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

Vol. IX
No. 3.

TORONTO, NOVEMBER 1, 1876.

Price 30 Cents.
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CINCHO-QUININE.

CINCHO-QUININE, which was placed in the hands of physicians in 1869, has been tested in all parts of the country, and the testimony in its favor is decided and unequivocal. It contains the important constituents of *Peruvian Bark*, Quinia, Quinidia, Cinchonina and Cinchonidia, in their alkaloidal condition, and no external agents.

"I have tested CINCHO-QUININE, and have found it to contain *quinine, quinidine, cinchonine, and cinchonidine.*"
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F. A. GENTH, Prof. of Chemistry and Mineralogy.

"I hereby certify that I have made a chemical examination of the contents of a bottle of CINCHO-QUININE, and by direct analysis I made a qualitative examination for *quinine, quinidine, and cinchonine*, and hereby certify that I found these alkaloids in CINCHO-QUININE."
LABORATORY OF THE UNIVERSITY OF CHICAGO, February 1, 1875.
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3d. It is less costly; the price will fluctuate with the rise and fall of barks; but will always be much less than the Sulphate of Quinine.

4th. It meets indications not met by that Salt.

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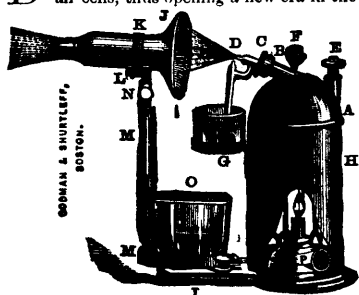


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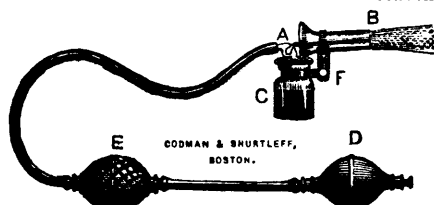


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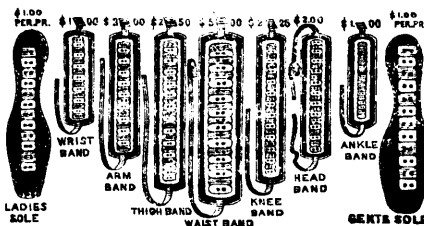
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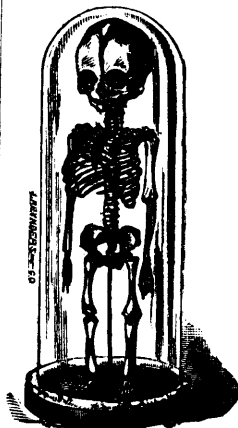
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A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE.

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Original Communications.

ON THE TREATMENT OF THE PEDICLE AFTER OVARIOTOMY.*

BY F. W. STRANGE, M.R.C.S., ENG.; F.O.S., LOND.; TORONTO.

In view of the fact that the operation of ovariectomy is now recognized by all surgeons as not only a justifiable operation in suitable cases, but absolutely imperative for prolonging, to the natural period, the life of the unfortunate sufferer from ovarian disease, and as the treatment of the pedicle is the only point of difference existing in the mode of operation in the hands of different surgeons, I have ventured to bring before your notice a brief comparative synopsis of the various methods employed in treating the pedicle after the tumor has been removed.

For the sake of brevity, I shall divide the various forms of treatment into two classes, the first embracing the modes of treatment by leaving the extremity of the pedicle outside of the abdominal walls; the second, embracing the modes of treatment adopted when the pedicle is returned into the pelvic cavity. In the first class, the pedicle may be secured outside the abdominal walls by Spencer Wells' clamp, by callipers of various forms, or by transfixing the end of the pedicle with a needle, which, by being passed through the lower parts of the abdominal incision and transfixing the pedicle between the walls, does the double duty of preventing the return of the pedicle, and at the same time closing the lower part of the abdominal incision. The rationale of these plans is the same whatever method is employed, viz., the arrest of hemorrhage from the pedicle by pressure, and the prevention of its return within the abdomen. This class of treatment possesses great advantages

in those cases in which the pedicle is long and the vessels of the pedicle large, since it insures all safety, so far as the pedicle is concerned, against internal hemorrhage and suppuration; but it labors under the disadvantage that where the pedicle is short it is difficult of application; it pulls the uterus out of place, disturbs the pelvic organs, and frequently gives rise subsequently to uncomfortable dragging sensations in the lower portion of the abdomen and in the pelvis. The second class of treatment in which the pedicle is returned into the pelvic cavity obviates these objections, but is more prone to the dangers of internal hemorrhage and suppuration. Cases imperatively demanding this method are those in which the pedicle is very short and where the ovarian tumor is almost sessile, so to speak, to the uterus. The plan adopted by some surgeons in these cases is to secure the pedicle by transfixing it with a strong silk or hempen ligature, or by silver wire, tying both halves tightly, cutting the ends off short, closing up the abdominal incision, and trusting to Providence that the ligature or wire may do no harm. The risks in this case are, first, that the ligature or wire may slip over the end of the pedicle and fatal internal hemorrhage ensue; or, secondly, that danger having been escaped, that their presence may excite inflammatory action; and, thirdly, that the disintegration and sloughing of the constricted end of the pedicle may cause a collection of pus to accumulate, for which there is no egress. Another plan of internal treatment is to secure the end of the pedicle by a strong ligature, silk, hemp, or whipcord, and allow the end of the ligature to escape through the abdominal incision. This plan is open to most of the objections just enumerated, but is a decided advance in treatment in this respect, that in case of internal collections of pus and debris from the extremity of the pedicle the ligature serves as a guide for its discharge externally. The principal objection is that in some cases, recovery is greatly retarded on account of the ligature remaining firmly attached to the pedicle for three or four weeks or even longer. This persistence is, I believe, due to the fact of too much tissue having been taken up by the ligatures or by their not having been drawn sufficiently tight. Time, however, ultimately triumphs, the ligatures come away, but not before having caused considerable delay and annoyance, especially to those

* Read before the Canadian Medical Association in Toronto, Aug. 1876.

patients who have left their homes to be near their surgeon. There remains another method which, I believe, will ultimately be adopted by surgeons as the safest, most rational, and at the same time the neatest way of treating the pedicle. I allude to its division by means of the actual cautery for which the profession is indebted to the late Mr. Baker Brown. As I have not yet met with the records of any case of ovariectomy performed in Canada in this manner, I will briefly describe its application. As soon as the tumor has been brought fairly outside the abdominal incision, a clamp is applied to the pedicle. A cautery iron heated just short of white heat is pressed backwards and forwards against the pedicle until it gradually burns its way through its thickness. The clamp is then removed gradually, care being taken to see that no hemorrhage occurs on its removal, and the pedicle is allowed to slip back into the pelvic cavity. The extremity of the pedicle shows no evidence of having been cauterized beyond an eschar, which looks like a fine hair; there is no irritating ligature or wire to give rise to inflammatory action; there is no strangled extremity to slough and cause suppuration; and actual experience in more than one hundred cases has shown that there is not the least fear of secondary hemorrhage. If hemorrhage occurs at all it will take place immediately the clamp is removed, and while the pedicle still remains outside the abdominal incision, and if it does take place then, which is of very rare occurrence, it can be immediately arrested by a ligature. Statistics are proving that the rate of mortality by this treatment is less than that by any other. Of fifty consecutive cases treated in this way by the late Mr. Baker Brown, forty-five recovered, bringing the rate of mortality to ten per cent. More recently, Mr. Alexander Keith of Edinburgh has excelled even this brilliant record, having had forty-six recoveries out of fifty consecutive cases treated in this manner, thus bringing the rate of mortality down to eight per cent. Supported by this splendid success, and backed by our own experience when associated with the late Mr. Baker Brown, I have every confidence in bringing the treatment of the pedicle by actual cautery under your notice to-day, and most heartily recommending a trial of it by all ovariectomists in this country, endorsed as it is by such distinguished surgeons as the late Mr. Baker Brown, Mr. Alex.

Keith, and the late Dr. Tanner. The latter lamented gentleman, in his "Practice of Medicine," fifth edition, published in 1865, when treating of this subject, says: "Mr. Baker Brown has recently resorted to the use of the actual cautery; and I cannot but think that if this plan works well on further repetition, it will supersede all others." Of the unsuccessful cases in Mr. Baker Brown's series, I have the notes of the operation and post-mortem of three which proved fatal in the London Surgical Home for Women.

Case No. 1.—M. R., æt. 25, unmarried. Catamenia always regular. Her health had been perfectly good till three years ago, when pain in the left side first came on. The swelling has lasted only seven months. Seven weeks before admission the tumor was tapped but rapidly refilled. In February, 1865, under chloroform, an incision was made disclosing several adhesions between the peritoneum and the front and sides of the tumor which were divided by actual cautery. The tumor was then tapped and sixteen pints of fluid removed, when it was found to be further adherent to the left iliac crest, to several inches of the sigmoid flexure, to the meso-rectum and bladder. These adhesions were divided by actual cautery as far as practicable, and in all twelve patches were seared. One bleeding vessel, however, deep down between the uterus and rectum, which could not be reached either by actual cautery, or for the purpose of ligature, was suffered to remain patent, partly in consequence of the severe loss of blood already undergone and the exhausted state of the patient, and partly because it had ceased to bleed before the operation was completed. The pedicle having been also divided by cautery was then returned to the cavity and the wound closed by silver sutures. The patient died twenty-seven hours after the operation, exhibiting symptoms of internal hemorrhage during the last five hours. On careful post-mortem examination, the pelvis was found to contain about a pint of nearly pure blood, the source of which was traced to the site of adhesion to the meso-rectum, to which it was found impracticable to apply the hot iron. Signs of commencing peritonitis were also present. As this was the first case in which we had an opportunity of making a post-mortem examination after the pedicle and adhesions had been divided by actual cautery, it is of great practical importance to ob-

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serve, that no one spot so divided gave way but that the hemorrhage was entirely from the spot not cauterized.

Case No. 2.—A. M., æt. 45, single. A needle woman, who, to use her own words, "has had to spend more money on lodgings than food, as she could get no work unless she lived in respectable lodgings." Swelling first noticed 22 years ago. Catamenia regular but scanty. On March 16th, 1865, under chloroform, a primary incision of five inches was made. The adhesions were few and easily broken down. Ten pints of fluid having been drawn off, the tumor was withdrawn and pedicle divided by actual cautery and the wound closed. A low form of peritonitis set in 48 hours after the operation, which speedily carried her off 90 hours after removal of tumor. On post-mortem examination, a very imperfect attempt at union of the lower part of the abdominal incision was found. Intestines were inflated with gas and matted together by recent lymph. A few ounces of serum were in the abdominal cavity, but the seared pedicle was perfectly free from any symptoms of secondary hemorrhage. The heart was hypertrophied, the aortic valves thickened and puckered. The right lung was very adherent from old pleurisy. Other organs healthy.

Case No. 3.—M. H., æt. 55, married. Has ceased to menstruate for four years. Eighteen months ago first noticed a swelling in abdomen. Chloroform was administered July 19th, 1866, and an incision of six inches made. No adhesions were found anteriorly, but four pints of fluid, opaque and milky, were evacuated from the abdominal cavity. The tumor was extracted, and a small adhesion of the omentum exposed. This was separated, and the clamp applied to the pedicle, but, through failure of the cautery, two large arteries were tied by twine ligature. There was cystic disease of the omentum, two large layers of which were separated and formed a cavity containing transparent fluid which was evacuated. Low peritonitis ensued, to which the patient succumbed the sixth day after the operation. Post-mortem. No union of wound. There was general peritonitis, with yellowish lymph and universal slight adhesions, the right side of the heart containing a clot, the left side empty. No blood had escaped from the seared surface of the pedicle which was not included in the ligature.

These cases are to me most satisfactory evidence of the value of the actual cautery; and where to these one adds the large proportion of recoveries from operation after this method, I think I may safely commend it to my brother surgeons. In conclusion, allow me to suggest to the profession, that it would be even an advance on this treatment if we could show that the galvanic cautery could be safely substituted for the actual cautery.

CASE OF IDIOPATHIC TUBERIFORM MELANOSIS.

BY JAMES CATTERMOLLE, M.D., M.R.C.S., ENG.,
LONDON, ONT.

Mrs. H., aged 38 years, six months advanced in her fourth pregnancy, discovered a small tumor of pulpy consistence on the scalp, over the superior part of the right parietal bone. This was quickly succeeded by others in its immediate vicinity; these little tumors gradually increased in bulk, and finally coalesced, forming a large lobulated swelling. Small tumors soon appeared on the rest of the scalp, also over the thorax, abdomen, and lower extremities, varying in size, from the minutest granule to that of a pea.

Her general health during the first four months of the malady was but slightly impaired; alvine and urinary discharges regular and normal. The skin was unusually dry, and she felt rather weaker than usual, but not more so than in former pregnancies. At the usual period she gave birth to a fine, healthy child. The lacteal secretion was sufficient and healthy, and in less than a month she was able to resume her domestic duties. The disease had now existed four months in a very mild form, thus far progressing slowly, but in the fifth month, the tumors over the whole surface increased rapidly in number and size; a sense of constriction was now felt in the thorax, with occasional pains, respiration somewhat hurried, and troublesome dry cough. She felt a sense of oppression and fulness in the epigastrium, and the whole abdomen was somewhat tumid. An impaired condition of the gastrointestinal mucous membrane existed, causing troublesome flatulency, with occasional vomiting and some little diarrhoea.

From this period to the commencement of the tenth month of the disease, the morbid action had

steadily advanced both externally and in the thoracic and abdominal viscera, yet notwithstanding this large amount of melanoid deposit, the woman continued able to assist in doing her house-work. During this month, however, the symptoms became more urgent; her general appearance cachectic; countenance care-worn and anxious; limbs attenuated; abdomen much larger than natural; biliary and renal secretions too scanty; pulse over 90, small and hard; extreme debility and languor followed. The secretion of milk gradually diminished, and subsided completely by the end of December. The cough now became very troublesome, the breathing uneasy and quick, but no fixed pain in the chest; in some parts the sound on percussion was rather dull, with feebleness of respiratory murmur. The hepatic pains were also more severe, putting on occasionally the character of spasm; a tumefied condition of the liver could now be easily made out.

On the exterior of the body, the tuberiform masses increased in magnitude, and probably from the impaction of small nerves in their structure, aching sensations were felt in different parts of the thickly studded surface.

The left eye now became involved, but apparently not in the usual way, as described by Morgan and other writers, who hold that the disease invariably begins in the interior of the globe, whereas in the case under consideration the conjunctiva was the first part of the eye which received the morbid deposit, and this near the inner canthus. The whole membrane at first was bulging and loose, resembling chemosis, at first semi-transparent, but very soon the interstitial and vascular structures were injected with dark grumous looking fluid, which gradually extended over the whole sclerotic conjunctiva (leaving the corneal portion free for a time) and passing round into the orbit, so that the entire tunica oculi became injected with the melanotic fluid, and enormously thickened and swollen. Three or four weeks elapsed before the sight was much diminished, but the cornea eventually received its share of infiltration, and was completely cased over by pigmentary crust.

The melanotic deposit in the orbital cavity increased so as to project the eyeball from between the lids, in the form of an irregular globular tumor with a staphylomatous bulging of the inferior half of the sclerotic. The diseased eye was now three

times its natural size, and its exposed surface presented a dark livid appearance. In twelve weeks after the eye was first attacked, it was brought to this frightful condition—*i.e.*, in the 13th month of the general disease.

The tumors on the head had now attained the size of hazel nuts, and formed large masses. Both mammæ were thickly studded, and a large lobulated mass extended from the right breast down to the groin. On the left side of the body the tumors were smaller and less numerous. The inguinal glands were enlarged and surrounded with melanotic nodules; the deposits were large on the inside of the thighs, but small about the legs and feet. The colour of these deposits was a bluish-black. On puncturing one of the tumors with a lancet some black glossy substance, firmer than jelly was pressed out, which imparted to the skin a deep black stain; this, however, was easily removed by a moderate use of warm water. In the submucous cellular tissue of the mouth and fauces there were innumerable small deposits, one rather large on the posterior pillar of the fauces and added much to the difficulty of breathing from its proximity to the larynx. With this augmentation of the disease, about the end of the 15th month, the respiration became still more hurried and difficult, cough troublesome, with copious expectoration, occasionally tinged with blood. However bad this condition, a worse soon followed—the pulmonary parenchyma became more engorged, producing urgent dyspnoea; in some portions of both lungs respiration was inaudible, and of course so affected, a variety of abnormal sounds existed.

The liver reached below its costal boundary and attained such proportions as to fairly tilt out the ribs by its pressure.

The patient by this time, (*viz.*, 14th month of the disease,) presented a sad and unsightly appearance, with enlarged abdomen, wasted limbs, disorganized eye, and tuberosus exterior.

Finally the chest symptoms increased in intensity, accompanied with copious expectoration of blackish matter. The brain also became implicated and probably had to bear its share of the morbid deposit, as partial paralysis of the left arm and leg occurred.

Her sufferings were much increased by frequent paroxysms of spasmodic dyspnoea, caused by the tumor in the fauces; deglutition and articulation

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were rendered difficult by the same cause; finally after remaining in this half-asphyxiated condition some three or four days, she died.

I regret much that I could not obtain leave to make a *post mortem* examination. The tumors on the surface varied in firmness, from the consistence of jelly almost to the density of cartilage. No extreme softening or sloughing occurred except in the disorganized eye, from which, for three or four days prior to death oozed a dark thin sanies.

This peculiar disease has been regarded by some authorities as mild and innoxious, except from the quantity of morbid material produced; this opinion is in a measure sustained by the above case, as not until there existed strong evidence of morbid deposits in the parenchymatous structure of the viscera, did the health materially suffer, but as these formations acquired bulk, it may be inferred that the mechanical irritation became so serious as to be amply sufficient to destroy life independently of any malignancy or deleterious principle "*sui generis*," common to carcinomatous diseases, amongst which it was ranked by Tanner and other writers on the subject.

