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ORIGINAL ARTICLES.

ON THE METHODS OF TREATMENT TO BE  
ADOPTED IN OBSTINATE CASES OF THE  
CYSTITIS ATTENDANT UPON HYPER-  
TROPHY OF THE PROSTATE.

BY W. HUTSON FORD, M. D., ST. LOUIS.

[*Read before the St. Louis Medico-Chirurgical Society, May 10th. 1880.*]

THE treatment of the cystitis which, sooner or later at-  
tends upon senile enlargement of the prostate, is in  
some fundamental respects very clearly detailed by our  
systematic writers. The use of the soft catheter for the  
evacuation of the bladder as often as may be deemed pru-  
dent in the progress of the case, with washing out of the  
bladder when the urine becomes alkaline, through the am-  
moniaccal fermentation of its urea, the due obviation of  
the constipation which almost invariably exists, and the  
use of anodyne suppositories, diuretics, and tonics directed  
toward the genito-urinary organs, with such alkali as may  
be needed, are the measures in general use.

When the cystitis, however induced directly, although

long since imminent, has reached a point where our patient is no longer able to go out to his usual business, we place him upon a lounge, advise him to recline as much as he can, and to drink moderately of an infusion of pareira-brava, of *triticum-repens*, or of *uva-ursi* with buchu. Of these I like the pareira best. A claret-glassful of the infusion, with an equal quantity of cold water, into which ten or fifteen grains of bicarbonate of soda, or twenty grains of citrate of potash is dissolved, should be taken four times a day. The patient should take a hot hip-bath every night, and a rhubarb and magnesia pill, (Griffit's) or one containing a little podophyllin on going to bed. Next morning he should take some Friedrichshall or Hunjadi Janos, or other aperient water, and aid it with an enema of salt and water if necessary, as is very often the case. The bladder must be drained of its residual urine, and for this purpose the use of the soft catheter must be begun. All the patient's future ease and safety depend upon its employment. But there are many difficulties attendant upon its frequent use.

For years, it must be recollected, the urinary apparatus has been in a condition of irritation, ready to explode into inflammation under the influence of very slight causes. The load of residual urine, carried so long, and the impaired circulation of the base and neck of the bladder through the weight and pressure of the prostatic overgrowth, concur to establish a condition where cystitis is almost certainly developed, as soon as the inevitable introduction of even the softest catheter, by the most skillful and gentlest hand, is systematically begun. If rough and forcible attempts are made at catheterization, by inexpert hands and with improper instruments, cystitis is almost immediately provoked, with an intense degree of inflammation of the entire urinary tract, often running into suppurative prostatitis, pyelitis, and latent or even acute pyelonephritis. To avoid these dangers, we must of course adopt all possible precautions, insisting upon recumbency, with the use of alkalies and anodyne suppositories, and

the observance of the utmost gentleness. It is not my purpose to speak of these measures in detail at present, but to consider the resources we may have at our command when such cases become critical, and seem to be steadily declining towards the grave. There are many of these cases, which fail to improve, however skillfully handled, and at a certain point begin to grow steadily worse. The skin gets paler and more waxy, the tongue flabby, the eyes watery and hollow, the facies hippocratic, the muscles feeble, and the bowels still more obstinately constipated than usual. The patient is now confined to his bed, his appetite is lost, or becomes very capricious, and thirst becomes constant and great. There is a dull pain felt above the pubes, which is intensified by pressure, the calls to make water are very frequent, once every hour, or even oftener, day and night. The urine is apt to be passed in considerable quantities, sometimes as much as ten pints a day,—polyuria. Soon, dull pain is felt in the region of the kidneys and in the groins, and the tongue begins to get dry, and the force of the patient to decline still further. The urine itself, in spite of the washing out of the bladder twice a day, is loaded with muco-pus, and is distinctly alkaline, and, very probably, possessed of some fetor, notwithstanding all precautions in the way of medication of the injected fluids. Now, I say that this condition of things is very apt to occur in certain old men, although their cases had been highly promising at first, perfectly well managed, and up to a short time before, regularly progressive toward amelioration. Sir Henry Thompson alludes to this state of things in the following paragraphs:

“You often find (and this is a matter of considerable importance) that although up to the time of the attack, or of the necessity for the use of the catheter, the water has been perfectly clear, yet, after you begin to use the catheter habitually, the patient gets more or less cystitis, and is feverish and unwell. That stage has very often to be passed by those persons who suddenly change from a natural mode of micturition to an artificial one. It requires some

judgment to say when that change should be made; but as soon as you find it necessary to pass the catheter regularly, the patient will often show some change in his general condition; and you should be aware of this and watch the results. The preventive method is this: Do not empty the bladder on each occasion of using the catheter. \* \* \*

The rule under such circumstances, is to proceed cautiously. \* \* \* If the patient has been in the habit of retaining a pint of urine, instead of drawing off a pint, draw off half a pint; leave some behind and so make a compromise between the condition of the bladder and the general condition of the patient. \* \* \* You will thus relieve him a little, and so, gradually, in the course of a month, you may accomplish the entire emptying of the bladder, and all will go on smoothly and well. Notwithstanding all your care, now and then you will find a case in which, during this process, the tongue grows slowly more red, dry, and contracted; the powers of life gradually fail; the senses become impaired, and the patient sinks. You will always find in such cases, by autopsy, old standing pyelitis, with dilatation and injury to the renal structure, and you will know that in no circumstances could the patient have long survived." (*Lectures, pp. 78, 79*).

But, we may ask, is it not possible to do more for our patients than merely to wash out the bladder regularly, draw off the urine with due care, relieve the vesical tenesmus with anodyne suppositories, and the constipation with appropriate remedies, while we support the flagging forces with wine and strong animal broths? All this will not save our patients sometimes; things will get worse from day to day; the tongue will become drier and the senses more obtuse, the skin parched, and the urine either very scanty or abnormally abundant. The prostration will become so great that the patient cannot turn himself in bed, and is totally unable to pass a catheter for himself. I beg leave to mention some of the measures to which I have had recourse of late years, in such a condition of things, viz.: the use of jaborandi, puncture of the bladder through

the rectum, and the injection of strong solutions of nitrate of silver into the bladder.

Each of these procedures is adapted to peculiar cases, and one or more may be combined in any special case. Jaborandi is indicated where there is reason to suspect that latent or subacute nephritis is threatened. Under such circumstances there is a disposition toward a typhoid condition; the tongue is parched and shrivelled, and thirst usually pronounced. The temperature ranges about  $102^{\circ}$  or above it; the pulse is weak and abrupt, sometimes dicrote, and frequent. Nutrition must be systematic with strong animal broths; quinine and carbonate of ammonia, and a moderate quantity of stimulus, preferably a good Rhenish wine, Catawba, California or Kelly Island wine, freshly bottled, should be administered. It has been my practice to give from twenty-five to thirty drops of the fluid extract of jaborandi in water at bed time, and another similar dose at four A.M. Sweating usually comes on within an hour after each dose; there is some variable amount of ptyalism, which after a time ceases to make its appearance. The secretion of the kidneys is increased, and the patient sleeps under the temporary depression of the drug, which is prevented from becoming too pronounced by the associated alcoholic stimulus. The jaborandi is administered in this way every night for a week or ten days, or until the tongue remains moist, the skin becomes supple and perspirable, and the polyuria or its reverse abated. No bad effect has been observed by me from the use of jaborandi in this way, indeed, only very satisfactory results in some cases, and in others at least temporary benefit. It does not enhance the existing cystitis, and I am convinced, directly relieves the congestion of the kidneys, and saves the system from the threatened uremic intoxication. I have used it in this way in three cases, all of which eventually recovered.

I have said that in certain of these cases of cystitis dependant upon prostatic hypertrophy, a time arrives when all the symptoms become aggravated in spite of the most

careful and systematic catheterization and washing of the bladder. The urethra, especially about the bulb, and in its fixed course particularly, becomes so sensitive that the passage of even the smallest and softest catheter is almost intolerably painful. The calls to urinate become again more frequent; the patient rising six to ten times a night to strain ineffectually, and fearing to pass the catheter. The urine is milky, full of muco-pus, and no amount of washing, either with simple water, with a solution of borax in glycerine, or with hypo-sulphite of soda, will prevent the continual decomposition of the urine, which is maintained by the mucus secreted from the walls of the bladder. A most dangerous degree of depression is associated with this condition, which continually becomes more marked. The dilemma is obvious; viz.: the bladder must be evacuated and cleansed, but the introduction of the catheter maintains the irritability of the urethra, and enhances that of the bladder; what then can be done under such circumstances? Aspiration over the pubes relieves the pressing retention, when the bladder cannot be reached by the catheter, either in consequence of spasm of the deep urethra, excessive sensibility, or the existence of swelling in the prostatic portion due to advancing or recent prostatic abscess, all of which cases have fallen under my care. But in such cases, aspiration must be practiced three or four times in twenty-four hours, and a grave objection to the procedure is that no washing of the bladder is practicable through the slender needle we are obliged to use when making such frequent punctures. In two cases where the conditions have been such as are here described, in one of which I had practiced forty-five aspirations over the pubes, I had recourse to puncture of the bladder just behind the prostate, or possibly through its posterior portion, by the rectum. In some of these cases a curved, sharp-pointed, guarded bistoury was used, in the other the ordinary rectal trocar. In each case the urine began to flow by the rectum within forty-eight hours after the puncture, and continued to do so until the anterior passages were able to



bear the use of the catheter. No attempt was made to retain the cannula in the case alluded to, aspiration over the pubes being practiced three times a day until the rectal orifice had become permanently patulous. In one case, after three weeks, during which time all interference with the urethra was avoided, except for washing the bladder twice a day, the urine was almost wholly discharged by the bowels; in this case some little power still remained to expel a spoonful of urine at a time by the natural efforts. In the second case the retention was absolute, not a drop of urine being passed by the penis during five weeks. Meanwhile, the existing prostatic abscess had closed, the irritability of the urethra had almost wholly disappeared, the patient improving so much as to leave his bed, and walk out in the yard of his dwelling on fine days in winter. He was generally called to pass water, or have an action by the bowels, and he could not in his situation clearly define which of the two it was, about six times at night and four or five times by day.

