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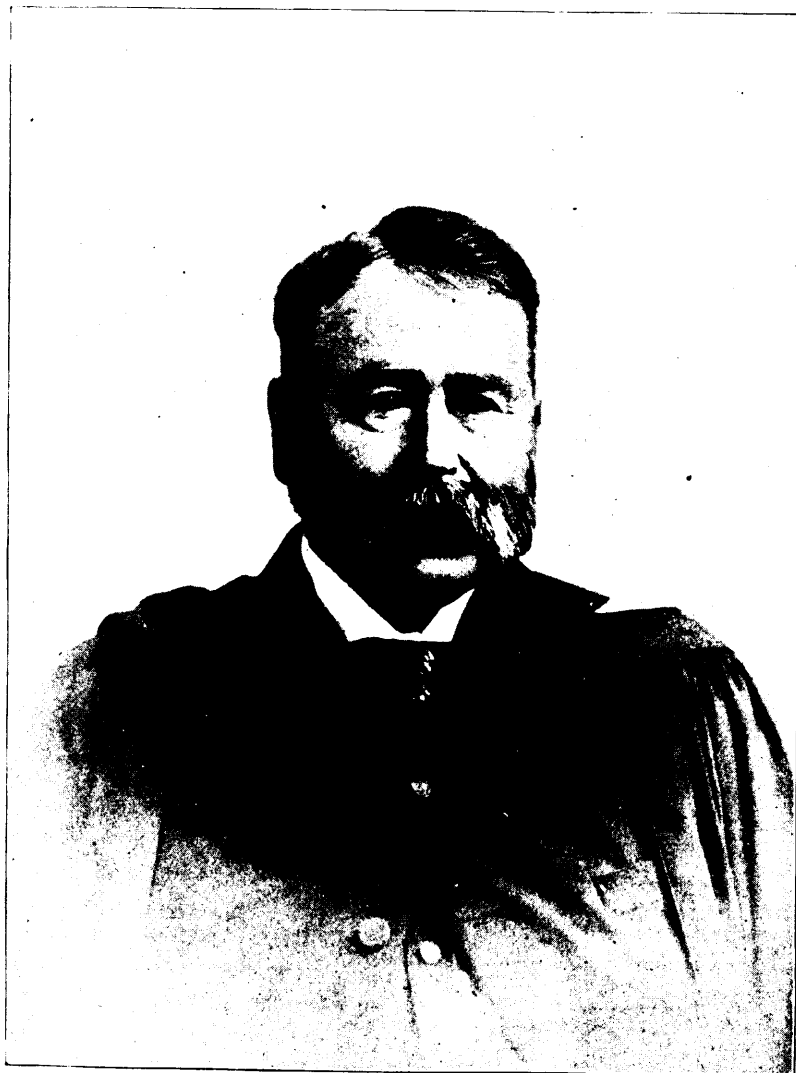
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DR. LAUGHLIN M'FARLANE.

The Canada Lancet.

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TWO CASES OF MOVABLE BODY IN THE KNEE-JOINT.

BY GEO. A. BINGHAM, M. B., TORONTO,

Associate Professor of Clinical Surgery, Trinity Medical College, Toronto.

CASE I.—J. T., æt. 46, a foreman printer, consulted me on January 7th, 1895, in reference to a difficulty in the left knee-joint. The history he gave was as follows: Both father and mother suffered from rheumatism as long as he can remember. His only sister is also a sufferer, and he himself has had occasional light attacks during the last ten years. About six months ago he noticed the knee somewhat larger than its fellow, and it appeared to him as though fluid was present in the joint. From that time onward he wore an elastic knee-stocking, and though the knee would feel very tired after a day's work, he did not trouble himself further about the matter. Two months after his first observation, while walking home from his office, he was seized with a sudden unbearable pain in the joint, fell to the pavement and had to be assisted home in a carriage. When I saw him an hour later, he was lying comfortably in bed, with his leg flexed almost to a right-angle, and he declared he would not extend it for the world, as it would bring back the pain. Suspecting a movable body in the joint, I failed to discover it on manipulation, and gradually extended the limb. Explaining the probable nature of the case, I urged him to watch carefully for the foreign body, and if he discovered it or had another seizure, to let me know.

He declined to consider operative procedure at this time, and I saw no more of him until he called at my office on January 7th, when he said he had had three additional attacks since the first one in September last, and was able at times to

feel a movable body at the inner side of the patella. He had begun to dread the recurring attacks so much, that he had called to ask me to remove the offending mass. On examination, the joint gave evidence of fluctuation, and there was a difference of one and a-half inches in the circumference of the two joints. By manipulation, combined with flexion and extension, I was able after some time to locate the body at the inner border of the patella. Taking care that he had carefully weighed the possible dangers of the operation, I removed it the following day at his home. Using cocaine anæsthesia, I made an incision parallel with the inner border of the patella down to the body, which I was able to locate, and, by firm pressure with the fingers, to hold in position. Seizing it with tenaculum forceps, I slightly incised the synovial sac and squeezed the body out of its position into the wound, at the same time giving exit to a considerable amount of synovial fluid.

The body—measuring three-quarters inch long, half inch broad and half inch thick—was still held by a narrow pedicle, which was snapped off close, the wound flushed with bichloride solution, the synovial incision closed with two fine catgut sutures, the superficial wound closed with silk-worm gut, the surface dusted with iodoform and covered with iodoform gauze. Plenty of aseptic dressing and absorbent cotton was placed over this, and a fairly firm bandage completed the dressing. The limb was placed on a posterior splint and union by first intention resulted.

Just fifteen days afterwards the limb was en-

cased in a light plaster-of-Paris bandage, which he wore for a fortnight, during the last week of which he was at his work. The joint has returned to its normal size and he has had no further trouble.

CASE II.—J. F., æt. 40, consulted me on April 16th, in reference to a pain in the left knee. The family history given was excellent. Absolutely denies any tubercular or syphilitic taint. Enjoys good health, with the exception of a large goitre, which somewhat interferes with breathing at times. All her teeth have recently been removed, having decayed very rapidly of late years. Patient is stout and anæmic. A few weeks ago, while turning in bed, she suddenly felt an intense pain in the knee, the leg became flexed and she was unable to extend it for an hour. Her knee was sore for a day or two, but she went about as usual. Ever since that time she has had occasional attacks, which invariably occur when she is sitting or lying down; no difficulty when walking about.

On examination, I was able to locate the foreign body over the external condyle of the femur. Explaining the difficulty, she begged for the operation, which was done under chloroform (the patient being exceedingly nervous) on April 18th. The body was the size of a large bean. In this case, also, the deep wound was closed with catgut and the superficial wound with silkworm gut.

On the 5th day, indications of suppuration were present and the superficial stitches were removed. Burrowing of pus continued in spite of every effort. From time to time counter openings were made and the sinuses packed with iodoform gauze, after being flushed out thoroughly from day to day. Dr. Teskey, in consultation, agreed with me that some cachexia must exist, possibly syphilitic. Under large doses of the iodide she improved considerably in health, but the local condition has not appreciably improved. Up to this date (May 24th) the synovial sac does not appear to be invaded, the deep wound having evidently united. The case is still under treatment.

The origin of these bodies, as described by Barwell in his work, is as follows:—

1. Hypertrophy of and changes in synovial fringes, which by pressure may become converted into a cartilagenous mass.

2. Metamorphosis of extra-synovial tissue by inflammatory changes, the resulting mass being gradually forced into and ultimately becoming free within the synovial sac.

3. Osteophytes growing from the end of the bone, intruding into the joint cavity and working loose.

4. Effused fibrin or blood-clot deposited in the joint, as the result of injury, and becoming organized.

5. Eochondrosis — growth of a pedunculated tumor from an articular cartilage.

6. Portions of normal cartilage detached by injury; and we may add,—

7. Detached semilunar cartilage.

I am anxious to know if the experience of others coincides with my own experience and observation, viz.: that this condition occurs most frequently in those with some cachexia. I am inclined to think this is true in classes 1, 3 and 5, and that it should modify our treatment somewhat.

In cases where a gouty, rheumatic, tubercular or syphilitic tendency is discoverable, I shall hereafter hesitate to operate; at all events, before submitting my patient to a thorough course of constitutional treatment, and this I shall persistently carry out after operation.

The points in the operative treatment which I wish to emphasize are:—

1. Rigid asepsis. By this means we will reduce to a minimum the mortality given by Barwell, of 21 per cent.

2. Defer opening the synovial sac until the body is isolated and controlled.

3. The smallest possible opening in the sac, consistent with the removal of the body.

4. Closure of the deep wound by independent absorbable sutures.

5. Fixation of the limb after operation.

6. Finally, the patient must decide voluntarily in favor of the operation, after due consideration of possible danger.

AFTER much smoking the mouth feels like a furnace. To relieve this add to half a tumblerful of water a teaspoonful of a solution of salol, 4 grains; tincture of catechu, 20 minims, in an ounce of any nice aromatic tincture and use as a wash.—*Chemist and Druggist.*

FIVE YEARS' EXPERIENCE WITH THE COLD-BATH TREATMENT OF TYPHOID FEVER.

BY WILLIAM OSLER, M.D.,

Professor of Medicine in the Johns Hopkins University, Baltimore.

During the first year of the hospital service, typhoid fever was treated symptomatically. The number of severe cases admitted was unusually large, and there were eight deaths among thirty-three patients—a percentage of 24.2. For the past five years, ending May 15th, 1895, systematic hydrotherapy has been used—the method of Brand, with certain minor modifications. In the first Report (Vol. IV.) the plan was given; but I may repeat here that each patient receives a tub-bath of twenty minutes at 70° every third hour, when the rectal temperature is at or above 102.5°. Frictions are applied in the bath, and a warm drink or a stimulant is given afterwards. In a large proportion of the cases no other treatment is employed. If the pulse is feeble whisky is given, and strychnia. The diet is either wholly milk or in part broths, and egg albumen. It may be noted that all the cases come under my immediate care, or, in my absence, that of Dr. Thayer, the Associate in Medicine.

In estimating the value of any plan of treatment, it is important that all circumstances should be taken into account. In the previous report I dealt with the statistics as so many patients admitted, of whom so many died; and this, I think, should be done in all institutions—give the total number of cases of each disease treated to a conclusion, and the number of deaths, irrespective altogether of the length of stay in the hospital, or the condition on admission. General hospitals are everywhere liable to be repositories of the more severe or troublesome cases, and in typhoid fever, more particularly of protracted cases in which serious symptoms have developed late in disease. A high rate of mortality in any given acute disease may be an indication of a special usefulness of the institution. As already given, the general statistics of the hospital in typhoid fever are:

Cases admitted during the six years ending	
May 15th, 1895	389
Number of deaths	34
Percentage of mortality	8.7

Cases admitted before the introduction of hydrotherapy	33
Number of deaths	8
Percentage of mortality	24.2
Cases admitted since the introduction of hydrotherapy	356
Number of deaths	26
Percentage of mortality	7.3
Number of cases bathed	299
Number of deaths in the bathed cases	20
Percentage of mortality in the bathed cases	6.6

The percentage 7.3 represents the total mortality during the past five years; but as it does not represent the mortality of the cases treated by hydrotherapy, the figures must undergo a further analysis. Many circumstances interfere with the systematic carrying out of the plan, among which the following are the most important.

In the first place, a number of cases are admitted in the second week, and even in the third week, with a falling thermometer, and the fever constantly below 102.5°. Cases, too, are admitted early, which have low temperatures and mild symptoms throughout. Brand and others urge that these should also be bathed; but in a large proportion of all such cases, this seems superfluous. There are exceptions, however,—cases in which the fever is low on admission, and even remains low for a week or ten days, to be followed by active and threatening symptoms. Nos. XXII and XXIX of the fatal cases were of this kind, and in both one could not but regret that the baths had not been used from the outset. In the very mild cases, seen more frequently in private than in hospital practice, the baths are unnecessary. Last year we admitted an unusually large number of such mild cases.

In the second place patients are admitted late in the disease, and are too ill to bathe. A patient brought in at the end of the third week, with high fever, rapid, feeble pulse, meteorism, and diarrhoea, stands, I believe, a much better chance, with careful sponging, to reduce the fever, than

he does with tubbing every fourth or fifth hour, and the disturbance unavoidable in the lifting out of bed. There were five patients admitted in too feeble a condition to bathe, not one of whom died.

Thirdly, there is a group of cases which on admission present serious complications—hæmorrhage, signs of perforation, very intense bronchitis, pneumonia, pleurisy or intense meteorism with severe diarrhœa. On account of hæmorrhage the baths were postponed on several occasions. There was no instance in which on admission the pulmonary symptoms seemed to contraindicate the treatment.

Fourthly, there are cases which were not bathed at first because the diagnosis seemed doubtful. Two of the fatal cases, to which reference will be made shortly, were not recognized clinically as typhoid fever. Each autumn we have a certain number of cases of malaria which present features closely resembling typhoid fever—so much so that baths have been given. These are instances of the so-called æstivo-autumnal fever, in which the organisms may at first be difficult to find. In other instances with a strong suspicion of malaria for a day or two, the symptoms of typhoid fever have developed subsequently, but the temperature meanwhile has fallen below the bathing point. In several cases the condition at first resembled tuberculosis.

And lastly, the baths have been frequently changed to cold sponges, on account of hæmorrhage, profound weakness, tenderness and swelling of abdomen, signs of perforation, and in a few cases because of the active protestation of the patient. The sponging, when thoroughly done, is almost as formidable a procedure as the cold bath; indeed, we have had patients ask to have the baths resumed.

The following are among the most important reasons which caused transient suspension of the method: Hæmorrhage, 13 cases; perforation, in which condition even sponging is rarely allowable, but in which the extremities may be bathed without disturbing the patient; on account of great weakness and prostration, 11 cases; on account of active mental symptoms, for one day in one case, for two days in another; for extreme tenderness of the abdomen, for one day, one case; for severe bronchitis, for intense laryngitis, after operation on abscess of parotid, for severe phle-

bitis, for pleurisy, each one case. In many of the fatal cases the baths were suspended for twenty-four, sometimes forty-eight hours before death.

There were several instances in which the symptoms of relapse were so slight that the treatment was not rigidly enforced.

Of the 356 cases treated during the five years, 299 were bathed, of these 20 died, a mortality of 6.6 per cent.

Of the 57 cases which were not bathed for various reasons, usually because of the mildness of the disease, six died, a percentage of 10.3. This high ratio of mortality in the unbathed cases is, of course, due entirely to the circumstance that conditions mentioned below, interfered with the use of the baths in a group of cases of unusual severity. In the six fatal cases, the histories of which are given in full in another place, in two, *Cases, XI and XVIII*, the diagnosis was wrong; in the one an old man of 70, with consolidation of the lower lobe, the disease was thought to be lobar pneumonia; and in the other, the patient had been in the hospital the year before with enterocolitis, and on re-admission with severe diarrhœa, typhoid fever was not suspected.

In *Case XXVII* the disease was at first thought to be tuberculous cerebro-spinal meningitis—the temperature was low, the nervous symptoms marked, and it was not until parotitis developed that our suspicions were aroused about typhoid fever.

In *Case XXVIII*, after twelve days of moderate fever, severe symptoms developed, with tympany and abdominal tenderness and diarrhœa. It was thought best to use the cold sponges; death was probably due to perforation.

In *Case XXXII* the patient was admitted, bleeding profusely from the bowels, and

In *Case XXXIII* the fever was low, only touching 104° at entrance, and subsequently not rising to bathing point. Death occurred from thrombosis of the middle cerebral arteries.

Two advantages are claimed for hydrotherapy in typhoid fever—a mitigation of the general symptoms of the disease, and a reduction in the mortality. Our experience during the past five years bears out these claims.

In general hospitals, to which cases rarely are admitted before the end of the first week, the full benefits of the cold bath, as described by Brand,

cannot be expected ; nevertheless, in any large series, the severer manifestations appear to be less common. As has been urged so often and so ably by many writers, the beneficial action is not so much special and antipyretic as general, tonic, and roborant. The typhoid picture is not so frequently seen, and we may have twenty or more cases under treatment without an instance of dry tongue or of delirium among them. It is a mistake to claim, as do the too ardent advocates of the plan, that severe nervous symptoms are never seen. I have taken the pains to go over carefully our records on this point. There were in the first three years thirteen cases, in the past two years nine cases with delirium. Most of these were protracted cases which had from 75 to 120 baths.

A far more important claim is that the use of the cold bath reduces the mortality from the disease. The comparison of death rates as a measure of the efficacy of any plans of treatment is notoriously uncertain unless *all* the circumstances are taken into account. In our own figures for the past five years, for example, illustrate this—6.2 per cent. in the bathed cases, 10 in the unbathed cases—as the latter group is made up entirely of cases entirely too mild to bathe, and six patients in whom either the disease was not recognized or who were too ill on admission to treat.

Statistics have a value in this connection only when the figures on which they are based are nu-

merous enough to neutralize in some measure their notorious mobility. Small groups of cases are useless ; 24 per cent. of mortality in our first year in thirty-three cases, and a series of nearly fifty bathed cases without a death, illustrate the liability to error in discussing a few cases. Unfortunately, typhoid fever is a disease in which the cases may be reckoned by hundreds and thousands, and the average mortality in general and special hospitals throughout Europe and America is easily gathered. The rate may be placed between 15 and 20 in each hundred cases. In the Metropolitan Fever Hospitals, London, the death rate as given in the Report for 1893, was 17 per cent.

The cold-bath treatment, rigidly enforced, appears to save from six to eight in each century of typhoid patients admitted to the care of the hospital physician.

While I enforce the method for its results, I am not enamored of the practice. I have been criticized rather sharply for saying harsh words about the Brand system. To-day, when I hear a young girl say that she enjoys the baths, I accept the criticism and feel it just ; but to-morrow, when I hear a poor fellow (who has been dumped like Falstaff, "hissing hot" into a cold tub), chattering out malediction upon nurses and doctors, I am inclined to resent it, and to pray for a method which may be, equally life-saving, and, to put it mildly, less disagreeable.

SURGERY

IN CHARGE OF

GEO. A. BINGHAM, M. B.,

Surgeon Out-door Department Toronto General Hospital; Surgeon to the Hospital for Sick Children. 68 Isabella Street.

CARCINOMA OF THE BREAST.

The first case I shall show you to-day is a carcinoma of the breast of two years' standing. The important point in the history of the case is the advice given—unfortunately too commonly—regarding the matter of operation. At that time the disease was in a small area situated near the surface, and close to the nipple. Her physician advised against operation until she began to suffer pain. This reminds me of a case in which a physician brought to me a woman suffering from very extensive carcinoma of the breast, and remarked that he had been observing it for about a year, and congratulated himself that he had brought her to me at just the right time for operation. While in the present case it is our object to relieve the patient of an ulcerating process, our main object is to prevent a recurrence of the disease. The ulcerative cases I look upon as less favorable than others for two reasons, viz.: (1) The opportunity for doing an aseptic operation is not so good; and (2) the presence of ulceration in the skin itself shows a tendency to skin involvement, and I think one is more likely to find the lymphatics of the skin involved to a greater or less extent than occurs in other cases.

The operation that I shall do will be the one that I have been employing for about a year past. It is a very extensive operation, and the object of it is to remove all the tissues that are apt to contain deposits of the disease, or are likely at some subsequent period to become the seat of recurrence. Any procedure which falls short of gaining these objects is radically defective. The operation will be done in such a manner as to remove all that portion of skin which is likely to contain cancerous elements. It will then be carried on so as to remove all the contents of the axilla, because in the axilla and in its connective tissue are numerous lymphatics which will otherwise carry the disease up into the neck and adjacent parts. We shall also remove the pectoralis major muscle and the pectoralis minor with, perhaps, the exception of a small portion of the latter. One reason for removing these muscles is to allow of perfect dissection of the axilla, which cannot be done even by the most expert operator

without their removal or displacement. Another reason is that very many minute lymphatic vessels are found running down from the seat of disease underneath the pectoralis fascia and the muscles. Microscopical examination, even after apparently a most thorough dissection, will show, usually, that unless these muscles are removed, some of the diseased tissues or infected lymphatics have been allowed to remain. No patient upon whom I have operated by this method has died from the effects of the operation, and they have all made good and rapid recoveries. There has also been excellent motion of the arm, and the whole result has been very gratifying indeed.