Most writers agree in attributing the origin of melanosis to the accidental formation of carbonaceous pigment analogous to the colouring matter of the blood, that during the disease the system is surcharged with carbon, but how or in what way this extraordinary quantity of carbonaceous substance is accumulated, has not been very clearly demonstrated, and whether it may depend on defective oxidation of the blood in its passage through the lungs, or insufficient decarbonization occurring from other eliminating sources, is somewhat uncertain.

The views of modern pathologists evidently lean to the belief of the malignant nature of idiopathic melanosis; amongst the most prominent is Paget, who holds it to be medullary or encephaloid cancer, modified by the deposition of black pigment. And Erichsen states that in microscopic structure it resembles encephaloid, consisting of a stroma with caudate, granular, and compound cells, but containing a large quantity of pigmentary matter in granules, molecules, and masses.

The treatment of the above case was simply palliative. Could any one suggest a remedy?

CASE OF LITHOTOMY—LATERAL OPERATION.

BY V. A. BROWN, M.B., F.R.C.S.E., LONDON, ONT.

The idea has often, struck, me during my professional career, how useful and advantageous a practice it would be, not only for the profession at large, but more especially for its younger members, if all the various steps taken, and everything actually done, at all difficult and dangerous operations were at the time carefully noted down and afterwards more generally given to the profession. Prompted by this idea and with this object in view, I have written fully and exactly every step in operating on the following case:—

The subject, an old resident of West Zorra, six miles from Ingersoll, æt. 65, was the patient of Dr. McCausland, of that town, who kindly handed him over to me for operation, on the 3rd of August last. He had suffered from urinary derangement for the last twelve years, and had received as may be supposed a variety of treatment, "old women," "Indians," and various "Pathies" having been invoked and tried at different times but without avail. A calculus however, was never suspected until Dr. McCausland sounded him two days ago, when he readily detected one. He advised its removal and the operation was at once assented to. He is a small spare man, apparently just the one for a dangerous operation; his bladder had been for a length of time in a most unusually irritable condition, so much so that he found it impossible to retain any urine for the operation.

I was ably assisted by Drs. McCausland, Williams and Bowers, of Ingersoll, and Dr. Kains, (resident surgeon of the London hospital.)

A purgative was given the day before, which fully emptied the bowels in the morning. It was found impossible to introduce a sound into the bladder in consequence of its extreme irritability, so that I was obliged to have recourse to a large prostatic catheter which Dr. McCausland passed after much patience and trouble. This readily detected a large stone lying in the bas-fond of the bladder.

In consequence of the bladder being so irritable and consequently unable to retain any urine, it was determined, in order to inject the bladder, to chloroform him first, contrary to the usual custom of

doing so after the staff has been passed and the patient tied up. Eight ounces of luke warm water were then injected into the bladder, but was not retained more than two minutes.

He was then tied up, and the staff, (Markoe's, of New York,) grooved on its convexity, was readily introduced. It was placed in the hands of Dr. Kains, with directions to keep it hooked firmly under the arch of the pubis, exactly in the mesial line and perpendicular to the body, which he faithfully and efficiently carried out. The next step was to mark out the line for the external incision, viz., $1\frac{1}{4}$ inches in front of the anus and two lines to the left of the raphe of the perineum, for the commencement, from which to a point midway between the anus and the left tuber ischii, for the line of incision; this was necessarily only $1\frac{1}{2}$ inches long on account of the narrowness of the space between the two tubera ischii which measured only three inches.

The forefinger of the left hand was then introduced into the rectum for the purpose of taking the bearings of the staff and prostate gland, this I found afterwards a most useful precaution. The knife (an ordinary scalpel) was then boldly plunged in a direction upwards and backwards towards the staff to a depth of three-fourths of an inch; it was then carried downwards and outwards along the line marked out, shallower at the bottom. The point of the left index finger was next passed into the upper angle of the wound in a direction upwards and forwards towards the staff which, from my previous knowledge was readily found. Here some delay was experienced in satisfying myself that the point of the knife was in the groove which was too wide and shallow for practical purposes. When the necessary slit was made in the membranous portion of the urethra posterior to the bulb, Sir H. Thompson's button pointed scalpel, was immediately shoved into the bladder, its cutting edge being lateralised (as is so explicitly laid down in Erichsen,) so as to follow the line of first incision. As there was no abrupt termination to the end of the groove in the staff, (another fault,) the point of the knife was brought up by the stone grating against it. It was then very carefully withdrawn along the staff, finger still in situ; this was next pushed into the bladder, the entrance into which was found to be sufficiently large for its passage. This was exactly as I

wished, as I had designed in the plan which I had formed for the operation to be as limited as possible in incising the prostate, my finger being rather short, the prostate very much enlarged and the bladder contracted, considerable pushing was found necessary before I could satisfactorily reach the stone, so that it might serve as a guide for the introduction of the forceps.

The next step in the operation was the withdrawal of the staff and the passing in of the forceps, (medium sized and curved). This was cautiously done along the upper surface of the finger, blades horizontal, until they touched the stone, which was found, as I have already stated, in the bas-fond of the bladder behind the prostate and pressing on the rectum. By a little careful manipulation the stone was secured and its withdrawal commenced, but after some steady traction and working to and fro, similar to the use of the midwifery forceps, the blades slipped off; a longer pair was then introduced, but the stone, after a most careful searching, could not be found, the bladder had evidently drawn it up and contracted upon it. The large catheter was again inserted by Dr. McCausland, and after some searching it was found in the upper fundus, being held there by the contractile powers of the bladder coats. These subsiding, it was soon dislodged into its old situation and readily seized, but a second time its withdrawal, though managed with more caution proved a failure, a considerable portion of its surface being crushed off. Another attempt also was a failure. I then reluctantly concluded to enlarge the opening at the neck of the bladder. This I did by means of a long straight bistoury passed along the finger, the blade being held horizontally for fear of wounding the rectum and the cutting edge turned towards the ramus of the left pubis. The smallest nick was made, similar to division of stricture of a hernia, the forceps was then reintroduced, and after a little manipulation the stone was again seized and removed. It proved to be the triple phosphate—weight, independent of what was lost, 390 grs.—circumference, $4\frac{3}{4}$ in. by $3\frac{3}{4}$ in.

The hemorrhage was unusually small. Immediately after the operation the bladder was well syringed with luke warm water by means of a Matison's syringe, for fear of the retention of any of the debris. He was then put to bed on oil cloth; knees close together; no drainage tube was

inserted into the bladder in order to avoid fresh irritation. A large sponge was arranged under the wound, and a solution of bromo-chloralum $\frac{1}{3}$ to $\frac{2}{3}$ water directed to be freely used all round him, both on the sponge and under the bed clothes.

Diet to be farinaceous for two or three days; 1 gr. pul. opii. in the evening, to be repeated in four or five hours if necessary.

4th. Had a very good night, complains of a little pain, supra pubis; urine passing per wound; expresses himself as perfectly comfortable.

5th. Went to see him to-day, found his general condition to be as favorable as could be desired. P. 84. Slept well under an opiate, slight tenderness over bladder to left of pubis; says it is less than yesterday; urine trickling nicely through wound; bladder was well syringed with luke warm water, and a small catheter inserted, with directions to be removed in six hours, when the wound was to be syringed with a permanganate lotion, grs. v. ad. ʒj. , this was ordered as the odor was very offensive. Most particular injunctions were given as to cleanliness, the issue of the case now really depending upon it.

The last report sent me at the end of three weeks: Patient going on well, urine passing by urethra. Every appearance that the operation will prove a perfect success.

REMOVAL OF THE RIGHT THYROID GLAND.

BY W. A. WILLOUGHBY, M.D., COLBORNE, ONT.

(Reported by J. A. Sinclair, Trin. Coll. Med. School.)

The subject was a young man of nineteen years of age, of healthy parentage, and good constitution. The gland began to enlarge four years ago, and since then he has been constantly using remedies with a view to prevent its growth and lessen its size. Having ascertained that he had been under every available form of treatment, as far as drugs were concerned, the Dr. advised excision as the only remedy that could hold out any hope of permanent cure. The gland increased in size but very slowly at first, and then remained stationary for about three years. Lately, however, it has grown so rapidly that it was three times as large when operated upon, as it was three months before.

The following were the appearances as found on examination previous to the operation:—

The neck was enlarged from immediately below the chin down to the clavicle, and measured sixteen inches in circumference. The gland felt quite solid to the fingers and could be handled in every way without giving the patient any pain. It could be moved slightly on all sides except internally, near the isthmus, where it was more firmly attached. The reason of this was seen while operating, for the gland was found adherent to the thyroid cartilage for nearly two inches. The gland had grown so large, that internally it pressed against the larynx so as to displace the pomum Adami two inches to the left side. During the last week or so the patient could not exercise rapidly without being completely out of breath (as he said), and in a full state of perspiration. The pressure was increasing with the rapidly enlarging gland, and the difficulty of breathing was becoming so great that death from apnoea was likely soon to result. Externally it was in close contact with the common carotid artery, jugular and other veins, all of which it had displaced considerably. Anteriorly, several large superficial veins could be seen, and the sterno-hyoid muscle distinctly traced over it, towards the outer side. Posteriorly, it pressed upon the pharynx and cervical vertebræ, and was firmly adherent to the larynx on the inner side of this surface. Superiorly, the pulsations of the superior thyroid were to be traced along most of this side, and those of the subclavian below. The skin was freely movable over the whole of the gland, and although the gland itself was slightly moveable, still it was attached to the sheaths of all the adjoining structures. No fluid could be detected upon the closest examination, and on moving the fingers carefully over its surface a glandular unevenness could be felt—a circumstance which told that there was very little, if any fluid in it.

Drs. Thorburn and Gould were present at the operation; the former administered the chloroform. An incision was made, from a point to the right of and a little below the upper surface of the right thyroid cartilage, vertically to the clavicle, and another incision to the right along the bone for about four inches. The gland was carefully dissected out and successfully removed, the operation lasting about an hour. Very little chloroform was used, and not more than eight ounces of blood lost.

The wound was dressed soon after with a few sutures, adhesive plaster, and bandage. The gland was heart shaped and somewhat larger in size than the human heart. It had a slightly glistening appearance, and when cut, measured five and a half inches in its long, and three and a half in its short diameter, and weighed one pound. There was a very small quantity of fluid in which was a small hard clot in the centre of the large end. Near this were several hard nodules. The whole substance presented a solid glandular appearance. The healing was rapid. On the sixth day after the operation the patient said that he had enjoyed the best night's rest he had had for two years. The neck now only measured eleven inches in circumference. The second week he was able to be around and take out-door exercise.

Correspondence.

SPONTANEOUS INVERSION OF THE UTERUS.

To the Editor of the CANADA LANCET.

SIR,—I have been induced to send you a report of the following case from the fact that, to me, it was a rare one, having never heard or read of one similar. In no obstetric work that I had perused have I seen it stated that such an accident is at all likely, or even liable, to occur.

About 4 p.m., on the 28th of last December, I was hurriedly summoned to attend Mrs. C., æt. 24, residing in the northern part of the township of Belmont, sixteen miles distant from this village, and who, I was informed, had been delivered of her second child about noon the same day. The messenger stated that the placenta had not been extracted; that she was losing large quantities of blood, and was still having most terrific pains, much more violent than before the child was born. Speedily equipping myself, and crossing Round Lake on the ice to save time, I reached the scene of trouble a little before 6 o'clock. I found the patient exceedingly prostrated from excessive loss of blood, although all hemorrhage had ceased about an hour before my arrival, but still suffering most violent pains, recurring at intervals of from one to two minutes, and extending over a period of two or three minutes. On examination, I found

the placenta almost entirely extruded through the vulva, and apparently only requiring slight traction on the cord to complete its removal. The slight traction, however, did not have the desired effect, and only served to convince me that something unusual had happened. Passing in my hand for the purpose of ascertaining the cause of the difficulty, I found the placenta firmly adherent over a space equal to about four square inches, to what, on still further examination, proved to be the inverted fundus of the uterus. Two very severe pains occurred while my hand was in the vagina, and each time the placenta was pushed forward, and the uterine inversion became more nearly completed. Having satisfied myself of the true condition of affairs, and administered a stimulant and anodyne draught containing one drachm of *spts. ammon. arom.* and forty minims of *tr. opii.*, I proceeded, carefully, to remove the placenta, which, without much difficulty, I accomplished, the seat of the adhesion being easily reached. Contrary to my expectations, what I anticipated being the most serious difficulty—viz., replacing the inverted organ *in situ*—did not occasion much delay. By pursuing the method advised by Prof. White, of Buffalo, which I had become familiar with while a student in his class in 1864, the uterus gradually resumed its normal position, the operation being completed by a little jerk, which quite astonished me. The patient made a good recovery.

To those who may ask if the accident was not produced by traction on the cord made by some one previous to my arrival, I may say that only two women were present, in whom, from long acquaintance, I have every confidence; both of whom, also, are naturally timid, and very unlikely to interfere; and they both assured me that they did nothing but cut the cord and remove the child. The husband also, whom I have no reason to disbelieve, assures me that he never left the room until after my arrival, and that no interference took place on the part of the women or himself. The cord, too, was an unusually long one, and therefore not at all likely to drag while the child was being removed. These facts, together with the peculiar action of the pain on the placenta, and the progress of the inversion which I observed while making the examination, convinced me that the case was one of almost complete *inversio uteri*.

produced solely by the efforts of the organ itself to expel an adherent placenta.

Yours truly,

S. P. FORD, M.D.

Norwood, September, 1876.

Selected Articles.

GASTROTOMY FOR THE REMOVAL OF A FORK FROM THE STOMACH.

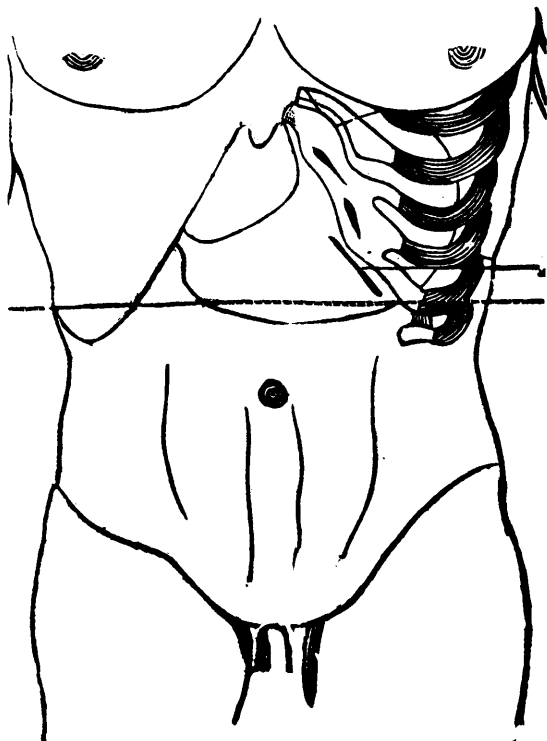
By Dr. LABBE, Hopital de la Pitie.

On March 30, 1874, Lousseur, æt. 18, swallowed a plated fork, the prongs of which he was holding with his teeth. This was a trick which he had seen done by mountebanks, and which he, at different times, had repeated with impunity. But on that day, during a sudden movement provoked by a joke of one of his friends, the part which he held with his teeth escaped him, and the foreign body sank deeply in the larynx. Dr. Lepere was called and with a long polypus forceps seized the prongs of the fork; but in a moment of great pain, Lousseur pushed him back suddenly, and the foreign body sank deeper in the œsophagus.

I saw Lousseur a few moments afterward; he was not suffering, and accepted his new situation rather cheerfully. On the following day I made numerous explorations to ascertain the presence of the fork in the stomach. Once only, with the aid of an *Instrument a renforcement du son* (an œsophageal sound carrying a very simple apparatus, transmitting sounds), did I succeed in getting a positive result. Fifteen days afterward Lousseur was suddenly taken with gastric symptoms in the form of intense pains and repeated syncope. At the end of twenty-four hours after this crisis a rather large tumor appeared, corresponding with the greater curvature of the stomach; the end of each meal was marked by intense pains. A year passed, during which he had intervals of great pain and comparative comfort; a part of the time he followed his usual avocation; but his health failed and his sufferings became more urgent, and as the prongs of the fork could be distinctly felt through the thinned walls of the abdomen, he desired that something should be done to relieve him.

After consultation with Profs. Gosselin and Larrey we decided upon surgical interference, first by the aid of caustics to determine adhesion between the internal surface of the abdominal wall and the stomach, and second, gastrotomy with the knife. Numerous applications of Vienna Paste and Ganquin's Paste were made; but owing to the excessive mobility of the stomach, no adhesion took place.

The operation with the knife was next undertaken. The stomach is accessible to surgical operation only in a part of its anterior surface, in a triangular space of which the base is inferior and corresponds to the greater curvature, and the sides are formed on one side by the lobe of the liver, and on the other by the edge of the left false ribs. The patient being under the influence of chloroform an incision four centimeters in length was made, one centimeter within, and parallel to the left false ribs, the left extremity of which corresponded with a transverse line passing through the cartilage of the ninth rib.



Layer after layer was divided until I reached the parietal peritoneum. With a small forceps, introduced through the incision, I seized the anterior wall of the stomach and drew part of it outside. A thread was passed through the fold thus made, and the fold held fast against the lips of the abdominal wound. Then with a curved needle, I penetrated the organ from without inward, issuing from within outward through the abdominal wall at about one centimeter from the borders of the incision. I thus applied the visceral against the parietal layer of the peritoneum to the extent of one centimeter around the edge of the wound. I attained this result with eight points of suture.