I ceased to visit him more than once or twice a week, until five weeks had passed, and then, assuming and hoping that the irritation of the urethra had subsided, the cystitis abated, and the gap in the urethral wall, due to the rupture of the prostatic abscess into the canal, so filled up as not to catch the point of the catheter, I began once more to attempt a systematic entry into the bladder. After ten days, and the use of a great variety of catheters, I was finally obliged to construct one on a novel principle, by inserting a spring wire into a Mercier sonde coudée. This passed readily, and the patient was, with a good deal of trouble taught to introduce it himself, to draw his urine with it and to wash out his bladder, relying exclusively upon his catheter for urination. He was forbidden, at this juncture to pass water by the rectum, and the rectal orifice so long and so freely patulous, closed permanently, the patient promptly recovering and resuming his business, after an illness of two months and a half.

Puncture of the rectum in the cystitis of enlarged pros-

tate is not a procedure for which we can find definite rules and precedents. Operators seem to have been deterred by fear of a permanent recto-vesical fistula, from practicing this operation, which has been done, as far as I can learn and read, almost entirely for retention due to stricture. Practiced for the cystitis, it is really a mode of cystotomy and a far less formidable measure than any other of this class, being promptly followed by temporary recovery in the great majority of cases. The object of the operation is to drain the bladder and to allow the cystitis to subside, until in the course of time, the uréthral canal again tolerates the catheter, or until swellings, tortuosities, or cavities due to prostatic abscess shall have disappeared, so that it shall have become possible to pass a catheter. As soon as all the urine passes once more by the urethra, either naturally or artificially, the recto-vesical orifice will almost invariably close, and, if it does not, its existence will be a matter of no special moment. The decussation of the muscular fibres of the bladder in the situation of the puncture, strongly disposes to this result, and indeed the orifice may actually become as subject to the will of the patient as if surrounded by a true sphincter muscle.

Notwithstanding the surgical rule, that puncture of the bladder by the rectum should not be practiced under any circumstances when there is not a probability of a speedy reëstablishment of the natural urinary channel, I have been greatly pleased with the result of this operation, which is by no means one often performed. In the case of prostatic hypertrophy with cystitis and prostatic abscess, the operation is imperative, for aspiration is too troublesome, annoying to the patient, and altogether ineffective as regards cleansing and even thoroughly emptying the bladder. In such a case, even while we may be yet in the dark as to the length of time during which it may be proper or unavoidable to allow the rectal orifice to remain open, and while we may not know with certainty that the urethra will not be permanently encroached upon, or so deflected, as to render the frequent passage of a catheter for the ob-

jects properly aimed at, almost or wholly impracticable, it will nevertheless be the best and most satisfactory practice to puncture promptly by the rectum.

A third category of cases still remains to be met by a special method of medication, viz.: the injection of comparatively strong solutions of nitrate of silver. The indications for the employment of this measure, consist in advancing cystitis with increasing pain upon catheterization, pain during and especially after urination or the use of the catheter, and increasing general prostration. Here the customary routine of catheterization and washing must be interrupted and other measures adopted. The urethra has become excessively tender, especially at the bulb and throughout its membranous portions, the mucous membrane being abraded, swollen, perhaps ulcerated in patches. The lining membrane of the bladder is doubtless in a similar condition, particularly in the neighborhood of the outlet of the organ. True ulceration no doubt exists at this point, and perhaps elsewhere in some of these cases. Injections may be tried, (and I have tried them myself in various ways) but will almost always fail. Carbolic acid will surely irritate and aggravate the cystitis, even when used in the proportion of a drop or two to six ounces of water. Acetate of lead, sulphate of zinc, sulphate of quinine, have all proved irritating in my hands even when employed in very dilute mixtures. So also with the dilute solutions of nitrate of silver, such as Thompson recommends, one-fourth of a grain to one grain to the ounce, used every other day. The solution is too weak to accomplish what is really desirable, or what nitrate of silver is competent to effect, and the frequency of the injections altogether too great. Hence, such injections become irritating like all others practiced frequently through a catheter. The plan I have adopted and have now used with the most remarkable and satisfactory results in four cases, is to begin with five grains to the ounce, and after from four to seven days to increase the dose to ten grains to the ounce, and then again after a proper interval by five grains more, for

three or four injections until the patient is well and the cystitis absolutely cured, or nearly so. In my first case I injected two ounces of a twenty-grain solution, and my patient was well ten days afterwards. In my second case I injected a similar quantity, viz.: two ounces of a solution containing five grains, for the first injection, ten grains to the ounce for the second injection, fifteen grains to the ounce for the third injection, and ten grains to the ounce for the fourth injection, the patient being finally cured. In my third case, I had occasion to inject but twice, at intervals of a week; the first time a solution of ten grains to the ounce, the second time, one of fifteen grains to the ounce. The patient was promptly cured of his cystitis, the urine becoming perfectly clear, and remaining so, at least for six weeks. The patient had meanwhile returned to his accustomed occupation.

I take pleasure in acknowledging my indebtedness to Dr. T. G. Richardson, of New Orleans, for the hints which have led me to use injections of nitrate of silver in this way. In the *New Orleans Medical and Surgical Journal*, for May, 1875, we have the details of "A Case of Chronic Cystitis, of Many Years Standing, Cured by Three Injections of a Strong Solution of Nitrate of Silver," reported from the Charity Hospital Clinic of Dr. Richardson. The patient's age was 44, and he was pronounced by Dr. Richardson to be suffering from undoubted chronic cystitis. "There was a constant sense of weight and uneasiness behind the pubes, itching at the external meatus, inability to retain the water longer than an hour or two, frequent incontinence, and a large admixture of mucus and pus in the urine." There was no stone found upon sounding. The case seems to me to have been one of neglected prostatic-cystitis, consequent, very probably, upon large strictures, either at the bulb or elsewhere, but of these there is no account, nor any mention of careful examination with bulbous bougies. The age precluded the existence of true prostatic hypertrophy. Dr. Richardson stated in his comments upon the case, that for several years prior to 1875,

he had invariably employed in such cases, solutions varying in strength, from ten to sixty grains to the ounce of water, and with almost uniformly successful results. There is nothing whatever in the paper to show that such injections had ever been proposed or practiced by Dr. Richardson in the cystitis of prostatic hypertrophy. The class of cases in which he had used the remedy, had been similar, as he seems to imply, to the one detailed, viz.: cases of chronic inflammation of the prostatic urethra and neck of the bladder, with occasional cystitis of wider extent, due to systemic causes, such as a rheumatic or gouty diathesis, with concentrated and acid urine, to contractions of the urethra, etc. In the case cited, and from which I first conceived the idea of using similar strong injections in prostatic hypertrophy, the urethra was *pervious*, there was no close stricture, and there was no retention, but, on the contrary, incontinence. When the urine cannot be passed by the efforts of the patient, the practice would seem hazardous, for the injection sometimes notably exalts the grade of existing cystitis and provokes very painful tenesmic contraction of the bladder. I had great doubts, therefore, whether such a practice could be justifiable or advantageous in the class of cases to which I proposed to apply it, and I could find nothing whatever in the literature of the subject, or in the published account of Richardson's practice in ordinary cystitis, to enlighten me. I was fearful that the irritation of the injection might provoke a total retention, where only a partial one existed before, which it might be very painful to relieve by catheterization through a cauterized urethra, or very inconvenient to aspirate as often as would be necessary, for the relief of the probable vesical irritability. Such an injection, if followed by retention, might necessitate cystotomy, or, at least, a rectal puncture. The shock and pain, moreover, it seemed to me, of such an injection into the bladder of an old man, by the supposition very greatly prostrated and enfeebled already, might be of a dangerous amount. All such fears and prudential considerations, however, are

set at naught, under the terrible pressure of an important case where the patient is steadily growing worse, and life is evidently failing. In such a dilemma, determining that either a rectal puncture or such an injection must be done, as my patient was growing day by day more feeble, and making up my mind to aspirate over the pubes, if the injection caused a retention, and not to pass a catheter for at least thirty-six hours afterward, I made an injection of two ounces of water holding forty grains of nitrate of silver. A sharp exaggeration of the cystitis followed, but nothing like retention; my patient never needed another injection; the urine cleared up within a week, so that I dismissed the case ten days afterward, in March, 1877.

I wish it to be distinctly understood that injections of the character considered, should be administered only in sub-acute cases which fail to be benefited by the systematic use of the catheter, with regular washing of the bladder. I would not think of venturing to use them in anything like acute cystitis, or even in a very pronounced exaggeration of a chronic condition. A previous operation of rectal puncture in no way contraindicates the caustic injection, which I have practiced with prompt, full, and permanent benefit after such a puncture. I would emphatically insist upon the point, that the contents of the bladder shall be susceptible of evacuation, *either* through an opening into the rectum, *or* by catheterization, before recourse is had to the injections. If complete prostatic retention were habitually present, aspiration over the pubes would be necessary, or tying in a catheter, if catheterization were found painful or irritating. I am now conducting just such a case with marked success, where a catheter has to be tied in for twelve hours after each injection. In such a case the best course would be to make a rectal puncture first, and after waiting some weeks, to endeavor to wind up the case by a course of injections. But when the retention is only partial, and the patient can get rid of some of his urine by the urethra, even in the temporary intermission of the use of the catheter, which I purposely enjoin, there is nothing

in my experience to contraindicate the use of the injections.