You can readily believe that a discharging, ulcerated area infects the skin in the vicinity to a much greater degree than where there is no such ulceration; for this reason we must be particularly careful about disinfecting the skin in the region of operation. A very good way of disinfecting the ulcerating area is by the application of thermo-cautery, and this is the plan which I shall adopt in the present case. The general plan of operation is to uncover the tendinous borders of the axilla, anteriorly and posteriorly, and subsequently to uncover the whole of the pectoralis muscle. I have now exposed the wall of the thorax, and shall proceed to make the innermost incision, which is practically outlined by the sternum. Although it is desirable to get as far away from the breast as possible, and, therefore, to make the flaps thin, they should not be made so thin as to endanger their vitality. The dissection can be made in two different ways, viz.: (1) The method recommended by Halsted, beginning at the sternal end of the pectoralis major, separating the muscle and approaching the axilla; and, (2) the method recommended by Meyer, to uncover in the first place the outer edge of the axilla, the part close to the vessels, and then explore the axilla from without inward, working towards the sternum. I consider the latter method decidedly preferable. Having thoroughly exposed the parts in this way, using my finger as guide, I divide the pectoralis major muscle, and carefully dissect it up from the axilla inward towards the sternum, following the axillary vein closely. During and after the dissection it is well to irrigate the field of

operation occasionally with normal salt solution. It is true that this method of operating makes a monstrous wound, but the amount of blood lost is slight, and none of my patients upon whom I have operated in this way have suffered from acute anæmia, or greatly from shock.

I have now removed the whole breast, the surrounding area of skin, the whole pectoralis minor muscle, and the connective tissue in the axilla. These are the tissues especially likely to be the seat of recurrence of the disease. You might think that these patients would be greatly disabled by such an extensive removal of muscle, but such is not the case; on the contrary, the motions of the arm are exceedingly good shortly after the operation; all the motions can be made with comfort, although, of course, the muscular power of the limb is diminished. The incisions are not made with reference to the closure of the wound, but with reference solely to getting rid of all the disease. If we cannot bring the parts together completely, the open portion can be grafted with skin after two or three weeks. This might be done at the time of operation, but would prolong it unduly. I attach great importance to the accurate opposition of such skin flaps as one intends to bring together, and although it is a slow process, it is one which well repays the surgeon for the additional time and labor expended. I find that I can secure a satisfactory coaption of the edges of this large wound. Having done this, a drainage tube is inserted, and the wound once more irrigated with salt solution before the application of the usual dressing of sterilized gauze and cotton. These cases all do better under very bulky dressing, and especially, the first dressing. I think one can hardly be too generous in his application of a compress or covering in these extensive flap operations. Notwithstanding the length and extent of the operation, the patient's pulse appears to be perfectly normal.—Charles McBurney, M.D., in *Inter. Jour. of Surg.*

CELIOTOMY WITH AND WITHOUT DRAINAGE.

Dr Czempin refers to the great fluctuations of opinion of authoratative operators, and notes that drainage is being less and less employed each year. He refers to the method advised by Säger (the glass drain) and Mikulicz (the iodoform-gauze drain), and also to the indications for drainage as pointed out by Veit, Olshausen, and Martin. He notes that Säger employs this form of drainage no more; that he has practically discarded drainage; that Veit believes the indications are very few; and that opinions are so varied that there are no fast rules to follow in any particular case.

Czempin, through a period of nine years of operative work, has at times followed the advice of each of the above investigators, and has carefully followed the subject. He has found that each year fewer cases require the drainage-tube. From his observations the cases in which drainage may be indicated are divided into two great groups. First, operations upon non-infectious tumors, with unfavorable complications caused by the condition of the relations of the operation wound. Second, operations upon infectious tumors or those thought to be infectious, and operations complicated through injury to the intestine, the escape of pus or decomposed fluid. First, complicated non-infectious operations. To this group belong (a) intra-ligamentary-developed new growths resulting in the necessary extensive separation of the pelvic connective tissue; (b) where the new growth has extensive adhesions with neighboring organs and the parietal peritoneum, therefore necessitating extensive injury to the peritoneum. Under these headings the writer reports a series of cases with results which vary too much to be of practical use. In the first group, the separation of the pelvic connective tissue and the extensive wound results in the formation of the best culture medium for infectious organisms, and that infection takes place either through faulty technique, infection from without, or through intestinal bacteria, the result of injury to the intestine. He says that it is doubtful whether drainage does good in these cases; that the resulting exudate is quite as readily absorbed and eliminated by nature. As regards the second group of cases, he refers to the statistics of Zweifel of one hundred and three adnexa operations, with one death, where the rubber drainage-tube was employed, but says it proves nothing. The method of Schauta, Wertheim, and Fritsch (the microscopical examination of pus during operation) he believes has the correct object, but is not positive; that the organisms may not be virulent, they may be few in number and not found, and a certain number of cases are thus unnecessarily drained. The use of drainage complicates the operation, often causing suppuration in the abdominal wound, fistula, and hernia. Finally, he concludes that the result in complicated celiotomy is only rarely improved by the use of drainage, and that in the greater number of cases where it is used it is not essential. If virulent organisms are present, it can scarcely save life; if the virulence is extinct, it is not necessary. Where in the removal of a non-infectious new growth the pelvic connective tissue is separated, drainage is not only unnecessary, but often does harm. Where there is a closed-off acute inflammatory process in a tumor in the peritoneal cavity, infection is to be feared. Particular caution should be taken that the least amount of the peritoneum is infected, and the

material should be carefully removed with the sponge. The use of the iodoform-gauze tampon does not physically or chemically influence the result. The opening of acute inflammatory connective tissue in adnexa operations is very dangerous. Whether drainage can save the patient's life is questionable. In such cases he believes complete hysterectomy gives the best results. In adnexa operations he advises that the operation be performed six months after the last exacerbation. In cases in which the pelvic connective tissue is widely separated in the removal of a tumor (hæmatoma of the broad ligament) drainage is not necessary. In very difficult operations, where the pelvic connective tissues is widely separated and the case is septic, the best results are gained by complete hysterectomy and drainage with iodoform gauze through the vagina.—*University Medical Magazine*.

SURGICAL SUGGESTIONS.

Dilatation of Urethra.—A large percentage of female patients suffering with subacute vesical symptoms, such as painful micturition, bearing-down sensation, and a feeling that the bladder is not emptied after micturition, can be readily relieved by dilatation of the urethra. The greatest amount of practical good that has been obtained in bladder troubles by the use of the cystoscope may be attributed to the dilatation necessary to the introduction of the instrument.—Baldy.

Facial Paralysis.—1. Facial paralysis usually attributed to cold is frequently caused by mild otitis media. 2. This otitis is due to a pharyngorhinitis. 3. The aural origin of facial paralysis accounts for a number of symptoms not otherwise easily explained—pain, etc. 4. The prognostic significance of this etiological fact is very great, for usually facial paralysis of aural origin is readily cured.—Launois, *Ann. des Mal. de l'Oreille et du Larynx*.

Frost Bites.—

R—Ichthyol,
Resorcin,
Tannic acid, āā 1.00
Water, 5.00—M.

Apply with a brush at night.

Should this, for one reason or other, be objectionable, the following formula may be substituted:

R—Resorcin, 2.00
Mucilage of gum arabic,
Water, āā 5.00
Powdered talc. 1.00—M.

Apply topically with a brush. —Boeck.

Amputations.—I have always held that a circular skin flap, with or without a lateral incision, as the emergency may demand, is the ideal flap, the muscles being divided an inch or more above the level of the circular incision through the skin, and the bone sawed on a level with the muscle. Dissection of the periosteum from the end of the bone in order to secure a periosteal flap is entirely unnecessary and should not be done.—Wyeth.

Tumors.—Every tumor first noticed in the breast after the thirty-eight years' epoch is, in the great majority of cases, primarily malignant; in the remainder it is certain, sooner or later, to become associated with malignant features in one form or another.—Snow.

Aneurism.—Hydrated calcium chloride in doses of about a drachm a day, in conjunction with rest and other suitable adjuvant measures.—Cohen.

Furunculosis.—Extract of colchicum, in doses of from 2 to 4 cgm. (gr. $\frac{1}{2}$ to gr. $\frac{3}{4}$), in conjunction with topical applications of spirit of camphor.—Brocq.

THE TREATMENT OF TUBERCULOSIS IN CHILDREN WITH IODOFORM INJECTIONS.

Wieland (*Deutsche Zeitsft. Chirurg.*) finds the conservative treatment, with ten per cent. iodoform injections, of tuberculosis of the soft parts, bones and joints, much more satisfactory in children than in adults; and analyzes in support of this view the report of the Children's Hospital of Basle for the last five or six years.

He finds tuberculous abscesses treated in this way healed very often. The method employed was to empty the abscess with an aspirator, then irrigate with a 4 per cent. boracic acid solution, and, after the cavity had been well washed out, to inject 20 to 50 ccm. of a 10 per cent. iodoform emulsion, either in glycerine or oil or in water, adding a small quantity of gum arabic to hold the iodoform in suspension. As often as the abscess refilled, the operation was repeated.

It is essential to keep the part treated at rest, and to firmly support it with a flannel bandage.

Of twenty-one cases treated in this manner, sixteen, or 80 per cent., were fully cured, four were removed from the hospital by parents before treatment was completed, and one case was a positive failure. In eleven of the sixteen successful cases one injection sufficed; in one two were necessary; and in four the patient required three injections. Fistulæ at the point of injection occurred four times and once there was septic infection of the large abscess.

Twelve cases of joint tuberculosis were treated in this way. Nine, or 75 per cent., were cured, and two were much improved. Joint cases required from six to thirteen injections given during a period of two to six months.

Four cases had acute nephritis from the iodoform, which, however, speedily disappeared. In one case there was severe iodoform intoxication, but in this case 20 per cent. emulsion was employed.—*Kansas Med. Rec.*

SURGICAL HINTS.—When a wound, either accident or operative, shows signs of infection, wait for suppuration. Immediate incision, thorough disinfection, and drainage, if necessary, relieve pain, shorten the duration, and prevent extension of the inflammatory process.

In draining a suppurating wound, never cork it up by packing gauze in it. The smallest strip that will reach the bottom of the cavity, very loosely applied, is the best.

Constitutional treatment is all-important in all forms of diffuse surgical inflammations.

Recurrence of carbuncles and boils suggests an examination of the urine for diabetes.

See that patients have a good night's sleep the night before an operation.

Skin grafting will not succeed upon an unhealthy surface.

Watch patients with burns of the pharynx and larynx: be ready to operate at once. Severe dyspnoea may occur with appalling suddenness. If the patient is getting cold and feeble, his ability to feel pain has greatly disappeared. Waste no time in anaesthesia in emergency tracheotomies.

Remember that the skins of young children and delicate women may be blistered by 1 to 1,000 solutions of bichloride of mercury, and that 1 to 40 solutions of carbolic acid have produced gangrene of fingers and toes, when used in wet dressings.

When first attending a case of urinary retention due to prostatic enlargement, it is a very common mistake to endeavor to empty the bladder with very small catheters, and this very often fails. A large catheter will frequently pass much more easily, and should always be tried first.

In case of severe orchitis, acupuncture generally gives great relief. Use a strictly clean, long needle, with a cutting point. This must rapidly be thrust two or three times through the substance of the swollen testicle. The procedure gives, when skilfully done, much less pain than might be imagined.

In local inflammations of a septic character, the external application of iodine is worse than useless.

In hydrocele, the tenseness of the sac, and not its size, is the indication for operation. Never

introduce the trocar obliquely, but perpendicularly to the surface.

An ice-bag left all night upon an inflamed surface has been known to produce extensive sloughing of the parts. The skin under an ice-bag should be frequently inspected.

The tissues of the ear are possessed of a great degree of vitality. If a portion of the ear has been so cut as to hang by nothing but a mere shred, it is always worth while to stitch it in position again, suturing cartilage to cartilage, and skin to skin, separately, whenever possible.

Tincture of arnica, except for the alcohol it contains, is believed to possess absolutely no value as an external application. It sometimes produces an amazing degree of cutaneous irritation and inflammation, sometimes even assuming an erysipelatoid character.

Never give a good prognosis in the case of very extensive burns in children, however well they may appear a few hours, or even a day or two after the receipt of the injury. Sepsis usually followed by pneumonia and shock often develops late, and the mortality is very great.—*Inter. Jour. of Surg.*

ULCERS OF THE LEG; ALL CAN BE CURED.—

This paper was read by Dr. Carter S. Cole, of New York. Whatever constitutional conditions obtained that favored morbid states, or that retarded a return to a healthy state, he said, such a diathesis should receive its proper treatment, whether ulcers exist or not. For systematic purposes, ulcers of the leg were designated by the author according to their appearance as healthy, irritable, indolent, etc. In intractable cases, he was inclined to place foremost thorough washing with soap and water and good scrubbing with a stiff-bristle hairbrush. If the ulcer was inflamed, irritable, or painful, anaesthesia might be required for this and subsequent steps. The next step was a thorough cleaning out of all soft granulations and the base of the ulcer with a sharp curette. The edges of the ulcer were scraped away, and in many cases with a curved sharp bistoury he nicked the circumference at intervals of about a quarter of an inch. If much hæmorrhage followed, a pad of gauze wrung out of a two-per-cent. solution of carbolic-acid was placed over the wound, and a firm compression bandage applied from the toes to knee, the wound having been previously cleansed with the carbolic-acid solution. The dressing, when used, was allowed to remain for twenty-four or forty-eight hours, after which he considered the ulcer to have become a simple one and amenable to treatment as follows: No further lotion was used. The wound was wiped off with dry cotton, and over it and completely covering it he placed strips of diachylon plaster to protect the ulcer. Over the surgeon's plaster he applied a pad of sterilized

gauze, held in place by strips of rubber adhesive plaster, or often simply by a bandage. He then used a firm muslin bandage from the toes to the knee, making equable compression. The bandaging should be carefully done. Sometimes he used two bandages three inches wide and eight yards long. This bandage was not removed unless the discharge came through, or the leg became painful, or the bandage got loose. When he redressed the ulcer he again used simply dry absorbent cotton to cleanse the wound, and proceeded as before. Often after two or three dressings the bandage might remain from five to seven days without being disturbed. In some cases a thin scum formed on the ulcer, which must be removed by going over the surface lightly with a curette. With this treatment, in ordinary cases, about three weeks would suffice for an ulcer of even a dozen years' standing. In extraordinary cases as much as six weeks might be necessary.—*New York Med. Jour.*

TREATMENT OF CHRONIC HYDROCEPHALUS.—Dr. Raczyński concludes as follows with regard to the value of punctures in chronic hydrocephalus: 1. Puncture is not a dangerous procedure, if carried out under antiseptic precautions, and if the fluid is evacuated in small quantities at intervals of several weeks. 2. The employment of permanent drainage is more dangerous than evacuation of the fluid by puncture or even aspiration. 3. Although the results thus far obtained have not been brilliant, the statistics will improve when the operation is resorted to at an earlier stage, before much thinning of the brain substance has occurred. The most difficult question to decide is in what cases and what period an operation is to be undertaken. It is known that some of hydrocephalus get well spontaneously, while others, with marked enlargement of the head, live for many years; on the other hand, if left to itself, the disease often gives rise to the most unfortunate results. By interfering too early the surgeon exposes himself to the reproach of having performed a perhaps harmless, but unnecessary operation; while by delaying it may be inefficient. According to the author's opinion, puncture is indicated in those cases in which in a previously healthy child symptoms of hydrocephalus rapidly develop; if a progressive enlargement of the head is distinctly noticeable; if marked bodily or mental impairment be threatened; in short, if we have everything to gain and nothing to lose.—*Internat. Jour. of Surg.*

CASE OF DOUBLE LIGATION OF THE VASA DEFERENTIA FOR HYPERTROPHY OF THE PROSTATE.—The patient was a cab-driver, aged seventy, married. For nine or ten years he was troubled with frequent urination. Five years ago he had a

sudden attack of retention with constant dribbling, which yielded to Sitz baths, rest, and catheterization. Afterward involuntary dribbling from overdistention troubled him at times, and frequency was greater than it had been before. Two weeks ago he was attacked similarly, and after five days' treatment as before was sent into the hospital. The prostate was symmetrically enlarged to about the size of a billiard-ball. After about three weeks' rest in bed with regular catheterization, the patient showed no improvement. Ten minims of a four-per-cent. solution of cocaine were injected into the tissue around the spermatic cords, close to the external abdominal ring. The vasa deferentia were separated to the extent of an inch from the cords, and double ligatures of fine silk were placed a quarter of an inch apart on each vas. The vas was not severed. The wounds were sutured and the usual iodoform dressing applied. For seven days after the operation all urine was drawn as before. On the seventh day, about two drachms passed voluntarily. Improvement continued, and the patient reports himself feeling better than during the last ten years. I frequently test the amount of residual urine, and find it to vary from three and one-half ounces to two ounces. The prostate is about the size of a duck's egg.—*Med. and Surg. Reporter.*

NOTES ON A SERIES OF ONE HUNDRED CONSECUTIVE CASES OF APPENDICITIS.—A paper on the above subject by Dr. Robert T. Morris was read before the New York Academy of Medicine. The death rate had been two per cent., the hernia rate zero. Acute appendicitis with abscess, 34; chronic appendicitis with abscess, 4; acute appendicitis without abscess, 12; chronic appendicitis without abscess, 40. The others were cases of tuberculosis and cancer. Females, 24. Of the 38 abscess cases 2 died, one from suppurative nephritis, the other from septic peritonitis. The appendix was removed in all but 5 of the acute cases. One case of fæcal fistula had not yet closed. In all the acute cases he followed the general plan of the smallest useful incision. He cleansed the abscess cavity with peroxide of hydrogen and salt solution, and sutured the abdominal walls separately and accurately. In his hands he thought the use of gauze packing and opium would probably have lessened the favorable results. None of his cases without abscess had died or had had post-operative hernia. In two cases the appendix had become twisted upon itself, narrowing the lumen, which was distended with mucus. He had made it a rule on arriving at a diagnosis of appendicitis to operate, no matter what the stage. The appendix was like a cap which might snap and cause an explosion, and nobody could tell in advance just what might happen in a particular case.

APPENDICITIS AND RHEUMATISM.—Dr. Beverley Robinson said he believed to-day even more strongly than he did about two years ago, when he expressed the opinion for publication, that in many instances the only correct interpretation of appendicitis was the recognition of an underlying rheumatic condition. He did not wish it understood that he was opposed to surgery; he believed that at a certain stage of the disease it was the only means of saving life. But before that stage had arrived many patients could be cured by anti-rheumatic treatment, just as many cases of tonsillitis responded to such treatment when without it local measures seemed ineffectual. Salicin, salol, salicylic acid, etc., were the efficient remedies in this class of cases. He believed the latest anatomical investigations showed a large amount of lymphoid structure in the cæcum, more especially in the appendix. This pointed to similarity of structure with the tonsils, which were known to reflect the rheumatic tendency. Mild laxatives, not active purgatives, were beneficial. Opium was harmful, not only because it obscured the symptoms, but also because it dried up the secretions. He felt certain that by acting on these suggestions many cases of appendicitis could be checked before the stage of suppuration and sepsis.

Dr. Gibson said Dr. Morris' results, only two deaths in one hundred, none of post-operative hernia, seemed wonderful. He did not think it was due to the method of operating. It looked as though he had had a hundred cases, the great majority of which were easy ones. The statement that there had been no case of hernia was remarkable, and it suggested the question whether he spoke of hernia in the same sense that another practitioner might. His method of closing the abdominal wound was not different from that practised by other good surgeons, who, nevertheless, had reported some cases of hernia.