I now incised the anterior wall of the stomach and penetrated within the cavity of the organ. I was then enabled, with my left index finger, to feel the foreign body, and ascertain its position;

but I became at once convinced that the extraction could not be easily performed, for the opening in the stomach tightened around my finger and held it as fast as if within a vice. I then decided to throw the mucous membrane outward and fix it to the periphery of the wound. From this moment on the operation became an easy one; my finger re-introduced served me as a guide, and with a long polypus forceps I seized the fork and removed it.

Symptoms of peritonitis appeared, but these were quickly mastered by the use of a thick layer of collodion on the abdomen and the use of iced champagne wine. The patient improved rapidly; on the fifth day he was well enough to take solid food; he has since returned to his ordinary alimentation, and finds himself in excellent health. The wound is very small and the gastric fistula which exists is very narrow and hardly permits the introduction of the little finger. The applications of this operation would be very limited were they reserved only for cases of foreign bodies in the stomach, but it seems to me that it might be really utilized in taking up an idea presented and ably defended by Professor Sedillot. This eminent surgeon had indeed proposed to apply gastrotomy in cases of insurmountable stricture of the œsophagus and cardia, and to practice in such patients what he called a *stomachal mouth*, permitting life to be prolonged by introducing nourishment directly into the stomach.

The patient's health is now nearly perfect and the gastric fistula is almost obliterated and allows only the passage of a small probe.—*W. Lancet.*

NEW OPERATION FOR UNUNITED FRACTURES.

In a brief pamphlet of eight pages, Dr. M. Hill, of Bootle, Liverpool, gives the details of a new operation which he has devised for attempting to secure osseous union in ununited fractures. It is an ingenious modification of Diffenbach's operation for the same purpose—viz., the introduction of ivory pegs into the fractured surfaces. The method proposed by Dr. Hill is to drill the bones and introduce the pegs through a small opening made with a tenotome knife, performing the operation as far as possible subcutaneously, and sealing up the aperture antiseptically at its conclusion, thus avoiding the conversion of a simple into a compound fracture.

The instruments required for the operation are—"an Archimedean drill-stock, a steel drill four or five inches long, and a few ivory stilettes of the same length and diameter (or slightly tapering) as the drill. The drill and stilettes are similarly graduated in half inches, and the ivories are, moreover, grooved like a director in order to slide along the drill."

"The *modus operandi* consists in entering the drill through a puncture made by a tenotome down to the bone; the depth of the soft parts is now read off by means of the graduations; then if it be desired to bore into the bone to the depth of an inch, the drilling is proceeded with until the steel has penetrated an inch further than the original reading. The ivory stilette is now filed *half way* through an inch from the point, and after being soaked in carbolic oil, is guided by its groove down alongside the drill to the brink of the perforation in the bone, from out of which the steel is next lifted, the ivory slipped into its place, hammered, and by a smart lateral movement broken off at the filed notch. The operation is completed by withdrawing the remainder of the stilette and sealing the puncture with a bit of lint and plaster. By carefully following the foregoing details it will be found that an inch peg is accurately placed in an inch hole, consequently there is no portion of it projecting into the flesh, and of this we may be certain by seeing before it is broken off, that the reading on the ivory at the surface of the skin tallies with the previous reading on the drill, both being graduated alike. A further object is secured by the peg being grooved: a channel is thereby provided for the escape of fluids in the event of osteomyelitis being set up, thereby avoiding the danger and suffering caused by the damming up in the bones of inflammatory fluids as would necessarily be the case were the peg solid."

This operation, as far as the manipulative details are concerned, was successfully carried into effect by Dr. Hill in the case of one of his patients, a gentleman, æt. 35, who sustained a fracture of the thigh at the junction of the middle and lower third, the result of a railway collision at Wigan on the 25th of December, 1874. Unfortunately, owing to some peculiarity of constitution, probably connected with the rheumatic dyscrasia, the operation failed to secure the desired union; this failure, however, could not in any sense be attributed to defect in the operation itself.

The case is one of great interest, illustrating as it does the difficulties which may sometimes be met with in practice in dealing with cases of fracture. With the exception of some attacks of acute rheumatism, the patient seemed to possess a good sound constitution; there was no history of excesses, syphilis, cancer, scurvy, or scrofula; he was well nourished, if anything, being inclined to *embonpoint*. Undoubtedly want of union was at the outset due to the disturbing influence of a severe hacking cough, induced by elongation of the uvula. This was remedied by removal of the pendulous uvula, and brushing out the throat with perchloride of iron. Every measure that was adopted failed to secure the desired union, though the records of treatment extend over the space of a year. In December last resection was performed. The difficulties attending this operation were so great

that Dr. Hill is more than ever confirmed in his desire to give a fuller trial to the operation he proposes, and it certainly seems deserving of fair and impartial consideration at the hands of the profession at large.—*Med. Press and Circular.*

TREATMENT OF COMPOUND DEPRESSED FRACTURES OF THE SKULL.

By SAMSON GAMGEE, F.R.S., Queen's Hospital, Birmingham.

Gentlemen: Is the trephine to be employed or not in compound fractures of the skull, with depression? No question more than this has engaged the attention of practical surgeons: it is still unsettled, and I shall endeavour to lead you to a correct understanding of its merits in commenting on three cases which I have to bring before you. In each case the scalp was divided, and the bones of the skull were broken and driven in, without, however, producing evidences of injury to the nervous centres. In none of the cases was the trephine employed; in all the result has been perfectly successful.

The man before you, Thomas Moran, a brick-layer's labourer, aged 55, was admitted to Ward 3, on September 15th. While he was at work just previously, a brick fell from a considerable height upon his head, making a Y-shaped scalp-wound about two inches and a half in length, and situated rather above the middle of the left parietal bone. The flap of the wound being turned back, a Y-shaped fracture became visible, with its centre depressed to one-third of an inch; the sides of the fracture sloping evenly towards the central and most depressed point. The man seemed little affected by the accident, and had no idea of its serious nature. The edges of the wound, admitting of easy approximation, were brought together and dressed with dry lint; and for the first fortnight the patient was kept perfectly quiet in bed, on milk diet, with an ice-bag on the head. No signs of constitutional disturbance appeared, and the man was discharged at the end of seven weeks, to use his own terms, "in as good health as ever he was in his life." The wound was then quite healed, and the area of the depressed bone measured one inch and a half longitudinally, seven-eighths of an inch transversely; its depth was three-eighths of an inch in the centre.

The next patient, Henry Hadden, a machinist, aged 25, was admitted into the Queen's Hospital at 11.20 p.m., on September 25th. A few minutes previously, in a street row, a brick had been thrown at his head, producing a wound an inch in length over the left temporal ridge, in a line above and in front of the ear. The hemorrhage was considerable. The probe passed into a very abruptly

punctured fracture of the skull; the amount of depression being half an inch, and the edges on one side at least, being quite perpendicular. Mr. C. W. Keetley, our house-surgeon, to whom I am indebted for the notes of these cases, made a memorandum at the time, to the effect that, in Hadden's fracture, a small piece of bone appeared to have been driven right in. The man was quite sensible, though faint from loss of blood. He was put to bed, with an ice-bag on the head. At 8.30 next morning, a little headache was complained of; the pupils were even; temperature 101 deg. A magistrate took the depositions at the bedside in the afternoon.

Sept. 27th, morning. Pulse 80; temperature 98 deg. There was a thin drab fur on the dorsum of the tongue. The bowels were not open. He had slept well; was very hungry. The wound was healthy. His eyes were slightly swollen.

The bowels acted the next day. The wound gradually healed; and on October 9th, the ice-bag was left off, a flannel cap allowed to be worn, and the man to get up. At the end of another fortnight the man was discharged in perfect health; the cicatrix was quite sound; and the depression at the seat of fracture admitted the end of the little finger, which did not seem to touch bone at the bottom.

The third case which I have to bring before you is that of T. Smith, a joiner's labourer, aged 25. He was stooping down at his work, when a brick fell on his head from a height of thirty feet. When admitted to Ward 1 (4.15 p.m., October 15th, 1875), half an hour after the accident, he was quite sensible. A wound on the left side of the head was bleeding freely; corresponding to it was a depressed fracture of the skull, the depressed piece of bone being horse-shoe shaped, and situated near the middle of the lambdoidal suture. The depressed surface was about one-eighth of an inch below the surrounding bony level. No head symptoms. Pulse 80; temperature 99 deg.; respirations 24. The edges of the wound were approximated and dressed with dry lint. An ice-bag was ordered to be kept on the head constantly.

Oct. 16th. Temperature 99 deg.; pulse 72; respirations 20. He was perfectly sensible. He had taken plenty of milk. He was ordered to have an ounce of castor oil.

17th. He slept four or five hours in the night. The bowels had acted. Temperature 101 deg.; pulse 104; respirations 22.

18th. Temperature 101.6 deg.; pulse 76; respirations 25.

Nov. 19th, morning. Temperature 99.2 deg.; pulse 84; respirations 22. There were still no symptoms of serious lesion or constitutional disturbance.—7 p.m. Temperature 104.4 deg.; pulse 104; respirations 32. He had a rigor half an hour ago. A full dose of castor oil was ad-

ministered, and the bowels freely relieved. No other untoward symptoms occurred, and the rigor and rapid rise of temperature remained an inexplicable incident.

Dec. 8th. He had continued perfectly well, and for the last month had acted as assistant porter in the hospital. He was now discharged, and I made the following note: "The length of the cicatrix is one inch and three quarters. The depressed portion of bone measures one inch and one-eighth by seven-eighths of an inch. The depression is deepest in the centre, where no bone can be felt. The man looks perfectly well, and says that he is so."

You have here three cases of compound depressed fracture of the skull, admitted within a period of one month, treated successfully without the trephine or elevator. You may form some idea of the interest attaching to these cases, by a statement of Erichsen, that, with a single exception, he does "not recollect ever having seen a case recover, in which a compound depressed fracture of the skull occurring in the adult had been left without operation."

Prescott Hewett's counsel is given in no doubtful terms. "What," he asks, "is to be done, supposing there be a wound leading down to the bone in a depressed fracture of the vault without symptoms? The rule is that we are to operate and at once." With the utmost regard for this dictum of one of the most thoughtful surgeons of our time, who has made injuries of the head the special object of his clinical studies, and conceding that, in his advocacy of operative interference in compound depressed fractures of the skull, Prescott Hewett is at one with many eminent surgeons, especially British, I am clearly of opinion that the practice followed in the cases before you should be the rule of practice.

When addressing you on the treatment of compound fractures of the limbs, I have sought to impress upon you the wisdom of the precept, "to aim at reducing a compound to the condition of a simple fracture, and to treat both alike." This precept is equally applicable to compound depressed fractures of the skull, when the brain is not injured.

Although unanimity has not yet been attained, the progress of surgery has powerfully contributed to the establishment of this proposition. A century ago, operative interference was the rule in all fractures of the skull. It was Quesnay, himself an advocate of the practice of interference, who gave force to the opinions of dissentients, by the very title of one of those masterpieces of clinical study embodied in the memoirs of the old Academy of Surgery. It fell to the lot of another of the academicians to substitute for traditional empiricism rules of practice as prudent and safe in their application, as their conception was enlightened and

their demonstration closely and carefully reasoned. With few reservations, Desault was opposed to the use of the trephine in fractures of the skull. It was otherwise with his great rival on this side of the Channel, Percival Pott. The elevator and trephine were his favourite instruments, and so great was his ascendancy in the surgical world, so much more fascinating for the multitude, than as now, were boldness and complication than prudence and simplicity, that his heroic action had many imitators; foremost amongst whom was his most illustrious pupil, John Hunter, who went so far as to advocate the trepan in some doubtful cases, "as the application can do no harm." The impending French Revolution, and its attendant slaughter on the battle-fields of Europe was soon to furnish those lessons which, in surgical as in other experience, make men judicious.

When, after the battle of Talavera de la Reyna, the order was given for all the wounded who could leave the town to march, Surgeon Rose found himself in charge of a large number of the disabled Guardsmen. Twelve or fourteen of them had compound fractures of the skull, some with depression. In none of these was the trephine employed. The retreat in the burning sun lasted sixteen days, and yet every one of those who were wounded in the head recovered.

Hennan relates the case of corporal Corkeyne, wounded by a musket-ball in the head at Waterloo. The fractured portion of bone was driven into the brain (being exactly an inch and one-fourth from the surface of the scalp). No operation was performed, and yet the man was discharged cured in a few weeks. After quoting a similar case, Hennan sums up: "We have here sufficient proof that there is no absolute necessity for trepanning, merely from depressed bones from gunshot"—an opinion strengthened by the cumulative experience of military surgeons, many of whom now entirely discard the trephine, while almost all are agreed that its use should be restricted to very exceptional cases.

Desault's conservatism told directly on the civil practice, not merely of his own countrymen, but of British surgeons. John Bell with his true surgical instinct, with his impetuous energy, and with the furbished eloquence of his ripe culture, threw in his lot against the trepan. "After the expiration of my apprenticeship at these hospitals," Astley Cooper has placed on record, "I went over to Paris, to see the practice of Desault at the Hotel Dieu; and there I found that scarcely ever under any circumstances did he trephine; and he was more successful than the English surgeons." Abernethy and Lawrence, too, were in this matter disciples of Desault, and on the same side must be mentioned one of the most enterprising surgeons of the century—a master who combined in a very rare degree fearlessness and judgment, power of

brain and skill of hands—I allude to Robert Liston. In his *Practical Surgery* he thus writes: "When fracture of the skull is complicated with wound of the scalp, the surgeon will not in general mend matters much by trephining, as has been advised, merely because there is a wound; if the depression is pretty extensive, and unless he has a better reason to give for the proceeding than the mere circumstance of the fracture being compound, as it is called, he will often thus add as much to the injury and to the risk which the patient is subjected to by it, as he would by dividing the scalp in simple fractures."

This warning is of special significance, emanating as it does from one who had had abundant opportunities of witnessing the effects of the trephine and elevator, and who possessed operative skill and courage in so high a degree that he never felt the temptation to inaction as a refuge from responsibility.

Samuel Cooper was equally conservative; but it is due to you to state that three of his contemporaries—Guthrie, Brodie, and Velpeau—in the very first rank of surgical authorities, rather inclined to the heroic practice of Pott than to the physiological watchfulness and the gentle medical measures of Desault. Italian surgery has gradually come round to non-interference as the rule of practice in fractures of the skull, while the German school has traditionally been opposed to the trephine. Neudorfer, writing after the Franco-German war, sums up directly against it. Mac Cormac reflects the experience of the French and German surgeons on the battle-field of Sedan, in the statement that, "as a general rule, the largest proportion of good results (in gun-shot fractures of the skull) obtain amongst those cases where the amount of operative surgery has been at a minimum."

Jules Rochard has contributed an interesting summary of the international position of the question. Speaking of trephining, he says: "The spirit of reserve distinguishes French surgery. It holds a position between the practice of the Germans, who scarcely ever trephine, and that of the English and of the Americans, who, though resting on the same rules as ourselves, have much more frequently recourse to this operation. Leon le Fort has analysed the trephine operations on the two sides of the Channel from 1855 to 1866. He has found one-hundred and fifty-seven of them in England, and only four in France in that period."

The authorities I have quoted will be sufficient to convince you that the masters of our science have treated this question as a very important and difficult one. From their differences you will learn caution and toleration in judging others, and the need of most careful inquiry, before you determine to use the trephine. The three patients whom I have brought before you with compound depressed fractures of the skull, successfully treated

without the trephine or elevator, have not recovered by accident or in virtue of a curious coincidence. As many authorities are against me, I have deemed it my duty to compare my opinion with that of others, for your instruction. In examining the question from an historical point of view, I do not pretend to have exhausted it; but I do hope to have proved that the progress of opinion has, on the whole, been in favour of non-interference, when the scalp is wounded and the skull broken and driven in; without, however, producing symptoms of brain-lesion. The lesson very impressively taught by a careful study of the subject is this: that whereas the trephine was almost indiscriminately employed before surgery attained to the position of a science, its use has steadily decreased as enlightened experience has accumulated. Many surgeons, from being advocates of the trephine, have gradually abandoned it; but so far as my researches have extended, I cannot find an instance of conversion to the practice of trephining by a surgeon whose reason indisposed him to adopt it, or whose experience had once led him to relinquish it. That there may be cases of compound depressed fracture of the skull justifying operative interference I do not deny, and I myself had occasion to operate successfully on such cases in this theatre. Another opportunity may present itself for discussing these cases. For the present, I shall limit myself to again impressing upon you my conviction that, in compound depressed fractures of the skull without brain-symptoms, the proper course of practice is NOT TO TREPHINE.—
British Med. Journal.

TREATMENT OF CHOLERA INFANTUM.

Waiving the question of prophylaxis and its corollary, the question how to directly destroy or neutralize the organic irritant (if such exist) after its introduction into the body, the first indication is to correct the dangerous and unfair distribution of the blood in the body, to which the purging, vomiting, cramps, and coldness, seem to be directly due, and later the greater danger of coma, convulsions, or paralysis of the heart.

Second. If we fail in the first attempt, or do not succeed until late, we should supply the water and perhaps also the salts drained from the blood, as the thickening of the blood would prevent the good effects of the natural turn of the disease, should we have to wait for that, and perhaps dispose to various organic lesions.

Third. We should attend to the general hygiene, diet, etc., of the patients.

As to the first indication, the problem is how to cause dilatation of the peripheral vessels and contraction of the overloaded abdominal ones. If we had any means of getting directly at the splanchnic

nerves, we could probably by galvanization of them directly, cause the contraction of the mesenteric vessels. Ludwig and Thiry found that after section of the spinal cord in the neck, whereby dilatation of the mesenteric vessels was caused, galvanization of the lower segment would cause extreme contraction of them. Possibly galvanization applied over the middle dorsal region of a patient might produce the same effect. Chapman maintains that he can occasion it by ice-bags applied to the spine, which he uses to check diarrhœas and reflex vomiting.