It is best to begin with five grains of nitrate of silver to the ounce of water, always injecting two ounces at a time. A hot sitz-bath, and a rubber hot-water bag being in readiness, one-third of a grain of morphine is given by the rectum. A soft catheter is then introduced into the bladder, the urine evacuated, and the bladder gently but thoroughly washed with warm water. Very nearly two ounces of the solution is then injected into the bladder through the catheter, and when this has been done, the catheter is withdrawn just beyond the vesical neck and a drachm or two injected into the prostatic urethra, the catheter being at once pushed back into the bladder. The syringe nozzle being removed, the solution is allowed to remain in the bladder until pain begins to be severe, and is then allowed to run out. The bladder is now washed out once or twice with three or four ounces of warm water each time. The patient seats himself in the sitz-bath, to which hot water is added from time to time. The temperature of the bath should be about  $104^{\circ}$ , and may be increased to  $110^{\circ}$ , or even  $115^{\circ}$ . Its use greatly alleviates the acute pain. In from ten to twenty minutes, the first acerbity of the pain is past, and the patient may get into bed, and apply the hot water bottle to the supra-pubic region and another of the same kind to the perineum, if necessary. Later a suppository of opium, belladonna and camphor, should be given. After from three to five hours all pain ceases, and if the injection has been done just before bed-time, as is perhaps best, the patient sleeps well during the latter part of the night. He will not usually feel any desire to pass water until next morning, and will then be greatly surprised to find that he does so without any pain or straining whatever. A perfect calm seems to have succeeded the perturbation, pain and annoyance hitherto experienced. The urine is clear, depositing only a little cloud of mucus and some chloride of silver, resulting from the decomposition of the nitrate by the urinary salts. No attempt at catheterization should be made for at least thirty-six hours.

When again used, the introduction of the catheter will be found to be almost painless, at least as compared to the acute smarting lately felt during its introduction, and for a variable time afterwards.

The appearance of the urine should now be watched. As soon as cloudiness begins to reappear, and the act of catheterization becomes again somewhat painful, another injection should be given. The interval of time is from six to ten days. A second injection should consist of two ounces of water, holding in solution ten grains of nitrate of silver to each ounce. It will not give by any means as much pain as a first injection of five grains to the ounce, doubtless because many abraded and ulcerated patches of the mucous membrane have been healed. A third injection should contain thirty grains of nitrate of silver, or fifteen grains to the ounce. A fourth injection may be needed, and if so, should be of the strength of twenty grains to the ounce, if the symptoms are decided, but if not, one of ten grains to the ounce will be productive of quite as much benefit. Such is my experience at least.

Under the influence of these injections prompt improvement sets in. The patient confined for weeks to his bed is able to sit up in a week or ten days, and in a fortnight or three weeks, is able to go out and at least begin to resume his customary duties. The sedative and curative influence of this method of treatment are so conspicuous and so permanent, that both patient and physician are filled with surprise. Its effect is really wonderful. The method is a painful one, but only during the first one or two injections, although a good deal of pain may be felt whenever the urethra and neck of the bladder become excoriated by the repeated passage of the catheter. Instead of producing retention, the injections appear to relax the urethra, so that the stream of water is fuller and passed with less straining than under any other circumstances. The salt seems to act as a powerful sedative upon the intensely irritated organs.

Under the use of these measures, the dangerous conditions, viz.: advancing cystitis, and threatened nephritis with



progressive uremic intoxication, will be successfully met, I hope, in the hands of others, as thus far they have been in the limited number of cases I am able to report up to this time.

Puncture of the rectum has been practiced by Mr. Cock over thirty times for acute retention, and is recommended by Bryant in prostatic hypertrophy when the urinary passages have been injured by maladroit catheterization, or or involved in the inflammation attendant upon prostatic abscess. Writing in 1874, Thompson says, that he had practiced the rectal puncture but twice in prostatic enlargement, and four times for stricture during a period of twenty years. A very considerable enlargement of the prostate, says this author, makes the supra-pubic puncture with the plain trocar, (*i. e.*, without aspiration) necessary. Judging from the great benefit derived from the rectal puncture in the two cases in which I have practiced it myself in prostatic hypertrophy, I am strongly inclined to believe that it should be practiced greatly oftener, and shall, in future, not fail to do so myself, whenever the urinary tract becomes rebellious against repeated catheterization, should the nitrate of silver injections fail, or be refused by the patient. One or the other, or both, with stimulants and jaborandi are the only resources I know of in these painful and desperate cases. Aspiration over the pubes, in enlarged prostate, is only a means of temporary alleviation, as a method under which the urethra may sometimes recover itself so as to allow the inevitably frequent introduction of the catheter. In all this it is wholly inferior to the rectal puncture, but it is at the same time almost absolutely devoid of danger, which cannot be so positively affirmed of the rectal operation.

A "CRÉDÉ" METHOD AMONG THE KIOWA  
INDIANS.—A CONTRIBUTION TO OB-  
STETRIC LITERATURE.

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BY G. A. MOSES, M. D., ST. LOUIS.

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**D**R. L. L. McCABE, Surgeon to an Indian Agency, relates to me the following interesting fact in aboriginal obstetrics:

An Indian woman, of the Kiowa tribe, one of the wildest tribes, which has come scarcely at all in contact with the whites, had been in labor for three days, and, it being apparent to the friends and midwife squaw that successful natural delivery was impossible, and that under the native treatment by incantations, beating of tom-toms, etc., the woman's strength was becoming rapidly exhausted, assistance of the Post medical officer was desired. It was only after several visits to the wigwam that the doctor finally was allowed to make a very hasty and imperfect digital touch. The head was arrested in the cavity. After still further delay he was permitted to apply the forceps, which, to the intense amazement of the lookers on, drew forth a living infant. As soon as this was effected, the physician was rudely pushed aside, and the Indian midwife took charge of her case, compelling the woman to rise to her feet. She was sustained in a bent posture, grasping with both hands the centre pole of the tent; then the squaw proceeded to carry out methodically, Credé's method of expressing the placenta, by compressing the uterus through the abdominal walls, with both hands pressing in the direction of the pelvic cavity, until the placenta appeared at the vulva, when it was seized with one hand and withdrawn; the patient was then allowed to resume recumbency, and a highly ornamented buckskin bandage was adapted to pelvis and abdomen; this was drawn snugly

by buckles and straps. The Doctor says it looked as though it had been in use some time, and was a most perfect fitting bandage. The patient made a good recovery, and the white man's "iron hooks" are established in reputation among the band.

If the Indian mother gives birth to twins, only one is allowed to live. In case of the birth being male and female, the latter is delivered to an old squaw, and nothing further is heard of the luckless papoose. In case of both children being of the same sex, the feeblest is put out of the way.

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## CASES FROM PRACTICE.

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### A CASE OF PUERPERAL ECLAMPSIA.

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BY H. L. STAUDINGER, M. D., MARTHASVILLE, MO.

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As it is generally admitted that next to rupture of the uterus, eclampsia is the most fatal of puerperal accidents, the report of every case ending in recovery, may be worth the consideration of the profession.

The treatment pursued in these cases is especially interesting to the practitioner, whilst the history of the patient respecting her physical constitution, hereditary and acquired nervous predisposition, may furnish valuable material to the pathologist, who is groping for the obscure etiology of this dreadful malady.

September 13, 1879, 9 o'clock A. M., I was summoned to visit Mrs. H., aged 30, a robust German woman, without any apparent nervous or hysterical predisposition whatever, mother of six children, all labors normal.

Her mother, of whom she is an exact picture, bore eighteen

children besides the patient, all without convulsions. She is sixty years of age, weighs about 175 pounds, is still a hard worker on her farm, and never had globus hystericus in her life.

From this it will appear, that mother as well as daughter were, what Prof. Maughs would call, "women of coarse nerves." The father and rest of family being of an equally coarse-nerved constitution, a hereditary predisposition to nervous disorders may safely be excluded.

I found Mrs. H. in the beginning of the ninth month of pregnancy, complaining of headache, pains in her back and general malaise; condition of bowels and bladder, regular. Malarial fever being very prevalent at this time, several members of patient's family being affected, herself having had an attack just three weeks before, which was ushered in with the same prodromata, I anticipated a return of the chills. I gave her one drachm potas. bromid., and left powders of pot. brom., gr. x., morph. sulph. gr. one-sixth. I directed one to be given every hour until relief or sleep.

On my return home in the afternoon, I found a summons to hurry to my patient. The husband made the following statement:

The patient had taken four of the powders, they first relieved all symptoms of pain, but after 12 M., she became more restless, and we gave no more medicine.

At 12.30 P. M., the patient jumped out of her bed, ran around the room like a crazy woman; said she could not see anything; staggered, and nearly fell. We carried her back to bed, where she fell in a senseless condition, and from that time we could no more arouse her.

At 2, 2.30, 3 and 3.30 P. M., she had convulsions which became continuous, the first ones lasting from ten to fifteen minutes each.

At 4 P. M., I arrived. Patient still in convulsions. Pupils dilated, do not respond to light; stertorous breathing. The cold douche on bare face and chest, produces no effect; pulse slow but compressible; face cyanotic.

As soon as I could straighten her arm, I bled her to the amount of 36 ounces. During the flow of the blood the pulse became firmer. After bleeding, all muscles completely relaxed. I now dissolved one drachm chloral hydrate, which I gradually made her swallow by reflex action.

Introduced a catheter into the bladder; only an ounce of thick, syrupy looking urine escaped, which, on application of heat, became almost solid in the test tube.

At 5 P. M., I gave twenty grains of calomel, with two drops of croton oil. Os uteri not dilated; no signs of labor pains; no movements of child; no pulsation of child's heart, nor placental murmur.

At 7 P. M., slight convulsive movements. Gave half a drachm potas. brom. Introduced catheter again; not a drop of urine appeared.

At 8 P. M., I made a copious injection of water with magnes. sulphat., which soon returned without feces. Gave a half ounce of castor-oil, with two drops of croton-oil.

9 P. M.—No operation. Made a copious injection with ol. terebinth. All returned as fast as injected. Still profound coma.

10 P. M.—Perceptible uterine contractions. Some convulsive movements of extremities. Gave a half drachm of chloral hydrate, which she swallowed better than the first.

10:30 P. M.—Convulsive movements ceased. Os beginning to dilate.

