of active gastric juice in chronic febrile diseases increases the hope of good results from forced feeding.

**EARLY EXCISION IN TUBERCULAR DISEASE OF THE HIP-JOINT.**—The London correspondent of the *Med. Rec.* says that Mr. Barker read a paper at the Medical and Chirurgical Society, in which "he urged that at a certain stage of the disease, the complete removal of the tubercular tissue ought to be possible. When treatment by rest had failed he would perform excision. He maintained that in many cases the wound ought to heal by first intention throughout, and often without drainage. He then related a case which he had successfully treated. The patient was a boy, five years of age, who had been under careful treatment for a year. The head of the femur was destroyed and an abscess of the usual kind had formed. Excision was performed, and primary union took place, without drainage, under one dressing. The patient left hospital on the fourteenth day, wearing a double Thomas' splint."

**TREATMENT OF TYPHLITIS.**—The following plan of treatment is recommended by Bouchard, *France Med.*—1. Alleviate the pain, either by injections of morphine or the application of belladonna oint-

ment under a hot poultice. 2. Wash out the large intestine by copious hot enemata, consisting of at least a quart of hot water in which ʒjss of borate of sodium is dissolved, or to which two or three teaspoonfuls of a mixture of equal parts of tincture of benzoin and spirit of camphor is added. 3. The patient must be kept absolutely quiet. 4. Only the mildest kind of purgatives, if any at all, should be used. 5. Food should consist of milk diluted with alkaline waters, with the yolk of an egg at a later period.

**THE USES OF GELSEMIUM SEMPERVIRENS.**—Dr. Garland concludes an article in the *Boston Med. and Surg. Jour.*, in which he speaks highly of the drug, as follows:—The dose of gelsemium depends upon the preparation used and the effect which one desires to obtain. For the relief of neuralgia one should give 3 to 5 drops every half-hour or hour, according to the intensity of the pain. To produce sweating, 1 drop every half-hour is sufficient, provided the patient be well wrapped up in bed; 1 drop of the fluid extract will relieve the cough and discomfort of acute bronchitis; the tincture of gelsemium sempervirens is slightly weaker than the fluid extract.

The advantages which gelsemium sempervirens can legitimately claim, are:—1. It has an agreeable taste, and is not repulsive to adult or child. 2. It does not irritate the stomach or bowels. 3. It produces no depressing after-effects from ordinary doses, the sleep is natural, and the patient awakens refreshed. 4. In ordinary doses it causes no depression of the heart, and it can be used in all forms of organic diseases of the heart. 5. It does not create a habit. There is no depression of nerve-centres following its use, and therefore no craving for more of it. 6. Its toxic symptoms are very characteristic and striking, and they appear early, so that plenty of warning is given. Morphine is the best antidote, combined with digitalis and artificial respiration.

**MASTITIS.**—In the Columbia Hospital for Women (*Obs. Gaz.*), a liniment composed of half an ounce of camphor, dissolved in three ounces of turpentine, has been found most effective in checking the secretion of milk in mastitis; it alleviates pain, lessens induration, and is more effective in reducing inflammation than any other remedy that has been tried.



## Books and Pamphlets.

A CLINICAL ATLAS OF VENEREAL AND SKIN DISEASES, by Robert W. Taylor, A.M., M.D., Surgeon to the Charity Hospital, New York, and to the Department of Skin Diseases of the New York Hospital; late President of the American Dermatological Association; Joint Author of Bumstead & Taylor's "Pathology and Treatment of Venereal Diseases." In eight very handsome imperial folio parts, with 58 full-page chromolithographic plates, containing 191 figures from original paintings, and selected from the works of Bæsensprung, Cazenave, Clerc, Cullerier, Tilbury Fox, Fournier, Hebra, Hutchinson, Kaposi, Mayr, Neumann, Ricord and Balmanno Squire, as well as numerous woodcuts from original sources, and from the works of Albert, Demarquay, Durkee, Gosselin, Guérin, Leloir, Marcacci, Montméja, Parrot, Parry, Profeta, Tillaux and Voillemier. Price, per part, \$3.00. Sold only by subscription. Specimen plate will be sent post-paid on receipt of ten cents in stamps. Montreal: The Canadian Subscription Co., 647 Craig Street.

In parts III. and IV. of Taylor's Atlas, we recognize again the hand of a master, both in the text and in the plates. The plates are as nearly life-like as plates can well be. As illustrations of the clinical character of eruptions they are without an equal, and those members of the profession who desire a thorough knowledge of the subject will do well to subscribe to the work.

CLINICAL LECTURES ON DISEASES OF THE URINARY ORGANS, delivered at University College Hospital, by Sir Henry Thompson, Surgeon-Extraordinary to H. M. the King of the Belgians, etc., etc. English edition. London: J. and A. Churchill; Toronto: Vannevar & Co.

The chief additions to this wonderfully useful and popular book "relate to the supra-pubic operation for stone and tumor; to the results of digital exploration of the bladder; to the most recent modes of affording relief by operation in cases of advanced prostatic disease; to the latest operative treatment for tumors of the bladder; and embraces a *résumé* of my entire experience of operations for calculus, made up to the end of the year 1886, numbering about 900 cases."

Those who know the former editions will be pleased that so great a master has given to the world the latest advances in the surgery of his

domain. The work before us consists of 470 pages, the size and usefulness being greatly increased. Every practitioner should have it.

THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE RECTUM, by Wm. Allingham, F.R.C.S.E., Senior Surgeon to St. Mark's Hospital, etc., etc. London: J. & A. Churchill.

In this fifth edition, anatomical and pathological questions are entered into only when essential to diagnosis and treatment. It embraces, in a revised form, all that appeared in former editions, and special chapters have been written on "Inguinal and Lumbar Colotomy," "Excision of the Rectum," and "Incontinence of Fæces." The illustrations are good and most of them have been drawn by H. W. Allingham, F.R.C.S.E., the son of the author. Many forms of rectal disease obstinately resist all treatment hitherto available, therefore a work so comprehensive and essentially practical in character will be of great service in the every-day work of the general practitioner; and, being minute in its description of operations, it cannot fail to commend itself to the surgeon.

THE VEST-POCKET ANATOMIST. Founded upon "Gray." By C. Henri Leonard, A.M., M.D., Professor of the Medical Diseases of Women and Clinical Gynæcology in the Detroit College of Medicine. *Fourteenth revised edition*, containing 193 illustrations, "Dissection Hints" and Visceral Anatomy. Cloth, 12mo., 304 pages. Price, \$1.00. Detroit: Illustrated Medical Journal Co. Toronto: Carveth & Co.

This useful little work has been increased by about 100 pages. It will no doubt be as popular as heretofore.

FAVORITE PRESCRIPTIONS OF DISTINGUISHED PRACTITIONERS; with Notes on Treatment. Compiled from the Published Writings or Unpublished Records of Drs. Fordyce Barker, Robert Bartholow, Samuel D. Gross, Austin Flint, Alonzo Clark, Alfred L. Loomis, F. J. Bumstead, etc. By B. W. Palmer, A.M., M.D.

This number of Treat's Medical Classics gives a large number of the most careful prescriptions known. It should be very useful to the busy practitioner.

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## Births, Marriages and Deaths.

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At Port Hope, January 28th, Dr. M. Lavell of Smith's Falls, Ont., to Maggie Shepherd of Smith's Falls, Ont.