Bruckner, a German writer, claims that cold sand-bags of moderate weight, laid on the abdomen of cholera patients, mechanically check the access of blood to the abdominal vessels and favor its escape. Transudation is thus hindered, and perhaps absorption is favored; moreover the peristaltic movements of the bowels are not so free. These sand-bags might be used carefully, with hot applications to the extremities.

We have a much better chance of success, however, if we try to unload the abdominal vessels by relaxing the peripheral ones by means of strong derivatives applied to the surface. Steiner strongly urges baths of from 99° to 104° Fahr. in the algid stage, combined with stimulants internally, and Leube, in Ziemssen's Cyclopædia, recommends the same. The distinction, too often neglected, between a warm bath and a hot bath is of vital importance here. No bath of less than 99° would be desirable. A writer in an English journal within a year or two, whose name I have lost, mentions his very gratifying success in treating the algid stage of Asiatic cholera by prolonged hot mustard packs. In accordance with this plan I treated three cholera infantum patients last summer, who were rapidly cooling off and assuming the characteristic pinched appearances of collapse, by suddenly wrapping them to the chin in cloths wrung out in hot water and mustard, with a blanket outside, and while thus mummied feeding them with plenty of ice-water and a little brandy. The pack was kept up half an hour or more, and during that time the change in the child's appearance was remarkable; the color and warmth returned to the surface, the tissues filled out, the features lost their pinched and old look, a natural perspiration broke out, the vomiting ceased, and the discharges grew less frequent. The mustard sheet was then withdrawn, but the child left enveloped closely in the warm, moist blanket. The pack in one instance had to be renewed at intervals, as a tendency to relapse manifested itself after some hours, but the condition of all mended in a marked manner after the first application, and all made a good recovery.

With regard to medication, if the choleraic state last any length of time, the blood must necessarily be altered by its drain of water and salts. Water, then, is the first medicine indicated, and should be

constantly given in the form of ice-pills or spoonfuls of ice-water. Small enemata of slightly salt water immediately after a dejection might help to supply the lost fluid. Should vomiting and purging go far enough to cause a fear that the blood was becoming too much thickened, intravenous injections of water should be tried, and if it were thrown in at a temperature of 100° the heat might help relax the surface vessels. Milk and blood have also been used, but water seems more indicated, as in this disease the blood loses little albumen and no corpuscles.

As to the administration of drugs by the mouth, the fact of the probable very slight power of absorption at that time is usually overlooked. It is found that belladonna introduced into the stomach in large doses will not dilate the pupils. The medicines, stimulants, and food, then, can have little power in the present condition, nor yet help to bring on reaction, and if often repeated they may, when reaction sets in, be all greedily absorbed at once, and so do great harm, a fact to which Meigs and Pepper very properly call attention with regard to pouring in opium and alcohol in the algid stage. Internal administration of antiseptics has not so far seemed to fulfill the expectations of its advocates. As for calomel, it seems hardly indicated in the pure choleraic stage, unless there is the best reason to believe that some crude ingesta still present in the intestine demand a cathartic.

In the *Practitioner* of July, 1875, was a very striking article on the use of subcutaneous injections of chloral in the evacuant or algid stage of cholera, by Surgeon A. R. Hall, with accounts of cases treated by him and Mr. Higginson, another English army surgeon. The number of cases treated by these two gentlemen was large, and the onset severe and alarming, but they lost hardly a case. They injected, two-grain doses of chloral, diluted in ten times as much water, into the arms and legs of patients, some in extreme collapse, and in almost every case good and speedy recovery ensued. Few patients have more than eight to ten grains in all. Mr. Hall's theory was that the vascular condition was due to extreme vaso-motor irritation, and that the usual stimulant treatment only heightened the difficulty, as was shown by its small percentage of recoveries, sometimes only eighteen per cent. So he looked about for a sedative to relax the general spasm, and tried chloral with the brilliant results above mentioned. It is interesting to know that the government in India have taken pains to publish and circulate Mr. Hall's happy experience in the treatment of cholera collapse. His method seems to be well vouched for, and I see no reason why it should not be applicable to the choleraic state in children, if the injections were given progressively and carefully watched.—*Dr. Emmerson, Boston Med. & Surg. Journal.*

PUNCTURE OF THE PERICARDIUM.

In a paper communicated to the Académie de Médecine, by M. Henri Roger, the author dwells upon the difficulties in the diagnosis of pericardial effusions, and he quotes in illustration two cases operated upon by Tigla and Trousseau, in one of which a thin-walled dilated heart was mistaken for an effusion into the pericardium; in the other case a hypertrophied heart, surrounded by membrane floating in only a small quantity of serosity, was found post mortem. But even when the diagnosis is made, it is very difficult to decide on puncture, inasmuch as the grave symptoms may not be due simply to the presence of the effusion, and operation may do serious injury (in six out of fourteen cases collected by Roger, death followed so closely that it seemed to be attributable to or at least hastened by the operation). We must not forget, either, that evacuation of the serum in a case of acute pericarditis will almost necessarily be followed by pericardial adhesion.

Paracentesis of the pericardium is a far more delicate operation than puncture of the chest cavity. The mammary artery coursing along four or five millimetres from the margin of the sternum, diaphragm, the left lobe of the liver, sometimes much enlarged, the lung and pleura, and finally and most importantly the heart itself, have to be avoided by the surgeon. M. Roger quotes two cases, one of M. Baizeau's and one of his own, in which the right ventricle was apparently punctured in operations designed for relief of effusion into the pericardium, and one hundred and two hundred and twenty grammes of venous blood respectively removed. Both cases survived the operation. Another disagreeable occurrence which may happen, even if the right place be chosen, is that the puncture is followed by no escape of fluid. The pericardium, being only in lax connection with the wall of the chest, and much thicker and harder than the pleura, readily recedes before the trocar. With the fine needle of the modern aspirator, however, this is less likely to happen. The puncture should always be made directly from before backwards, with a slight subsequent inclination of the point of the needle downward, as advised by Dieulafoy, in order to avoid the ventricle during systole. The fifth intercostal space at a point intermediate between the sternum and nipple, but rather nearer the latter, is the place to be chosen, as a rule, for puncture. But the heart's apex, instead of impinging against the fourth space of fifth rib, as is usual in such cases, may be lowered by dilatation, or drawn downwards by an adhesion to the diaphragm, when a lower point must be chosen for the puncture.

In only one case of the fourteen was a "true cure" effected, and M. Roger concludes that, notwithstanding undoubted improvement in the

modern operation, it remains a dangerous and doubtful remedy, to be hazarded in extreme cases. *Boston Medical and Surgical Journal.*

THE BLISTER TREATMENT OF RHEUMATISM.

This treatment has often been observed not only at the London Hospital, but at St. Thomas's, and some other of our larger hospitals. Dr. Peacock, in an article in *St. Thomas's Hospital Reports*, says:—"Of late years I have generally adopted in cases of rheumatism, whether simple or complicated, the blister treatment, as recommended by Dr. Herbert Davies. I believe the blisters to be very efficacious in arresting the inflammation in the joints, and when several are employed simultaneously or in rapid succession, in relieving the constitutional disturbance also. The benefit which results from the treatment is, I think, in direct proportion to the freedom with which the blisters are applied; and though the first effect is generally to increase the febrile disturbance, and raise the temperature for a few hours, the most remarkable amendment, both local and general, ensues. I have been repeatedly told by patients that the pain caused by the application even of four or five blisters at the same time, is far less than that which they had experienced from the disease. In a recent instance a man whom I had twice previously treated for acute rheumatism, in the one attack by blisters, and in the other by general means, told me that he was much more completely and more rapidly relieved by the blister treatment; which was therefore again employed in his third attack. The blisters are applied around the limb above all the affected joints, and the surfaces are poulticed till they entirely heal. Though I have generally employed the anti-rheumatic treatment in conjunction with the blisters, when the patients have been much exhausted from the long duration of the symptoms before admission into the hospital, or from their being the subjects of old heart disease, or being weakened by any other cause, as by prolonged nursing, I have sometimes relied exclusively upon the blisters, and have never had reason to doubt the propriety of having done so. In some cases, however, of severe rheumatic fever, I have thought, on reviewing the cases, that the constitutional treatment might with advantage have been more freely used in combination with the local measures.

"In reference to the effect of the blister treatment upon the development of the cardiac complications of rheumatism, I believe it is both preventive and curative. As the heart and other internal organs become affected almost always in the earlier and more active stage of the disease, any treatment which tends to shorten the duration

of this stage must lessen the liability to the occurrence of such complications; and I have no doubt that more rapid and complete relief of the local inflammation is obtained by blistering than by any other means. I think, however, that the treatment does more than this. I have seen, in cases in which complications were very decidedly threatened, the progress of the internal disease apparently entirely arrested by the application of blisters to all the affected joints at the same time."—*The Doctor.*

TREATMENT OF CHRONIC ECZEMA BY GLYCEROLE OF SUBACETATE OF LEAD.

In a little pamphlet of thirty-two pages, reprinted from the *Medical Times and Gazette*, Mr. Balmano Squire discusses the treatment of a form of eczema which he describes as including only those persistent conditions to which the term was originally limited; that is, those which are characterized by a colorless viscid sweating from the skin; but equally whether that sweating be abundant, so as to keep the surface of the skin bathed in gluine, or so as to concrete in large scabs; or whether it be merely scanty; and occur even in minute, discrete, but more or less clustered spots, so as to present either only thin, small, transparent, dry, gum-drop-like deposits, which on detachment are found to be concave on the under surface, and conceal a small drop of viscid exudation; or, as the case may be, small, raw, scattered, but more or less clustered, weeping excoriations. He includes also that condition in which numerous but tolerably minute moist cracks in the reddened surface are present.

He therefore considers these conditions in which there is, either obviously or substantially, a moist and viscid exudation from the skin, and excludes those in which there is only a mere papulation, or a mere plastic thickening of the skin, or a simple dry scurfiness of its surface; in short, he refers to a wet disorder, and not to a dry one.

After alluding to the almost universal use of zinc ointment or zinc lotion in the treatment of such cases, Mr. Squire asserts that he has found lead to be a much more soothing and, at the same time, a much more astringent application. It unquestionably allays the itching, restrains the discharge, and diminishes the hyperæmia of chronic eczema far more speedily than zinc does. As a lotion, however, it fails on account of the evaporation of the water, and the failure of the remedy to reach the surface of the skin through the dry scab by which it is covered. After many trials, glycerin has been found in his hands to be superior to either oil or water as a vehicle for applying remedies in the case of chronic eczema; and the mixture which has been

uniformly successful is to be prepared as follows. Take of acetate of lead, 5; litharge. $3\frac{1}{2}$; glycerin, 20. Heat for half an hour in a boiling glycerin bath, constantly stirring, and filter in gas-oven or other kind of heated compartment. The result is a perfectly clear and colorless liquid, which may be used in the strength of from one to two drachms to the ounce of pure glycerin.

Mr. Squire considers and disposes of the objection which may be advanced, that the use of such an ointment might give rise to constitutional symptoms from lead absorption, and denies in toto the possibility of any such occurrence.—*Med. Times Phila.*

INTEMPERANCE AND PHYSICIANS.

—"It would seem as if physicians, who know so well the seductive character of alcohol, and see so much of its disastrous effects, would guard themselves against its diabolical power. Yet they are but men with the same passions and appetites as others, and seem to be just as easily enchanted by the voice of the syren. They are peculiarly tried. Their irregularity of meals, their want of rest, their anxiety of mind, and their periods of idleness, seem to demand something to buoy them up. Alcohol will do it for the time; and, as it is to them always easy of access, it is too often their resort. Thus we find that a larger percentage of physicians than of other classes become oinomaniacs."

The above statement is generally believed, by many, to be correct, and for the reason expressed by the author of the above paragraph. But from careful inquiry, we are fully satisfied that such a belief is erroneous. Let any one who desires to investigate the subject, take up a City or State Directory, go over the list of physicians, and similar lists of those engaged in other occupations, and he will very soon be satisfied that the medical profession are singularly free from the sin of intemperance. In this city there are nearly four hundred practicing physicians, and we believe it would be difficult to find a dozen who, under any pretext, drink to intoxication. While there are, as Dr. Potter says, peculiar temptations for physicians to indulge any appetite they may have for the cup that makes the heart glad, there are exceedingly strong temptations for them to resist the inclination. As they know full well that moderate drinking is apt, sooner or later, to lead to over indulgence, and that just as soon as their patrons discover the propensity, away goes business and reputation. No other class of men, with the single exception of the clerical, are so easily and quickly affected in their business by the habit of drink as physicians. In these days when doctors are so abundant, and such ample opportunities are afforded for a choice among many, the people in this enlightened age will not place their lives in jeopardy by knowingly employing a physician who habitually drinks even in moderation.—*Lancet and Observer, Cincinnati.*

CHOICE OF SEDATIVE FOR THE YOUNG OR AGED.—Dr. Stokoe (Guy's Hospital Reports for 1876) says: "If we purpose giving a sedative to the very old or very young, we must be cautious, especially in using any of the preparations of opium, as with them they are not only prepotent, but often cumulative in their effects. As a consequence of this, for some years past I have trusted almost entirely to sedatives other than opiates in treating children in their first septennate, and I have seen no reason to believe that any want of success has ensued from this exclusiveness. That such a precautionary measure is not altogether uncalled for has been impressed upon me by my experience of the method of medication adopted by the more ignorant (including nurses and nursery-maids), whose frequent habit is to increase the prescribed dose several-fold, or to repeat it with undue persistence, if it should fall short of the expected effect; with what result may be conceived when two or three minims of laudunum have been ordered for an infant. With potassic bromide and conium for the various morbid conditions incidental to teething; chloroform for administration during the paroxysm of a convulsive attack; chloral for those derangements in which insomnia is the prevailing symptom; aconite for inflammations, fevers, and feverishness generally; belladonna and hyoscyamus for many visceral disorders of a painful or obstinate nature; and combinations of these and other drugs to soothe coughs and the innumerable aches and pains of neuralgic, myalgic, or rheumatic origin—to say nothing of a host of external sedative applications, many of which are very potent—we need be under no apprehension lest we should be incapable of coping with the assaults of disease in children as effectually as we could do with one more weapon in our repertory."

For the Aged.—"If we think fit to employ opium as an anodyne or hypnotic with those who have attained to or are on the high road to second childhood, it is judicious to combine chloral and spirit of chloroform with it; the opium being prescribed in excess when pain, the chloral when restlessness, and the spirit of chloroform when cramp predominates; and the quantities of the several ingredients need not be large, as each of them intensifies the effect of the others. The addition of from ten to twenty minims of the tincture of Indian hemp, a very invigorating soporific, to such a mixture as the above is most serviceable in dealing with a heart enfeebled by advanced age or exhausting illness; and in thus prescribing it I have invariably met with an exemption from the distressing symptoms which sometimes result from the oppressive action of opiates on the respiratory system."—*Louisville Med. News.*

TREATMENT OF ERYSIPELAS.—After reviewing cursorily the treatment of this disease by Gross, Quain, Elliotson, Velpeau, Malgaigne and others, the

Professor gives, in one of his excellent clinical lectures his treatment of this disease, which is here epitomized. Local remedies are not highly flattered by the lecturer. The only "grateful" external application mentioned (unenthusiastically, however,) is the benzoated oxide of zinc ointment with carbolic acid, one grain of the latter to ten or twenty of the former. A closely applied roller bandage, in some cases kept moist by warm or cold lotions, is recommended when the extremities are the seat of the disease. If incisions are thought best, they should not be more than an inch long, or, at most, two or three inches long, carried along the direction of subjacent muscular fibre, deep enough to reach the matter. For œdema, simple lancet punctures are sufficient. In simple cases, in patients of "fair constitutions," an emetic should be administered, followed by a mercurial purge, combined, if necessary, with an opiate. In many cases naught more is needed. If, subsequently, the disease persist, then cooling remedies will be needed. If debility ensue ultimately, the general treatment should be tonics and stimulants. Food should be given in small quantities, and of the blandest kind. Muriated tincture of iron is a specific with many physicians, but not with the Professor. After a protracted, methodical trial of this agent in erysipelas, along with the late Professor Rogers, the conclusion reached by these two gentlemen was, that they were not able to see any special good from it, except in cases where tonics were clearly indicated, and in those cases, occasionally met, where *albumen was found in the urine.*" In the latter class of cases, the iron possesses *peculiar efficacy.* "Indeed, it seemed that the power of the muriated tincture was just in proportion to the amount of albumen contained in the urine." Quinine is unequivocally good in two classes of cases only; *first*, in those occurring in malarial districts or malarial seasons; *second*, in those where the septic movement is greatly in the ascendant, as in traumatic examples of the disease. In the former it will seldom disappoint, and in the second it is "well nigh the only ground of hope." No *specific* treatment exists, hence none is given by the Professor.—*Louisville Med. News; Chicago Med. Jour.*

ERGOT OF RYE AS AN ANTIPYRETIC.—The writer tried ergot in cases of enteric fever, with the object of lowering the temperature. The results were very satisfactory, and its employment in this disease seems to M. Hayem preferable to that of quinia or digitalis. Under ergot there is a much more rapid effervescence; and at the period of the acme, instead of there being a rise in the temperature chart, a plateau is obtained. In some cases in which the ergot was given during the day, the evening temperature was not so high as the morning. The dose varied from thirty to fifty grains in the twenty-four hours.—*Rec. de Therap; Chicago Med. Record.*

SULPHATE OF CINCHONIDIA.—Dr. Bensley, one of a committee appointed by the British East India Government to test the value of the cheap alkaloids of cinchona bark, says of sulphate of cinchonidia, it is admirably adapted to those cases requiring a tonic febrifuge, in which there is at the time a great tendency to diarrhoea, or where diarrhoea already exists; that where quinine produces these disturbances, the cinchonidia is well borne. None the less valuable is it in consequence of the mildness of its influence on the nervous system. He further says: "I have used it extensively in the fevers of children on account of its mildness, and because it is less liable to produce head and bowel disturbances than the other alkaloids." Dr. Compton, Kentucky, says in a paper on the remedy: "Upwards of thirty of my cases were children, varying in age from one to nine years. I have such confidence in it that it is the only preparation I prescribe for children. It is a well known fact that there exists with many persons a strong prejudice against quinine, and it is a great advantage to be able to say to such persons that you have a remedy that will be equally efficient, in all cases where quinine is indicated, without being liable to the objectionable effects of that remedy. The advantages to be derived from the use of sulphate of cinchonidia may be summed up as follows: Fewer relapses follow its administration; it is better tolerated by the stomach, not being nearly so liable to produce nausea and vomiting; it does not create the same amount of ringing and noise in the ears that characterizes quinism; it is not liable to produce temporary deafness; it does not produce the nervous excitability; it does not produce or increase diarrhoea; it obviates the prejudice existing against quinine; its cost is but one third that of quinine."