11 P. M.—Os very dilatable. Here now arises the question as to the propriety of artificial delivery. Nature is a good accoucheur. But nature's means to effect delivery, expulsive labor pains, are in this case dangerous to the patient. They are the exciting cause of the dreaded convulsions which may destroy life. Therefore, if for this dangerous *vis a tergo* of nature we can substitute a *vis a fronte* by art, which answers the same purpose without imperiling the patient, it should be done. Happily by means of the obstetrical forceps this *vis a fronte* is at our disposal.

In breech presentations, we substitute our hand for the forceps, and in malpositions, we do no more than in otherwise uncomplicated cases in this stage of labor, and that is turn and deliver. Delivery is a *sine qua non*, the sooner completed the better. I therefore put instruments and everything that might be necessary, in readiness for immediate use and ruptured the membranes. In this case, however, the forceps were not needed. The mother being a multipara with large pelvis, the child comparatively small—her other children were all ten to twelve pounders—two slight pains immediately following the

rupture of membranes, aided by external manual pressure, effected the delivery of a dead child.

Had this child been another twelve-pounder, the *vis expul-siva* effecting this precipitous labor would not have been sufficient. But with the forceps well applied, the child could have been extracted in the same time, and with the same result.

September 14th, 1 A. M.—Patient still comatose. No evacuation of the bowels yet. Should I give elaterin or try to eliminate the excrementitious matter from the blood with jaborandi. My anxiety being greatly relieved by the successful completion of delivery, and everything else being favorable, I resolved to wait till morning.

6 A. M.—Still comatose; another copious injection of soap-suds, to which I again added some ol. terebinth., with the view of stimulating the kidneys, returned, only bringing away some feces from the lower part of the rectum. I drew off six ounces of very albuminous urine.

9 A. M.—Patient can be aroused with difficulty, but only for a few moments.

1 P. M.—Some consciousness on being aroused. Bowels not moved. Gave solution of sal Rochelle continually.

5 P. M.—Drew off a little more albuminous urine.

8 P. M.—Patient had an operation from the bowels. All symptoms favorable.

September 15th, 7 A. M.—Patient answers questions, but says she cannot see well.

1 P. M.—Patient is rapidly getting better. There is complete oblivion of all that has happened during the last forty-eight hours. When told that she had been delivered, she would not believe it until she examined her abdomen.

September 16th, 8 A. M.—She still sleeps most of her time, says that her eyesight is still dim. There are still traces of albumen in her urine.

April 25th, 1880.—I saw Mrs. H— yesterday. She is well and hardy, and again in the fourth month of pregnancy.

Without theorizing on the etiology of puerperal convulsions, I merely wish to point to two facts, which I think this case clearly illustrates: First, if there really exists a neurotic predisposition that tends to develop eclamptic attacks, as contended by the neuropathologists, it is certainly very perfectly hidden in some cases. Second, eclampsia puerperalis selects

for its victim not only the delicate, refined city lady, but also the rustic, steeled by hardship and daily exposure to air and light and all kinds of weather.

In conclusion, I would say, that I attribute the success in this case to the prompt abstraction of blood and the antispasmodic action of hydrate of chloral. Cathartics although indicated did not act at all.

In another case of eclampsia that I have treated since—in February, 1880—bleeding and chloral hydrate were the remedies on which I relied. This was also a very robust female, a primipara. As the convulsions happened post-partum, I will not say, that the patient would not have recovered without this treatment. But, the convulsions were severe, she had one after another; and after the abstraction of eighteen ounces of blood and the administration of one drachm of hydrate of chloral, had not a single return. This patient also made a good recovery.

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## POST-MORTEM DELIVERY, WITH REPORT OF FOUR CASES.

BY P. V. SCHENCK, M. D., *Surgeon in Charge Female Hospital, St. Louis.*

An able article upon this subject in the *American Journal of Obstetrics*, for January of this year, by E. L. Duer, M. D., makes it unnecessary to give the history or statistics of this operation.

There is no other condition in obstetrics or surgery in which life is so evidently saved in the midst of death. Life and death are but links in the chain of continued existence; the cut down tree will sprout again; except the grain die, it cannot live. The life and nutrition of an unborn child are guarded with especial care. Encased within the womb of a consumptive and hectic mother, a mother whose loss of appetite and consequent emaciation is rapidly tending to place her in the grave, the fetus comes into the world well formed and healthy; thus protected in its nutrition, it is protected also from bodily

harm; a stroke upon the abdomen of the mother that would ruin her for life, scarcely disturbs the rest of the fetus as it lies in God's water-bed.

The duty of saving life, on the part of the profession, is too plain to need comment, and the life thus saved is all important to the world. Cæsar cut from his mother, and Moses snatched from the bulrushes, have made as great a mark in history as if their early beginnings were less surrounded by contingencies. About such beginnings there is even an enchantment, as Macduff says to Macbeth: "Despair thy charm; and let the angel whom thou still hast serv'd tell thee Macduff was from his mother's womb untimely ripped."

During the last five years I have had at this Institution four post-mortem deliveries, all by abdominal section:

CASE I.—Rosa T., aged 24 years, was admitted, suffering from phthisis pulmonalis. She was eight and a half months advanced in her first pregnancy. On the day following her entrance, she was seized with severe hœmoptysis. The next day the bag of waters ruptured, but before the os dilated, she expired. In fifteen minutes afterwards the child was removed by abdominal section. It was alive, the heart beating; it remained alive about twenty minutes.

CASE II.—Mary C., colored, aged 32 years, multipara, was admitted at midnight. The person who brought her, said her husband had left her two months before, since which she had been intoxicated nearly all the time. She was in a moribund condition, and was pregnant at full term. She died two hours after admission. The child was removed twenty minutes afterwards—it showed but little signs of life, further than the feeble beating of the heart. After insufflation mouth to mouth, and artificial respiration, the child commenced to respire, after which it did well, and was taken from here by its grandmother when it was two weeks old; the child was then hearty, with every promise of continued life and health.

CASE III.—Anna D., colored, aged 22 years, a multipara, suffering from double pneumonia, was in the ninth month of utero-gestation, and died on the second day after admission. Section was made within fifteen minutes afterwards. The child gasped twice, but all means for resuscitation failed.

CASE IV.—Susan F., aged 34 years, multipara, in the eighth month of pregnancy. She had valvular disease of the heart.



Her limbs were swollen, and she had edema of the lungs. She died before there were any indications of labor setting in. The child was immediately removed; it was asphyxiated; all attempts at restoration were in vain.

One success in four cases is certainly flattering, in favor of a procedure where, as far as life is concerned, all is to be gained.

The only plan is, be certain the mother is dead, then strive to save the child. Quibble not with prejudice. Counsel not with superstition. The functions of the mother have all ceased—pluck the remaining fruit of the greatest function of her existence, a function which in its history goes back and touches near divinity; in its future reaches further than any other towards immortality.

The talisman of the retort is chemical affinity, that of the fecundated egg is life, which it is our duty to save, whether we find it *in utero* or *ex utero*.

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## REPORT OF CLINICS.

FROM CLINIC OF PROF. J. P. KINGSLEY AT ST. JOHN'S HOSPITAL.

*Reported by S. Emory Lanphear.*

April 17th.—Freide H—, aged five years. Has been complaining for about four years; has been under the treatment of various physicians, but without relief. Complains of an intolerable itching around the anus; for a long time has been vomiting after meals, the ejections being acid in character; has slight fever every morning; appetite poor, but she appears quite well nourished. Diagnosis: Pruritus ani and indigestion. Treatment:

Internally: R.	Bismuthi subnit.	ʒij.
	Syrupi simplicis,	
	Aquæ cinnamomi aa.	fʒj.
M. S.	Teaspoonful three times daily.	
Locally: R.	Acidi carbolicæ,	gtt.x.
	Empl. plumbi	
	Ungt. petrolei, āā.	ʒss.
M. S.	Apply.	

April 30th.—Better than she has been since commencement of affection. Itching entirely allayed.

This case is one of interest, inasmuch as it illustrates the effect of a few simple remedies, when the nature of the case is thoroughly understood and the proper remedies selected. In relieving the indigestion by the administration of the bismuth, one great point in the treatment was accomplished, namely, the removal of a cause tending to keep up the irritation; and by the use of the carbolic acid the intense itching was allayed until the source of the irritation could be removed. Others had treated the case by local applications alone, which could result at best in but a temporary relief, while combined with the internal treatment, a successful termination was the result.

March 24th.—Katie F—, aged four months. Had a slight cough for about three weeks. During that time has been troubled by persistent diarrhea, but unaccompanied by any marked febrile action. Vomits; very cross and restless. The discharges from the bowels very slimy, but no appearance of blood; acid in character; contain undigested milk. Diagnosis: Entero-colitis. Treatment:

R. Sodii bicarbonatis,                    ℥j.  
 Aquæ cinnamomi,                        fʒij.

M. S. Teaspoonful every three hours.

March 29th.—Diarrhea entirely disappeared.

These cases of intestinal catarrh in infants, are of very frequent occurrence, especially during the summer months. Although the affection may arise from a variety of causes, yet in the greater proportion of cases, it may be traced to some error in diet or to indigestion; if due to the former, a removal of the cause will often suffice, while if it proceed from indigestion, the administration of some simple remedy will often effect a cure. In this case the disturbance evidently proceeded from indigestion, as is proven by reference to the history; moreover, the matter vomited was acid in nature, as were the passages, hence the indication for an antacid. So, instead of giving opiates, astringent preparations, etc., as is so often done in these cases, a little bicarbonate of soda was administered. And what was the result? Five days later the child was reported well, in better health than it had enjoyed for some time.

February 3d.—Harriet S—, aged four years. Three months ago she became paralyzed in both lower extremities; could

move left leg a little; complete paralysis of right. Suffered great pain in the limbs for two weeks; since pain subsided, electricity has been employed with great benefit. Can now stand upon left leg. Diagnosis: Infantile paralysis. Treatment: Faradaic current, locally.