ASBESTOS AS A SURGICAL DRESSING.—Dr. E. O'N. Kane, of Kane, Pa., recommends asbestos as a practical and useful substance for surgical dressings. These dressings, he says, may be carried in any parcel, paper bag, or hand-satchel, may be handled by dirty hands, spattered by blood or any sort of filth, and yet can be rendered absolutely aseptic in less than two minutes by tossing them upon the coals or into the blaze of an ordinary kitchen stove. After having completed an operation, and just before he is ready to apply the dressings, they are thrust into the coals or flame of the nearest stove. The same dressings can be used, if necessary, though here it is advisable to wash off some of the discharges before the dressings are burned. Repeated burnings seem to injure the quality of the material somewhat. The form of asbestos most used is the asbestos fibre, which is

as soft as silk floss, and its absorbent qualities are greater than those of absorbent cotton. Asbestos wicking, packing, and cording are adapted for drainage tubes.—*New York Med. Record.*

VILLOUS TUMOR OF THE RECTUM.—At a recent meeting of the Liverpool Medical Institute, as reported in *The Lancet*, Mr. Paul related the case of a woman, aged fifty-six years, from whom he had removed a very large villous papilloma of the rectum. Symptoms of bearing down, a constant desire to defecate, and the passage of blood and mucus had existed for five years. The growth formed a broad band two or three inches deep around the rectum about two inches and a half from the anus. The patient made a slow but otherwise good recovery. The tumor had the typical structure of villous papilloma and did not infiltrate the submucous tissue. The origin of the growth could be distinctly traced to the neck of Liebergkühn's follicles, and Mr. Paul suggested that the historical distinction between the three usual neoplasms in this situation was as follows: Papilloma commenced as an upward growth of the neck of the glands, polypoid adenoma as an over-growth of the entire glands, and carcinoma as a downward growth of the deep portion of the follicles.

TREATMENT OF EPIDIDYMITIS.—The affected testicle should be wrapped in lint and be moistened constantly, either with lead water and opium, or the following:—

R—Tincture of aconite,
Tincture of opium, āā fl. ʒ j.
Dilute lead water,
Water, āā fl. ʒ ij.

—Dennis' *System of Surgery.*

A MAGAZINE'S INFLUENCE.—The enormous circulation of such a magazine as *The Ladies' Home Journal* can, in a sense, be understood when it is said that during the last six months of 1895 there were printed, sold and circulated over four million copies—(in exact figures 4,058,891). Figures such as these give one some idea of the influence which may be exerted by even a single one of the modern magazines.

SPRAINS OF FOOT.—Most successful treatment is use of hot foot-baths for fifteen minutes three times a day; follow each bath with massage for fifteen minutes; then apply snugly a Martin rubber bandage from toes up as high as ankle and have patient walk, *Railway Surgeon.* Ballet dancers use this method with such success that they are seldom incapacitated for work longer than a week.

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is the condition of the woman who has been relieved from some functional disturbance to her state before relief. Don't you know Doctor that there are few cases that pay the physician so well as those of women—and the Doctor that relieves one woman, lays the foundation for many more such cases—all women talk and your patient will tell her friends. ASPAROLINE COMPOUND gives relief in all cases of functional disturbance—Leucorrhœa, Dysmenorrhœa, etc., and in the cases it does not cure it gives relief. We will send you enough ASPAROLINE COMPOUND—free—to treat one case.

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Dr. Eggers of Horton Place, Physician and Surgeon St. Louis and Suburban Railway System, also reports in the treatment of an attack of diphtheria in a member of his own family, that to obtund the pain consequent upon the injection of antitoxine-serum, which ordinarily lasts from three to four hours, he exhibited antikamnia internally which secured relief in a few minutes. Clinical reports verify the value of codeine in combination with antikamnia in the treatment of any neuroses of the larynx, coughs, bronchial affections, la grippe and its sequelæ as well as chronic neuroses; the therapeutical value of both being enhanced by combination. The tablets of “Antikamnia and Codeine,” containing $4\frac{3}{4}$ grains antikamnia and $\frac{1}{4}$ grain codeine, meet the indications almost universally.

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MEDICAL LIBRARIES, THEIR DEVELOPMENT AND USE.

BY JAMES R. CHADWICK, M. D

In accepting Dr. Osler's invitation to give to you a short address upon the medical library, its development and use, at the inauguration of the new building of the Medical and Chirurgical Faculty of Maryland, I find myself handicapped by lack of time for adequate preparation and an experience which is restricted to one locality, the City of Boston. Still I have had practical knowledge of the building up of a library from a few hundred to twenty-six thousand volumes and twenty-three thousand pamphlets. The lessons learned in the twenty years of labor may not be devoid of interest and value to you.

Soon after a young man graduates from the medical school and assumes the responsibility of the lives and health of his fellow beings, he realizes the limitations of his knowledge, and looks about to remove them. He finds two principal means of adding to his meagre acquisitions, hospitals and books. Hospitals, including dispensaries, if assiduously frequented, certainly teach him more of immediate practical value than do books. But the knowledge there acquired does not always bear upon the particular case in his private practice which is causing him anxiety, and moreover the hospital has the disadvantage of being available only during certain hours of the day and of necessitating absence from his field of labor during the hours when he ought to be earning his livelihood.

To the printed words of his masters and colleagues he must consequently turn, and where shall he find them? His own few shelves contain the treatises from which he learned the first rudiments of his knowledge, but in our day every one of these is superseded in two or three years, by the rapid advance of medical science.

In the early years of practice, few men can afford to buy or even give shelf-room to a tenth part of the books that he needs; no man, whatever his means, can possibly acquire all. A library is consequently indispensable in every centre of population, or the health and lives of the commu-

nity will be jeopardized by the ignorance of its medical practitioners. Could this fact be realized by the liberal men of means in our midst, self-protection, if no higher motive, would stimulate them to endow our medical libraries with as free a hand as they now evince toward hospitals. The benefit conferred upon suffering humanity would be greater, though less manifest, to the ordinary man of wealth.

Admitting then, that a medical library for the use of the profession in every community is indispensable and recognizing that we must not expect many contributions from the public, by what direction of our efforts can we procure it?

I appreciate that you do not need to be told how to make a start, for I well know that in the thirty-third year of your age (1832) you established a library in your Society under the fostering care of Dr. Samuel Baker; that in 1852 the first catalogue was published by Dr. John W. Woods; and that a few years later Dr. George W. Miltenberger raised funds for the increase of the library with such marked success that you already possess about 10,000 volumes, ranking among the larger medical libraries of the country.

As a stimulus to fresh effort to increase your already large library, I have had a chart constructed showing the yearly rate of growth of the seven largest collections of medical books in the country.

The first library to be founded was that of the Pennsylvania Hospital in 1762; there has been a comparatively steady increase to the present day, no annual enumeration having been made. It now numbers 15,007 volumes. The difficulty of procuring books in the last century and the early decade of this can be appreciated from a printed circular distributed about 1805 to the members of the Second Social or Boston Medical Library, in which it is stated that "the books ordered last year from Europe have not yet been received."

The second library in order of seniority is that of the College of Physicians in Philadelphia, which was commenced in 1788. Its curve of growth shows such great fluctuations that a brief study of them will be profitable in making evident the means by which a library is augmented. You will note that the increase was very slow for sixty years,

when in 1858, 1,265 volumes were received from Dr. Thomas F. Betton. In 1864-5 the library was almost doubled in size, chiefly by the gift of 2,500 volumes from Dr. Samuel Lewis, who from that date until his death was a constant contributor to its alcoves, the aggregate of his donations ultimately reaching the grand total of nearly 10,000 volumes. The erection of a fire-proof building in 1864 also contributed to securing many accessions. Between 1882 and 1886 the growth was very rapid owing to the receipt successively of the libraries of the late Dr. William F. Jenks, Dr. Alfred Stille, Dr. Samuel D. Gross, Dr. I. Minis Hays, Dr. John S. Perry and that of the Obstetrical Society of Philadelphia.

In 1880 to 1882 Dr. S. Weir Mitchell contributed \$2,000 as a journal fund, and, later, when president, roused by his love of books and his enthusiasm the greatest interest in the library, whereby it grew rapidly. The falling off of its curve and that of the New York academy of Medicine in the 80's merely means that duplicates were thrown out. The College now contains 49,748 volumes, besides 28,384 unbound pamphlets, reports and transactions.

The library of the New York Hospital was founded in 1796, had a steady increase until 1876 when, like all the others, it took on a more rapid growth. It now numbers 22,383 volumes but has practically no pamphlets.

The library of the Surgeon-General's office in Washington, begun in 1845, grew so slowly that in 1865 it contained less than 2,000 volumes. Its increase from that date has been so phenomenal that we are warranted in pausing to seek an explanation, which is not, however, hard to find. It was in that year that a young army surgeon, Dr. John S. Billings, who had shown literary tastes and marked executive ability during the War of the Rebellion, was detailed to take charge of this insignificant collection of books. He at once conceived the idea of developing this nucleus into a grand national library. By importuning Congress year after year he secured large annual appropriations of money (the annual appropriation for the purchase of books has averaged nearly \$7,000 from 1867 to 1895 inclusive), and by persistently canvassing, personally and by letters, the profession of every State in the Union he secured large donations of books. Exchanges were effected with other medical libraries not only in this country but in all parts of the world. From these two sources about one-sixth of the total number was derived. The result of his labors is the most complete medical library in the world, consisting of 116,847 volumes and 191,598 pamphlets.

The influence of this one man's work is not seen in the growth of this library only, but is made manifest by the impetus given to all existing libraries and to the formation of innumerable new

ones, of which my data are still incomplete. The publication of the index-catalogue of this library, the first series of which, in sixteen volumes, was begun in 1879 and completed in 1895, will, when the new series of five or six volumes is issued, be practically an index to all the medical literature of the world up to the end of this century.

Its value to medical scholars is inestimable, superseding, as it does, all the time-wasting labor that used to be expended in bibliographical research. By its aid we obtain a reference to every rare case that has been recorded since printing was discovered in A. D., 1450. But by indexing the articles and reports of cases in every periodical, past and present, obscure and famous, this catalogue has immensely extended the scope of medical research and created a demand for an array of books and especially of periodicals that is simply appalling. What is an earnest seeker after knowledge to do when he has, for instance, a case of inflammation of the pancreas and refers to this catalogue for the writings on the subject, when he discovers a reference to a case in the *Medicinische Jahrbuchbericht von Peter-Pauls Hospital in St. Petersburg*, to another in the *Bulletino di scienza medica di Bologna*, to another in the *Moniteur scientifique* and to another in the *Zeitschrift für die gesammte Medizin* of Hamburg, so on *ad infinitum*? He cannot possibly have complete files of these various periodicals upon his own shelves. He must have within reach a library, in which most, if not all, these volumes may be found or he will fail to learn all that can be learned about this subject and, as a consequence, his patient will suffer from treatment based on half knowledge.

The demand thus created for periodicals of all kinds and countries has done more than anything else to promote the growth and foundation of public medical libraries throughout our country. This publication is therefore the great factor in determining, during the past fifteen years, the rapid rise of the curves of all the libraries represented upon this chart. The pressure of the demand for an extensiveliterature thus created will never wane.

The library of the New York Academy of Medicine, inaugurated in 1847, had the same slow growth as all the others until 1846-7, when Dr. S. S. Purple gave to it his large collection of medical periodicals. Its subsequent rapid growth owed much of its impetus to the energy of my old and dear friend, Dr. Fordyce Barker, who, combining the wisdom of age and the enthusiasm of youth, was foremost in securing funds for a new building in 1880, when he was president. In 1890 a new impetus was given to this library by the erection of a superb new fire-proof building. This library is fast becoming worthy of the metropolis of the country. It contains 33,140 volumes and 13,000 pamphlets.

The medical department of the Public Library of Boston was founded in 1852 and has grown, by purchase and gifts, at a comparatively uniform rate. It now contains 19,609 volumes.

The Boston Medical Library Association, of which I have been the librarian since its foundation, in 1875, has had a rapid growth from the outset, chiefly because, in its early years, it took into its fold the libraries of several local societies. Its growth has been almost entirely by donations and exchange, having no funds regularly available for the purchase of books.

Its value is greater than its size would indicate for the reason that nearly 16,000 of its 26,000 volumes are periodicals, and this class of literature is of most practical value to the medical public. The completeness of our files of journals and transactions I attribute largely to the existence of the volume I hold in my hand, my "want-book," wherein, upon the left-hand page is entered every periodical of which we have any part, while on the opposite page is entered every volume or number needed to complete the file of that particular journal. By invariably carrying this with me upon my travels in this country and Europe, I have been able gradually, at a trifling expenditure of money, to complete the files of all the leading periodicals of the world. I submit this to your special attention if you know how to build up a medical library with practically no funds for the purchase of books. This library now contains 26,082 volumes, and 23,595 pamphlets.

I have sought by the analysis of these curves to indicate the principal factors in the growth of a medical library. The lessons to be drawn from this enumeration are, that if a valuable collection of books is accumulated, the profession will rally to supply for it a suitable abode; and, as my friend, Oliver Herford says, "It's a poor pill that will not work both ways," so we find that if a fine building is erected, the library will soon be forthcoming. In either and every case some one man must work early and late to secure contributions, and especially to make complete the files of periodicals.

I would not be understood as intimating that money is not needed for the building up of a library. As the Chinese say, "With money you can move the gods; without it you cannot move a man." Money and much money is needed for the maintenance of a library. The continuous service of a librarian and perhaps one or two assistants must be paid for. Many hundred volumes must be bound every year. A certain number of periodicals must be secured for your reading-rooms as soon as published, and therefore by subscription. The list of these may be supplemented immensely by securing gratuitously the exchanges of your medical journals; the journals received by your instrument-makers and manufacturing chem-

ists, etc., in return for their advertisements; the journals circulated in journal clubs of medical men after they have gone the rounds. You may also obtain in exchange for your own *Transactions* the publications of nearly all kindred societies.

Finally, an author, subject and title card-catalogue must be kept up to date, no matter what the expense. "Who wants a lock without a key, a ship without a rudder, a binnacle without a compass, a check without a signature, a greenback without a goldback behind it?" [O. W. Holmes.]

Before closing, I want to say a word about pamphlets, with regard to which you will have noticed that policies differ widely; the New York Hospital keeps no pamphlets, the Surgeon-General's Library has sixty per cent. more pamphlets than books, the Academy of Medicine has only one-third as many pamphlets as books. Some of this discrepancy is doubtless due to different relative classifications of books and pamphlets. In order to secure uniformity, the rule of the Washington Library should be universally followed: To classify as a pamphlet everything that is unbound, up to a hundred pages, and everything that contains less than thirty pages, even though bound; to classify as a book everything above thirty pages, if bound, and everything above one hundred pages, even though unbound. This is purely arbitrary and may not be invariably followed, but it is as fair a classification as can be devised. No accurate comparison of the size of the different libraries can be made if, as in my knowledge has happened, one library counts everything above thirty pages as a book, whether bound or unbound. It may thus surreptitiously add many thousand volumes, so-called, to its aggregate of books, and take thereby an illegitimate rank among the libraries.

Pamphlets should be carefully kept and catalogued in one library in every city. They include most of the graduating theses, which are often compilations of inestimable value; they often contain the results of extensive laboratory experiments; they contain much local history, reports of special committees who have investigated water-supply, drainage, epidemics, quarantine, etc. Reprints of journal articles are of use, even though the library has the file of the journal in which they appear, because they may circulate for home-reading when the journal may not be allowed to leave the building.

Classify your library by subjects, making the sub-divisions more numerous from time to time, as the books accumulate. Do not agree to keep a man's library, if on various subjects, together as a unit, if you can help it, for you thereby break in upon your regular system of classification and make the library harder to administer and less available to the readers, besides storing many duplicates uselessly.

As to the use of the books, make it as free as is consistent with their safety. Where the users of a library are all members of an association and consequently known personally to the custodian, it is generally deemed safe to allow them free access to the shelves. All books that can be readily replaced may circulate for home reading, but not periodicals, for the loss of one volume of these depreciates the value of the whole series.

It is useful to make duplicate files, as occasion presents, of the leading periodicals for home reading. Beyond this be liberal in the disposal of duplicates; there is no market for medical books, so you may as well bank on the future, by giving freely of your duplicates to other kindred institutions on open exchange account, which is never meant to be balanced. You hereby establish a claim upon such institution for any favor it may be in position to do you in future.

But I find that I am dropping into technical details that can have no interest for any one but your librarian and committee on the library.

In conclusion, I want to parry the charge of having too prosaic a view of a medical library, of seeing only the utilitarian side of it. To the deep student, to the true lover of books, nothing that I can say will add or detract from his appreciation of it. Remember what Confucius says, "Learning without thought is labor lost; thought without learning is perilous."—*Boston Med. and Surg. Jour.*

BARBER'S ITCH.

BY HENRY W. STELWAGON, M.D.

True barber's itch, an example of which is shown in the patient now before you, is a disease of the bearded parts of the face, due to the invasion of the integument by the ringworm fungus. The disease has been, and is still, called variously parasitic sycosis, tinea sycosis, tinea trichophytina barbæ, tinea barbæ, trichophytosis barbæ, and ringworm of the beard. As it is due to the ringworm fungus, trichophyton, the proper technical term would seem to be either tinea trichophytina barbæ or trichophytosis barbæ. In connection with this case I desire to give you a brief description of the several stages or varieties observed upon this region, using a few photographs of cases which have been before you from time to time, as illustrations.

The disease most commonly begins as one or two simple patches of ringworm,—rounded areas with clearing centres and reddened, elevated, slightly scaly, papular, vesico-papular, or vesicopustular periphery; generally the peripheral portion is merely reddened, elevated, and somewhat scaly. The disease may persist as such, the ring

or rings enlarging, possibly one or more new areas arising, the older ones, at times, partly disappearing, while in some patches the infiltration and elevation at the borders become more marked. This constitutes the superficial variety of the disease. This type is not uncommon and may present one large ring-like patch, as seen in Fig. 1, or several or more variously sized ring-like areas or segments some merely epidermic scaly rings, others more inflammatory and less superficial, the borders being quite pronounced, as portrayed in the photograph just shown. The borders may also show some pustulation. In these cases, if of considerable duration, the hairs are apt to present the same characters as in ringworm of the scalp, some falling out, others invaded by the fungus, becoming brittle and breaking off, sometimes presenting brush-like ends. As a rule, however, the hair is never so conspicuously involved in ringworm of the bearded parts as in the scalp-disease. In other cases the ring or rings have scarcely time to form before the deeper tissue is involved, and then you see small areas of papulo-tubercles, at first grouped somewhat circularly, later becoming confluent, and sometimes diffused, as in the case before you. (This case is shown in Fig. 2.) In this patient on the chin and the right side of the lower jaw there are several distinctly nodular, lumpy, deep-seated areas; those over the jaw still preserving, somewhat indistinctly, their ring-like shape. On the region around the right side of the mouth, invading the upper lip,—an unusual site,—the disease consists of a markedly infiltrated swollen area covered irregularly with pustules; on the other side of the chin are a few nodular infiltrations. The disease began three weeks ago. In other cases the usual beginning stages of the disease are soon lost or even wanting, it rapidly developing into one or several, small or large, sluggish or actively inflammatory, rounded or irregular areas made of deep-seated, distinctly lumpy or nodular masses, resembling somewhat flattened carbuncles; partly covered with pustules and partly showing a glairy mucoid or sero-purulent discharge from many of the follicular openings. The surface may become denuded here and there, and exhibit a tendency to papillomatous vegetations. In this form the hairs, as a rule, soon drop out. This nodular or lumpy type of the disease is the classic type, and is well shown in Fig. 3, the whole under part of the chin and hairy neck being the seat of lumpy, nodular infiltrations. The extent involved is here large; in exceptional cases the disease may consist simply of a single small area, from half an inch to an inch in diameter, and present the appearance of a carbuncle-like abscess, as shown in Fig. 4, a patient exhibited here last winter. I have known the disease in such cases as this last to be viewed as an ill-defined flat abscess or carbuncle, and

treated accordingly till the error in diagnosis became self-evident.