CÆSAREAN SECTION PERFORMED ON ACCOUNT OF CARCINOMA OF THE CERVIX AND VAGINA (Taufner: *Deutsche Med. Wochenschrift*, 1876, No. 8).—This operation was followed by a fatal result, but the results of the post-mortem examination, which demonstrated the unreliability of catgut for uterine sutures, are of special interest. The patient died on the third day after the operation, and the following conditions were found. The body was but slightly distended, the wound of the abdomen was almost entirely united, and in the abdominal cavity was a quantity of fluid and clotted blood. All the organs were hard and anæmic. The uterus was well contracted; the edges of the wound in it were gaping, and covered with clots. The catgut threads on both sides were still present in the tissues, but the knots upon them were either loose or had slipped and formed wide loops. Peritonitis was not found. The cervical portions of the uterus and the vagina were filled by a grayish-white, hard, stinking mass, which had to some extent undergone a cheesy degeneration. Death had been due to hemorrhage, which the catgut sutures had failed to control.

TREATMENT OF PLACENTA PRÆVIA.—In a paper on this subject, published in the *American Practitioner*, for June, Dr. Parvin, of Indianapolis, advises, in conformity with the teachings of Greenhalgh and Thomas, the induction of premature labor, and expresses a belief that the mortality of both mothers and children, in cases of placenta prævia, will undergo a marked diminution when this is adopted by the profession as a rule of practice. He considers Barnes' dilators to be the safest and best means for the induction of premature labor, and they moreover bring it on more rapidly than any other means. The vaginal tampon is difficult of application; is uncomfortable to the mother; does not remove the impossibility of a dangerous internal loss of blood, and possibly may lead to a separation of the placenta and death of the child. Ergot is objectionable, except when the os is well dilated or dilatable, and the labor can be speedily terminated, for the tetanic contractions it excites are apt to asphyxiate the child. Puncture of the membranes is obviously dangerous for the child, and as far as the mother is concerned is not free from danger, as it may possibly change an open into a concealed hemorrhage. Podalic version increases the risks to the child's life, and probably may be limited almost if not altogether to cases of shoulder presentation. Complete separation of the placenta, as advised by Sir James Simpson, is a method which ignores the child's interests, and has never received any general professional support. Finally the partial detachment urged by Dr. Barnes does not seem to be a rational mode of treatment, for it simply increases the bleeding surface.—*Med. Record*.

CITRATE OF SODA IN DIABETES.—The *Clinic*, Aug. 1876, copies from the *Medical Brief* a recommendation by M. Guyot Darmecy, of citrate of soda in the treatment of diabetes, given in daily doses of half a drachm to one drachm. Analysis has shown that sugar disappears from the urine when this salt is used with the food instead of common salt. And the researches of Wœhler have indicated that the alkaline salt of organic acid, when given in doses too small to produce purgative effect, are absorbed, and their acid being burnt up in the respiratory process, they are eliminated by the urine as carbonates. Citrate of soda may thus place the system under the influence of an alkaline carbonate, which is indispensable to the interstitial combustion of the glucose of the food.—*The Doctor*.

Dr. J. Marion Sims has lately been in London, assisting Spencer Wells in a number of important uterine operations, and in the excision of a hypertrophied spleen, which weighed between eleven and twelve pounds.

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PROF. SAYRE'S PLASTER OF PARIS JACKET FOR ANGULAR CURVATURE OF THE SPINE.

The great feature of the Section of Surgery and Anatomy of the American Medical Association, at its last meeting, was Prof. L. A. Sayre's demonstration of his new method of treating Pott's disease of the spine. On the first day of the meeting he read a paper on the subject, exhibited his apparatus for suspending the patient and making the application, and presented several cases which he had treated by this method. He showed how easy it would be for physicians to treat such cases; that there was no necessity for waiting to send them to a specialist, and thus losing valuable time. He said that if treated in its early stages, there was no necessity for deformity being the result of this much-dreaded disease. The constitutional treatment recommended was, the most nourishing diet, beef-steak, mutton chops, roast beef; relieve indigestion, if necessary, and give plenty of fresh air. Dr. Sayre's ideas respecting the relation of scrofula to this disease, as well as to morbus coxarius, have been misunderstood, and he took occasion to correct the misapprehension. He thinks that both these diseases, of the hip-joint and angular curvature *always* have a traumatic origin, but that strumous children are more easily injured, or that a slight injury is more apt to be followed by the development of disease in them than in children unaffected with the strumous diathesis.

To show the effects of suspension, a piece of flexible zinc is used, which accommodates itself to any curve, and is marked on paper. The child is then suspended so that his feet are free from the ground, the zinc is then re-applied, and the change in the curve, caused by the suspension, is noted. The jacket is applied as follows:—A flannel bandage is first soaked in water and then applied to the child's body, while he is suspended by the arms and head, beginning at the waist, at the smallest part, winding it around snug and smooth, completely encasing the body from pelvis to thorax. The plaster is then applied, and as it begins to set let the patient lie down until it becomes thoroughly dry. Soft pads are placed over any bony projections before the bandage is applied. The next day the patient can go about as well as if he had no spinal disease whatever. After one or two months he may be again suspended, and, if possible, the spine still further straightened. If applied sufficiently early, no deformity will occur.

Prof. Sayre writes us that he is making use of the same plan of treatment for *lateral curvature* with the happiest results. We strongly advise our readers to try this new application for the affections named. If properly used we will guarantee that both physician and patient will realize a success to be obtained by no other means.—*St. Louis Record.*

ON THE TREATMENT OF THE DIARRHŒA OF TYPHOID FEVER.

By GEORGE JOHNSTON, M.D., F.R.S., King's College Hospital, Lon.

The diarrhœa of typhoid fever, as it is one of the most frequent symptoms of the disease, so is it one of the most troublesome, and one which often causes the greatest anxiety. It is a fact generally admitted that in the great majority of cases the severity and danger of typhoid fever are in direct proportion to the intensity and duration of the diarrhœa. Delirium and other serious cerebral symptoms, pulmonary engorgement, and renal congestion with albuminuria, are comparatively infrequent complications. The treatment of diarrhœa, then, forms a very important part of the management of the disease. During the many years of my connection with this hospital, I have had the opportunity of seeing the diarrhœa of typhoid fever treated in very different ways and with very different results, and I propose now to give you, in a few sentences, the results of my experience with reference to this important practical subject.

For a number of years the practice strongly advocated by Dr. Todd was generally adopted throughout the hospital. This consisted in persevering attempts to arrest the diarrhœa by repeated doses of opiates and other powerful astringents. It was then a common practice to give an enema containing from ten to fifteen or twenty drops of laudanum after each liquid stool. The result of this treatment, in a large proportion of cases, was that the diarrhœa continued in spite of the repressive treatment, and meanwhile the intestines were distended with gas, and the abdomen became tumid and tympanitic. Then the patients were tortured by the application of turpentine stupes to remove the tympanitis. The results were altogether unsatisfactory. Nor is it difficult to explain the failure of this opiate treatment. Without entering upon the consideration of disputed pathological theories, it can scarcely be doubted that one effect of opium must be to render the intestines torpid and to lessen their expulsive efforts, and as a result of this their putrid contents are retained until they decompose and give off noxious gases by which the bowel is distended and irritated, and so the diarrhœa perpetuated and increased. It is pretty certain that the healing of the ulcers must be impeded by the continual contact of the fetid morbid secretions, and that the distension of the bowel must cause pain and increase the risk of fatal perforation or rupture.

Now, for a number of years we have entirely changed our treatment, and I have gradually arrived at the conclusion that in the treatment of typhoid fever careful nursing and feeding are of primary importance, while, as a rule, no medicines of any kind are required, and when not required

they are often worse than useless. The result of this change of treatment has been that diarrhœa is a less frequent symptom than formerly, and when it does appear it is far more tractable, while tympanitic distention of the abdomen is a rare event. The mischievous opiate enemata and the torturing turpentine stupes have disappeared together. I believe that one of the main reasons why we have less diarrhœa than formerly is, that we carefully abstain from the employment of irritating drugs of all kinds. As a rule, the fever patient has the "yellow mixture," which is simply colored water; and except an occasional dose of chloral to procure sleep, and a tonic during convalescence, we give no active medicine of any kind. We feed these patients mainly with milk, with the addition of beef-tea and two raw eggs in the twenty-four hours, and give wine or brandy in quantities varying according to the urgency of the symptoms of exhaustion, especially in the advanced stages of the disease; but in many of the milder cases, and especially in the case of children, we find that no alcoholic stimulants are required from the beginning to the end of the fever, and when not required they are of course best withheld. I have said that we give no irritating drugs of any kind. For a time I adopted the practice which has been strongly recommended, of giving repeated doses of diluted mineral acids. I have long since abandoned this practice, for I am sure that it was injurious, and it was injurious in a very obvious and intelligible way; it irritated the ulcerated mucous membrane of the intestines, it caused pain and griping, and I believe that it often increased the diarrhœa. I have no doubt that the comparative infrequency of severe and obstinate diarrhœa amongst my enteric fever patients during the last few years is partly attributable to the discontinuance of this mineral acid treatment. The extreme sensitiveness of the intestinal mucous membrane during the progress of typhoid fever is obvious and indisputable. It is admitted on all hands that the greatest care is required in returning to solid food during convalescence; a want of caution in this respect has often been followed by a return of pain and diarrhœa, an increase of temperature, and not seldom by a decided relapse. If, then, a slice of bread or a morsel of fish can excite such local and general disturbance even after the subsidence of the fever, how improbable is it that repeated doses of an irritating mineral acid can be given without injury during the height of the fever, when the ulceration of the intestines is actively progressing!

One more hint I wish to give you with regard to the diarrhœa of typhoid fever, which is, that in all probability it is often increased by the patient's inability to digest the beef-tea and eggs which are sometimes too abundantly given. When you have reason to suspect that this may be the case, I advise you for a few days to keep the patient

entirely upon milk, which contains all the elements required for the nutrition of the tissues in a form most easy of digestion. I have had a large experience of the effects of an exclusively milk diet in various forms of disease. In many cases of Bright's disease it is very efficacious, but one of the inconveniences in some of these cases is its tendency to cause troublesome constipation. In many cases of chronic diarrhœa and dysentery, milk diet will effect a cure without the aid of medicines of any kind. There is now in Twining ward a girl, aged fourteen, who for four months had been suffering from dysenteric diarrhœa, the stools containing much blood and mucus. She was put upon a diet of milk alone, without medicine: within a fortnight the diarrhœa entirely ceased, and she is now convalescent. For the reason, then, that milk has this anti-laxative and even constipating effect in various morbid states, it is, when given alone, one of the best antidotes for the diarrhœa of typhoid fever.

That our treatment of fever cases is not unsuccessful is shown by the results. I find on reference to my case-books, that during the past year, from November 1, 1873, to October 31, 1874, I have had under my care in the hospital twenty-nine cases of fever; fifteen typhoid, and fourteen typhus. Some of the cases have been very severe, but all have been discharged well; not one death has occurred. This very satisfactory result I attribute mainly to the admirable nursing which our patients receive, and to our abstinence from mischievous medication. To only one of these patients was opium given, and that was for the relief of an irritable condition of bowel which remained after a very severe attack of typhoid. A few doses of opium soon put a stop to this, and the patient made a good recovery.—*Practitioner.*

PHYSIOLOGY OF THE NERVE CENTRES

The following are Dr. Brown-Séquard's recently promulgated views:

1. As regards localization of function, a great many facts lead to the view that the nerve-cells endowed with the same function, instead of forming a cluster, so as to be in the neighborhood of each other, are scattered in the brain, so that any part of that organ can be destroyed without the cessation of their function. It makes no difference whatever whether the distance between nerve-cells employed in the same function is a small fraction of a millimetre or very much greater, as in either case their communications with each other must take place by conductors (nerve-fibres), the length of which is unable to interfere with the function.
2. Each half of the brain is a complete brain originally, and possesses the aptitude to be developed as a centre for the two sides of the body, in

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volitional movement, as well as in all the other cerebral functions. Still very few people develop very much, and perhaps nobody quite fully, the powers of the two brains; and, on the contrary, in most persons only one of these two primitively similar organs acquires greater power for certain actions, and the other for other actions.

3. Communications between the body and the brain can be more or less fully accomplished by means of a very much smaller number of conductors than would be necessary according to any view like the well-known clavier theory. As we know that the will only gives an order, and as we know by clinical facts that any part of the medulla oblongata can be destroyed without paralysis, and that in some cases a very small portion of it has proved sufficient for the persistence of voluntary movements, it would seem that the order may be transmitted as well by one fibre as another, and that it is necessary to recognize the existence of faculties of a much higher order in the nerve-cells of the spinal cord than those which are admitted to exist there. Many facts and a similar reasoning tend also to show that the nerve-cells of the spinal cord possess, as regards sensibility, faculties of a higher order than those which are admitted.—*Med. and Surg. Reporter.*

GASTRIC ULCER TREATMENT.

The most successful treatment is rest, meanwhile supporting the system by nourishment introduced through other channels. Fortunately, the large intestine allows this to be done, and for sufficiently long periods when care is exercised in the selection and preparation of articles of nourishment. In addition to the ordinary substances used, as beef-tea or juice, strained oatmeal gruel, and white of egg, attention has within a few years been called to the value of minced fresh meat, thoroughly incorporated with the pancreas of freshly-killed pigs in the proportion of two parts of the former to one of the latter. In a case of intestinal obstruction now in the seventeenth week, recourse was had to this among other methods of sustaining the strength without loading the bowels above the obstruction. Our method of proceeding was to have a messenger waiting at Squire's slaughtering establishment, who received the pancreas and brought it without delay to the patient's residence. Here the physician, after removing the fat and selecting the true glandular substance, mixed it thoroughly with the finely-divided meat, and placed it in the form of a soft sausage, as high in the rectum as was possible without inflicting pain. The result was highly satisfactory for a time. In from six to twelve hours the parts not absorbed came away in the form of a thick, creamy emulsion. Patient declared that he felt stronger, and derived

more benefit from this than from any injection of beef-juice. After repeating it ten or twelve times, however, the intestine became sensitive and painful, and we were compelled to discontinue it. I have thought frequently of giving this method a fuller trial in cases of gastric ulcer. The chief objection lies in the difficulty of complying with all the conditions. The pancreas must be fresh; if more than two hours from the living animal its value is much impaired or lost. The pig should be killed after a full meal. It is also desirable to get the mass high up in the colon, and this is by no means easy of accomplishment.

My thanks are due to Dr. Morrill Wyman for the suggestion of using this mode of treatment, though recently I have seen allusions to it in many of the journals. Simple and effectual as these measures are in the treatment of gastric ulcer, and familiar as they are to all connected with hospitals, little if any allusion is made to them in the books.

Case. Kate McD., aged twenty-three, seamstress, entered City Hospital, February 10, 1875. Family consumptive. Two years ago had slight attack of hæmatemesis. Has gradually lost strength for the last five months. Had much pain in epigastrium. Hæmorrhage was relieved by cold applications to epigastrium, and ice internally.

Two days before entrance the patient vomited a large amount of bright red blood mixed with clots. Hæmorrhage checked by means of cold externally and internally, with powdered alum and ergot.

Since, she has been free from pain. After entrance to hospital she vomited some clear mucus not mixed with blood. Injections, per rectum, of beef-tea, raw eggs, and brandy, every two hours, were ordered, alternate injections to contain twenty drops of tincture of opium.

February 12th. \mathcal{R} Bismuthi subnitratæ, grs. xx., Acidi Gallici, grs. v. M., three times daily.

\mathcal{R} Valentine's extract of beef, \mathfrak{z} i., Aquæ, \mathfrak{z} x. M. February 13th. Vomited small amount of blood last night. Ice-bags were applied over epigastrium, and ice was given internally. Also \mathcal{R} Ergotinæ, gr. i. Morph. sulph., gr. $\frac{1}{8}$. M., subcutaneously.

February 17th. Strained gruel was substituted for beef-tea in injections.

February 22d. Patient is more feeble. Champagne and milk, two drachms of each, were given every ten minutes. Valentine's meat juice and brandy have been given per rectum every hour since entrance. Slight swelling noticed over left parotid. Abscess of the parotid gland complicated the case, but notwithstanding, the patient improved and was discharged relieved on the 21st of April.—*Dr. Blake, Boston Med. & Surg. Journal.*

OIL OF EGGS FOR SORE NIPPLES, CHAPS, ETC.
—Heat yolk of egg until it becomes thoroughly dry; press it, and digest in boiling alcohol; filter while hot, and distil off the spirit.—*New Rem.*

GASTROTOMY FOR STRICTURE OF THE ŒSOPHAGUS.