Internally: R. Strychniæ sulph. gr.j.  
 Ferri pyrophosphat, ʒj.  
 Syr. aurantii  
 Aquæ cinnamomi aa. fʒiij.

M. S. Teaspoonful three times daily.

April 5th.—Has been coming regularly twice a week and is very much improved. The left leg which was also paralyzed, is now completely restored, and the right foot was moved voluntarily yesterday.

April 19th.—Recovering quite rapidly. Can now walk about quite well.

During the first two or three seances the muscular contractions were marked upon the application of the interrupted current, but after that the response was very feeble—almost imperceptible; yet had the continuous current been applied, the contractions would still have been noticed; for it is the rule that in all cases where recovery is possible, the muscles retain their contractility when the continuous current is employed. This paralysis made its appearance during a severe attack of intermittent fever; the child was confined to the bed for several days, and it was only when it attempted to arise that the paralysis was discovered. No cause could be assigned for its occurrence, and this is usually the case in true infantile paralysis. Neither is there much more positive knowledge in regard to the part of the nervous system which is the seat of the lesion giving rise to the paralytic disturbance.

The treatment which was instituted in this case, is that from which, as experience has proven, the most benefit can be derived.

## EDITORIAL.

VOL. IV.

JULY, 1880.

No. 1.

BATH OF COMPRESSED AIR IN THE TREATMENT  
OF OBESITY.

Among the therapeutic resources to which the attention of the medical profession is called at present, is the bath of compressed air. The *inhalation* of compressed air in the treatment of nervous asthma especially, but in other pulmonary affections as well, has been practiced quite extensively in Europe and in this country also. We are cognizant of quite extended series of observations made with most satisfactory results in our own city by Dr. Otto Greiner and Dr. W. E. Fischel in the treatment of pulmonary affections by this means.

The treatment by the air bath, however, is quite different from that; and we are not aware that it has been used at all in this country. In fact, it is as yet little known or practiced in Europe although approved and recommended by leading men in the profession there.

M. Paul Bert is the champion of this treatment, and it is through his experiments and enthusiastic recommendation that it is commanding the attention of the profession abroad. It has given remarkable results in diseases of the respiratory organs where respiration is short and the pulmonary capacity limited, as in asthma, emphysema, chronic bronchitis and laryngitis, and in obesity.

There are two difficulties in the way of the popularization of this mode of treatment. One is, that it necessitates quite elaborate as well as expensive apparatus; the other, that while in the apparatus the patient experiences nothing in particular except some humming in the ears during the first three or four séances. It is only after a time that the patient feels the

amelioration produced, the respiration change its type, the expirations become prolonged, the oppression disappear.

The air bath consists in the remaining for an hour and a half to two hours in a pneumatic "bell," so connected with an air pump as to allow the increase of atmospheric pressure to any desired extent. Provision is made also for the purification of the air within the bell by the removal of the carbonic acid generated by respiration. In the *COURIER* for June, p. 555, is a paper translated from *La Presse Belge Médicale* containing a detailed account of the apparatus employed.

Of the time spent in the apparatus, a half hour is occupied in gradually increasing the pressure to the desired degree, generally 30 centimetres (11.0 in.) of mercury, or two-fifths of an atmosphere added to the normal pressure. This is maintained during a half hour or an hour; and a half hour is allowed for the restoration of the normal pressure.

Dr. Charrier, writing in *L'Union Médicale*, says, that in case of anemia the bath of compressed air causes increase of fat, in case of obesity, diminution of fat; and considers this effect to be the result of a toning up of the digestive functions in the first cases and of stimulation of organic combustion in the second.

He thinks that this method of treatment is destined to enter largely into the daily practice of physicians.

In whooping cough it has been found of the highest value, diminishing the frequency and length of the paroxysms, and invigorating the appetite.

It is contra-indicated in most organic affections of the heart, and in acute diseases of the ear, but is of great use in a good number of cases of chronic deafness.

He reports two interesting cases of treatment of excessive obesity. In one, the weight was reduced from 232 to 210 pounds in twenty-five days. In both cases the difficulty of breathing and locomotion were entirely relieved with the diminution of weight.

The results reported already by men who are quite worthy of confidence in the profession, are certainly such as to give reasonable ground for expecting valuable success in the hands of others, as the treatment becomes more generally adopted.

THE QUESTION OF VIVISECTION AGAIN.

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Perhaps no more glaring exhibition of inconsistent sentimentality has ever been made than that afforded by the British Parliament in the passage of the bill prohibitive of vivisections. This bill, although involving interests of such weight and inestimable importance to science and human welfare, was hurried through towards the close of Parliament; the members being too impatient to get off to their game preserves, where were waiting their tamed pheasants to be slaughtered and maimed in their annual sport, to pay much attention to an act of legislation that aimed at the successful prosecution of a science, having for its object the relief of human suffering.

A similar attempt at crippling the progress of learning has not met with the same success in Germany. A petition for the suppression of vivisection was laid before the German Parliament. A commission was appointed for its reception, and Professor Virchow called upon, as one familiar with the question, to represent the medical side. Virchow declared the whole scheme of experimental study in medicine to be based upon vivisection, the method that is relied upon for modifications of medical opinion. Physiology, pathology, and pharmacology depend upon it; neither investigation nor teaching can dispense with it. Many branches of learning, especially the physiology of the nervous system, exists only through vivisection. Virchow testified that in England the law against vivisection has done so much mischief that since its passage not a single physiological work of value has appeared in that country. The commission having given the petition a proper and rational consideration, stated that the practice of vivisection in institutions of learning in the interest of scientific research *is indispensable*. An English authority deplores the success of the sentimentalists in Great Britain, declaring that the schools are fatally crippled, and that the students are obliged to visit the continent in order to prosecute their medical studies.

When we call to mind the extraordinary objections raised in England against other innovations, having no other view than the relief of humanity, we can understand its attitude in reference to vivisection. Physicians will remember the naive opposition to the use of anesthetics in midwifery, a practice that judiciously followed, results in immeasurable good. Even so late as 1866, we read in Churchill's text book, "System of Midwifery," fourth edition, a passage alike ludicrous for its solemn and ponderous defence of the use of chloroform in labor, and for the very medieval charge of irreligion against which the defence is directed. The passage is included in section 376, page 244.

"It is right, however, to notice respectfully some of the objections which have been made by most experienced and conscientious practitioners.

1. The first objection I shall notice is, that 'as in sorrow shalt thou bring forth children' was part of the original curse pronounced upon the sin of man, therefore any attempt to mitigate the suffering, is a direct and unwarrantable interference with an ordinance of God.

Now, it will be remembered, that labor ('in the sweat of the brow') pain and death were equally the result of the same sin, and inflicted by the same Hand, and yet we never hear of the wickedness of lightening labor, of relieving pain, or of postponing death, each of which *must* be wrong, if relieving the suffering of childbirth be wrong. It is monstrous that one sex should claim the privilege of relief, and object to its being extended to the other. If further argument be needed, the reader may refer to Dr. Simpson's critical remarks upon the Hebrew word translated 'labor.'"

Since the above was written, a popular American monthly has taken the trouble to notify the profession that its July number contains an article on the subject "Does Vivisection Pay," a title in itself indicating an inadequate appreciation of the importance of vivisection, nor does the substance of the article remove the impression. The writer admits that "It is undeniable that to the practice of vivisection we are indebted for nearly all our present knowledge of physiology," and, "As

a means of teaching physiological facts, vivisection is unsurpassed." It, certainly, is difficult to comprehend, after weighing these two statements, that the writer should appear as an opponent to vivisection. The article is not very logically written and bears the stamp of magazine manufacture, which is inexcusable in a discussion, at this late date, of a question so widely and hotly debated.

The writer claims to be among the initiated in medical science, with what justice let this statement decide: "Experiments upon living animals conduce chiefly to the benefit of the science of physiology, and little, if at all, at the present day to the treatment of disease or the amelioration of human suffering." This quotation is taken from its context, but so far as can be made out expresses the main principle of the writer's opposition to vivisection—and, at the same time, his incapacity to argue in the case at all. Every medical practitioner *knows* that physiology is the *basis* of his practice, that according to his knowledge of the functions of an organ will be his success in the rational treatment of the diseases of that organ—disease being recognized only through disturbance of function. How utterly fatuous and preposterous, then, is the notion that rational therapeutics are independent of physiology. The homeopath to be sure, does not need to know physiology, only symptoms, for he is above the law; the profession, however, is not yet of that persuasion.

Arguments are drawn from the testimony of English authorities upon the cruelty of vivisection, but reference has already been made to the peculiarities of the British mind, and Virchow has judged the result of English legislation upon the progress of science in that country; America cannot afford to accept the action of the British Parliament. It is hardly worth while to notice this magazine article further; we heavily censure the manner of presenting to the American public, views upon the great question of physiological research. To charge upon the practice of vivisection a "tendency to engender a sort of careless indifference regarding suffering," has the same force as the long reiterated argument against human dissections, that they rob the human body of its peculiar sacredness



and embrate the student. There are unfit men in every sphere of action; but the man who labors in the divine art in the true spirit, sees only the great object of his efforts, and values the means employed only as they enlarge his power.



### ON AFFECTIONS OF THE EAR ARISING FROM DISEASES OF THE TEETH.

It is well known that there is an intimate connection between the pathological conditions of the mouth and ear; that, specially, morbid states dependent upon the teeth are apt to superinduce aural disease, simply neuralgic (otalgia) or inflammatory (otitis). Patients complain of severe earache when the most careful examination discovers no sufficient aural lesion, but advanced caries of one or more teeth exists. That teething children are subject to purulent otitis is a common observation. Dr. Samuel Sexton in an able paper upon "Affections of the Ear arising from Diseases of the Teeth" (*Am. Jour. Med. Sciences*, Jan., 1880) gives an exhaustive analysis of aural disorders dependent upon the teeth through all their stages of eruption, caries, and death; and also of disorders indirectly due to apparatus for retention of false teeth, which are productive of more trouble than is suspected. In his introduction, Dr. Sexton calls attention to the fact that the ear may become diseased through reflex action dependent upon the vaso-motor system of nerves. To this reflex action he refers the morbid influence upon the ear of dental disorders. He objects to the theory "that the ear is nearly always invaded by disease extending from the throat per the Eustachian tubes." "The teeth are a prolific source of nervous diseases for sufficient reasons; their development and decay, ill usage by improper foods and drinks, the unhealthiness of the saliva, the lack of cleanliness, etc., are all sources of greater or less

irritation. The mouth, moreover, being richly supplied with nerves and bloodvessels, which are distributed to its extensive mucous membrane, is highly sensitive to all of these influences." Granting these premises the period of dentition is naturally prolific in aural disorders. The irritated gum gives rise to various symptoms, flushing of the cheeks, salivation, fever, nervous symptoms, etc. The milk teeth are much subject to caries. All these causes of oral irritation are apt to excite sympathetic hyperemia of the ears.