The usual sites of trichophytosis barbæ are the chin, under the chin and jaws, the adjacent hairy neck, and the bearded sides of the face; the extent involved, as you have seen, varying considerably in different cases. The upper lip is rarely invaded, even when the disease is quite extensive; in this respect the patient before you is exceptional. Ordinary ringworm patches may coexist on other parts; for instance, as you see, this patient has a typical ringworm patch on the back of one hand; and I may add also that his wife has in the past week developed a patch on the cheek. The several varieties shown in these photographs represent the disease as commonly met with. Almost all the cases are mild and superficial at first; some remain so throughout, others advance slowly, others rapidly, into the true classic, deep-seated, or nodular form. Exceptionally, instead of beginning as one or more simple ringworm patches, ill-defined small areas of superficial or deep postulation or follicular inflammation first appear, resembling folliculitis barbæ (sycosis vulgaris). Rarely it may begin as a few closely but irregularly grouped papulo-pustules or pustules.

The disease, as you know, is contagious, the trichophyton fungus being the infecting and contagious element. It is not uncommonly contracted in barbers' shops; hence the term "barber's itch." In the large proportion of cases the patient will state that the disease first appeared a few days after being shaved in a strange shop. In other instances it is contracted from a child or children of the family who may have ringworm of the scalp or upon non-hairy parts; ringworm of the scalp, as our clinic shows, is not at all uncommon. In other cases it is contracted from the lower animals.

As a general rule, there should be but little difficulty in recognizing the disease. In the superficial form the ring-like character is usually diagnostic. This type should not, however, be confounded with the circinate and serpiginous syphiloderm; the latter is slow in progress, the border more infiltrated and prominent, often showing ulceration, and the central or cleared-up part usually atrophic or scarred. In the deep-seated cases the peculiar lumpy or nodular infiltrated areas can scarcely be confused with any other disease. A single nodular tuberculo-pustular area resembling a carbuncle or flat abscess, already referred to, occurring on these parts should always be viewed with suspicion, and the probability of its being due to the ringworm fungus carefully considered. The history, the falling out of the hair, etc., are also important factors, and not infrequently a characteristic simple ringworm patch will be found to coexist upon non-hairy parts. In doubtful cases microscopic examinations

of several hairs from the invaded areas should be resorted to. Simple sycosis (sycosis, sycosis vulgaris, coccogenic sycosis, folliculitis barbæ), with which ringworm sycosis is apt to be confounded, does not present itself in rings, is slower and more insidious in its progress, is usually diffused and superficial and less patchy; the upper lip is frequently involved, either alone or in conjunction with the disease on other bearded parts.

Fortunately, the disease, although often presenting active and repulsive symptoms, is usually rapidly amenable to treatment. All cases are curable, and only in the worst type and in long-neglected cases is there any conspicuous permanent hair loss or other disfigurement. A period of several weeks or several months is required to bring about a cure. After apparent cure a relapse should be guarded against by occasional remedial applications for a few weeks or a month subsequently. The affection being a distinctly local one, constitutional remedies are, as a rule, not prescribed; but in those cases in which the pusformation is a conspicuous element, cod-liver oil, the hypophosphites, or similar nutrient tonics seem to have a favorable influence. An essential part of the treatment should be depilation,—extraction of the hairs from the diseased areas,—especially in the deeper seated types. I am convinced that this procedure will shorten the period of treatment fully one-third and possibly one-half. On unaffected parts the beard should for obvious reasons be kept closely cut. Almost any of the so-called parasitocides will be found efficient, such as ointments of sulphur, of carbolic acid, of white precipitate, or citrine ointment, lotions of sulphur compound, of mercurials, of carbolic acid, etc. The treatment here has gravitated to two plans, as being the most promising of rapid results,—one a sulphur treatment and the other a mercurial. Both are doubtless equally efficacious, but in some instances when process is slow or unsatisfactory from one plan a change to the other is found to be of advantage. In the sulphur treatment a lotion of sodium hyposulphite, one drachm to the ounce, and an ointment of precipitated sulphur of from ten to twenty per cent. strength, are conjointly prescribed. The mercurial plan consists in the use of a corrosive sublimate lotion, from half a grain to two grains to the ounce, together with the employment of an ointment of ten per cent. oleate of mercury, two or three drachms to the ounce of simple cerate, or simple cerate and lard, or, in place of the latter, a white precipitate or calomel ointment from thirty to sixty grains to the ounce. The plan being selected, the method of carrying it out is as follows: The lotion is applied freely, being thoroughly dabbed over the affected areas and somewhat less liberally over the whole bearded region,—over the latter in order to prevent the



FIG. 1.—Barber's Itch, superficial type.



FIG. 2.—Barber's Itch, medium type.

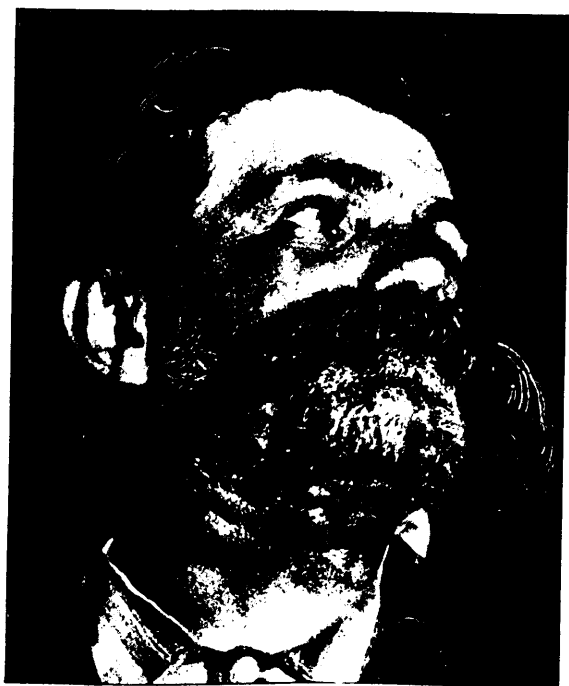


FIG. 3.—Barber's itch, classic nodular type.

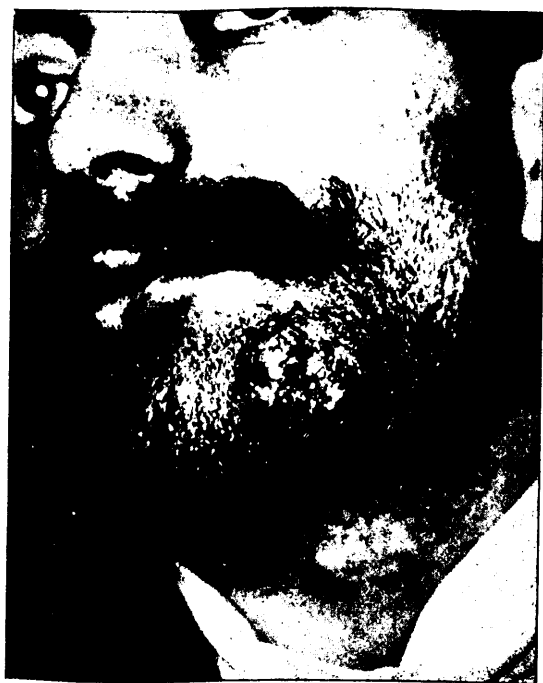


FIG. 4.—Barber's itch, circumscribed nodular patch.

infection of new areas; after the wash has dried, the ointment is to be well rubbed in, usually over the diseased places only, but, if there is a decided disposition towards spreading, the ointment as well as the lotion should be applied, once daily at least, to the entire bearded part of the face and neck. The applications should be made morning and evening, and in urgent cases three or four times daily. Before each reapplication the parts should be washed off with warm or hot water, with the use of soap when necessary. Treatment should be continued vigorously till all vestiges of the disease have disappeared, and then, as already stated, intermittently or less actively for several weeks. By this subsequent intermittent or less active treatment the possibility of relapse is reduced to a minimum.—*Inter. Med. Mag.*

ARTIFICIAL SERUM.

M. Lejars has published an interesting article which merits the attention of practitioners. He relates a case of diffused peritonitis from rupture of the intestine, followed by a flow of stercoral and purulent matter into the cavity. The condition of the patient was despaired of by the surgeons in attendance, in spite of laparotomy, which had been performed as soon after the accident as it was possible. As a last resource, and for conscience sake, a pint of artificial serum was injected into the subcutaneous tissue. The following day the patient was somewhat worse, the pulse was frequent (130) and irregular, the temperature below the normal, and black vomiting set in towards evening. The subcutaneous injections were renewed morning and evening. Twenty-four hours afterwards, the temperature rose to 102°, while the urine was rare. M. Lejars, at this stage, injected two pints of the serum into the vein of the arm. The pulse became a little stronger, and the patient expressed himself as feeling better. Two other intravenous injections were made that same day, and continued at the rate of three daily for four subsequent days. The general condition constantly improved under this treatment. After an interruption of two or three days the patient became less satisfactory, but on the ninth day, they were suppressed altogether. Consequently, in the lapse of nine days, the patient received *forty-five pints* of artificial serum! The patient was saved in spite of an accident which might have seriously complicated the situation. On the tenth day, through an effort at coughing, the line of sutures burst, and the mass of intestines bulged forward through the wound, covered only by the peritoneum.

Two other cases were related by M. Lejars witnessing in favor of intravenous injections of artificial serum, and from which he drew the following conclusions:—Intravenous injection of aseptic

serum at blood temperature and in massive doses (two pints three times daily) are inoffensive; these injections are capable of bringing about most un- hoped for cures in certain affections, especially those conncted with the peritoneum; the injections seem to act by provoking large evacuations of the toxins of the blood, through the kidneys.

The author terminates his article by giving a description of the *modus faciendi*. "Our method of operating is very simple. We use a glass recipient properly sterilised, and a glass cannula with a fine point; the vein is dissected through a small incision, tied and opened with every antiseptic precaution above the ligature, and the cannula introduced, care being taken not to let in a bubble of air. By raising the recipient the liquid enters by its own weight; a certain thrill felt by the finger indicates that the solution is penetrating. At the end of the operation the vein is tied above the wound and the skin brought together by two sutures. At the second injection a segment immediately superior of the same vein is opened or one of the neighboring veins. In proceeding thus by segments from below upwards from the bend of the elbow to the shoulder, on the superficial veins, quite a series of injections can be made, clets being entirely exceptional. In the case above related in detail more than twenty injections had been made in one arm.

"It might be possible to pierce the vessel directly with the point of the canula, if it were standing out in bold relief, but it must be remembered that the cases where these injections are useful the veins are frequently flaccid. Out of fifty intravenous injections we never observed the slightest accident, nor have we remarked that the operation was painful. Sometimes, however, we observed a little dyspnoea at the end of the injection. The patients feel the liquid penetrating, they experience, at first, an irritation of the tongue and mouth, then a difficulty in breathing and finally a sharp abdominal pain of short duration, all these sensations proving that the liquid was being rapidly diffused. As to the liquid, the useful formula of Prof. Hayem is—

- R—Chloride of sodium (pure), ʒj
- Sulphate of soda, ʒij
- Distilled water, 1½ pints.

"The question of intravenous injections as applied to certain diseases is still on its trial, but in my opinion we have here a therapeutic method of considerable value in the great struggle with death."—Paris Correspondent *Med. Press.*

GELSEMIUM is the most potent drug known for the relief of cold in the head. If taken early, drop doses of the fluid extract administered hourly usually secure most satisfactory results.

INTUBATION IN DIPHTHERIA.—Bokai (*Deut. Med. Woch.*) discusses the question of how long the tube must remain *in situ*, his observation being based on 763 cases of intubation. Of the 763 cases, 268 recovered. Ninety cases, with 45 recoveries, have occurred since the introduction of the serum treatment. Out of the 673 before the serum treatment, 223 recovered, and only in 8 cases was secondary tracheotomy necessary. The duration of intubation was from a quarter of an hour up to 240 hours, except in seven cases, where it exceeded 10 days. In 62.77 per cent. the tube was in under 72 hours, and in 82.33 per cent. under 120 hours. The author gives details of cases in which the duration was under 24 hours, and also of two cases in which it was 349 and 360 hours respectively, the latter being the longest time. The mean average duration was 79 hours in 215 cases. It is the author's custom to withdraw the tube after 48 hours; in the 27 cases in which the tube was out before this time, it was due to the child expectorating it or pulling it out by the string, and to further introduction being unnecessary. In the 45 intubated cases of recovery under the serum treatment a secondary tracheotomy was only once necessary. The minimum duration of intubation was 2 hours, the maximum 168 hours. In 77.26 of these cases the tube was left out within 72 hours. The author gives his tables which show that under the serum treatment the number of cases in which the tube can be left out within the first and second 24 hours is greatly increased. He compares these figures with those obtained from observations on withdrawing the cannula in tracheotomy, where the results are very different. Although the tube remained over five days in 16.2 per cent. of the author's intubated cases, yet there was no case of severe decubitus (erosion) in the larynx. Thus secondary tracheotomy can be avoided. If the above numbers are added to those of Bleyer and Baer, it is found that out of a grand total of 479 intubated cases the tube remained in no longer than 5 days in 19. per 2 cent. The author then discusses the relation of this length of time to the question of decubitus. Finally he draws the following conclusions: (1) That the time for withdrawing the tube varies within very wide limits; (2) that the average time was 79 hours before and 61 hours after the introduction of the serum treatment; and (3) that he can not share the opinion of some writers who maintain that a secondary tracheotomy must be done if the tube can not be left off within five days. No definite fixed time can be laid down. The unquestioned presence of severe decubitus in the larynx is an undoubted indication for a secondary tracheotomy, but the mere fear of such arising should not be taken as an indication.—*Brit. Med. Jour.*

MUSSER (*Univ. Med. Mag.*), in reporting a protracted case of typhoid fever, says: Anyone who is familiar with a protracted case of typhoid fever will readily appreciate at what wit's end one is often placed to meet the varying indications that are constantly arising. So many matters of therapeutic interest, and management arose in this case of decided interest that I venture to present a few of them, at least, for your considering. First, *diet* and *stimulants*. Milk was given for a time in the quantities usually advised, but it was soon found that the amount had to be considerably reduced. Even then it was rejected and cream substituted. Animal broths were refused by the patient. When the vomiting became pronounced the patient was fed by enema. The occurrence of the hæmorrhages forbade at one time feeding by this means. The one stimulant especially relied upon, and which seemed to be the most beneficial, persistently used, was *coffee*. This was given during the height of the disease to the period of deferescence. At first two tablespoonfuls could be taken, hot and without cream or sugar, every two, three, or four hours. Later it was given in larger amounts at longer intervals. Both champagne and whisky were used at different periods. During the time of the greatest gastric disturbance the champagne was the most acceptable. It was administered in the usual manner. I particularly wish to refer to the use of coffee, and urge the more constant use than we are accustomed to give it in acute diseases. I am quite sure that it contributed to the saving of the life of this patient, and it appeared to have a good effect in preventing vomiting.—*N. Y. Polyclinic.*

ON THE LINE OF ACTION TO BE ADOPTED IN THE CASE OF A WOMAN WHO IS ABOUT TO DIE WHILE YET UNDELIVERED.—Remy (*Journal de Médecine de Paris*) advises under such circumstances as these that an effort be made to save the life of the child, and as a means of accomplishing this three plans have been suggested. They are: (1) to wait for the mother's death and then immediately to extract the child; (2) to do Cæsarean section while the mother is yet alive; (3) to employ means to expedite labor and to extract the child by the natural passages as speedily as possible.

Remy then proceeds to discuss the relative advantages of these different modes of action. Prunshuber's statistics show that when the mother is allowed to die before the child is extracted by abdominal section only about 5 per cent. of the children survive. Puech's statistics are somewhat more favorable; but there can be no doubt that the chance of obtaining a living child under these circumstances is very small. The performance of Cæsarean section upon a dying woman who is unable to give her consent to the operation is undoubtedly open to sentimental objections. Gus-

serow and Manasse consider that the operation is justifiable under the following conditions: (1) when it is clearly proved that the mother is about to die, and (2) that the child is alive. Remy favors the plan of rapid dilatation of the cervical canal and extraction of the child per vaginam. Violent measures should be avoided, and the dilatation should be proceeded with as slowly as the condition of the mother will permit. The cervix may be dilated by means of Champetier de Ribes' bag or by the hand alone. If traction is made upon the bag, dilatation may be produced in less than half an hour.—*Practitioner*.

HOW TO ALLAY THE PAINS OF BURNS.—The immediate relief of the pain of burns and scalds is a matter of much practical importance to the surgeon as well as to his patients. Constitutional shock is thereby lessened and one of the initial dangers of injuries of that class is avoided. The subject is one of widespread interest, and it is not altogether surprising to find the lay newspapers giving prominence to a means of stopping the pain of burns said to have been lately introduced with great success by a surgeon of the Charité Hospital in Paris. The remedy, with which many readers are already doubtless familiar, is a solution of picric acid. That it is an altogether harmless application, as claimed by the Parisian surgeon, is a statement open to some question. Picric acid is toxic to man, as to the lower animals, and when given internally causes gastric disturbance, rapid wasting, and universal staining of tissues, without elevation of temperature. If, then, a solution of the acid were applied to a raw surface resulting from a burn or scald, absorption of a dangerous amount might readily take place. As every one knows, the pain of such injuries may be readily controlled by other means. Perhaps the best known is a solution of bicarbonate of soda, a teaspoonful to the pint of water, which often acts like a charm. A weak solution of carbolic acid has an almost instantaneous action in controlling the terrible pain resulting from such wounds, and a similar observation is true of various other antiseptics, among them preparations of sanitas fluid and oil. There could hardly be any more practical application of science than the relief of a distressing symptom of this kind by the modern surgeon.—*Med. Press*.

A CLINICAL STUDY OF ANTIKAMNIA.—The *New York Medical Record* contains an exhaustive article under the above caption by Samuel Wolfe, A. M., M. D., Physician to the Philadelphia Hospital; Neurologist to the Samaritan Hospital, Philadelphia. He summarizes as follows: "I feel justified from my experience, to formulate the following conclusions: That antikamnia is valuable for reducing temperature in febrile complaints.

That it is of service in many forms of pain connected with febrile diseases. That it has a field of use in rheumatic and gouty affections. That in neuralgic and myalgic pains, it is not only palliative, but along with other measures, assists in ultimate cures. That in neurasthenia, hysteria and migraine, it is a valuable adjuvant to the other recognized therapeutic measures. That in organic nervous diseases, it has a field of application. That it is the least depressing of all the drugs that can exercise so extensive a control of pain, and also least disturbing to the digestive and other organic functions." He further states:

"The scientific physician prefers always to treat a cause or condition, rather than a mere symptom. If he can remove pain, by abolishing its cause, he will do so, rather than to blunt the sensory structures so that the pain is not felt. The demand for relief from mere symptoms, however, frequently becomes imperative, and this is especially the case when pain is present. We could cease to respect the physician, who in the presence of an acute agonizing pain, which mechanical or other means could not quickly relieve, who would withhold the hypodermic morphia. On the other hand, we applaud the sentiment which seeks for measures to combat this symptom, carrying with them less of the remote dangers, which are inherent in the frequently repeated and long continued use of opiates."

FŒTAL HICCOUGH.—Singultus has been observed in the child in utero for many years. The author has recently seen two cases. He thinks that no pathological significance can be attached to the phenomenon. It has been observed as early as the seventh month and up to and during labor. Active movements on the part of the mother may cause an attack, and likewise prolonged and rough palpation; but the attacks may also occur during the woman's sleep.

Hink observed an attack of hiccough in a deeply asphyxiated child, unattended by the usual sound, and after removing some mucus from trachea the child had another attack, attended by the usual characteristic noise. He concludes from this case that there is a kind of singultus without the passage of air through the glottis, and that, therefore, this phenomenon can occur in utero. This movement can be distinguished from others by its position over the back and shoulders of the child; by its frequency, about every four seconds, which excludes fœtal or maternal pulse; and by the suddenness of the motion, its jerky character, and short sound, which distinguish it from partial contraction of the uterine or abdominal muscle.—*Chicago Medical Recorder*.