In the summer of 1875 a certain Charles M. drank from a bottle which instead of his favorite beverage contained caustic potash. He discovered his mistake in time to avoid swallowing much of the fluid, only a small portion going into the œsophagus. He at once cleansed his mouth with cold water, and he says the resulting disturbance was not sufficient to warrant his consulting a physician. About two months later he began to experience some difficulty in swallowing; food would pass down into the œsophagus, but would stick there. This difficulty, however, was not constant, and not enough to cause him any apprehension. He took little notice of it until last spring, when he felt compelled to seek medical advice, and presented himself at the hospital at the clinic of Professor Lucke for treatment. The examination disclosed a stricture of the œsophagus which was seated low down, near the cardiac orifice of the stomach. The attempt was then made to dilate the stricture by means of catheters frequently passed. The patient soon learned to use the catheter himself, and did not make his appearance at the hospital again until the middle of July, when he came, saying that he was unable to pass the catheter himself, and had not been able to take any solid food for more than a week. An attempt was now made to pass the catheter, and the stricture was found permeable only for the smallest catheters, and these with the greatest difficulty. The œsophagus had undergone a sac-like dilatation just above the point of stricture, which added to the difficulty of finding the orifice of the stricture. The patient could take nothing but liquid food. On the third day after his admission into the hospital the stricture became impermeable, and the patient was nourished by injections into the rectum. He now began to lose rapidly in flesh. The stricture was so low down that œsophagotomy was impracticable, and Professor Lucke advised the establishment of a gastric fistula as the only means of saving the life of the patient, for he was becoming very much emaciated. The consent of the patient could not be obtained to this operation until the ninth day after his admission, when he had become so weak that it was apparent to himself that there was no other alternative. The patient certainly was in a most unfavourable condition for such an operation, being in a state of great emaciation from so long a period of insufficient nutrition, having taken very little solid food during the week previous to his entering the hospital, and subsisting entirely upon liquid food for the following nine days, during six days of which time he was nourished entirely by injection into the rectum.

It would also require some time after the operation before food could be placed in the stomach,

and during all that time the patient must subsist upon food injected into the rectum. In spite of his unfavourable condition Professor Lucke felt compelled to operate. The patient was placed under the influence of chloroform, but not to complete narcosis. The operation consisted in an external incision through the abdominal walls, extending from a little to the left of the median line along the lower border of the ribs of the left side fourteen centimetres—five and three fifths inches—in length. Through this opening the stomach was found and drawn up; an incision was made through its walls seven centimetres—two and four fifths inches—in length. The edges of the opening into the stomach were then united to those of the external incision through the abdomen by means of sutures, and that part of the abdominal incision which remained to either side of the portion already united to the stomach was also closed by means of sutures. The operation was performed according to Lister's method under carbolized spray, and the wound dressed with disinfected material. After the operation it was necessary to continue the injections per rectum, for although there was now an opening into the stomach, the latter must be kept quiet, that the wounds might unite, which would be impossible were food placed in the stomach and peristaltic action excited. A few hours after the operation a grave complication set in in the form of a severe diarrhœa; everything was ejected from the rectum, and in consequence of the entire deprivation of nourishment the case terminated fatally twenty-four hours from the time of the operation. There is at least a great probability that the operation would have proved successful if performed at the time when first advised, for then the patient was in a much better condition, and in the course of a week food might have been given through the stomach, if only in very small quantities, yet sufficient to sustain life. There are records of cases somewhat similar in which life was sustained for many years; in fact, there is a case reported, operated upon by a surgeon of some distinction upon the Continent, who made an incision into the large intestine, thinking it was the stomach, the mistake not being discovered until after the wound had healed. The patient was fed through this fistula and life maintained for a number of months, the patient finally dying from some complication. The *post-mortem* examination revealed no peritonitis or other appreciable lesion, with the exception of the general pathological appearances characteristic of inanition.

Boston Med. & Surg. Journal.

THE HEAT IN INDIA during the past season is reported to have been extraordinarily intense, having ranged over 100° F. for several successive days, scarcely falling at all during the night.

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PLEURAL EFFUSIONS AND THEIR TREATMENT.

Dr. Ringer, of the University Hospital, says:—As to tapping, it was formerly reserved for extreme conditions, but now we aspirate, either to assist absorption, or to save the lung. Hence it may be done early, say when the chest is half full of fluid. The febrile state may last twenty-five or thirty days, we need not wait till it is over. The effusion contains so much albumen as to be practically a bleeding, and should be stopped as soon as possible. After an early tapping, I have known fever to continue a fortnight without fresh effusion. We may classify cases into those with simple serous effusion and simple purulent effusion; either may be *with* fever or *without*, and all will probably do well with aspiration. Then there are cases where the pus is fetid; if there be no high fever, give these a chance with simple aspiration; and even if there be fever, though the case then is very grave, one trial should be given to the same plan before an incision is made, for I look upon a free opening of the chest as a very serious and risky affair. The case before us has done well with a single aspiration. Examining for the results, and judging of the amount of expansion of lung, beside auscultating, etc., we look at the angle formed by the costal arch in front; in health the angle should be obtuse, and nearly equal on both sides, perhaps more obtuse on the right, owing to the liver, whilst, if the lung has not expanded, the arch will have sunk in somewhat, and the angle be more acute; the shoulder of the affected side will be lowered, and the spine, whilst often curved with convexity toward the same side during the stage of effusion, will have an opposite direction when the effusion has disappeared. Another case of pleuritis, in which five pints of serum had been removed by aspiration, was somewhat unusual, as being secondary to Bright's disease. In this form of malady the progress is usually insidious, and yet the effusion rapid. We know, from the effect of blisters in such patients, how quickly effusion may be poured out in any part. Dr. Ringer does not think it necessary to stop the withdrawal at any definite quantity, nor does he consider cough an indication for withdrawing the needle, only if much pain be complained of, or if blood begin to come.

The *Centralblatt* states that from a series of observations made during fifteen years in Frerich's wards, with special reference to operative interference, C. A. Ewald arrives at the following conclusions:—1. In cases of serous effusion in the pleura, puncture should be performed before the third week, only if life be in danger. 2. If puncture be made under exclusion of air and with previous disinfection of the instrument, no serous exudation becomes purulent. 3. The only means of determining with certainty whether a pleural effusion is serous or

purulent, is an exploratory puncture. 4. Incision, with puncture, should be made as early as possible into purulent exudations. 5. The mortality after incision into purulent effusions is from 50 to 60 per cent. when they are treated according to the present plan (incision in the sixth intercostal space between the nipple and the anterior axillary line, washing out with disinfectants once or twice daily, a catheter being retained in the wound, or one or more ribs resected). 6. Sanguineous effusion (in which blood becomes mixed with the exudation in consequence of the dilatation of vessels, leading to their rupture) is always the result of malignant growths of the pleura. 7. Serous exudations do not exclude the presence of tuberculosis and cancer of the pleura.—*Brit. Med. Four.*

SPLENOTOMY.

M. Péan recently presented to the Académie de Médecine two patients upon whom he had successfully performed the operation of splenotomy. One of these cases was operated on in 1867, and subsequently presented to the Academy in good health. The second case, which has just recovered, was a married woman aged twenty-four years. A splenic tumor had been growing, until at the end of eighteen months after its first appearance, when it filled the entire abdominal cavity, descending into the pelvic, and even to the right iliac fossa. Various symptoms, apparently secondary to the tumor, distressed her, and abdominal pain was constant. Yielding to the importunities of the patient, M. Péan excised the spleen on the 25th of last April. The *London Lancet* (Aug. 26th) thus describes the details of the operation:

“An incision was made along the linea alba from three inches above the umbilicus to two and a half above the pubes, and a corresponding incision was made through the peritoneum. The tumor was covered by the omentum; this was removed from below upwards and pushed to the right of the tumor, beneath the right hypochondrium, and both it and the intestines were kept back by sponges and warm napkins. The tumor had the characteristic reddish-violet color of the spleen. It was seized at its lower extremity and gradually raised within the lips of the wound until it rested on the hands of the assistants who were keeping back the intestines. No other organ escaped. The gastro-splenic omentum was about three-quarters of an inch wide at the level of the hilus; it contained blood-vessels and enormous lymphatics. One splenic vein was the size of the index finger. A wire ligature was passed around the whole pedicle, great care being taken to avoid the pancreas. The pedicle was then surrounded by sponges and the spleen separated from the hilus by a single cut, being at the same time turned quickly outwards. About a quart of blood

escaped in a jet from the spleen, but none fell into the abdomen; otherwise not more than thirty grammes of blood were estimated to be lost. No adhesions were met with. The sponges were removed, the great omentum spread out over the intestines, and the abdomen closed, the pedicle being retained between the lips of the wound. The progress of the patient was excellent. The febrile reaction was slight. Some blood appeared in the urine on the third day, but diminished and disappeared a few days later. The pedicle separated in a week. The patient's spirits were very good. Eighteen days after the operation she sat up, and a week afterwards returned home."

Medical Items and News.

RANULA—Ranula is admitted by all surgeons to be a most troublesome and in many cases a most intractable affection. It is sometimes so little amenable to treatment that some surgeons, and among them the celebrated Dupuytren, contrived different means by which to keep open a fistulous orifice in the tumor, in order to empty the contents of the latter in the mouth. Jobert de Lambelle endeavored to effect the same object by inverting a portion of the internal surface of the ranula, and uniting it by a suture with the mucous membrane surrounding the orifice. M. Panas, of the Lariboisiere Hospital, finding these methods of treatment unsatisfactory, and after having given a fair trial to the different remedies in vogue for the cure of this affection with equal unsuccess, has lately resorted to the practice of injecting these tumors with a solution (one to ten parts) of the chloride of zinc, the results of which are most encouraging. M. Panas injects into the tumor from three or four to eight or ten drops of this solution, which also varies in strength according to the age of the patient; and this he does with a Pravaz's syringe without previously emptying the tumor. But it is not only to ranulæ that M. Panas applies this treatment; he has found it successful in other tumors of the mouth, and thinks it may be advantageously employed in all cases of mucous or serous cysts in whatever part of the body they may occur.—*British Medical Journal*.

SULPHIDE OF CALCIUM.—Dr. T. Curtis Smith (*Southern Med. Record*, July, 1876,) confirms the observations of Ringer upon the value of this agent in boils, abscesses, carbuncles, and glandular enlargements. There is no other remedy which will cause the resolution of these affections equally well. He gives it in powder, with sugar, or in pill form, in the dose of one-half grain, every four or six hours, for children. Adults may take from one-half to two grains, with sugar, four or six times a-day.

A NEW METHOD OF USING SPONGE TENTS IN DILATING THE CERVIX UTERI.—Dr. T. H. Seyfert (*Medical Times*, July 8, 1876) gives the following method of obtaining the benefits of compressed sponge while avoiding its dangers. The apparatus consists of a small metallic or rubber tube, holding on its perforated extremity a sponge tent, which is completely enveloped by a close-fitting, thin piece of India rubber. The rubber, while permitting the sponge to dilate to its fullest extent, prevents it from absorbing fluids from the canal and protects the cervical mucous membrane from abrasions. Water reaches the sponge through the tube which has upon its vaginal extremity a distensible rubber ball for its reservoir. Instead of limiting the tent it may be made to envelop the entire apparatus, thus keeping the tube in constant contact with the water, which by entering the perforations made in the tube readily finds its way to the sponge.—*Detroit Review*.

TREATMENT OF PRURITUS BY THE SMOKE OF JUNIPER LEAVES.—Dr. Boeck, of Christiana, reports the results of this remedy in several cutaneous affections, in which itching forms a most distressing symptom, especially urticaria, pruritus, and prurigo. The patient is enclosed as for an ordinary mineral vapor bath, and beneath him, with proper precautions against the blaze which may ensue, is placed a pan of live coals, upon which the juniper leaves have been thrown. If not freshly picked, the leaves should be damped with water. The patient is to remain exposed to the vapor for twenty or thirty minutes, generally on every second day. In prurigo, the remedy is immediately effective, and many cases have, after treatment in hospital by this means, been discharged cured. The most marked effects were obtained in bad cases of chronic urticaria and pruritus.—*New Remedies*.

LIME WATER IN INFANTILE ECZEMA.—A writer in the *Bulletin de Therapeutique* recommends lime water in eczema of the head and impetigo of the face in children, especially in chronic cases, which have resisted other treatment, and states that a marked improvement is noticeable after using it for eight days. It is to be taken in quantities varying up to half a pint, according to the age of the patient, and to dust the part with carbonate of magnesia; but the latter is only necessary when the secretion is very irritant.—*Med. & Surg. Rep.*

HÆMOPTYSIS TREATED BY ERGOT.—REPORT OF FIFTY CASES.—Dr. J. Williamson (*London Lancet*, January, 1876,) reports fifty consecutive cases of hæmoptysis treated by ergot. Out of these the drug rapidly checked bleeding in forty-four cases. In the other six it failed, as did also gallic acid. *Detroit Rev. of Medicine*.

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TORONTO, NOV. 1, 1876.

REGISTRATION AND VITAL STATISTICS.

If history can be reckoned among the exact sciences by collecting and collating statistics, as is proposed by Mr. Buckle, in his learned work on the "History of Civilization in England," is it unreasonable to expect that similar means will contribute to place the science of medicine in the same category? An immense advantage would be derived from enforced registration by the Dominion or local governments, in preserving data for future times, that would enable medical historians to trace the succession of different diseases, and to learn the exact era when new diseases or modified forms of known ones, first appeared; what effects sanitary measures, as drainage, disposal of sewage, cleanliness and ventilation of buildings produced. When the returns shall be made as general in Canada, as they are in England and some of the States in the Union where State Medical Boards have long existed, many facts having interesting if not important practical bearings, will be well established. The influence of age, sex, occupation, habits, seasons, the comparative frequency and duration of different diseases, the prevalence of epidemics, and the medical geography of a country, can be determined by these means. The effect of the condition of the atmosphere in respect to temperature, moisture, electricity, presence or absence of ozone or oxygen in a particular state of disease, in connection with meteorological and mortuary records. The most formidable obstacles to the success of this measure, exists in the unwillingness of physicians to perform the necessary labour, not from the impossibility, as the example of many whose practice was more extensive, and whose habits of study were more industrious, has proved.

Witness, for example, the herculean labor performed by the leading London physician of his day, Dr. Chambers. It is known that for thirty-three years, he wrote out in full every case he treated in hospital and private practice. The books he used for his note-taking were quarto volumes, of about four hundred pages each, and they amounted to sixty-seven, besides various thin quartos. All the cases were regularly entered at night, with a copy of all the prescriptions that he had made during the day. These volumes of records of private practice were not all. The books which he kept at St. George's Hospital equalled in volume those of his private practice. All this was accomplished while he devoted himself to the duties of his profession with the most persevering and conscientious punctuality and assiduity, and whilst his fees amounted annually to from £7,000 to £9,000. He also found time to deliver lectures, and keep himself well informed in relation to the progress of medicine. The method of obtaining facts, by the registration of diseases occurring in private practice, is not a recent suggestion. It was acted on many years ago by eminent physicians and surgeons, and valuable tables and deductions have been preserved. Sir Gilbert Blane, then President of the London Medical and Chirurgical Society, read at a meeting on the 27th of July, 1813, "Observations on the comparative prevalence, mortality and treatment of different diseases, illustrated by abstracts of cases," which came under his care at St. Thomas's Hospital and in his private practice, embracing a period of twenty years. He thought the history of diseases in different ages indispensable in the cultivation of practical medicine; that all practical researches ought to be built on an induction of facts; that single objects of events are of little value, except in so far as they stand related to others, and that there are many complaints of which we are at a loss to make a comparative statement for want of records. He kept notes of all the cases which happened in the hospital during the greater part of the time from 1784 to 1794, and also in his private practice at all times, from 1795 to 1805. Sir Gilbert Blane's records show, that disorders of the stomach constitute about a ninth part in private practice, and only one thirty-fifth part of the hospital cases. Of liver complaints, one in forty-three in private, and one in one hundred and three

in hospital practice. In January 1817, Sir Charles Bell made a quarterly report of cases treated at the Middlesex Hospital and in private practice. Another admirable illustration of the value of medical statistics, is Captain Tullock's work on "Vital Statistics of the British Army." Also the Naval Statistical Report, ordered to be printed, by the House of Commons in 1840. The *Medico-Chirurgical Review* thus speaks of them: "They will tend to disabuse the mind of many erroneous, and some injurious impressions; and they will, we are confident, materially assist the progress of medical science." Dr. Holland, in his "Notes and Reflections," also expresses himself very decidedly in favour of the utility of statistics. Mr. Buckle, in the work already mentioned, thus speaks of general statistics: "Proofs of our actions being regulated by law, have been derived from statistics, a branch of knowledge which, though still in its infancy, has already thrown more light on the study of human nature, than all the sciences put together." Dr. Brinsinade on this subject thus speaks: "Another strong reason why the medical profession should be united, is that they may be able, in their collective capacity, to advise the public where to apply for relief when bewildered by the numerous systems, nostrums and specifics, which are presented to them on all sides. Physicians should consider themselves the guardians of the public health. It is obviously their province to counsel the adoption of regulations for the prevention and treatment of epidemic diseases, and this is recognized by governmental authorities, when an epidemic is sufficiently severe to attract their attention. But their care for the health and community should not end here. Public opinion on medical subjects needs to be modified, and it can be done only by those who know what modification is desirable. This task must be accomplished by medical men. Although they have no hesitation in advising the abatement of causes of epidemic diseases, and the adoption of general regulations for their prevention, they shrink from using their influence to prevent injurious methods of treating sporadic affections, more fatal to human life than all the pestilences and epidemics caused by contagion, neglect of cleanliness, ventilation and temperance." It should be the business of Government Boards of Health to examine and report on nostrums and so-called specifics,

weighing accurately their merits and demerits, and their adaptability or otherwise to the ailments for which they profess to be a cure. To answer affirmatively and satisfactorily the question, "Is there certainty in medicine?" the positive method of investigation must be applied, the first step to which is the accumulation of facts as to occurrence, topography, meteorology, phenomena, duration, terminations, concomitants and sequelæ of disease, modifying influences of age, sex, occupation and habits of life; and the means by which these facts are to be accumulated is registration. "It is only by the contribution of particular facts and of general results, that much good can be done to medicine. The time has arrived when a general and a well arranged system of hospital reporting must engage serious attention."—*British & Foreign Med. Chir. Review*. In another number of the same Journal the following passage occurs:—"We would suggest the combination of statistical reports that is, summaries of facts, and individual cases. For the purposes of general utility we should say that statistical records and collections of cases calculated to display the general laws of disease or treatment, are preferable to individual instances of rare complaints. The latter are too often chosen because they excite curiosity and interest. The accomplished physician or surgeon is too apt to measure the attainments, the appetites and the wants of the profession by his own. Things familiar to him, he too readily concludes to be equally familiar to all, and hence the prevalence of transcendental pathological papers in our journals and transactions. One sound and universal induction is worth much more, in a practical point of view, than the most extraordinary fact or the most imposing theory. Such should be the aim of those who write for the real instruction of the public, or of our clinical reporters. It is with facts that they have essentially to do, and their object should be to transfer the experience of the ward to the report." Thermometrical observations are invaluable, and should be made by all recorders at certain fixed hours of day and night. Dr. Brinsinade has shown, that barometric observations to be of use, must be studied in connexion with the hours of the accession of certain acute, and of the exacerbations of certain chronic diseases. Dr. Moffat in a paper read before the English Meteorological Society, has shown by a series of very elaborate