Of the second dentition, the first molar cut, is from its position specially liable to caries, and being regarded by the parents as one of the temporary set, its condition is neglected and the decay allowed to progress. It has been noted that otitis caused by the first dentition has been reëxcited upon the occurrence of the second dentition, earache and otorrhea attending the eruption of each tooth. The appearance of the wisdom tooth, or last molar, is very frequently the source of grave aural affections, and if there should be otitis at the time, it will be aggravated. This aggravation will be, of course, more serious if the tooth be in such an abnormal position as to press upon neighboring structures. It may lie more or less horizontally impinging against the next molar, or against the cheek, or palate.

Caries of the teeth may progress until the nerves be laid bare, before toothache occurs; this should be borne in mind in case of otalgia. Tartar accumulates upon the neck and gradually extends along the root, denuding the periosteum and exposing the sensitive fangs. Exostoses of the roots are the cause of obstinate neuralgia.

Dental appliances and fillings add their influence to the production of dental irritation. Amalgam fillings with excess of mercury will excite salivation. Necrosed matter and diseased pulp may be shut in by filling, if the dentist is not skillful. The enamel may break away from about a filling, leaving a jagged edge of metal to cut into the cheek or tongue. The plates that support false teeth are occasionally the source of disease. Vulcanite colored red with the sulphide of mercury (vermillion) is a common material used in the fabrication of these plates.

The plate is gradually dissolved in the fluids of the mouth and a mercury salt set free to the prejudice of the health. Both metal and vulcanite plates, through unnatural pressure, variations in conductivity, undue protection of the gum and palate, cause a greater or less irritation with corresponding tendency to aural complications. In conclusion, the writer insists upon careful oral inspection in all cases of aural disease suggestive of reflex irritation.

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#### MARGARINE BUTTER.

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In the *London Lancet*, May 29th, 1880, appears a notice of the action of the Paris Academy in reference to the wholesomeness of that notorious adulteration and cheat, margarine butter, or, as it is more imposingly termed with us, oleo-margarine, the "oleo" possibly being added to lubricate the resistance of the public mind.

At a recent meeting of the Paris Academy of Medicine, M. Riche read an important report, proposed to be forwarded to the Minister of the Interior, in reply to a question which he had addressed to the Academy, regarding the substitution of margarine for butter in the Paris Lunatic Asylums. Complaints of this had reached the ears of the Minister, and on inquiring of the asylum managers, he learned that the change had been made on economical grounds; and he now sought the opinion of the Academy in a sanitary point of view.

In the report the following objections to the use of margarine butter were stated: (1) It results from the trials made at the Asylum during three years, that the employees and many of the patients cannot tolerate the substitution in the preparation of the principle articles of their food; (2) Some very sensitive and delicate patients are placed by it in highly unfavor-

able conditions as regards their alimentation, and consequently as to the maintenance of their health; (3) margarine butter as manufactured, is open to various frauds—vegetable oils especially are introduced; (4) fatty bodies are only absorbed when in a state of emulsion. Margarine forms an emulsion less easily than butter, the emulsion is also less stable.

The amount of margarine butter manufactured in the United States is enormous, and probably it is often used by purchasers who would be greatly scandalized, if made aware of the true nature of their acquisition. The art of adulteration of food has reached such a high degree of perfection, that it is now often a matter of great difficulty to tell what it is we eat. And since that most delicate luxury of our table, butter, is become the object of successful imitation, the kitchen is bereaved indeed. Physicians are well aware of the value of good, sweet butter, as a food for convalescents or sensitive invalids; they must now be on their guard, lest indulgence in some abomination, colored and flavored by the dishonest dealer until the cheat is past easy recognition, seriously, and perhaps fatally, derange the health of their charges. The butter merchants have vainly tried to have the margarine manufacture under legislative control. The cheat is so successful that detection by the public is scarcely possible. Margarine butter, when examined under the microscope, betrays the crystals of margarine, pure butter exhibiting only globules of oil. The public might defend itself by demanding a guarantee of the dealers, and when the cheat is proven, enter a prosecution.

## COMMUNICATIONS.

## THE MEDICAL JOURNAL AND THE MEDICAL MAN.

*Messrs. Editors* :—I ask the liberty of presenting to you and your readers the following reflections, suggested by the excuses made at various times in my hearing by physicians when requested to put some of their extensive professional experiences in a form suitable for publication. I have always been of opinion, that doctors owe to the fraternity a share in the choice things wherewith Fortune favors them in the course of active practice.

In answer to the man who denied his political responsibility, saying that political affairs were out of his sphere, that he had no time to attend to nominations and elections, that his own private business absorbed all his attention, that, in fact, he disallowed any call upon him not arising from his own individual and particular views, and that the public service did not concern him, in answer to this short-sighted person, the admonition was made, man is *born* a citizen, he *becomes* a merchant, mechanic, or professional. The latter state is incidental only, the first is an inevitable condition of existence itself, and its requirements are obligatory.

The man who passes through the portals of the medical college into the world of medicine, assumes a duty to that world which is paramount to every other in this new sphere. This duty into which the medical graduate is born, and which consequently is not in any way optional, is the duty of recording what he observes in practice that is of interest or of positive value to the profession, and of taking pains to have these observations presented to the profession. The proper channel through which observations are to flow into the general knowledge, is the medical journal.

I perceive, in anticipation, the apprehensive chill that will traverse the editorial spinal filaments, as his eye catches the preceding statement. One of the most disagreeable and painful offices of the editor, is to review and select from the manu-

scripts that are crowded into his hands. Here is one from a respected and esteemed subscriber, upon inflammation (!) Its pages, thick as "the leaves that strew the brooks in Vallambrosa," probably reflect the actual condition of the visual organs that have labored over them so assiduously and devotedly by the waning light of the exhausted lamp. One to fortune and to fame unknown, seeks both in an article upon the merits of an operation for piles, a fundamental subject it is true, but one largely buried in the sands of Time. An enthusiast sends his individual views upon miasm; their originality is incontestable; neither heaven nor earth, nor the regions below have hitherto entertained the like. All these gentlemen have made a mistake; if their premises had been right, their conclusions would have been of value, but unhappily they are not.

Their mistakes in the first place lay in the supposition that their theories are novel and next that this busy world wants theories or hobbies at all. When Helmholtz published his wonderful treatise on the "Perception of Sound," a treatise that embodied at once the laborious and pains-taking research of experimental science and the poetical fire of the imagination; it was after a period of eight years' work. The book put into the hands of his readers, upheld no hazy dream nor clumsy, disjointed, ill-conceived hobby; it forms a solid, enduring block in the structure of learning, satisfying alike to the eye and to the reason.

Now, while every practitioner cannot hope to found a new principle or to propound a theory that shall claim universal respect and acceptance, he can and ought to note the peculiarities that occur in the course of his professional experiences, and contribute such additions to the general stock. Medicine is what it is, through the unwearied labors of those who have preceded us; lives have been enthusiastically devoted to the work irrespective of other reward than that flowing from a conviction of usefulness. We enter upon this inheritance, but each one of us is under obligation to see that the principal does not undergo diminution in our hands, that we add our contribution to the common store.

Apart from the usual routine matter of reviews, criticisms, editorials, etc., the medical journal presents subjects which may be placed under two heads, didactic and clinical. The first

comprises lectures and monographs, the latter reports of cases.

The first category demands originality, a perilous demand. An absolute novelty in medicine is a veritable *rara avis*, and, when announced, is greeted with universal welcome. Here is a great stumbling-block for both contributor and editor. How far may a man without a full consulting library at his command, insist upon the originality of his propositions, and, granting the author satisfied, shall the editor be equally complacent at the risk of the good repute of his publication for enterprise and erudition? The second class must ever be the chief and most valuable resource of the medical journal and the safest venture of the contributor. A well observed case not altogether common, carefully and concisely recorded, its etiology, pathology, symptomatology, and therapeutics all clearly and definitely stated, such a study is valuable to the practitioner and to the journal. Such records lie at the foundation of our science, and it is upon them that medicine can find its only support and sure basis for further growth. Every qualified practitioner meets cases in the course of practice that are needed for the cause; their scientific record is wanted by his brethren in practice, and by the Master-architect to whose skilful classification of such material and to whose genius for its generalization we must look for the advance of our profession.

MEDICUS.



## HIGH TEMPERATURE IN ACUTE PNEUMONIA—RECOVERY.

*Messrs. Editors:*—In the COURIER for May, (p. 525) is reported a case of high temperature in Acute Pneumonia. I attended a similar case this spring, and thinking it may be of interest, I send you the following history.

B. T., aged 30, a farmer, came to me April 12th, 1879, with an abscess in the palm of the hand, caused as he said by chopping, in clearing up new ground. There was a good deal of constitutional disturbance, foul tongue, and fetid breath. I opened the abscess, ordered a saline purgative, and warm

poultice to the hand. He stated that the previous spring he had been laid up with ague, not being able for any kind of work till harvest.