MIXED INFECTION IN PHTHISIS.—Spengler has endeavored, in fifty cases, by means of bacteriological examination of the sputum and carefully conducted autopsies, both from the bacteriological and anatomical stand-point, as well as by a careful comparison of their clinical histories, to get some explanation of the different types in which phthisis manifests itself. As a result he arrives at the following conclusions: 1. In tubercular phthisis only a small percentage of the cases are uncomplicated cases of tuberculosis of the lungs. If fever is present in these pure cases, the extent of the mischief is much greater than the physical examination would lead one to suppose, and the prognosis is unfavorable. They become still more unfavorable in case a mixed infection is added. These cases are adapted to the tuberculin treatment. 2. Most cases of phthisis are complicated by a mixed infection with streptococci, and may be classified as active or passive, according as fever is present or not. The prognosis of the active form is good if it complicates a local tuberculosis, remains circumscribed, and receives prompt climatic treatment. Other bacteria, as well as the streptococcus, may complicate tuberculosis, such as Fränkel's diplococci, staphylococci, tetragen, influenza and pseudo-influenza bacilli, and others. If secondary bacteria appear in a few colonies only in several sputum examinations, fever, if it be present, is not due to the mixed infection but to the tuberculosis, or to some focus of infection other than the lungs. If fever is absent and yet streptococci are found in considerable abundance, the sputum should be carefully washed in order to rid it of accidental impurities from the upper air-passages; and then, if they still persist, the presence of bronchiectasis or cavities may be inferred.—*Clin. Med. Rec.*

In response to the toast *The Medical Press*, at the Missouri Valley Medical Society, one of our fellow laborers in the vineyard has this to say of the medical journal.

"The editors of medical journals, do not boast of moulding medical opinion; aspiring only to be the avenue of the profession to the medical public—an exponent, not a dictator; an arena upon which physicians and surgeons and specialists may meet and exchange their views in any department of the science.

It is said that pharmacy is the handmaiden of the medical profession.

If so, then the medical journal is the bicycle, I should say the vehicle, in which she rides.—*Bul. Am. Med. Assoc.*

THE UTERUS IN ECTOPIC GESTATION.—Pilliet (*Ann. de Gynec. et. d'Obstet.*), has studied the histology of the modifications which the uterus undergoes in tubal gestation. He finds that the

development of a decidua in its empty cavity during ectopic pregnancy is more than a pathological phenomenon; it is a distinct clinical complication. As long as the decidua remains in place the uterus is practically in a condition of subinvolution; hence both hæmorrhages and membranous dysmenorrhœa may occur. When the decidua has been shed there is danger of diffusion of metritis to the whole uterine muscle. Pilliet adds rather significantly that the etiology and pathology of endometritis are both obscure, and that probably ectopic gestation, overlooked in the early stages, may account for many peculiarities in cases of endometritis hitherto hard to explain.—*Times and Reg.*

THE WISDOM TEETH AND THE TONSILS.—In the *Mercure Médical* for November 15th there is a paper which was read before the Bordeaux Society of Medicine and Surgery by Dr. Dunogier, who related a case of relapsing amygdalitis caused by the eruption of the lower wisdom teeth and a case of chronic amygdalitis kept up by difficulty in the eruption of a wisdom tooth. The treatment of such cases, the author remarks, is of two sorts—preventive and curative. In regard to the practice of extracting the first molar tooth at about the eleventh year of age, he confesses that he does not share the apprehensions that have led some of his *confrères* to advocate that procedure, and he adds that he has never seen the regularity of the dental arch interfered with by allowing the tooth to remain. Moreover, he does not consider that complications due to the appearance of the wisdom teeth occur often enough to call for the extraction of the first molars as a preventive. Curative treatment, of course, consists in doing away with the cause, meaning not necessarily the tooth, unless it deivates, but the gum.

Paul Bergengrün (*Archiv f. Laryngol. und Rhinol.*, Bd. ii, Heft 2) relates the histories of seven cases of laryngeal tuberculosis which healed without surgical treatment. He used locally lactic acid and iodoform. One patient was curetted and the lesions healed not only where the parts of the larynx were curetted, but also where they were not. In one case he used tuberculin, which caused intense local reaction, but resulted favorably in the end.

EXTIRPATION OF TUMORS OF THE BREAST.—F. H. Wiggin endorses the modern operation of complete extirpation in cancer of the breast (including pectoral muscles as well as axillary glands and intervening tissue), and emphasizes the necessity of early removal. Rapid cicatrization of the wound is secondary in importance to thorough removal of adjacent tissues.—*Lancet.*

OBSTETRICS AND GYNÆCOLOGY

IN CHARGE OF

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ON THE INDICATIONS FOR EXAMINATION AND TREATMENT OF CERTAIN CONDITIONS IMMEDIATELY FOLLOWING CHILDBIRTH.*

This subject would open up a wide field for study, were the attempt made to treat it exhaustively. My aim is to bring forward some practical points of daily occurrence which are important in consequence of their frequency, and because a too common neglect to receive prompt attention often leads to serious results. If a woman during her early puerperium be seized with a rigor followed by high fever and all the indications of septic poisoning, or by a free hæmorrhage, the indications for immediate and radical interference are forcibly brought to the medical attendant. But under less urgent conditions a more conservative course is too often pursued.

Minor disturbances, such as severe "afterpains" accompanied by free uterine flow and the escape of clots, a large, sensitive uterus, slight elevations of temperature, fœtid lochia with or without such febrile reaction, sensations of pelvic weight and distress, loss of appetite, and mental depression, represent the clinical picture in the class of cases to which I desire to direct your attention. In some cases the departure from a normal convalescence is so slight that the term "a slow getting-up" may apply, and it is in such that I make the plea to have the condition of the uterus investigated.

In no class of cases is the temperature range such a sure index of the condition of the patient as during the puerperium. No matter how well the patient expresses herself, if the temperature range is only one degree above the normal curve the attendant should not rest satisfied until he has explored the condition of the uterus and ascertained the cause. It is bad policy to neglect even these slight excursions of temperature, trusting to Nature to correct the difficulty, or to attribute the symptoms to some condition existing outside of the birth canal. The only safe course

is to consider that the cause of all these deviations from a normal convalescence exists in the reproductive organs, and to look elsewhere only after a careful examination has demonstrated it otherwise. It is a matter of astonishment that at times the examination finds so little to account for the tardy convalescence, and yet the correction of that little changes the entire aspect of the case. On the other hand, the reverse holds good, and we find local changes of a severe type accompanied by very little constitutional disturbance.

To illustrate these points I will briefly refer to experiences which are fresh in my mind.

On March 1st, 1894, I was called in consultation to see a primipara who had been delivered about three weeks before. Her temperature had been raging between 99° and 100°, tongue coated, bowels sluggish, no appetite, spirits depressed. After the tenth day she had sat up a little each day for a week, but after that felt no disposition to leave her bed. She had complained of tenderness over the right iliac space, for which a blister had been applied. Examination of the pelvic organs showing nothing abnormal, I suggested irrigating the uterine cavity. This was done with a warm two per cent. carbolic acid solution, and a little shreddy tissue escaped in the return current. The temperature became normal, and after three more irrigations the patient was fairly convalescent. In this case a mild endometritis was the cause of retarded recovery.

In another case I was consulted by a brother-practitioner about his wife, who had given birth to her first child four weeks before. For the first ten days there was no trouble, except a daily evening rise of temperature to 99.2°. After the ninth day carbolized vaginal douches had been given. On the twelfth day the temperature went up to 102°. An intrauterine douche was administered, and for the next four days the temperature was normal in the mornings but slightly elevated in the evenings. On the seventeenth day the temperature reached 101.2°, and the intrauterine douche was repeated with the same result. On the twenty-sixth day the temperature again went up to 101.2°, and I was asked to see the case, as

* President's address, delivered before the Washington Obstetrical and Gynecological Society 1895.

they were discouraged and anxious because of the persistent recurrence of these febrile attacks.

Examination revealed a large, retroflexed uterus. The malposition of the organ interfered with drainage, and the accumulated lochial discharge decomposed and produced the fever. The irrigation would cleanse it for a time, but, the condition being reproduced after a short interval, the fever would recur. The organ was replaced and held, at first with tampons saturated in a glycerine solution of boroglyceride, and afterward with a pessary. There were no further disturbances and the patient was soon out of bed. Later the pessary was discarded entirely and the organ remained in proper position. This patient had recently given birth to a second child and had a perfectly normal labor and convalescence, the uterus maintaining its proper position.

To emphasize the opposite state of affairs—viz., a severe type of local changes with little constitutional disturbance—I will briefly refer to a case that came under my observation during the past summer. The patient, a primipara, was placed in my charge by her family physician, Dr. D. W. Prentiss, at about the eight month of pregnancy. From him I learned that she had been of delicate health during girlhood, and about three years before she had suffered severely from Basedow's disease. Prominence of the eyeballs and accelerated heart's action were still apparent. She was placed upon strophanthus, and on July 16th I was sent for to attend her in labor. The confinement was normal in every respect. Although she got along nicely during the succeeding days and said she felt perfectly well, her evening temperature ranged about one degree too high. The lochia were normal for the first days, but later had some fetid odor. Antiseptic vaginal douches having been employed without any improvement of the odor, I determined on the seventh day to irrigate the uterus, although the temperature had never been above 100.2° and she expressed herself as feeling very well. The introduction of the irrigating tube was followed by the same result as if a trocar and canula had been thrust into an abscess: at least four ounces of thick, yellow pus escaped. After two or three irrigations the temperature came down to normal, and from the first one there was a rapid reduction in the amount of pus. The interest in this case was the absence of constitutional symptoms, except the very slight elevation of temperature, in spite of the presence of pus and the activity of the uterine absorbents.

Next to the thermometer the most valuable index of minor departures from the normal state is the condition of the lochia. They may be too free; may contain clots or shreds of tissue; the sanguinolent character may persist too long, or it may disappear to recur without cause or upon assuming the upright position. They may be

purulent, or they may present an odor, more or less marked, of putrefaction.

Any one or combination of these changes should demand attention, whether accompanied or not by constitutional disturbance. The cause is easily corrected, as a rule, and immediate danger or remote invalidism prevented.

Investigation of the uterus will generally bring to light some or other of the following faulty conditions:

1. The uterine tumor is larger than it should be and is slightly sensitive. Retraction has been deficient, and there has been oozing into the cavity and some blood clots retained.

2. Retention of some fragments of placental tissue or shreds of membrane.

3. The action of the bacteria of putrefaction on these tissues, and the development of ptomaines with or without absorptive fever.

4. Necrotic endometritis, localized or diffused, simple or purulent.

5. Displacements of the uterus.

Before taking up the treatment of these conditions, reference will be made to certain precautionary measures that should be employed in every case of labor.

Obviously it should be sought to secure:

1. Firm contraction and retraction of the uterus.
2. A perfectly empty and aseptic uterus.
3. A uterus in good position to secure free drainage.

Firm retraction of the uterus is essential to the guarantee of a satisfactory convalescence. It is Nature's ligature for controlling hæmorrhage from the open sinuses after placental separation. The hæmorrhage may vary in degree from an oozing to the most frightful escape of blood that one can have the misfortune to witness. Out of respect to my audience I refrain from giving the physiology and rules of conduct of the third stage of labor, but I ask to mention a few simple errors in this connection which are frequently responsible for failure. These are premature efforts to extract the placenta, insufficient rubbing and massage of the uterine tumor, injudicious traction on the funis, failure to follow down the uterus and to continue the rubbing and massage after expulsion of the afterbirth, and finally moving, raising, and changing the position of the patient while cleansing and fixing her in bed. If the woman has been delivered on her side the position should be changed for the dorsal before extracting the placenta. These may seem unimportant steps, but their neglect is often responsible for oozing and retention of clots *in utero*.

To secure firm retraction of the uterus in cases of hæmorrhage of minor degree, the best agents are massage and rubbing the uterus, the introduction of the aseptic finger and removal of clots, and the intrauterine irrigation of a hot antiseptic

solution. If these fail to promptly arrest the flow I have never been forced to apply but one other means, and that is the introduction *in utero* of iodoform gauze. This is removed the next day and the uterus washed out.

Next to firm retraction of the organ was mentioned the importance of a perfectly empty and aseptic uterus. The same measures employed to obtain firm retraction secure an empty uterus, and the evils mentioned in connection with the former apply equally well in the latter. Premature efforts to extract the placenta and injudicious traction on the cord are responsible for many failures to secure an empty uterus. In delivering the placenta by expression care must be taken that its exit from the vagina is not too rapid. It should be caught in the hand, held a moment, and the membrane twisted into a rope. Practitioners have been severely criticised because small pieces of placental tissue have been retained without their knowledge, and in one case I know of the accident was made the means of injuring the reputation of a careful physician. Not infrequently the afterbirth is delivered in a perfectly normal manner, it is apparently intact, and yet subsequent turn of events demonstrates that a small piece had been left attached to the uterine wall.

Several explanations may be offered to account for these failures. The existence of a placenta succenturiata is one. Cotyledons may become detached from the organ and remain adherent while the fully formed placenta is expelled. A very recent experience of this kind accentuates its importance. I had delivered a primipara after an easy labor and extracted the placenta and membranes naturally. The next morning her temperature was $99\frac{1}{2}^{\circ}$ and she was doing well, except that the uterine tumor was too large and sensitive and she complained of more or less constant pain in the organ. Compression reduced the size of the mass and expelled some dark clots. That they were not the source of trouble was shown by slight chilly sensations and rise of temperature to 101° during the evening of the same day. The uterus was still tender and large. The placental forceps was introduced within the uterus and a circular piece of placental tissue about one and a half inches in diameter was extracted. The douche curette was used but nothing more found. Prompt relief of the symptoms followed.

Another explanation for the retention of placental fragments is that the line of separation between placenta and uterus may not always follow that intended by Nature. This line is not the junction of fetal and maternal tissues, but it is within the cells of the decidua serotina, so that, when physiologically terminated, the expulsion of the placenta carries with it a layer of maternal tissue. Slight adhesive spots may deflect the line of separation and encroach upon placental tissue, leaving more

or less of the tufts of villi attached to the maternal structure. These adhesions may be the result of inflammatory action or simply a failure of those changes to occur, changes attributed to fatty degeneration, which mark the weakest spot and prepare the organ to separate and fall off like a ripened fruit. Exaggerated conditions of this kind are met with in the so-called adherent placenta, where great difficulty is sometimes met with to separate the attachment of the organ. In these cases the greatest care is necessary to remove all placental tissue. According to my observation abnormal adhesions of the placenta have been commonly associated with prolonged gestation. If there be any reason to suppose that the afterbirth is torn or any portion left attached, the finger should be introduced and the uterine cavity explored. In uncomplicated cases of placental delivery the indications for such examination would be a too free discharge of blood occurring in spite of the existence of a firmly retracted uterus and in the absence of lacerations of the birth canal.

In addition to an empty uterus it is important to have it aseptic. This point is passed by, as the importance of the subject and the methods of obtaining it are familiar to every one.

3. The uterus should be in position to secure drainage of the lochia. The deviations from normal are usually backward. The organ is enlarged, softened, and heavy, the ligaments lax and lengthened. After the fifth day of the puerperium involution reduces the size of the organ sufficiently to permit the fundus to fall under the sacral promontory. Retroversion is changed into retroflexion, and occlusion results at the angle of flexion. More rarely the heavy uterus bends forward and ante flexion produces the same condition. Retention of the lochia leads to their decomposition, endometritis, absorption of the products of putrefaction and fever. A uterus displaced before pregnancy is very apt to have the abnormal position reproduced afterward, and prudence would suggest in these cases the use of a pessary after the fourth day of the puerperium.

Primary displacements are favored by continual back position and the pernicious use of the compress. This contrivance, in the first place, is unnecessary, and, in the second, is often applied in such a faulty manner that it only serves to push the uterus backward. It is unnecessary, because a woman should not be bandaged until the uterus is firmly retracted and there is no danger of subsequent relaxation. The application is often faulty, because instead of being placed so that the tightened bandage forces the compress down above and behind the fundus, it is put over the anterior surface of the uterus and pushes the organ backward. Only the large size of the uterus soon after confinement prevents backward displacement resulting from this cause.

Primary displacements, if treated with a pessary, are nearly always cured in a few months.

Secondary or reproduced displacements are not permanently benefited. I have repeatedly attempted to take advantage of the process of involution to cure pre-existing displacements, but cannot recall a single success.

The symptoms and treatment of the complications mentioned next demand our attention.

1. Deficient retraction, oozing, and retention of clots *in utero*.

This is more likely to occur in multiparæ, and especially after rapid labors. The uterine tumor is larger than normal and sensitive. Severe after-pains are common. The thermometer indicates a slight elevation of temperature, but it rarely exceeds 100° in the evening unless putrefactive changes occur. The lochia are too free or continue too long and clots may escape. Putrefactive changes in the clots impart a disagreeable odor to the flow.

This is a simple condition, but is one too often left for Nature to correct. All the treatment necessary in the majority of cases is to give a vaginal douche, temperature 115° to 125°, and at the same time to empty the uterus by compression. The relaxed condition of the abdominal walls at such a time permits the physician to grasp the organ with both hands and to express the clots by Credé's method of placental delivery. This manipulation should be done by the physician himself and not left to the nurse. A purgative given on the second or third day, and the patient assuming a sitting posture during defecation, often expels clots from the uterus.

If these simple measures fail, the uterine cavity should be explored and cleaned out with the finger, placental forceps, or douche curette.

2. The retention of some fragments of placental tissue or shreds of membrane is a common complication. Unless the amount of foreign matter retained is not unusually great, the symptoms differ from the preceding in that the uterus is not enlarged nor sensitive. Afterpains are not prominent, and the condition is met with as often in primiparæ as in multiparæ. The one symptom common to both is excessive discharge of blood in the lochia. It occurs in this case in spite of firm retraction of the uterus and in the absence of lacerations of the birth canal. The complication may be manifested not so much by free discharge as by the persistence of the bloody lochia or by their repeated recurrence. These recurrences may appear while the patient remains in bed, but often do so on changing the position, or may be delayed until getting out of bed.

The early detachment and escape of the retained tissue is the most favorable termination. Sometimes the adherent placental tufts do not manifest their presence until late in the puerperium. I

recall the case of a primipara, delivered October 2nd, 1894, who passed through her lying-in period satisfactorily, and on November 5th, which was five weeks afterward, was taken with a hæmorrhage while out walking. The next day a profuse and alarming discharge of blood occurred before getting out of bed. With the dull douche curette a quantity of placental tissue was removed and no further trouble occurred.

The treatment of this complication is the removal of the foreign substance as soon as we suspect its presence. If bleeding such as described occurs after the third stage of labor, the finger should be passed into the uterus, the cavity explored and completely emptied. The conditions all favor this line of action. The uterus is easily depressed, the vagina is capacious, and the cervix dilated so that the finger is readily passed. When interference is called for later the placental forceps and douche curette must take the place of the finger, unless the cervix be dilated under anæsthesia. The placental forceps is objected to as a dangerous instrument. It is dangerous only when carelessly used, and the same objection will apply to any instrument. It is not in every way a satisfactory instrument, as some of the retained tissue may escape its search, and we have no means of knowing that the uterus is entirely emptied unless the finger can be inserted. The dull douche curette is more thorough, as we can go over the entire surface, scraping and loosening the attached pieces, while the current of the warm antiseptic solution washes them out. After this is done a piece of iodoform gauze is passed into the uterus for its hæmostatic effect, if such be indicated. It is removed the next day and the uterus washed out with a warm carbolic acid or creolin solution. Hot antiseptic douches, vaginal or intrauterine, meet all further demands for treatment.

The gauze is introduced, as stated, for its hæmostatic effect, and not for drainage. The professional ears of some may be shocked by the statement that I have discarded gauze for the purpose of drainage. At best it can only drain serous fluid; clots, débris, and pus are retained behind it.

If retained tissue does not become detached and expelled, or is not removed by the means mentioned, it is liable to be attacked by putrefactive bacteria. This process may hasten the separation and the putrid substance be discharged without further complication than producing a fœtid odor to the lochia. On the other hand, there is danger of its retention, followed by fever, necrotic endometritis, and finally serious inflammatory complications which are beyond the scope of this paper to consider.