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tables, that an apparent connection is discoverable between the first appearance, increase, decrease and disappearance of atmospheric ozone with the decrease and increase of the readings of the barometer and thermometer, and the state of the weather generally; also that prevalent diseases form groups corresponding with certain meteorological conditions. In the formation of these tables, Dr. Moffat paid strict attention to all the lesser fluctuations of the barometer and thermometer, being convinced that there exists a great necessity for so doing, from the slightest variations in the reading of the barometer being followed by a change in the direction of the wind, and the appearance and increase or decrease and disappearance of ozone. Borckel and other investigators, have concluded that the want of ozone constituted the predisposing cause of cholera. Ozone has been shown to be a powerful disinfectant and deodorizer. Having detected the presence of this imponderable agent in the atmosphere, may we not hope that at some future time we may be enabled to detect the presence of that other equally imponderable agent the miasm from decomposing vegetable matter, and to counteract measurably its deleterious influences. Auguste Comte, in "Positive Philosophy," says, "Some of the most important arts are derived from speculations pursued during long ages, with a purely scientific intention. For instance the ancient Greek astronomers delighted themselves with beautiful speculations on conic sections; those speculations wrought, after a long series of generations, the renovation of astronomy; and out of this has the art of navigation attained a perfection which it never could have reached otherwise than through the speculative labors of Archimedes and Apollonius."

"FAITH," AS A REMEDIAL AGENT.

Very much, from time to time, has been said of the influence of the mind upon the body and its various functions, but the influence of the mental state in producing or relieving many abnormal conditions of the vital organs, is a subject worthy the consideration and the closest practical observation of every physician. So materialistic have we become, that we have run into the extreme of being ready to ask that the germ of every disease shall be microscopically demonstrated, and in our

therapeutics far too much attention has come to be given, and too much virtue attributed to material agents and influences, and too little to the immeasurable power of the mind in the work of organic and functional renovation. It is a fact beyond question in the minds of many, and one that was strongly insisted upon by the late Sir Benjamin Brodie, that the *vis medicatrix nature* is all that is necessary, under favourable circumstances, for the restoration of the patient to a condition of health.

The influence of the passions are acknowledged by all, to be sufficient to produce an arrest or change of function and often violent disturbances of the system, and if this be true—as may be seen in the arrest of the process of digestion by any sudden emotion as surprise, joy, fear, apprehension, grief, &c.—why not accept the converse as indubitable, as may readily be demonstrated in the sick room.

The notion, that diseases may be controlled or removed and health restored by the agency of the mind alone, is almost too great a tax upon the credulity of many; and yet, no one upon reflection will doubt the important influence that confidence in a certain physician, or faith in a certain remedy, has in the result of the treatment. Who has not witnessed the buoyant influence of hope, the depressing influence of disappointment or despair, or the aggravating and harassing influence of anxiety, apprehension or dread? Yet many people who smile at the element of *faith* in the treatment of disease, have not the slightest hesitation in believing that infinitesimal doses of the hundredth dilution of some inert substance as the calcareo carb. or the carbogev. of the homœopath, or some fancied virtue in an unknown (to the patient) nostrum, will accomplish the renovation of a functional or organic disease, while to the imperial influence and godlike capabilities of the mind they attribute nothing. Such persons would invest inorganic matter with an imputed virtue greater than the soul is capable of exerting, and utterly ignore the supremacy of mind over matter, and the realm of material forces, forms and elements, even in the vital organism itself.

To the extensive and accurate observer it will be a fact only too apparent that familiar remedies possess less power for good than new ones with high-sounding titles, and cures are frequently

accomplished, when the agents employed possess no specific action whatever upon the system. As an instance of this, a case is narrated in which a lady was speedily cured of a long standing complaint by the administration of the ordinary "Hooper's cachons aromatic," under the name of "Electric pills." Few persons afflicted with chronic diseases are ever cured without strong confidence in the physician and his remedies. So true is this that when faith in a physician or remedy, however powerless in itself, is sufficiently strong, a visit or prescription from the physician with a word of encouragement, or the simple administration of the particular remedy is sure to be followed by the anticipated physical results. To the younger members of the profession of medicine, the influence of *faith* or the "will" power, as remedial agents, may appear trivial, but to the veteran practitioner the discovery has come with more or less force at times, that among the many agents comprehended in our therapeutics *faith* and will are quite as potent and far more desirable than *physic*. Indeed, the remedies comprised in the *Materia Medica*, often derive their principal action or power from the patient's preconceived notion of their curative properties; and in persons of strong will a firm exercise of it oft-times secures recovery. In proof of this statement, it is only necessary to instance the many cases in which inert substances as bread pills, acacia, or other simple powders and charcoal preparations have been administered, without the patient's knowledge of their real character, with satisfactory results. A patient who had become the victim of the morphine habit once applied for advice. A number of powders with pure muriate of morphine were first prepared in $\frac{1}{8}$ grain doses; then on more being asked for, a little calcined magnesia was added, and finally a number of powders were prepared with magnesia alone, flavoured with a little bitter principle, each time with the same results as regards influence upon the system. Finally by persuasion its use was abandoned with success. So that in many cases where the patient's faith or confidence is unwavering, sugar powders, bread pills, or peppermint water, will as readily accomplish the expected psycho-physiological effect as if genuine drugs had been administered. On the contrary the specific effects of the most valuable remedies are often neutralised by the physician's manner, and any

doubts respecting his capacity are often stronger than the most powerful tonics or judiciously applied remedies.

NEW METHOD OF TREATING CHOLERA.—Sergt Major Hall, Army Medical Department, E. I. Service, describes a new method of treating Asiatic cholera. It consists in using hypodermic injections instead of giving stimulants by the mouth. He observes that in his own case his heart beat was stronger than usual, while his pulse was stopped; that the want of pulse at the wrist does not depend on want of power at the heart; that the whole nervous system is extensively irritated instead of being exhausted, and the heart and all the arteries are in a state of spasmodic contraction. He considers vomiting and purging of secondary importance. He used an injection of solution of chloral hydrate (which has a very depressing action on the heart) in twenty cases of collapse, eighteen of which recovered. They were natives of Bengal; perhaps among Europeans a more powerful sedative may be required, and he recommends sol. prussic acid, calabar bean, bromide of potassium, and other true sedatives. Opium, which is not a true sedative, but a stimulating narcotic, and all alcoholic stimulants are to be avoided, and nothing given to the patient to drink during collapse except cold water, which may be taken in any quantity desired.

TETANUS.—The use of opium and chloral hydrate in cases of tetanus both idiopathic and traumatic, is much resorted to in the East Indies. The patient is kept almost continually under the combined effects of chloral hydrate and tr. opii, until all occurrences of spasm disappear. The medicine and food are administered by means of enemata. The power or action of these combined drugs is like the action of a heavy weight on a spring, which if the pressure yielded the spring would begin to rise, but being continually maintained, the morbid nervous phenomena gradually give way, and disease vanishes. If used by enema in hydrophobic cases they might also prove serviceable. Chloral hydrate and calabar bean are also recommended for lock jaw.

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HAY ASTHMA.—This is a most troublesome disease to many during the summer months in Canada. Its victims can never get heated, or work among hay in harvest gatherings, without experiencing the distressing symptoms of a violent coryza or cold in the head accompanied by severe headache, sneezing, inflammation of the eyes and difficulty of breathing. It has recently been discovered by Prof. Helmholtz to be due to the presence in the nasal cavities of numerous minute insects, known as *infusoria*. They adhere pertinaciously to the lining membrane, and are very active in high temperatures, and sluggish in cold. They slightly resemble the small creatures seen in stagnant rain water, but very much less in proportion. Prof. Binz another European investigator, has found that the infusoria may be destroyed by a solution of quinine. Of this fact Helmholtz availed himself by making a weak solution of quinine and lavng each nostril with it in his own case, (having suffered for twenty years from the disease) with immediate relief. An occasional repetition completely exterminates the offenders. His experience with it on himself has proved most satisfactory. It is now being tried with good results in the hay-fever of this continent.

NEW THEORY OF THE CAUSE OF ASPHYXIA.—Dr. Blandet, in the *Gazette Medicale*, denies that carbolic acid gas has any toxic effect in cases of asphyxia, and claims that it suffocates by simply filling the lungs to the exclusion of oxygen. Persons partially asphyxiated by Co_2 can usually be restored by inhalations of oxygen gas. The real cause of foul air poisoning, is thought to be *carbonic oxide*, which is disengaged prior to carbonic acid and does not diffuse itself in the blood, but remains and destroys the hemoglobine and the hematin. It may also be inferred from this, that the best remedies are inhalations of oxygen, frictions of the skin with oxygenated water, and decomposable oxides, such as those of manganese and cadmium. It has been suggested that sulphhydrate of ammonia administered hypodermically might decompose the carbonic oxide.

Wm. R. Warner & Co. have received the Centennial award for their soluble Sugar Coated Pills. This is the third grand World's Fair prize that attests to their excellence over competition at home and abroad.

THE TREATMENT OF RANULA.—Dr. Morton, of Sheffield, recommends, in the treatment of this affection, a metallic seton acting, to some extent, as a drainage-tube. An ordinary suture-needle, medium-sized silver wire, is passed directly through the sac-like tumor from one side to the other, the ends of the wire brought forward, twisted together, and cut off, leaving a small ring of metal half within and half externally. The wire is allowed to remain three weeks, then cut and withdrawn. It causes no irritation nor impediment, and a patent orifice remains after removal.

ASPIRATION IN TYMPANITIS.—Dr. Lee (*Chicago Med. Jour.*) relates a case of tympanitis, in which he used the aspirator with great benefit. The abdomen was greatly distended, and the patient was vomiting almost continuously. The smallest needle of the aspirator was used. It was plunged into the abdomen several times, and each time large quantities of gas escaped. The patient was greatly relieved, and finally made a good recovery.

PERIODIC INTERNATIONAL CONGRESS OF MEDICAL SCIENCES.—The fifth session of the above-mentioned congress will be held next year in Geneva. It will continue one week, and will open on Sunday the 9th of Sept., 1877. The proceedings will be conducted in the French language. All communications relative to the congress should be addressed to Dr. Prevost, general secretary, Geneva.

TO PREVENT POISONING BY IVY.—When obliged to work near poison ivy, wash the hands and wet the face in a strong solution of sugar of lead or sweet oil, before and after working where it is, and no bad effects will follow. A farmer when mowing in the midst of poison ivy covers his hands with machine oil and effectually prevents poisoning. If he neglects this he may be badly poisoned.

DEATH OF THE QUEEN'S PHYSICIAN.—The death of Dr. Laycock, physician to the Queen in Scotland, is announced in our English exchanges. Besides holding several important appointments, he was the author of several treatises on the nervous system, and numerous essays in medical and other journals.

INTEMPERANCE A CAUSE OF INSANITY.—Dr. Mann, medical superintendent of the Emigrant Insane Asylum, Ward's Island, New York, gives it as his opinion that it is impossible to estimate the complex influences exerted by intemperance upon the production of insanity. He states that he has traced intemperance as a cause in almost every case of general paralysis that has fallen under his notice, and that others have made similar observations. It is estimated that 50 per cent. of all the idiots and imbeciles to be found in the large cities of Europe have had parents who were notorious drunkards. Out of 350 insane patients admitted during two years at Charenton, insanity was attributed to drink in 102 instances. According to the statistics of all the insane asylums, fully one-fourth of all the admissions are due either proximately or remotely to intemperance. A case is now before the courts in Montreal, in which insanity is pleaded in defence in an action for separation for ill-treatment, whereas, it is proved that the defendant was under treatment for delirium tremens, which no doubt terminated in acute mania, ending in his being sent to Long Point Asylum, where he recovered under the treatment of Dr. H. Howard.

The well-known house of Macmillan & Co., London, publishers of the *Practitioner*, have undertaken the publication in England of "Micro-Photographs in Histology," the monthly work conducted by Drs. Seiler, Hunt & Richardson. A large edition is required for the English profession.

"To prove extinction of life," inject strong ammonia under the skin, if life exists there is no change, if the subject be dead a purple or blue colored patch is the result.

The next meeting of the American Pharmaceutical association will be held in Toronto on the 4th of Sept., 1877.

An opening for a medical man in a thriving village in Ontario. *See advertisement.*

Toronto Hospital Reports.

CENTRAL NECROSIS.

Louis Frank, a laborer, æt. 22, a German by birth, of healthy parentage, was admitted into the Toronto General Hospital, under the care of Dr.

Fulton, in the latter part of August, suffering from "a running sore" on his leg, near the ankle. He states that he never was sick in his life; but about eight years ago he received an injury to his leg, which resulted in necrosis of the tibia. He was admitted to the Buffalo General Hospital, and the necrosed portion of bone was removed by Dr. Miner. After some weeks he left the Hospital, but the leg was not entirely healed, a discharge still continuing at the lower part of the tibia, about three inches above the ankle-joint, on the anterior aspect. On introducing a probe into the small opening in the tibia, a portion of necrosed bone was detected in the medullary canal, and apparently loose. The tibia was very much enlarged and the bone very dense. The operation for its removal was performed in the following manner: The patient was brought under the influence of chloroform, and an incision was made through the skin, which was dissected back and a trephine applied to the bone. An opening was thus made down to the medullary canal, but was not sufficiently large; a second was then made alongside the preceding. Through this, the sequestrum was readily removed. It was about $1\frac{1}{4}$ inches long and $\frac{3}{4}$ of an inch wide, two lines in thickness, and presented an irregular, worm-eaten appearance. The wound was dressed with lint wet with water, and afterwards with carbolic acid lotion (1 to 40) and the wound allowed to heal by granulation. The case did well, and the patient was subsequently discharged cured.

POISONING BY OXALIC ACID.

W. B., æt. 52, a native of England, was admitted into the Toronto General Hospital, October 5th, under the care of Dr. Cassidy. Two weeks before his admission he had taken a large teaspoonful of oxalic acid by mistake for sulphate of magnesia. He vomited immediately after taking it, and for some hours afterwards. At the time of his admission, he complained of soreness of the stomach, headache and constipation. He gradually became worse. Two years ago he had had an attack of pericarditis. His heart was enlarged and displaced to the left, but he did not complain of any pain or uneasiness in that region. He was ordered his mouth subnitrate in milk twice a day, and milk and lime-water as a drink. On account of the predo-

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R—Pot. bromidi, ζ ss.
 Aquæ camphoræ, ad., ζ viiij.
 A tablespoonful three times a day.

Oct. 9th.—The patient appeared very dull and heavy; complained much of his head. There was also incontinence of urine. Slept very little, and was constantly moaning.

10th.—Eats nothing, very stupid and heavy; pulse 107; respiration 24.

11th.—Comatose, with stertorous breathing; pulse 154; respiration 50; temp. 103 F.; died at 8 p.m.

Post mortem.—Stomach empty, except some glairy mucus. The mucous membrane was congested, and of a dark color in spots, and other parts red. There was a perforating ulcer near the cardiac end, about the size of a five-cent piece. The heart was enlarged and weighed about 18 ounces, and was partially adherent to the pericardium, but no valvular lesions were present. On opening the cranial cavity, small ulcers were found on each side of the superior longitudinal sinus; a small quantity of pus was found on the ulcerated surfaces. There was no effusion, and the brain itself appeared perfectly healthy.

CEDEMA OF THE LOWER EXTREMITIES—AN OBSCURE CASE.

J. M., æt. 45, a native of Ireland, and a carpenter by trade, was admitted into the Hospital on the 18th of September, under the care of Dr. Delahaye. About two years ago, he had an attack of œdema of the lower extremities, of a temporary nature, from which he soon recovered and resumed his usual avocation. It was thought at that time to be caused by congestion of the kidneys. He has had no return of the trouble until a short time before his admission, when his feet and legs began to swell, and became œdematous. The swelling and œdema have now extended up the thighs and involved the scrotum and penis, and some small ulcers have formed on the legs near the ankles. There is no swelling on the face, eyelids nor upper extremities. There is dulness on percussion in the lower lobe of the right lung, and slight dulness in the lower part of the left lung, but no evidence of an accumulation of fluid. The right side of the

chest is slightly more prominent than the left. There does not appear to be any enlargement of the liver, at least it cannot be felt below the ribs. There is some enlargement of the heart, and the apex beat is felt about an inch to the left of the normal situation, but no valvular disease can be detected. The urine has been examined several times, but it contains no albumen nor casts. It is of the normal specific gravity, but somewhat scanty. The patient complains of no pain, tightness nor uneasiness in his chest or abdomen, and his condition is about the same as at the time of his admission. The treatment consists of tonics, baths, good nourishing food, and the following prescription :

R—Pot. acet., ζ ss
 Pot. nit., ζ iss.
 Vin. ipecac., ζ ij.
 Morphine, grs.ij.
 Aquæ, ad., ζ viiij.—M.
 A tablespoonful three times a day.