In a few days he went plowing, keeping the lame hand (the left) in a sling. About a week after, being sent for, I found that erysipelas had set in, involving the fore-arm to the elbow. There was general pyrexia. I tried cold applications, but without much benefit; the limb became extremely hard; two bands could be distinctly felt, with a sulcus between. I made an incision with a scalpel about four inches in length, which gave immediate relief; ordered carbolized lard, and warm bran poultices to be applied, and changed every two hours. This treatment had the desired effect, but he made a slow recovery, and could not do any work till harvest.

About the 19th of March last, the erysipelas returned in the same elbow. I advised saline purgatives, soda hyposulphite, in ten grain doses, every three hours, and warm poultices constantly applied. All seemed to go on well till the evening of the 27th, when he was seized with violent pain in the left side. I found he had all the symptoms of pneumonia well marked. At 10 P. M., the temperature was  $104^{\circ}$ ; next morning (28th) falling to  $102^{\circ}$ . At 10 P. M. it had reached  $105^{\circ}$ . 29th, morning,  $103^{\circ}$ ; at 8 P. M. it was  $110^{\circ}$ , and at midnight it was  $108^{\circ}$ . 30th, morning,  $102^{\circ}$ ; at 10 P. M.,  $103^{\circ}$ . On the 31st, morning, it was  $100^{\circ}$ , and in the evening it was  $100^{\circ}$ . For the following week it varied from  $100^{\circ}$  at night to  $98^{\circ}$  in the morning.

Convalescence was very slow; there remained a dull, painful spot about two inches square, which disappeared on the application of iodine paint. He says he feels as well now as he ever did.

I may state that the erysipelas left the joint when the chest trouble was established.

Yours, Etc.,

GEORGE McLEAN, L. S. A. LOND., ETC., ETC.

*Orrick, Ray County, June 4, 1880.*



## BOOK REVIEWS AND NOTICES.

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POST-MORTEM EXAMINATIONS, WITH ESPECIAL REFERENCE TO MEDICO-LEGAL PRACTICE. By PROF. RUDOLPH VIRCHOW. Translated from the second German Edition, by DR. T. P. SMITH. *Philadelphia: Presley Blakiston, 1012 Walnut Street.* 1880. 12mo., pp. 145. Cloth, \$1.25. (Through Hugh R. Hildreth Printing Co.)

“The present generation is conversant with pathological anatomy, only as a supplement of the clinic. As a rule, the clinical teacher determined while the patient was alive, which organ was to be the object of investigation; and the autopsy, likewise, was usually confined to that organ, or at least with all the others only in a secondary manner. The clinical anamnesis, consequently, determined the course of the anatomical examination. We all know what was the result. The fact is, that we can further the advance of medical science in the most essential manner, by acquiring the habit of submitting all the other organs of the body to a minute examination; for it is obvious that we can do as much by anatomical as by clinical examination.” This exposition by Virchow, in 1859, gives the key to the method of post-mortem examination, stated and explained in the book before us, a method which has received the official sanction of the German government, and is imposed upon all medical officers who may be concerned. The regulations governing the conduct of the post-mortem, establish the order in which the different steps of the examination are to proceed, the order and method of opening the three cavities of the body, and of examining the contained viscera. Minute directions are given for the proper dissection of each organ. The delightful thoroughness of the whole, will carry the reader back to those celebrated pathological halls, from whose abundantly stored records so much of our knowledge of morbid anatomy has come.

A complete post-mortem, made at the order of medico-jurisprudence, is a serious piece of business, involving, at times issues that touch human life. This book, with its concise, defi-

nite and comprehensive directions, will prove invaluable in the hands of the medical expert. It also is of great value to the general practitioner, saving him much time by lending a directness to his work and distinctness to the results, while he may not find it necessary to follow out the whole scheme of dissection, but will confine himself to a single organ, or group.

The reader should especially note the explanations beginning on page 40, of the method of laying open different organs with the view of retaining the parts in such a connection that they may be returned to their proper position as occasion demands.

Dissection of the brain and heart is minutely dwelt upon. On page 16 begins the explanation of the order of the opening of the cavities, and the reasons for this order; *e. g.*, the abdomen should be opened before the thorax, that the arch of the diaphragm may not be disturbed before examination; the thoracic organs should be removed before the abdominal, that the heart may not lose its contents, etc., etc.

To give further emphasis to the regulations, Virchow adds four reports of his own, of interesting post-mortems performed according to the rubric, which illustrates sufficiently their value.

No mention appears of the method of opening the spinal column after complete evisceration, by cutting away the vertebral bodies, which is a speedier procedure than that through the back.

The profession is much indebted to the translator as well as to the author for this manual, which may be well regarded as a final authority.

T.

STUDENT'S AIDS SERIES. AIDS TO CHEMISTRY. Part I.; pp. 72; Inorganic; the Non-metallic Elements. Part II.; pp. 60; Inorganic; The Metals. Part III.; pp. 114; Organic; by C. E. ARMAND-SEMPLÉ, B. A., M. B., Cantab, M. R. C. P., London. *New York: G. P. Putnam's Sons.* 16 mo. Uniform in size and price. Paper, 25 cents; cloth, 50 cents each.

Students have many friends, who, for a small consideration, are ready to furnish them *aids* of all kinds, to help them on in their laborious tasks, and assist them in *cramming* for the much dreaded examinations. The plan is followed by many, and the assistance may be well meant, but does it really afford any advantage? Though, as one of the commendatory notices says, "the student who can commit these little volumes to memory,

will doubtless be proof against pluck ;”<sup>1</sup> does he, after all his memorizing, understand anything about chemistry? And if the legitimate use of such aids is of so very questionable a value, what shall we say of the temptation held out to its illegitimate use, by the diminutive vest-pocket edition, for facility of clandestine inspection in the green room? The one before us is neither better nor worse than the most of its compeers, rather loosely compiled, sometimes prolix in non-essentials, vague in definitions, in some places brief to obscurity. A few errors, out of many, may suffice to give an idea of its accuracy. In various places, the final syllable *gen*, in the name of elements, is said to be derived from “*genesis, a generator,*” a translation which will hardly be acceptable to the classical scholar. We are informed that in preparing oxygen from mercuric oxide by heating, the metallic mercury *remains at the bottom* of the vessel; (although the red heat necessary for decomposition will convert the metal into vapor). While subtle tests for small quantities of oxygen are omitted, an experiment is cited as test No. 4, which will only succeed when quite a large quantity of oxygen is at command.

The frequently recurring expression, “*degrees of frost,*” is certainly unusual among scientific writers. In divers places where explaining atomicity, the element is said to *replace* a certain number of monad atoms, when from the given example it is evident that the author, in that place, meant to say it *combines* with them; thus on page 14,  $N H^3$ , and page 28,  $H C N$ . Hydrogen dioxide ( $H^2 O^2$ ) and hydroxyl are placed side by side as synonyms in the title line. Now it is generally held that hydroxyl,  $H O$ , is a monadic group and by no means identical with its polymer  $H^2 O^2$ . Cyanogen, on page 28, is said to be *monobasic, replacing* one atom of monad hydrogen, as shown in the composition of prussic acid,  $H C N$ ; the author evidently meant *monatomic, combining with* one atom, etc.

In part II., page 1, we find a definition of salt, neither exhaustive nor in agreement with modern theory. The term *precipitating*, on page 14, is out of place in speaking of the formation of solid calcium hydroxide from solid calcium oxide. Should any one attempt to burn plaster of Paris, according to

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<sup>1</sup> *Pluck* is a cant term used in English universities to signify rejection in examination.

the authors process, so as to expel all of the water  $2\text{H}^2\text{O}$ , he would obtain a material which would not again combine with water, but be, as the manufacturers call it, *burnt dead*. Neither will the hydrated calcium chloride lose its water by mere drying, so as to form a porous mass, but requires intense heating and fusion. The description, page 16, of the metal strontium, is so unfortunately brief as to lead the reader to think that it occurs in its metallic state in minerals, etc.

The fanciful explanation of the etymology of the name, bismuth, would show a profound German scholarship, if—it were only correct. In the appendix (page 50, etc.) incorrect definitions occur: for, although we assign to the *molecules* of all bodies the same size, the opinion that *atoms* are of the same size, has been abandoned. Nor is it universally accepted that the term alloy, excludes mercury.

While we have thus cited numerous instances of imperfections in the first two parts, we are gratified to be able to say of Part III., Organic, that it has evidently been prepared with more care and circumspection, and, while it is not faultless, it is far superior to Parts I. and II. It represents the present status of the science as well as limited space and the ever-varying theories of the molecular constitution of organic bodies will permit.

C.

AIDS TO PHYSIOLOGY. BY B. THOMPSON LOWNE, F. R. C. S., Eng. (Student's Aids Series.) *New York: G. P. Putnam's Sons.* 1880. 16mo., pp. 104.

A neat little epitome of physiology, very correct, very complete, pretty uniformly elaborated, and well up to date.

As "aids to the student" it has, however, two conspicuous faults: it is superfluously complete, burdened with fundamental definitions altogether unnecessary to the student who has already gone over the ground (as he is supposed to have done), and with anatomical descriptions out of place in a physiology, and too brief for an anatomy; and, moreover, its typography gives no help to the student, as it easily might have been made to do, by indicating at a glance what a page, paragraph or sentence deals with. A new edition could be much improved by the use of italics and the scissors.

As it stands, it can be made extremely useful, however, in the hands of the tutor who conducts recitations.

G. B.

A HANDBOOK OF PHYSICAL DIAGNOSIS, COMPRISING THE THROAT, THORAX AND ABDOMEN. By DR. PAUL GUTTMANN, Privat Docent in Medicine, University of Berlin. Translated from the Third German Edition, by ALEX. NAPIER, M.D., Fel. Fac. Phys. and Surg., Glasgow. With colored plates and eighty-nine fine wood engravings. New York: Wm. Wood & Company, 27 Great Jones Street. 1880. (Through C. C. Pease, Gen. Agent.)

“Wood’s Library of Standard Authors” contains many valuable works, but we doubt whether any will be more appreciated than this Sydenham translation of Dr. Guttmann. As a translation it is excellent, and is remarkably free from idiomatic expressions which so often mar a translated work.