The signs of putrefaction, fœtid lochia, and elevations of temperature, even slight, are strong

indications for prompt action to remove the foreign substance and cleanse the uterus. The finger, placental forceps, or dull douche curette will accomplish this end, and intrauterine irrigation must be employed to overcome the putrefactive changes and cure the necrotic endometritis.

The endometritis may be a mild localized inflammation surrounded by a protective zone, or it may be diffused and purulent. Even in the mildest cases there is some elevation of temperature and subinvolution of the uterus. As the local and general conditions improve, the amount of shreddy tissue washed away by irrigation gradually diminishes.

The final consideration remains—the treatment of displacements of the uterus.

This complication is not uncommon, and it is important that it should be recognized and corrected. The retention of lochia is followed by their decomposition and by endometritis. Only temporary relief is gained by the curette or irrigation. The discharge reaccumulates and symptoms recur. Fever from this cause does not appear until the end of the first week, or even later. The obstruction caused by the malposition must be overcome by replacing the organ in proper position. If a pessary cannot be used at once on account of sensitiveness, the organ should be held up at first with tampons of wool saturated in a glycerine solution of boroglyceride. Besides the case already reported a number of others have come under my observation in which obstinate fever was overcome only by restoration of the displaced uterus.

The following case was recently met with. A physician, careful and painstaking in all his work, on leaving the city for a vacation placed in my care a young primipara whom he had delivered ten days before. She seemed to do well after confinement, except that her temperature curve ran between 99° and 100° and clots were passed in the lochia. On July 24th, the eighth day after labor, her temperature went up to 101°. Her attendant gave an intrauterine douche, and the same evening a piece of placental tissue came away. She seemed better afterward, and when I first saw her, and for the succeeding four days, the temperature was slightly above 99°. On the afternoon of July 29th, the thirteenth day of puerperium, her temperature was 100.8° and she had a free bloody discharge. Examination showed the uterus enlarged and retroflexed. The douche curette brought away a considerable amount of placental tissue. The immediate effect of the manipulation was to cause a chill and send the temperature up to 104°. It fell rapidly, but for the next three or four days remained one or two degrees above normal in spite of intrauterine irrigation. The uterus was then placed in position and held by a

pessary. Drainage being good, the temperature became normal and remained so without any further treatment.

In presenting these clinical cases and remarks for your consideration, I am aware of the rudimentary character of the teaching involved. If I have not made the importance of it sufficiently plain to justify my action, it is due to the imperfect manner in which I have presented the subject. I am convinced it is important not only by my own work but by cases I have seen in consultation. Certain it is that even the most painstaking and careful obstetrician will meet with these cases in his practice, and my wish is to urge prompt interference. I have no reason to regret my action in these cases, and feel that experience has taught me a valuable lesson in so doing.—Henry D. Fry, M.D., in *Am. Jour. of Obstet.*

OPERATIVE INTERFERENCE IN PERIUTERINE HEMATOCELE.—Reynier condemns the expectant plan of treatment and points to the statistics of Martin: 265 cases treated expectantly, mortality 63 per cent; 585 treated by operation, mortality 24 per cent. The procrastinating method of expectant treatment is slow and exposes the patient to relapse, suppuration, and pelvic peritonitis. The most frequent case (90 per cent.) of periuterine hematocele is extrauterine pregnancy. Operative interference is advised for the following reasons: (1) to arrest the hæmorrhage; (2) to remove from the peritoneal cavity the blood and products of pregnancy; (3) to remove the diseased adnexa and thus assure definite cure. If the hematocele is suppurating, vaginal laparotomy should be performed, while the abdominal incision is selected in recent, non-suppurating cases. The author supports his views by a report of twelve cases, laparotomy and recovery in every case.—*Am. Jour. Obs.*

CHOLECYSTENTEROSTOMY BY MEANS OF THE MUPHY BUTTON.—Two cases are reported by Baer which possess features of considerable interest. In the first gall bladder was easily connected with a knuckle of intestine below the duodenum; the button came away on the eighth day together with five hundred and twenty-seven stones; patient sat up on the sixteenth day. In the second case the patient was very fat and it was only after the greatest difficulty that the operation could be completed; it was impossible to bring up a coil of small intestine, and the gall bladder was finally attached to the *transverse colon*; recovery was slow. Now, two years after the operation, both patients are in perfect health.—*Am. Jour. Obs.*

NERVOUS DISEASES AND ELECTRO-THERAPEUTICS

IN CHARGE OF

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ENDOTHELIOMA OF THE FISSURE OF ROLANDO : EXTIRPATION : CURE.

BY M. O. KAPPELER.

It is an undeniable fact that in spite of the progress of cerebral physiology and of diagnostic topography, the cases of extirpation of cerebral tumors followed by cure are not frequent. The author has just published an observation of this kind which merits being reported not only on account of the success which followed the intervention, but also on account of the precision which M. O. Kappeler exhibited in the diagnostic topography of the cerebral lesion.

The patient was a blacksmith 43 years of age who, except for a blow on the head twenty years previously, had always enjoyed perfect health. The family history showed no tubercular or syphilitic affection. Two years ago this man began to experience a slight weakness in the right arm and leg without any other cerebral symptoms. The 15th of January, 1894, he had an attack with loss of consciousness and sharp pains in the right arm. This attack was followed by a pronounced weakness of the leg and arm of the same side. Ten days after the attack was repeated and accompanied by convulsive movements of the right hand.

The patient entered the hospital of Munsterlingen the 31st of January. He was a vigorous man, and his head showed neither cicatrices nor any especially painful points. The same evening he complained at times of slight headache without precise localization. The examination of the cranial nerves did not show any changes in them. The right leg and arm were decidedly weak. All the movements were performed but without force and slowly. The patient could only walk with the aid of a stick, and the right leg dragged heavily. The tendon reflexes were normal and equal on both sides. Except for some pains and

a feeling of formication in the right arm, the sensibility was not altered. The attacks mentioned above were repeated very irregularly; sometimes they were frequently repeated during one day, sometimes they were separated by an interval of several weeks. These lasted from one to three minutes, and were always preceded by convulsive twitchings at first in the right arm, then in the right leg, then in the right side of the face. In the most severe attacks the convulsions extended to the left side of the face also. With each attack there was a more or less pronounced loss of consciousness. After the attacks the patient experienced headache and a certain difficulty in speech. In the beginning of April he left the hospital, but was obliged to return at the end of twenty days on account of the attacks becoming more severe and more frequent, as well as an increased weakness of the right side: the patient then desired surgical interference.

The existence of a typical Jacksonian epilepsy and the fact that the paralysis only implicated the arm and leg, but not the facial nerve nor the hypoglossus, determined the author to admit that the cause was a cerebral lesion. The absence of affection of the optic nerve, of tubercular or syphilitic history, together with the course of the disease, permitted the precise diagnosis of a tumor (glioma or sarcoma) of the upper end of the fissure of Rolando.

After having determined the Rolandic line after the method of Kocher, M. Kappeler proceeded to operate. He laid bare the duramater in the middle and upper part of the fissure of Rolando. This membrane was scarcely incised when a reddish-grey tumor was perceived, of a soft consistence and the size of a duck's egg, enclosed between the ascending frontal and ascending parietal convolutions situated consequently in the fissure of Rolando. The operator succeeded without the aid of any instrument in enucleating

the tumor without difficulty, as it was encapsuled and fixed by a slender pedicle to the pia mater. The cavity itself in which the tumor was lodged was entirely lined by this membrane. The hæmorrhage, which was not abundant, was chiefly venous. After having tamponned the cavity, M. Kappeler partially closed the wound. The pulse was very frequent during two days in spite of a nearly normal temperature which never exceeded 38.2°. The cerebral symptoms following the operation consisted at first in a slight degree of aphasia, then in convulsive twitchings in the right facial which appeared later in the left. On the following day these symptoms became less marked and the patient rapidly improved. A month after the operation he could walk without assistance, and on the fiftieth day he commenced to write with his right hand.

The patient quitted the hospital soon after. Seen again at the end of four months, he was quite well and had resumed his trade. The right hand was a little stronger than the left; he used it freely and wrote without difficulty. The right leg was also stronger. The epileptic attacks had completely disappeared since the day of operation.

The histological examination of the tumor showed an endothelioma, the starting point of which was in the coverings of the brain. According to the experiments of M. Hanan and the teaching furnished by medical literature, these tumors do not generally give rise to metastases, and do not invade the surrounding tissues. The prognosis of the case related by the author must consequently be considered as favorable, thanks to the brilliant operation which was performed.—Translated from *La Semaine Médicale* by CAMPBELL MEYERS, M.D.

TRAUMATIC NEUROSIS.—Strümpell (*Munch. med. Woch.*) says that in most cases the manifestations are really psychical. The term "traumatic neurosis" is open to some objections; it is not a disease in itself, but includes hypochondriacal, neurasthenic and hysterical manifestations, etc. The psychogenic origin of these cases is generally admitted. It is mostly easy to decide whether organic disease really exists or not. The general appearance of the patient, the facial expression, behaviour, actions, and subjective complaints are characteristic. If pain is complained of in a part, the lightest touch there may give rise to much complaint. It is not really the pressure but the imagination of some disease affecting the part which causes the sensation of pain. In investigating such conditions the patient's attention must be directed away from the part. The idea of physical disability is so marked that the required innervation is not forthcoming. By attention to small details in the examination, a sound conclusion can generally be arrived at.

The author discusses the so-called objective symptoms in the traumatic neuroses. He recommends that a too careful examination of sensation should not be made in cases where there has been no severe injury. The patient's power of work is not affected by disturbances in sensation which are the outcome of auto-suggestion. The estimation of the field of vision is of even less value than the disturbances in sensation. The examination is dependent on the accounts given by the patient, and the results are often variable. As far as work is concerned, the diminution in the field of vision has no significance. From the side of the heart or lungs the so-called objective symptoms carry little weight. Even the increase in the pulse-rate, due to pressure on a painful spot, has a psychical explanation. Thus all the so-called objective symptoms of the traumatic neuroses must be accepted with reserve. At times the distinction between simulation and hysteria may be difficult. In the latter case there are diseased ideas which force themselves with much persistence into the patient's consciousness. General rules for the detection of simulation cannot be given. Besides the mental condition any objective evidence, as well as the constancy of the symptoms, must be taken into account, together with the previous condition of the patient. It is mostly only the strength of the fixed idea that will convert the previously capable and vigorous worker into a hypochondriac devoid of energy.—*Br. Med. Jour.*

SELF-INJURY IN HYSTERIA.—Krecke (*Munch. med. Woch.*) discusses a case at length in a woman, aged 61, under observation for thirteen years. Injuries are self-inflicted either on account of anticipated advantages, or owing to abnormal mental states. The injuries inflicted on themselves by the hysterical are mostly of a chronic character. In the above-named case the injuries were chiefly on the arms, legs, and face. Various forms of lesions were noted—reddening, blisters, old crusts, ulcers, and scars. They were made by means of a caustic alkali (*Laugenstein*). The author gives a short account of some of the well-known cases, such as those recorded by Strümpell, C. Fox, etc. These patients, as in his case, almost always present signs of hysteria. The author thinks that his patient first inflicted these injuries as the result of some imperative idea, and that later the comfortable hospital life played an important part in the etiology. The patient also suffered from mania operatoria. In the simplest cases the injuries are inflicted by means of friction with the nails and ends of the fingers, then by rubbing the bandage backwards and forwards, and lastly by a chemical agent. The question of diagnosis is important; the condition, if suspected, is generally recognized.—*Brit. Med. Jour.*

PATHOLOGY AND BACTERIOLOGY

IN CHARGE OF

H. B. ANDERSON, M. D., C. M.,

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ULCERATIVE ENDOCARDITIS DUE TO THE GONOCOCCUS.

In a recent number of the *Archives de Médecine Expérimentale*, Thayer and Blumer report an interesting case of gonorrhœal septicæmia with endocarditis due to the gonococcus.

After speaking of the unsatisfactory evidence in many of the reported cases that the organism present was the gonococcus, the authors give the history of their case:

The patient was a female, thirty-four years of age, who entered the Johns Hopkins Hospital complaining of cough, feebleness, and general pains. The family history was negative, but she gave a previous history of two miscarriages. The present illness dated from an attack of rheumatism, which occurred three months previous to admission; in this attack most of the joints were affected, the pain being acute and passing rapidly from one joint to another; it was accompanied by very little swelling. The day previous to admission the patient had a severe chill.

On physical examination showed a slight enlargement of the heart, with a presystolic thrill at the apex; in the same region two murmurs were to be heard, a light sharply localized presystolic murmur and a soft systolic transmitted to the axilla and the base; the second pulmonic sound was accentuated. No malarial organisms were found in the blood. From the time of her entrance to that of her death, nineteen days later, the patient gradually emaciated; during this whole time she had daily exacerbations of temperature at very irregular intervals, and often accompanied by severe rigors.

Both the heart-murmurs had increased in intensity before death. The patient became very anæmic, the red corpuscles at the time of death numbering only a few over a million. The spleen was palpable from the first.

The autopsy, made two hours and a half after death, showed an acute ulcerative endocarditis of the mitral valve, sub-acute spleen-tumor, and infarcts in the lungs and spleen.

Microscopical examination showed the presence of gonococci in the valvular vegetations.

Cultures made from the blood during life on a

mixture of blood and agar resulted in the growth of an organism morphologically resembling the gonococcus, decolorizing by Gram's method, and refusing to grow on ordinary media.

Cover-slips made at the autopsy from the vagina, uterus, and vegetations on the mitral valves showed a similar organism, which likewise failed to grow on ordinary media, and which decolorized by Gram's method. A mouse inoculated at the root of the tail with a portion of the valvular vegetations did not react.

The authors conclude that they are justified in believing that the organism isolated from the blood during life, and found on the valvular vegetations at autopsy, was the gonococcus, for the following reasons:

- a. Its form and disposition were characteristic.
- b. Though often free, the organism was often found within the protoplasm of the leucocytes in the valvular thrombus.
- c. The organism did not develop on ordinary media.
- d. It easily grew on a mixture of human blood and agar (one-third blood).
- e. It decolorized by Gram's method.—*Archives de Médecine Expérimentale*.

—

PYLEPHLEBITIS AND ABSCESS OF THE LIVER FOLLOWING TYPHOID.—Lannois has recently described pylephlebitis and abscess of the liver following typhoid, in which the bacillus of Eberth was present in the pus from the abscess, though not in pure culture.

He states that liver-abscess following typhoid is very rare, occurring, according to Schultz, of Hamburg, once in thirty-six thousand and eighty cases.

Lannois divides abscess of the liver following typhoid into three classes:

- a. Metastatic abscesses having an external suppurative focus as a point of origin.
- b. Abscesses from typhoid ulceration of the biliary passages.
- c. Abscesses due to pylephlebitis.

He places his case in the last class.

The case occurred in a man of twenty-eight years of age, and came on at the end of the attack,

the patient having been afebrile for three days. At the end of this time he was taken with a violent chill with fever, and the signs of pleural involvement at both bases. This was followed by swelling of the abdomen and great pain in the right hypochondrium. There were no positive physical signs in the abdomen, and the case was regarded as one of tubercular peritonitis on account of the pleural involvement and the swelling of the abdomen.

The patient died three days after admission, the autopsy showing healed ulcers in the ileum, and also partly healed ones, both in this part of the intestine and in the appendix. The vena portæ, the inferior mesenteric vein, and the splenic vein all contained adherent ante-mortem clots. In the liver a number of abscesses were found containing creamy yellowish pus. A number of organisms were present in the pus, and one was isolated which resembled the typhoid bacillus in every way, except that it slightly liquefied gelatin. The author ascribes the liquefaction to impure culture, and states that this is the only case recorded where a satisfactory bacteriological examination has been made.—*Revue de Médecine*.

NECROPSY.—In the interests of euphony and accuracy of statement it seems desirable to direct attention to the words used by medical men to denote the pathologic examination after death.

The *Medical News* not long since admirably discussed these terms. The most frequently used term is at present undoubtedly *post mortem*, as all know two Latin words meaning "after death." This term is awkward and difficult to anglicise and has nothing to recommend it.

The next most frequently used term is "autopsy," derived from two Greek words meaning literally "to cut one's self;" the secondary meaning is, of course, "to cut for one's self," *i. e.*, so as to see for one's self the morbid anatomy.

In our opinion the preferable term, both by reason of its etymology, of its euphony, and of its clearness of meaning, is the word "necropsy." This means of course "to cut a dead body," and is, hence, accurate in significance. It is rapidly coming into general use among the best medical writers and speakers, and we would urge our readers to use this term in the future, both because its use is bound to spread and because of the good reasons stated above.—*Cleveland Med. Jour.*

TUBERCULAR ENDOCARDITIS.—Leyden, in a recent paper before the Berlin Verein für innere Medizin (*Berliner klin. Wochenschrift*, 1896, No. 49), spoke at length on the connection of disease of the heart and tuberculosis. Besides giving a review of the historical aspect of the subject he mentioned some recent observations made in his clinic. In four cases of recent warty endocarditis

tubercle-bacilli were found in the lesions. One of the patients, a woman, admitted with advanced tuberculosis, had a history of rheumatism. There was a systolic murmur. From the progress of the case a fresh endocarditis was diagnosed. An autopsy confirmed the diagnosis. Tubercle-bacilli were present not only in the vegetations, but also in ante-mortem thrombi. An interesting feature was that the bacilli were largely in the cells. Leyden thinks that the bacilli do not enter the cells in the vegetations, but are transported by the cells, so that the latter, so far from protecting the body against infection, favor the spread of the bacilli.—*Am. Jour. Med. Sc.*

PATHOGENESIS OF URÆMIA.—Ajello and Para-veandalo (*Lo Sperim*, an. 49, fasc 4), as the result of numerous experiments on animals, believe that uræmia is closely related to the presence or absence of an internal renal secretion. Just as other glands have internal secretions, so has the kidney. The authors found that animals, after unilateral nephrectomy and without any treatment, died in from eight days to eleven months with albuminuria and cachexia. On the other hand, animals, after unilateral nephrectomy, when inoculated with renal juice prepared after the method of Brown-Séquard and D'Arsonval (20 c.cm. injected daily in dogs, 10 c.cm. in rabbits), did not present any albuminuria or cachexia, and lived in good health until killed for other experiments. After double nephrectomy without treatment the animals died in four to forty-eight hours; if treated with renal juice they lived from forty-eight hours to four days and more. The implantation of kidneys, whether subcutaneously or in the peritoneal cavity, gave negative results.—*Brit. Med. Jour.*

ALBUMINURIA CONSECUTIVE TO CHLOROFORM-INHALATION.—Dr. Patein has made seventy-six observations, each one comprising specimens taken before anæsthesia, during anæsthesia but before the operation, and after recovery from the anæsthetic. Albuminuria was found before anæsthesia in 12 per cent., during anæsthesia but before the operation in 35 per cent., and after the operation in 73 per cent. of these cases. This albuminuria disappears generally by the end of two or three days, is not proportional to the duration of the anæsthesia, and appears to depend solely upon the chloroform. With patients who are already albuminuric, the quantity of albumin may be increased, but this is not generally, nor is there any fixed rule. The kidneys do not undergo any serious alteration, the uric acid and chlorides are generally more abundant, but there appears to be nothing more than a passage of serum-albumin at the glomerulus.—*Am. Jour. Med. Sc.*

NOSE AND THROAT

IN CHARGE OF

J. MURRAY McFARLANE, M. D.,

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COMMON SORE THROATS.