Reports of Societies.

NORTH BRUCE MEDICAL ASSOCIATION.

The adjourned meeting of this medical association being also the annual meeting, was held at Paisley, on the 11th ult., the President, Dr. Scott, in the chair. The minutes of the previous meeting were read and confirmed.

The election of officers was next proceeded with, resulting as follows:—Dr. Scott, President (re-elected); Dr. Reily, 1st Vice-President, and Dr. Washington, 2nd Vice-President.

On motion, Dr. Sinclair was appointed Secretary, and Dr. Cook, Treasurer.

The Secretary having read Dr. Douglass' resignation as member of this Association, it was moved by Dr. Reily, seconded by Dr. McLaren, —that the same be laid on the table until next meeting.—*Carried.*

The Association adjourned, to meet at Port Elgin on call of the President.

Correspondence.

To the Editor of the CANADA LANCET.

Sir,—Will you allow me to suggest that the authorities of the principal Universities in Canada

should take steps to have their medical degrees made registerable in England. I feel sure it only requires a united representation to have such degrees as those given by the Toronto University, Trinity College Toronto, McGill College, and some others made registerable, by publication in the English Gazette. This was done quite recently in the case of several of the Australian and New Zealand Universities, and Canada is certainly not behind these. No doubt all those graduates of Canadian Schools and Universities will bear testimony, as to the advantage they would have derived when they came to England, had their degrees been registerable; at present only the tickets of attendance at lectures are recognized. I trust this suggestion may meet the eye of those able and willing to obtain, what in at least several Universities and Schools in Canada probably only requires to be asked for, to be granted.

Yours truly,

FREDERIC M. T. HODDER, M.B., M.R.C.S., Eng.,
Army Med. Dept., Aldershot, 13th Oct. 1876.

[This is a most important communication, and we trust some action will be taken in the matter at once.]—ED.

Books and Pamphlets.

A TREATISE ON THE THEORY AND PRACTICE OF MEDICINE, by Frederick T. Roberts, M.D., M.R.C.P. Lond. Second American from the last London edition, revised and enlarged, 8vo., pp. 920. Philadelphia: Lindsay & Blakiston. Toronto: Hart & Rawlinson.

We are much pleased with the new and improved edition of this popular work on the Practice of Medicine. That the work has been received with much favor, is shown by the fact that a new edition has been so soon called for. Most of the reading in small type in the old edition has been set in larger type, and added to the body of the work. A separate chapter has also been introduced, on the "Diagnosis of Acute Specific Diseases," and some diseases, before briefly noticed, have been considered more in detail. The author has given a most excellent, clear and comprehensive treatise on the theory and practice of medicine—a work fully up to the existing state of knowledge and observation.

A TREATISE ON THE DISEASES, INJURIES AND MALFORMATIONS OF THE URINARY ORGANS, by S. D. Gross, M.D., LL.D., D.C.L., Oxon, Philadelphia. Third edition, revised and enlarged. Philadelphia: H. C. Lea. Toronto: Willing & Williamson.

The present edition of this work has been revised and re-written by Dr. Gross' son (S. W. Gross, M.D.) The chapter on tumors of the bladder and prostate are entirely from his pen. It is in Dr. Gross' usual clear and happy style, and is replete with instruction and experience in the medical and surgical treatment of urinary affections. It is unnecessary to say anything in praise of a work from an author so well known as Prof. Gross.

A MANUAL OF CHEMISTRY—GENERAL, MEDICAL AND PHARMACEUTICAL, by John Attfield, Ph.D.; F.C.S. London. Seventh edition, revised. Philadelphia: H. C. Lea. Toronto: Willing & Williamson.

This excellent little work has passed through several editions within a short space of time. We know of no work so well adapted to the wants of the medical student as this, combining as it does the principles of chemistry with pharmacy. It treats of both organic and inorganic chemistry; quantitative and qualitative analyses; tests for the various substances, etc., etc., and is a work of great practical utility.

LINDSAY & BLAKISTON'S PHYSICIAN'S VISITING LIST for 1877, bound in the best manner, with Tucks, Pockets, and Pencils. Price, for 25 patients weekly, \$1.00; 50 patients weekly \$1.25. Interleaved edition, \$1.50 and \$1.75.

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Births, Marriages, and Deaths.

On the 14th ult., Dr. L. C. Sinclair, Mayor of Tilsonburg, to Miss Lillie, daughter of E. T. Tilson, Esq., of Tilsonburg.

Died, at Kilcolman, Township of Clarke, on the 3rd ult., J. P. Lovekin, jr., M.D.

THE

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VOL. IX

BY F. L.

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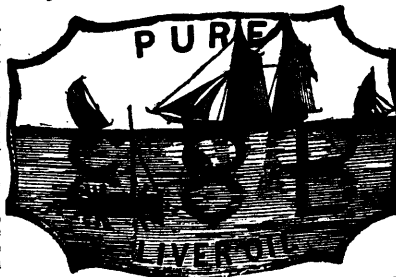
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- NORMAN BETHUNE, B.A., M.D.**, Edin.; M.R.C.S., Eng.; F.R.C.S., Edin.; F.O.S., Lond.; Physician to Toronto General Hospital, and Burnside Lying-in-Hospital. 198 Simcoe-st.
- WALTER B. GEIKIE, M.D.**, F.R.C.S., Edin.; L.R.C.P., Lond.; F.O.S., Lond.; Physician Toronto Gen. Hospital.—3 Fleming's Terrace, Elm-st.
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- W. COVERNTON, M.D.**; M.R.C.S., Eng.
- JAMES BOVELL, M.D.**, L.R.C.P., Lond. Emeritus Prof. of Pathology.
- J. ALGERNON TEMPLE, M.D.**; M.R.C.S., Eng.; F.O.S. Lond.; Physician to Toronto General Hospital, and Attending Physician Burnside Lying-in-Hospital.—206 Simcoe-st.
- J. E. KENNEDY, A.B., M.D.**; F.O.S. Lond. 68 John-st. Prof. of Materia Medica and Therapeutics.
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- THOMAS KIRKLAND, M.A.**, Lecturer on Chemistry, Botany, &c., Normal School.
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- J. FRASER, M.D.**; L.R.C.S., Edin.; L.R.C.P., Lond. Demonstrator of Anatomy.
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- FRED. LE M. GRASSETT, M.B.**, L.R.C.S., Edin; M.R.C.S., Eng.; Physician to the Burnside Lying-in-Hospital, and the Toronto Dispensary.—158 King St., West.
- NIVEN AGNEW, M.D.**—Cor. Richmond and Bay Streets. Sanitary Science.

The Session will commence on MONDAY, the 2nd of October, 1876, and continue for Six Months. The Lectures will be delivered in the new College building, close to the Toronto General Hospital. Full information respecting Lectures, Fees, Gold and Silver Medals, Scholarships, Certificates of Honor, Graduation, &c., will be given in the annual announcement.

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"Yours truly,

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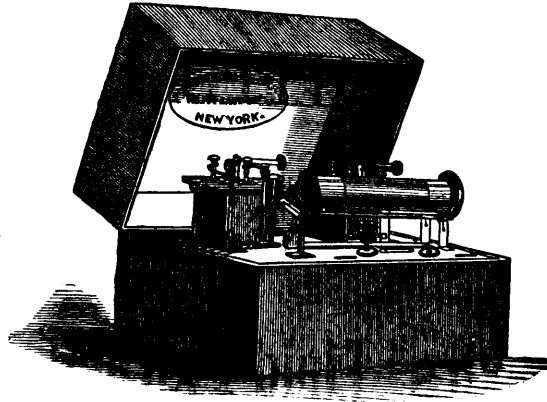
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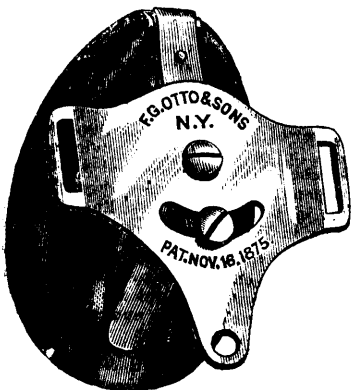
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THE PRELIMINARY AUTUMNAL TERM for 1876-77 will commence on Wednesday, September 13, 1876, and continue until the opening of the Regular Session. During this term, instruction, consisting of didactic lectures on special subjects, and daily clinical lectures, will be given as heretofore, by the entire Faculty. Students designing to attend the Regular Session are strongly recommended to attend the Preliminary Term, but attendance during the latter is not required. *During the Preliminary Term, clinical and didactic lectures will be given in precisely the same number and order as in the Regular Session.*

THE REGULAR SESSION will commence on Wednesday, September 27, 1876, and end about the 1st of March 1877.

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FORDYCE BARKER, M.D., Prof. of Clinical Midwifery and Diseases of Women.

AUSTIN FLINT, M.D., Prof. of the Principles and Practice of Medicine, and Clinical Medicine.
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JOHN P. GRAY, M.D., LL.D., Professor of Psychological Medicine and Medical Jurisprudence.
EDWARD L. KEYES, M.D., Professor of Dermatology, and adjunct to the Chair of Principles of Surgery, etc.
EDWARD G. JANEWAY, M.D., Professor of Practical Anatomy. (Demonstrator of Anatomy.)
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Fees for Tickets to all the Lectures during the Preliminary and Regular Term, including Clinical Lectures.....	\$140 00
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Fees for the Spring Session.

Matriculation (Ticket good for the following Winter).....	\$ 5 00
Recitations, Clinics, and Lectures.....	35 00
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Students who have attended two full Winter courses of Lectures may be examined at the end of their second course upon *Materia Medica, Physiology, Anatomy, and Chemistry*, and, if successful, they will be examined at the end of their third course upon *Practice of Medicine, Surgery, and Obstetrics* only.

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		\$ c.			\$ c.			\$ c.
Acid, Carbolic		0 07	Iodine, resub	oz.	0 50	Rad. Rhei. pulv.	lb.	2 00
" Sulph. Ar.	8 oz. bot.	0 20	Jalapin	"	1 75	Santonine	oz.	0 90
" Hydrocyan	"	0 23	Lin. Saponis	8 oz. bot.	0 24	Sodæ Bicarb.	lb.	0 14
Ammon. Carb.	1 lb.	0 25	Liq. Ammon	"	0 17	" Potass. Tart.	"	0 32
Ather, Nit.	8 oz. bot.	0 22	" Arsenic	"	0 20	Spir. Camphor	8 oz. bot.	0 28
" Sulph.	"	0 33	" Bismuth	"	0 40	" Ammon. Co	"	0 25
" Co.	"	0 28	" Donovan	"	0 28	Syr. Aurant.	"	0 20
Antim. Pot. Tart.	oz.	0 08	" Opil Sed.	"	1 30	" Codeia	"	0 90
Balsam Copaib.	8 oz. bot.	1 30	" Potassæ	8 oz. bot.	0 17	" Strych. Phos. Co	"	0 40
Bismuth, Car.	"	0 63	Mist. Ferri Co.	8 oz. bot.	0 20	" Hypophos	"	0 85
Cerri Oxalas.	oz.	0 30	Morph. Sul.	oz.	4 00	" Phosph. Co	"	0 45
Chloral Hy rate	"	0 30	" Mur.	"	4 00	" Senegæ	"	0 40
Chlorodyne	"	0 13	Ol. Crotonis	"	0 20	" Scillæ	"	0 38
Chloroform	"	0 15	" Jecoris Asselli	lb.	0 25	" Tinct. Aconit	"	0 20
Cinchon, Sul.	lb.	1 40	" Olivæ Opt.	oz.	0 30	" Arnica	"	0 24
Ergot, pulv.	oz.	0 50	Opium.	oz.	0 60	" Calumb.	"	0 20
Emp. Lyttæ.	"	0 15	" Powd.	gross.	0 30	" Camph. Co	"	0 20
Ext. Belladon.	lb.	1 25	Pil. Aloes	"	0 30	" Cardam. Co	"	0 24
" Colocynth Co.	oz.	0 20	" et Ferri	"	0 38	" Catechu	"	0 20
" Gentian	"	0 12	" Myr.	"	0 30	" Cinchon Co	"	0 24
" Hyosciam, Ang.	"	0 05	" Assafetid.	"	0 45	" Colch. Sem.	"	0 20
" Sarza Co., Ang.	"	0 20	" Cath. Co., U. S.	lb.	1 00	" Digital.	"	0 20
" Nucis Vom.	"	0 30	" Hydrarg, Mass.	lb.	0 30	" Ergot.	"	0 80
" Taraxacum	"	0 75	" Subchlor. Co.	gross.	0 35	" Ferri Perchlor.	"	0 18
Fol. Buchu	"	0 07	" Rhei. Co.	"	0 40	" Gentian Co.	"	0 20
" Senna	"	0 50	" Podophyllin, Co.	"	0 25	" Hyosciam	"	0 20
Gum. Aloes Soc.	"	0 30	Plumbi Acet.	lb.	0 60	" Iodine	"	0 45
" pulv.	"	0 90	Potass. Acet.	"	0 35	" Nucis Vom.	"	0 24
" Acacia, pulv.	"	1 10	" Bicarb.	"	0 90	" Opil	"	0 50
Glycerine, pure	"	0 60	" Bromid.	"	0 20	" Rhei Co.	"	0 30
Ferri, Am. Cit.	lb.	0 30	" Iodid.	"	4 75	" Valer	"	0 20
" et Cit.	oz.	0 12	Pulv. Creta Co.	"	0 75	" Verat Vir	oz.	0 24
" Citro. Cit.	"	0 65	" C Opio.	"	1 00	Ung. Hyd. Nit.	lb.	0 60
Ferrum Redact.	"	0 13	" Ipecac.	"	2 60	" Zinci	"	0 40
" Chlor.	"	0 15	" Co.	"	2 25	Vin. Ipecac.	8 oz. bot.	0 80
Hydrarg, Chlor.	"	0 10	" Jalapa	oz.	1 50	" Antim.	"	0 20
" C Creta	"	0 07	Quinæ Sul.	"	2 35			

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Fig. No. 3, is a comfortable support to the abdomen, but is not so effective as No. 8 in supporting the bowels, spine or chest.



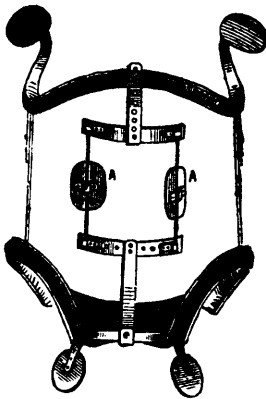
The Improved Body Brace.
Abdominal and Spinal
Shoulder and Lung Brace.



Fig. No. 8, is a general and grateful support to the hips, abdomen, chest and spine, simultaneously; and by itself alone, is ordinarily successful; but when not so, (particularly in spinal and uterine affections), the corresponding attachments are required.

Fig. No. 18.

Improved Revolving SPINAL PROP.



Unrivalled for the treatment of Angular Curvature, gives no pain, restrains no motion, and makes no show through the dress.

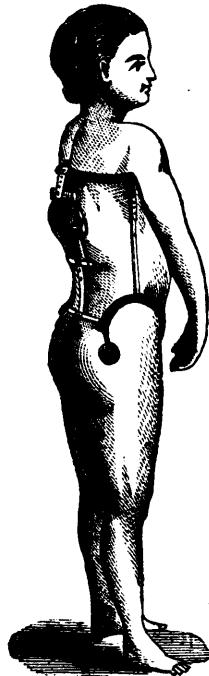
Fig. No. 12.



The above cut represents BANNING'S NON-FRICTION SELF-ADJUSTING BRACE TRUSS, applied for the retention of inguinal, femoral and umbilical hernia. Acts upon the principle of removing visceral weight from hernial openings. Is light, cool and self-adjustable, and absolutely a Non-Friction Truss.

Fig. No. 19.

SPINAL PROP APPLIED.

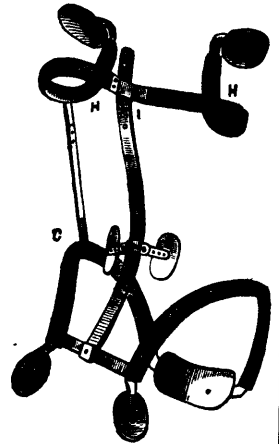


How to measure for any of these appliances.
1st Around the body, two inches below the tips of hip bones.
2d Around the chest, close under the arms.

3d From each armpit to corresponding tip of hip bone.
4th Height of person. All measures to be in inches.
Measure over the linen, drawing tape measure moderately tight.

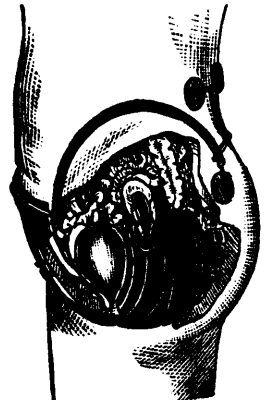
Fig. No. 14.

Improved Centripetal SPINAL LEVER.



For lateral curvature of the spine. The general action is to reverse the body's weight, and so deprive gravity of its depressing force.

Fig. No. 7.



The above cut represents THE IMPROVED ABDOMINAL SUPPORTER, removing visceral weight, and correcting the trunical bearings, while its attachment, BANNING'S IMPROVED BIFURCATED UTERINE ELEVATOR, in supporting the vaginal cul de sac on each side, thus, while elongating the vagina, restoring the diseased or overtaxed uterus (without touching it) to its normal position.

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