In the *Lancet* for February 15th Dr. Clement Dukes, physician of the Rugby School, alludes to the importance of seeing invalids in the very earliest stage of their indisposition, as we are able then not only to learn the symptoms of the onset of the disease, but a circumstance of still greater moment to the individual patient, to place him early under the most favorable conditions as regards himself, and to isolate him if need be for the protection of others. In his very early days of office at the school, he says, he recognized the importance of knowing the condition of the throat in the young, it being, involved in so many illnesses; consequently the habit arose intuitively of looking at the throat of every boy who expressed himself as not feeling well, without waiting for any complaint from him concerning it. Whenever the least deviation from a healthy appearance was noticed, says the author, however trivial strict isolation was enforced, and the patient was kept away from the healthy boys until he had quite recovered. In this way all ailments attended with sore throat, some of them of the greatest moment to the young, had been prevented from spreading. It is scarcely necessary to point out, he says, that it is the first cases that require attention and isolation if the diseases are to be limited in extent. On inspection of the throat in the young in the very earliest stage of its abnormality certain common conditions are discovered which gradually assume the various forms typical of recognized diseases, and these throats, says Dr. Dukes, are seen and the patients isolated often long before a diagnosis is possible. When a case can be diagnosed at first sight, it is far too late for the welfare of the individual and for the protection of others.

With regard to inflammatory sore throats, he says, the first stage of all the common sore throats, which are termed amygdalitis, is that the membrane of the fauces generally appears smooth, dry, glistening, and as if all secretion and the superficial layer of the mucous membrane had been scraped off and the surface polished. Many throats under treatment proceed no further than this stage. In the next condition this superficial layer of the mucous membrane is swollen, which causes it to assume a dusky-red velvet appearance, and this

also may proceed no further. This is succeeded in a large proportion of cases by swelling of the tonsils, which gradually become covered with minute isolated white dots, which are occasioned by an excess of the normal secretion, owing to the inflammation, from the follicles of the tonsils. This secretion in certain cases—and these individuals usually have this kind of throat whenever they take cold—becomes so excessive as not only to appear at the orifices of the follicles, but to join one another until the surface of the tonsil becomes covered with a thick, soft, ashy-gray, dirty-looking membrane, but one which bears no more relation to diphtheria than chicken-pox does to small-pox. The same individual invariably has the same kind of inflammatory throat, and whenever he takes cold it is in the form of, or accompanied by, a sore throat. In the last phase of these cases of amygdalitis the inflammation and swelling—often after a prior subsidence, so as to seem almost like a recurrence—increase, extend, and involve the soft palate, and a quinsy is formed. All these forms of amygdalitis, says the author, are infectious in the young, and they spread in the same way, but not to the same extent, as common colds.

Respecting septic sore throats, he says, which may arise from defective arrangements in the water supply, drainage, etc., he urges the necessity of flushing drains and emptying drinking-water cisterns and filters before the reassembling of school after each vacation.

The sore throat of scarlet fever in its initial stage consists of a diffuse, dull, brick-red appearance of the membrane or the fauces—in fact, it is a diffuse rash on the mucous membrane similar to that which occurs subsequently on the skin. It begins at, or at all events is most visible on, the wings of the soft palate, extending to the tip of the uvula, but it involves the whole of the mucous membrane of the fauces. In a large proportion of cases it begins and ends in this, though in many it progresses to every phase of ulceration, which alone is sometimes difficult to assign to scarlet fever; but the character of the rash, together with the peeling tongue on the fourth day, leave little doubt as to the diagnosis. It is the slight sore throat accompanied by merely a transient rash which causes the main difficulty in diagnosis.

In the *sore throat of diphtheria*, at the onset,

there is usually a dark redness and swelling of the tonsils and the fauces generally, with very marked œdema of the uvula, which appearances are quite undistinguishable from acute amygdalitis. Hence, says Dr. Duker, the necessity of at once isolating all patients with amygdalitis, as no one can possibly be sure what form of sore throat it will prove to be. Subsequently the whole or a part of the fauces becomes covered with a grayish secretion, sometimes assuming the character of a dense membrane like wet wash-leather, which arises in patches, and rarely in the small white regular dots which coalesce into a patch incidental to amygdalitis. These patches spread and may become continuous, involving the whole of the fauces.

The sore throat of varicella is occasioned by spots on the mouth and pharynx similar to those on the skin, and they often greatly resemble the small ulcers common to stomatitis, from which they are distinguishable by the eruption on the skin.

The sore throat of epidemic rosela (Rothehn) resembles closely the early stage of the throat of scarlet fever, but it is accompanied by very early enlargement of the posterior, cervical and other glands. There is no peeling of the tongue on the fourth day.—*N. Y. Med. Jour.*

TWO CASES OF CHANCRE OF THE TONSIL.

Mr. A—, æt. 32, married, consulted me on December 8, 1893, for a sore throat, of which he gave the following history: Seven weeks ago he began to have slight pain and soreness on the left side of his throat in the tonsillar region; this gave him little anxiety, as he frequently had sore throat from excessive cigarette smoking. Not improving after a week or ten days he consulted a physician, who prescribed a gargle which was used for some days without any relief. Two weeks later, while on a Western trip, he consulted another physician, and received tincture of iron and chlorate of potash to take internally and to gargle. On November 25th he returned home, feeling weak, and with considerable pain of a stinging character over the left tonsil and running into the left ear. The submaxillary gland of that side was slightly enlarged, and he felt the sore place on the tonsil with his finger, and describes it as a bare lump which seemed to pass up behind the soft palate.

On examination I found Mr. A— looked pale, exhausted, and complaining of burning pain in the left side of pharynx and ear, especially severe at night, and accompanied by profuse perspiration, necessitating a change of night shirt. Temperature ranged from 99½° F., a.m., to 101° p.m., pulse 100, left tonsil moderately enlarged

and very hard at its upper part. Its surface was red, and a small, superficial grayish-looking ulceration was apparent at the superior end of the tonsil; below this some grayish, sticky fluid adhered to the surface. Another small, grayish, superficial ulceration appeared on the anterior surface of the soft palate, just above the margin of the arch, and close to the uvula. The surrounding tissues were moderately red and hardened. The anterior and posterior pillars, especially the latter, were red and hard. The same condition extended to the left lateral fold of the pharynx and passed up behind the soft palate. The right tonsil and other parts of the pharynx and mouth were healthy.

There was little pain in swallowing. The left submaxillary gland was enlarged, but not tender. On questioning he admitted that about two weeks before his throat began to be sore, that "a friend" had put her tongue in his mouth a great many times while he kissed her. Some sputa and small pieces of grayish membrane taken from the ulcerated surface were referred to an expert microscopist, who reported as follows:

"Six cover-glass preparations from the well-teased specimen, double stained Nelson Ziehl method, fuchsin and methyl blue, were examined with a Zeiss apochromatic one twelfth homog. immers., and the four and five compensating eye-pieces failed to indicate the presence of any tubercle bacilli. Pieces of the membrane subjected to a special microscopic examination were found to possess the following characters:

"Fibrillar connective tissue, the greater portion consisting of intercellular substance, with isolated portions containing connective-tissue corpuscles and a few puss cells." Dr. A. H. Smith examined the lungs and pronounced them sound. Primary chancre of the tonsil was diagnosed, and two-grain tablets of hydrargyrum cum cretâ ordered every two hours, with a soothing gargle, and a hot bath every night. Three days later Mr. A— appeared with a macular rash on the neck, arms, chest, and back. The throat had improved in appearance, and the hardness of the tonsil and submaxillary gland much lessened.

On December 22nd, fourteen days after my first examination, the sore on the tonsil and soft palate had healed, and the surrounding hardness of the tonsil and submaxillary gland nearly disappeared.

In June of this year I saw another case of chancre of the tonsil, but with several others, did not diagnosis for some time after first seeing it. It was supposed to be a later manifestation of syphilis, and treated with iodide of potash without any benefit. From further information obtained regarding the man's habits, and subsequent developments, it proved to be a primary affection of both tonsils which yielded at once to mercurial

treatment. Previous to reading Dr. L. Duncan Bulkley's report in the "Transactions of the Medical Society of the State of New York," I had supposed that a primary sore on the tonsil was extremely rare. It would seem, however, that its occurrence is not at all uncommon, but may be easily overlooked.—Walter F. Chappell, M.D., New York.

A NEW NASAL TABLET.

BY MURRAY M'FARLANE, M.D., TORONTO.

I have been for a long time dissatisfied with Seiler's and Dobell's solutions for cleansing purposes in nasal work, finding them too irritating in the great majority of cases and containing a large number of oils and antiseptics out of place in ordinary nasal disease without pus-formation. Looking around for some substitute that would consist of a slightly alkaline solution, as nearly the specific gravity of the blood-serum as possible, thereby preventing too much osmosis and endosmosis in the nasal cavity, I was taken with the fact that a tablet could be made containing the soluble salts of the blood-plasma, which, when added to two ounces of lukewarm water, would form a solution as nearly comparable with blood-plasma as possible.

Parke, Davis & Co. complied with my desires, making an excellent tablet containing the soluble potassium and sodium salts of the blood, with the addition of one-sixteenth of a grain of menthol to each. I have found it of great service as a cleansing agent, and have received a large number of letters from medical men who have tried the solution and found it answer the purpose in a very satisfactory manner. Parke, Davis & Co. will supply any desiring them.

The tablets are called "Plasma Nasal," and are added to two ounces of lukewarm water, and used as a spray for cleansing purposes, in the nose and throat, whenever a mild and non-irritating solution is desired. Those who make use of them and avoid astringents in the nasal cavity will find a gratifying result both for themselves and patients.—*Therapeutic Notes.*

A CASE OF TUBERCULOSIS OF THE THYROID GLAND.—I. G.—, male, aged 15 years. Father died of phthisis at the age of 30. Two sisters died of the same disease in their twentieth year. Mother and three brothers alive and well. This patient was quite well up to his thirteenth year when he had a sore throat, which lasted about five days. Two months later the thyroid gland began to enlarge and became hard and tender. The anterior and posterior cervical glands underwent a

similar change. This continued some three months, the skin over the thyroid region becoming red and gradually deepening in color until a small opening appeared over the isthmus of the thyroid from which a watery fluid, containing small white curdy masses, escaped. A troublesome cough and hoarseness appeared simultaneously with the enlargement of the thyroid, and has continued more or less ever since. On presenting himself at the Hospital in June, 1892, I found him considerably emaciated. Temperature 101 F., pulse 132; weight 80 pounds; the thyroid gland considerably enlarged and very hard, with some surrounding cellulitis and cervical and mesenteric adenitis, small abscess above the right clavicle, considerable dyspnoea and a constant desire to cough. A small sinus over the isthmus of the thyroid gland, discharged a fluid already described, which was found to contain the tubercle bacillus. The apices of both lungs gave signs of advanced tuberculosis, and tubercle bacilli were found in great numbers in the sputa. The mucous membrane covering the vocal cords, arytenoid cartilages and posterior commissure of the larynx, was red and thickened; spasmodic cough and profuse perspiration caused much distress at night. The case is reported on account of the rarity of tuberculosis attacking the thyroid gland.—W. F. Chappell, M.D.

MEDICAL MEN TO AVOID.—The one who has acute exacerbations of insanity when exposed to any new fad. The one who is always successful with all his difficult operations. The one who always sees hundreds of cases of a rare disease. The one who can always match your case and improve on your treatment. The one who always finds you have omitted something in the examination of your case. The one who thinks he can talk well and is always ready to discuss any paper of the evening. The one who is always the first to do the new operation. The one who is in a chronic fear of being anticipated in his important discoveries. The one who in consultation feels it is his conscientious duty to explain to the patient why he differs with the attending physician.

THE ANTIVIVISECTION ACT is again to the front at Washington, D.C., where a bill has been introduced into both Houses of Congress for the purpose of curtailing the freedom of scientists in the matter of vivisection.

BLENNORRHAGIC VAGINITIS.—

R—Pure creosote, 3 parts.
Solution of potassium hydrate, 3 parts.
Camphorated water, 240 parts.

Sig.—Two dessertspoonfuls are injected two or three times a day into the vagina.

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Editorial.

DR. LAUGHLIN MCFARLANE.

It is our sad duty to record the death of one of the ablest and most popular members of the profession in Toronto—Dr. Laughlin McFarlane. Space will not permit us to say a tithe of what an affectionate remembrance of the genial, manly, inspiring Doctor brings to mind; but we sadly add our sincere tribute to the many great ones he has already received from some of the best and greatest men of our city and country.

Dr. McFarlane was born in Caledon Township, Ontario, 56 years ago, and from his earliest years showed the man he was to become. He began the study of medicine in 1864 at the Toronto School of Medicine, and received his degree of M.B. in 1867.

His abilities as a student, and his success in practice, soon got for him a position, that of Assistant Demonstrator of Anatomy in his *alma mater*. Shortly after he was appointed to the chair of Clinical Surgery, which position he honorably and efficiently filled till the day when he met his death in the performance of an operation connected with his office. For fifteen years he was an indefatigable worker on the Hospital staff.

His love for his profession brought him closely into touch with medical men everywhere, and he was an enthusiastic member of various medical societies, in which connection it will be remembered that he occupied the position of President of the Toronto Clinical Society and of the Ontario

Medical Society. He was for 22 years a member of the Senate of Toronto University. While he was so well and favorably known through his public life, perhaps his best side will be known only to the individuals to whom he acted as firm friend and medical adviser—his patients. The Doctor had pre-eminently the power of winning and holding the confidence of his patients, to whom he acted the part of warm friend and counsellor. Many secret tears have been shed by persons who feel the loss of their beloved—we say it advisedly—physician and friend.

He was married in 1876 to Miss Bond, of Guelph, whom he leaves to mourn his loss. Mrs. McFarlane received from the Board of Trustees of the Toronto General Hospital the following resolution of condolence, which we think worthy of being repeated here:—

“The Trustees of the Toronto General Hospital record upon their Minutes the deep sense they entertain of the great loss sustained through the death of the late Laughlin McFarlane, Esq., M.D., one of the senior Surgeons on the acting Staff of the Hospital. They at the same time assure Mrs. McFarlane of their sincere sympathy with her in the loss of a devoted husband, and with the sorrowing relatives, who have lost a brother beloved, and a true friend.

“They look back with pleasure and gratitude to the noble devotion of Dr. McFarlane, during a period of fifteen years in the Hospital, where his skill as a surgeon, his kind words of cheerfulness, and his geniality of character, helped many a sad and suffering patient, and made him the trusted and common friend, not only of the patients, but of the whole Hospital staff.

“His sudden demise is keenly felt by all who knew him; but especially by those who were so intimately associated with him in the daily work of the Hospital.

“The Trustees feel and trust, that it may be some consolation to his many friends to remember that he nobly met his end in the performance of professional duty; and that his life was sacrificed in giving gratuitous services for the relief of a suffering human being, a stranger in a strange land, who was a patient in the public wards of the Toronto General Hospital.”

We give with this issue a cut of our dear friend and fellow-laborer, which we are sure will be welcomed and treasured by thousands of his friends and admirers all over the Dominion.

As a rule, Dr. Cantrell prefers *lactic acid* over other caustics to be used about the face, because its action is so easily checked by dusting powdered starch over the part operated upon.

SURGICAL TREATMENT OF RETRO-DEVIATIONS OF THE UTERUS.

Dr. Augustin H. Goelet, of New York, in a paper read before the N. Y. State Medical Society, at Albany, declares that displacements of the uterus are not accorded the consideration they deserve, and that the routine plan of inserting a pessary and dismissing the case from further attention is an error too often committed. He thinks the majority of cases, especially those of long standing where structural changes have taken place in the walls of the organ, require surgical intervention for their cure. The pessary alone is never sufficient except, perhaps, in very recent cases. The concomitant metritis and endometritis must be overcome before a radical cure can be effected.

After discussing the merits of Alexander's operation, and the intraperitoneal methods of shortening the round ligaments and vaginal fixation, he described an operation for retroflexion which he has employed with success for the past twelve years.

The Alexander operation, which is only applicable in movable retro-deviations, he thinks unnecessary. Its chief disadvantage is the time it requires and the prolonged convalescence it entails.

Intraperitoneal shortening of the round ligaments requires more time for its execution, and the convalescence is longer than suspensio-uteri, and the results have not been so good.

Vaginal fixation is objectionable because it substitutes a fixed ante-flexion for a movable posterior displacement. The recent unfavorable reports of complications during labor following it, offers another very serious objection to this operation. The best evidence of its inefficiency is that its originator, Mackinrodt, has abandoned it.

Where the uterus is fixed by firm adhesions, the author advocates opening the abdomen by means of a small incision, breaking them up and suspending the uterus by its posterior face from the anterior abdominal wall. This does not fix the organ as when ventro-fixation is done. In time the uterus recede from the abdominal wall, close to which it is first suspended, and swings in an easy position of nearly normal ante-flexion. This he prefers to ventro-fixation because the uterus occupies a nearly normal position and is

fairly movable. Its execution consumes less time than intra-peritoneal shortening of the round ligaments. The results have been very gratifying.

When the adhesions are not very firm or extensive, they are broken up by manipulations under anæsthesia without opening the peritoneal cavity, and the case is then treated in the same manner as when the organ is movable.

The method of procedure which he advocates in place of Alexander's operation in movable retro-deviations, has this to recommend it, viz. : that it aims at a cure of the co-existing metritis and endometritis, the maintaining cause of the displacement, and requires but a week's confinement in bed.

For retroversion he dilates the canal, cures the cavity with iodoform gauze. The vagina is then tamponed with the same gauze in such manner as to throw the uterus into a position of ante-version. This dressing is removed every day, the cavity is washed out with a one per cent. solution of lysol, and it is re-applied. This is done for a week, during which time the patient is confined to bed. Then a vaginal pessary is fixed to hold the uterus in a correct position. The cavity is then irrigated twice a week until a healthy endometrium is reproduced.

For retroflexion the same procedure is adopted, but instead of packing the uterus with gauze, a straight glass drainage stem is used which serves the purpose of a splint and keeps the uterus straight. It is then maintained in a position of ante-version by means of vaginal tampons of iodoform gauze. The gauze tampon and stem are removed every day, and after cleansing the stem it is re-inserted. At the end of a week the stem is removed, a vaginal pessary is inserted, and the patient is permitted to get up.

The success which he has obtained with this method leads him to believe that the other more complicated and hazardous operations designed for movable retro-deviations, are unnecessary.

TUBERCULIN.—At the Académie de Médecine M. Grasset read a paper on the early diagnosis of phthisis in man by means of injections of tuberculin, *Paris correspondent Med. Press.* Everyone understood the utility of detecting the nature of this malady in its incipient stage, but all practi-

tioners are well aware that the diagnosis is far from being easy and conclusive, for the bacilli do not appear in the expectoration until a relatively late period. The difficulties are still further increased where the tuberculosis is seated in the bones, the brain coverings, etc. Consequently, a new sign, if it be sure and without danger, is not to be despised. Tuberculin seems to furnish these two conditions, as testified by that great authority, M. Straus, who declared that "this substance constitutes an excellent diagnostic means in incipient phthisis."

The tuberculin was furnished M. Grasset for his experiments by the Pasteur Institute, and the dose employed was infinitesimal but sufficient, 150th of a grain. The mode of using is simple. The patient is kept in bed two or three days and his temperature taken morning and evening and marked. The hypodermic injection is then made once a day for two or three days or more, in the thigh, and the temperature carefully registered three times a day. No abscess follows or any local irritation. M. Grasset cited a series of cases in which he was able to arrive at an exact opinion on the nature of the affection. A man, *æt.* 43, entered the hospital presenting symptoms of rachidian meningitis, without any external sign of lesion of the vertebræ. For four months he had been suffering from inter-costal pains, coming on in paroxysms, the spine was painful to pressure, especially over the dorsal vertebræ. The left eye showed symptoms of exophthalmia, while the upper lid drooped. The body had evidently been wasting for some time. The temperature was normal, but after the injection of the tuberculin, it rose to 100°. M. Grasset pronounced the case to be one of tuberculous meningitis.

A patient, *æt.* 23, presented the symptoms of Addison's disease. He had a costo-vertebral cold abscess, which got well after operation. The bronzed coloring had commenced five months before he entered the hospital, and for the previous month he had a slight cough. At the apex of the lung in front, expiration was found to be slightly prolonged, and behind, vesicular expansion was diminished; there were no bacilli in the sputa. The temperature, which had been oscillating between 97° and 98°, rose to 100° six hours after the injection of tuberculin, justifying the tuberculous nature of the disease of the renal capsules.

After giving the details of several other cases (14 in all), the report concluded by stating that the results obtained warranted the prosecution of further clinical experiments which would permit the Academy one day to draw up instructions for diagnosis of tuberculosis in man by tuberculin, as it has been called upon to do in the case of the bovine species.

M. Weber read, in answer to a letter from the Minister of Agriculture, consulting the Academy on the value of tuberculin as a means of diagnosing tuberculous disease in the bovine species, a report, of which the following is an abstract.

Tuberculin at the dose of from six to ten grains provokes in tuberculous animals a rise of temperature attaining from two to five degrees, a reaction sufficient to affirm the existence of tuberculous lesions, in no matter how slight a degree, whereas the same dose has no appreciable effect on non-tuberculous animals, although they may be attacked by grave lesions of the lungs or of the other viscera. The febrile reaction appears between the twelfth and fifteenth hour after the injection, and lasts several hours. It was said that tuberculin produced no reaction in certain animals recognised tuberculous at the autopsy. The fact is true, but these animals are always in such an advanced stage of the malady that the diagnosis is easily made by the ordinary methods of examination without having recourse to tuberculin. The reproach was also made that tuberculin hastened the evolution of the disease. This objection has no foundation, for tuberculin presents no danger to the animal.

Nothing is so easy to-day as the removal of tuberculous disease from a stable; it is sufficient to submit all the animals to the tuberculin tests, separate the healthy animals from all those which show a reaction after the injection, disinfect the stable and allow no animal to enter it without careful examination.

In concluding, the speaker proposed the following resolution:—"Tuberculin is an excellent means of establishing the diagnosis of bovine tuberculosis, and its employment should be recommended."

THE USE OF VINEGAR TO PREVENT VOMITING AFTER CHLOROPFORM INHALATION.—Lewin, *Revue de Chirurgie*, states that he has used this method

for the prevention of vomiting after chloroform anaesthesia in 174 cases. These embraced all kinds of operations. In 125 success was complete. In the remaining 49 cases vomiting occurred, but it was slight in amount and consisted mostly of glairy mucus. It usually occurred towards evening of the day of operation and ceased by 9 o'clock the next morning. The infrequency as well as mildness of the vomiting constituted a practical success, because under the usual chloroformization he has seen vomiting last three days.

Some of the patients vomited because the use of the vinegar cloth was not continued a sufficiently long time.

The following is the method of procedure: A piece of linen the size of a napkin is wet with ordinary vinegar; the surplus vinegar is wrung out and the cloth laid over the chloroform inhaler. This latter is then withdrawn from under the cloth without removing it. This is to prevent the patient respiring air which has not been impregnated with the vinegar vapor. The cloth should remain on the face as long as possible, and at least three hours. Should the cloth become dry by the evaporation of the vinegar, it should be again moistened. Should the patient desire to expectorate, a cloth or handkerchief is to be slipped beneath the cloth wet with the vinegar. The author claims that it is the sudden inspiration of pure air that causes nausea.

A CARICATURE OF AMERICA.—One of the most amusing descriptions of America is that which recently appeared in the *Nachrichten; Literary Digest*. It runs as follows: "America is a country in comparison to which Europe is but a small peninsula. The United States is an empire by whose side the powers of Europe appear as petty states. America is the land of unmeasured capacity and dimensions, the land of dollars and electricity, the land where the plains are wider, the rivers greater, the waterfalls higher, the bridges longer, the express trains faster, the catastrophes more horrible than in all Europe; the country where the buildings are taller, the rascals more numerous, the poor poorer, the millionaires richer, the thieves bolder, the murderers less bothered, and educated people more rare than anywhere else. It is the land in which the teeth are

more false, the corsets tighter, diseases more dangerous, corruption more common, insanity more systematic, the summer hotter, the winter more chilly, fire warmer and ice colder, time more costly and men more restless than in sleepy old Europe. The land where old men are younger and youths older, the niggers blacker and the whites yellower than elsewhere, the land of immeasurable natural resources, and of the most prodigious avarice. In short: America is the land of the greatest contrasts, the craziest presumption, the most reckless hunt after the dollar; it is the land of everything colossal and unapproachable—the last, of course, from the American point of view."

THE RELATION BETWEEN THE SPECIFIC GRAVITY OF THE BLOOD AND ITS HÆMOGLOBIN PERCENTAGE. By F. C. Bush, B.S., and A. T. Kerr, Jr., B.S., under the direction of Herbert U. Williams, M.D., of Buffalo.

After extended observations on the relation of the percentage of hæmoglobin in the blood to its specific gravity, these authors conclude, first, that the percentage of hæmoglobin in blood, in most cases, may be predicted from the specific gravity with sufficient accuracy to be valuable for clinical purposes; second, Fleischl's hæmometer is liable to an error of ten per cent.; third, Gowers's instrument is liable to an error even greater than that of Fleischl's; fourth, that the error in technique with the specific gravity method is likely to be very slight; fifth, in following up a case with Fleischl's or Gowers' instrument, very erroneous conclusions may be drawn. Mistakes may be made of five per cent. or ten per cent. too low one day, and five per cent. or ten per cent. too high on another day; sixth, in following up a case the specific gravity estimation seems to give very slight error, and even if from it the absolute percentage of hæmoglobin could not be determined, yet the relative increase or decrease of hæmoglobin from one day to another might be quite accurately estimated; seventh, because of its being based on the instrument of Fleischl, Hammerschlag's table is, of necessity, only approximately correct.

THE INFLUENCE OF MIND.—Great brain and nerve strain, as in insanity, says C. H. Hughes, M.D., brittles the bones; grief and fright blanches the face and hair; fear paralyzes the heart, de-

presses temperature, causes excessive and clammy perspiration; anxiety arrests secretion and shrivels the skin; remorse wastes away the body; anger flushes the face and so fills the brain with blood that its vessels burst and the victims fall with apoplexy; shame flushes the cheek, slows the heart and respiration; sorrow shows itself in tears; love and good fortune brighten the countenance and quicken the step and pulse and lift up the form; while adversity and remorse sadden the face, slow the pulse, bend the form, and depress the bodily movements. These things, and many needless to mention, show us the potency of mental influence, through its proper neural channels, on the movements of the organism. We cannot deny them in regard to the stomach. On the contrary, as we see the systole of the heart arrested by emotion, so we see digestion stayed by disagreeable and depressing thought. Mental force, through psycho-neural media, pervades the body, and the stomach is not exempt from its invigorating or depressing influence over its physiologic functions.

DR. JAMESON.—Dr. J. Jameson, of Transvaal fame, is a Scotchman, forty-three years of age, his medical studies having been pursued in the University College—*Brit. Med. Jour.* Entering this institution in 1870, he became a member of the Royal College of Surgeons in 1875, and graduated as an M.B. and B.S. in the University of London in the same year, receiving the degree of M.D. in 1877. As house-surgeon under the late Professor John Marshall, house-physician under Sir Russell Reynolds, and resident medical officer to the University College Hospital, his early medical training started off propitiously. As a young man Dr. Jameson gave evidence of the same personal magnetism which has so endeared him to all sorts and conditions of men; of generous instincts, though impulsive, there was nothing ignoble about him. Sir Cecil Rhodes, King Lobengula, and President Krüger have been patients of his, and all seem to be very grateful for the services rendered them during severe illnesses.

ON THE INFLUENCE OF ETHER AND CHLOROFORM UPON THE KIDNEY.—*Deutsche Zeitschrift für Chirurgie; Internat. Med. Mag.*

By a careful chemical and microscopic examination of the urine prior to and subsequent to nar-

cosis by ether and chloroform, the author has studied, in one hundred and thirty cases, the relative action of the two anæsthetics upon the kidney, as evidenced by the alteration in the constituents of the urine and their relative amounts before and after narcosis.

He summarizes his study in the following conclusions:

1. Albuminuria that already exists is more frequently increased in amount by ether than by chloroform.
2. Albuminuria follows chloroform narcosis more frequently than other narcosis; the proportion being thirty-two to twenty-five.
3. On the amyloid kidney their action is similar.
4. Tube-casts either accompanied by or without albumin follow the use of both drugs with equal frequency, but albumin disappears more rapidly after ether narcosis. This late action has been proven to be more harmful in the case of chloroform than in that of ether.

The author details an interesting case of necrosis of the parenchyma following chloroform narcosis.

HOW AUSTRIA DEALS WITH DRUNKARDS.—Austria proposes to deal with persistent drunkards by treating them as mentally incapable, and detaining them in special retreats for a term of two years—*Albany Med. Annals.* They may go in of their own accord or on compulsion, but cannot leave at will until their term has expired, except in certain cases on probation. Persons may be sent to the retreat either by order of the magistrate or on the petition of the parents or children, or of the husband and wife, or trustees, or of the chief of a lunatic asylum in which a drunkard may be detained. Inebriates may further be assigned to retreats by the action of the public prosecutor, or by the mayor of the town or village in which the habitual drunkard resides. In all cases the inebriate must be legally tried and convicted, the court being bound to hear witnesses, including the drunkard himself, as well as the doctors, more especially experts on mental diseases. The term of detention will be generally for two years, but the patient may be released on leave after one year, but will be confined again in case he relapses into his former bad habits.

STRYCHNINE IN PREGNANCY.—Olenyn has successfully used strychnine in sixteen cases for the correction of weak labor-pains, in doses of 1-32 to 1-25 grain twice daily, at intervals, during the last six or eight weeks of pregnancy, *Kansas City Med. Rec.* Four of these cases were anæmic primiparæ from nineteen to thirty-two years of age, with weak muscles; three were multiparæ under thirty years, with habitual weak labor-pains; four suffered from chronic metritis and had been pregnant at intervals of from three to twelve years; one patient had a small uterine fibroid; two had flabby uteri and relaxed abdominal walls; one had tertiary syphilis and general debility, and another diseased appendages with hysteria. In two primiparæ the forceps had to be used, and in one the child was dead; but in all the other cases delivery was rapid and regular and the children lived. The third stage lasted from ten to twenty minutes and *post-partum* contraction of the uterus was excellent.

SANMETTO IN RETENTION OF URINE.—Have given Sanmetto a good trial and find it one of the best preparations I have ever used. Case No. I.—John D., age 70, Ireland—has been troubled for a long time; unable to pass his urine. After treatment with other remedies with no benefit, placed him on Sanmetto with following results: The first day the pus increased in quantity, on second day diminished, by fourth day could urinate himself; before this he had to be catheterized. Dose one drachm every four hours for the first three days, afterwards one drachm three times a day. Discharged in ten days, a complete cure of cystitis. A. C. Forman, M.D., House Phys. Bayonne Hospt., Bayonne, N. J.

BRETHREN, BEWARE!—Let all medical men take a lesson from the dearly bought experience of Dr Playfair, the eminent and fashionable London doctor and author. He was mulcted in \$60,000 damages for having made the statement to his wife that a Mrs. Kitson was unchaste. She communicated it to Sir James Kitson, the brother of Mr. Arthur Kitson, with the result that Sir James, who is a millionaire, withdrew an allowance of \$12,500 which he was making to Mrs. Kitson after her separation from his brother. Mrs. Playfair is a sister of Sir James and Arthur

Kitson. Of all women, doctor's wives should be discreet.

TREATMENT OF HÆMORRHOIDS.—Dr. Schmey, *Allg. Med. Centr. Ztg.*, recommends a simple means of treating hæmorrhoids which he has successfully employed in a number of cases, three of which are reported in detail. It consists in painting the nodules once daily with a 2 per cent. solution of nitrate of silver, which causes a gradual reduction in size without the least pain. In the cases reported the tumors had entirely disappeared in the course of one or two weeks. As there are many patients who positively refuse operative treatment this new procedure is well worthy of attention.

THE nutrient enemata of emulsified oil recommended by Professor Revilloid, of Geneva, are made as follows, *Pract*:

R—Ol. Morrhuæ ℥ xvij.
Vitelli ovi n° ij.
Aquæ calcis ℥ xvij.

To diminish the irritability of the mucosa 7 per cent. of salt can be added. The cod-liver oil may be replaced by olive oil. The injection should preferably be made at bedtime, commencing with a dose of four ounces, and increasing afterwards to twelve or fourteen ounces.

INCONTINENCE OF URINE:

R—Strychniæ sulph., gr. j.
Pulv. cantharidis, gr. ij.
Morphiæ sulph., gr. iss.
Ferri redacti, gr. xx.—M.

Ft. pil. no. xl.

Sig.—One pill thrice daily to a child ten year old.—*Gross.*

IMPOTENCE:

R—Tinct. phosphori, ℥ iss.
Tinct. cantharidis, ℥ iijss.
Elixir simplicis, ad ℥ v.—M.

Sig.—One teaspoonful three or four hours before retiring. Increase the dose carefully.—*Van Buren and Keyes.*

At Johns Hopkins University on the 22nd ult. the degree of Doctor of Philosophy was conferred on Mr. Harry L. Wilson, a graduate of Queen's College.

A. B. GRIFFITHS, Ph.D., F.R.S. (Edin.), F.C.S., says "I have made an examination of Stearns' Wine of Cod Liver Oil with Peptonate of Iron. It is an excellent preparation and contains the leucomaines, alkaloids or active principles of Cod Liver Oil with Peptonate of Iron. The alkaloids of Cod Liver Oil were first isolated by my friend Professor Armand Gautier of Paris; and they are not products of decomposition, as some writers (who know very little about the animal alkaloids) assert, but occur in the fresh liver of the cod, being produced by living cells—in other words they are true leucomaines. There is no doubt that the alkaloids of Cod Liver Oil are the active principles, as the percentages of iodine and bromine present in the oil are extremely small, and some oils, especially those that are light colored, contain none of these elements. At most, there is but 0.000322 per cent. of iodine present, a quantity which is too small to be of practical benefit. The same may be said of the bromine.

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Books and Pamphlets.

ELECTRICITY IN ELECTRO-THERAPEUTICS. By Edwin J. Houston, Ph. D., and A. E. Kennelly, Sc. D., two electricians holding high rank in the electrical profession. 412 pp., and 128 illustrations. \$1.00. New York: The W. J. Johnston Co.

Prof. Houston has served two terms as President of the American Institute of Electrical Engineers, and is a co-inventor of the well-known Thomson-Houston system of electric lighting. He has given special attention to electricity as applied in electro-therapeutics, in which department he is a lecturer in medical courses.

Mr. Kennelly has made many contributions to the higher branches of electrical science, and at the same time is widely known from his connection with its practical applications. For many years he was the principal assistant of Thomas A. Edison, and is the inventor of several pieces of commercial therapeutic apparatus. Mr. Kennelly is a Vice-President of the American Institute of Electrical Engineers.

The combination possessed by these authors, of a thorough knowledge of electrical science, together with an extended acquaintance in the field of electro-therapeutics, should peculiarly qualify them for the task which they undertook in the preparation of this volume. There is reason to believe, that the result of their work will meet in a high degree the requirements of physicians who desire to read a treatise on the fundamental electrical principles of electro-therapeutics, which is at once authoritative and expressed in simple language requiring no special training in electrical science to understand.

A TEXT-BOOK UPON THE PATHOGENIC BACTERIA FOR STUDENTS OF MEDICINE AND PHYSICIANS. By Joseph McFarland, M.D., Demonstrator of Pathological Histology and Lecturer on Bacteriology in the Medical Department of the University of Pennsylvania, etc. With 113 illustrations. Philadelphia: W. B. Saunders, 925 Walnut Street. 1896.

This conveys to the reader a concise account of the technical procedures necessary in the study of bacteriology, a brief description of the life-history of the important pathogenic bacteria, and sufficient description of the pathological lesions accompanying the micro-organismal invasions to give an idea of the origin of symptoms, and the cause of death. It is a work of 350 pages, and deals with such diseases as tuberculosis, leprosy, glanders, syphilis, actinomycosis, madura foot, rhinoscleroma, diphtheria, tetanus, rabies, anthrax, typhoid fever, cholera, pneumonia, relapsing fever, influenza, malignant œdema, measles, bubonic plague, chicken cholera, mouse septicæmia, typhus, and the various septic conditions induced by germs found in suppurative processes. The aim of the work has been to describe only such bacteria as can be proven pathogenic, and will surely find its proper sphere of usefulness in the hands of

medical students. Its pages will, however, be found to contain much knowledge and interest to the general practitioner. The illustrations are as good as the world affords, and are equal to anything covering the ground. Price \$2.50.

A TREATISE ON THE DISEASES OF INFANCY AND CHILDHOOD. By J. Lewis Smith, M. D., Clinical Professor of Diseases of Children in the Bellevue Hospital Medical College, New York. New (8th) edition, thoroughly revised and rewritten and much enlarged. Handsome octavo of over 900 pp., with about 250 illus. and 4 full-page colored plates. Philadelphia: Lea Bros & Co. Toronto: Carveth & Co.

The leading position achieved by *Smith on Children* as the standard text-book and work of reference on its important subject is shown by the demand for eight editions. The opportunity has thus been afforded to the author to revise the work repeatedly and to keep it always in touch with the advances in its department. In the present issue the subject of surgical diseases of children has been added, this portion being treated by Dr. Stephen Smith, whose own work on *Operative Surgery* is well known. The new edition of the *Diseases of Children* is therefore not only thoroughly revised, but also greatly enlarged, and it will be used by students and practitioners as a complete and authoritative guide to the surgical as well as the medical aspects of the diseases of childhood. The new issue will contain five times as many illustrations as its predecessor.

AN ATLAS OF THE NORMAL AND PATHOLOGICAL NERVOUS SYSTEMS. By Dr. Christfried Jakob. New York: William Wood & Co.

We have examined the above work with much pleasure, recognizing the fact that the best method of teaching nervous diseases is by illustrations. Dr. Jakob has compiled this work with that object in view and has given, so far as is compatible with the size of the book, an excellent general idea of the whole ground. The plates on Normal Anatomy are very, very practical, since he devotes his attention more especially to those parts of the brain which are most frequently the seat of disease. Hence the internal capsule is well shown, first, by horizontal sections and then by vertical ones, the latter demonstrating clearly how the posterior limb passes into the cerebral peduncle. The photographs of the cross sections of the cord are good

and give a clear idea of the relations of the various structures in the vertebral canal to one another. The plates on Embryotomy, the origin of the cranial nerves and of the ganglion cells are also good. This portion of the book will be found useful to the student who desires to obtain a concise idea of the anatomy of the nervous system, and who intends pursuing its study in larger and more comprehensive works.

The plates devoted to Pathology are excellent, and the synopsis of the disease which accompanies each lends a greatly increased interest to the case. The general pathology and therapeutics is all that could be desired in a book of this size. We have much pleasure in recommending the work to any one who desires to obtain a clear and concise knowledge of the nervous system and the diseases to which it is exposed.

ATLAS OF TRAUMATIC, FRACTURES AND LUXATIONS. With a Brief Treatise. By H. Helferich, M.D., Greifswald. With 166 illustrations after original drawings, by Dr. Jos. Trumpp. New York: William Wood & Co. 1896.

This is one of a series of atlases on medical and surgical science which, as the publishers say, "for accuracy, beauty and compactness is believed to exceed anything heretofore produced." This is the finest work of the sort we have seen. The plates are in varied tints and colors, and are splendid reproductions of the lesions. There are from fifty to seventy-five or more full-page plates in each volume, and accompanied by a condensed outline of the subject to which it is devoted. This publication is worthy of perusal, as a book of reference it is invaluable.

Births, Marriages, Deaths.

The charge for inserting notice of births, marriages and deaths is fifty cents each insertion.

BIRTHS.

CLOUSE.—On Thursday, March 5th, the wife of Dr. E. Clouse, of a son.

SPENCER.—On March 5th, at 8 Bloor Street East, the wife of Bertram Spencer, of a daughter.

ROSS.—At Toronto, March 17th, the wife of J. F. W. Ross, M.D., of a daughter.

DEATH.

BALDWIN.—At Hamilton, March 3rd, 1896, Ridley Warren Baldwin, aged 2 years 5 months, son of Dr. W. Warren Baldwin, Toronto.