The term “Physical Diagnosis,” which is in the majority of books applied strictly to the diseases of the chest, is here used in its most comprehensive sense, and is made to include an examination of the different organs of the body, forming altogether a most complete manual of the signs of disease.

The book is divided into the following sections:

Examination of the organs of respiration.

Examination of the organs of circulation.

Examination of the abdominal organs.

Examination of the larynx.

In treating of the physical signs of the organs of respiration, the author not only enumerates the signs of health and disease, he goes fully into the details, and gives the theories of their mode of production. In a thoroughly German manner, each theory is taken up, discussed and analysed, and the preference given to the one the author deems most plausible.

As a new sign of cavity, we find what is called the *metamorphosing respiratory murmur*. He describes it according to Seitz, as occurring only in inspiration, as being distinguished at the outset by great harshness, and changing suddenly after the first third of inspiration to a bronchial breathing, accompanied by a metallic echo or ordinary râles. He considers it to be a sign of a cavity, the entrance of which is greatly occluded by secretions. We find, also, mention made of an “indeterminate murmur,” which corresponds to the broncho-vesicular murmur of Flint.

Some twenty pages are given to the examination of the sputa, containing numerous engravings of various microscopic appearances.

The chapters on the organs of circulation are unusually full

and rich. The theoretical part is interesting reading to one who would gain a thorough knowledge of the mechanism and causes of disturbed cardiac action.

With the exception of the work of Paul Niemeyer, we know of none which deals more fully with the physiology and pathological signs of the heart and the vessels.

We notice a radical difference of views in regard to inorganic cardiac murmurs from that found in Flint's Handbook. The finding of inorganic or blood murmurs at the mitral, although stated by Balfour, is not usually recognized by English writers. Guttmann states that next to the pulmonary valve, they are found most often over the mitral valve—more seldom over the aorta. He believes they originate here, and not, as stated by Balfour, that the sound is conducted by the blood column from the pulmonary.

A new and distinctive characteristic is given to the diastolic murmur of mitral stenosis—the so-called pre-systolic murmur. He says that it is generally divided into two or even three parts, feeble and soft at first, it speedily becomes louder, and towards the end of the diastole, it is usually rough, rasping or grating in character. In some cases, the commencement of the murmur is inaudible, and the latter part constitutes the pre-systolic murmur.

Under the head of cardio-pulmonary murmurs, we find mention made of a rare but interesting condition, the production of a systolic murmur, caused by a cicatricial contraction of lung tissue about an important division of the pulmonary artery, producing a stenosis of the artery—such a murmur, as it may be diffused over the whole upper part of the chest, may be mistaken for aneurism.

The section on examination of the abdominal organs is comprised in the chapters, Inspection, Palpation, Percussion and Auscultation of the abdomen. Each portion is treated in a thorough manner. The author rejects the idea, that a peculiar hepatic fremitus is characteristic of hydatid cysts.

Twenty-seven pages are given to an examination of the excreta, the chemical and microscopic examination of the urine, the discharges from the stomach and intestines.

The book concludes with an appendix, devoted to laryngoscopy. Directions are given for the use of the laryngoscope, and the symptoms and morbid appearances of the principle diseases of the larynx are mentioned.

THE HYSTERICAL ELEMENT IN ORTHOPÆDIC SURGERY. By NEWTON M. SHAFER M. D., Surgeon in charge of the New York Orthopædic Dispensary and Hospital, etc. *New York: G. P. Putnam's Sons.* 1880. Royal 8vo., pp. 66. Price \$1.00.

A very seasonable brochure, first read before the New York Neurological Society, and afterwards published in the *Archives of Medicine*, and now given to the profession in book form with the addition of foot notes and remarks.

As an introduction, our attention is called to the fact that in acute articular lesions the vascular system plays an important role, more so, probably, than the nervous; while on the other hand, chronic lesions of the joints find expression more especially through the nervous system, the vascular in many cases being not at all apparent, and thus the difficulty of distinguishing between the chronic and the purely hysterical joint troubles in which the functional nervous is the chief expression. As an aid in diagnosis between these two, the observations of Dr. Shaffer will be of great assistance.

After a few remarks on the subject in general, the special joints affected with nervous mimicry are taken up in order: The knee, the hips, the spine—including both Pott's disease and spinal curvature—and club-foot. Cases of each are given, with diagnosis and treatment, and thus, taken as a whole, the subject is more thoroughly treated of than by any author preceding.

Many years ago Brodie called attention to the subject in England; and there was a time when there seemed to be danger in Great Britain that many joint troubles in which there existed actual lesion, would be called "hysterical." Commenting on this, Holmes Coote remarks: "It has been said, that contraction of the limb is very common in girls, the subjects of hysterical affections of the joints. \* \* \* But if hysterical affections of joints are common in practice, I have been unfortunate in having had but a limited experience. Some cases of "hysteria" of the knee have turned out, when we have had opportunities for examination, to have been disease of the cancellous tissue of the bone. \* \* \* Cases of "hysteria" of the hip have proved instances of chronic rheumatic inflammation with the usual changes of cartilage and bone."

It were easy for the general practitioner to say of an obscure joint lesion "hysteria," and thus allow the golden moments for

possible successful treatment to slip by. On the other hand, a purely hysterical affection might be called "articular disease," and treated heroically, not merely to the discomfort, but also to the permanent injury of the patient. The little book before us helps us out wonderfully in the correct recognition of these knotty cases. How certain it is that the prime element in true practice consists in *diagnosis*.

We find on page 45, an illustration of the remark made above, also an honest confession and a little irony. "Fortunately, the error of calling a hysterical spine a true lateral curvature, is not so likely to be followed by serious results as is that of attributing to a habit or hysteria the progressive curvature of true scoliosis, than which there is nothing in the whole range of orthopædic surgery more insidious in its onset, or, when it is fairly established, more difficult to arrest even by means of the rejuvenated gallows and the much lauded plaster of Paris bandage."

The opinion has largely prevailed, that simulated joint lesion could only occur in those who had been witness to or who were familiar with the expressions of those lesions. A perusal of this work will show the contrary, namely, that a patient may have a hysterical joint trouble who had never known aught of the real disease. While it is true that the disease *may be* one of fraud (intentional or otherwise) yet it is not necessarily—probably not usually—so.

A valuable observation is given on page 58, speaking of hysterical talipes: "It will be noted that in addition to the varus positions, there is a peculiar and extreme flexion of the toes. In every case I have seen, this same peculiar flexion occurred. \* \* \* In true talipes this condition does not often exist, and its presence may be looked upon as an indication of the hysterical state."

The work is quite free from typographical errors; a few however, exist; on page 59, middle third, read "axillary" for "auxiliary."

Dr. Shaffer certainly deserves the thanks of the profession for his valuable contribution to this obscure and not sufficiently recognized subject.

A. J. S.



A GUIDE TO THE PRACTICAL EXAMINATION OF URINE. For the use of Physicians and Students. By JAMES TYSON, M. D., Professor of General Pathology and Morbid Anatomy in the University of Penna., etc. Third Edition, Revised and Corrected, with Illustrations. *Philadelphia: Lindsay & Blakiston.* 1880. 12mo.; pp. 183. Cloth, \$1.50. (Through Book and News Company).

This little book of Dr. Tyson's is already too well and too favorably known to the profession, to demand anything more than a notice at our hands. It is eminently practical and clear in its directions, and we know no better work upon the subject either for students or physicians. No very material changes have been made in this edition, those which have been made, being chiefly in the way of omission of some less important parts in order to reduce the size of the volume.

SEA-AIR AND SEA-BATHING. By JOHN H. PACKARD, M. D., Surgeon to the Episcopal Hospital, etc. *Philadelphia: Presley Blakiston.* 1880. 16mo., pp. 124. Cloth, 50 cents. (Through Hugh R. Hildreth Printing Company.)

In these days when more and more every year the residents of the inland towns and cities seek during the summer months the refreshment and tonic effect of a sojourn upon the sea-coast and the taking of baths, such books as this little "Health Primer" of Dr. Packard are likely to meet large demand.

In addition to the chapters treating of General Considerations as to Seaside Resorts, and those devoted to the subject of bathing and the accidents which are liable to occur in sea-bathing, there are others that are very suggestive and interesting upon Amusement at the Sea-shore, Cottage Life, Sanitary Matters, Excursions to the Sea-shore and The Sea-shore as a Winter Resort.

The book is a very readable one, and will be of good service to many who shall tarry for a few days or for a longer time at the sea-shore.

TREATISE ON THERAPEUTICS. Translated by D. F. LINCOLN from French of A TROUSSEAU, Professor of Therapeutics in the Faculty of Paris, etc., and H. PIDOUX, Member of the Academy of Medicine, etc. Ninth Edition, Revised and Enlarged with the assistance of CONSTANTINE PAUL, Professor Agrégé in the Faculty of Medicine of Paris. Vol. I. *New York: William Wood & Company.* 1880. 8vo., pp. 302. Cloth. (Through C. C. Pease.)

This fifth volume of Wood's Library of Standard Medical Authors, consists of the translation of part of the classic work of Trousseau and Pidoux, which will be completed in succeeding volumes of the series.

The volume is divided into four chapters treating of Reconstituents, Astringents, Alteratives and Irritants, the latter part of each chapter being devoted to general considerations on the use of the classes of remedies considered in the preceding pages.

Probably no writers upon therapeutics have exerted a wider or stronger influence upon the practice of medicine in our day than have Trousseau and Pidoux, and the translation of their work will be valuable volumes in Wood's Library.

A TEXT BOOK OF PHYSIOLOGY. By M. FOSTER, M. A., M. D., F. R. S., Prælector in Physiology and Fellow of Trinity College, Cambridge. From the Third and Revised English Edition with Notes and Additions by EDWARD T. REICHERT, M. D., Demonstrator of Experimental Therapeutics, University of Pennsylvania. With two hundred and fifty-nine illustrations. *Philadelphia: Henry C. Lea's Son & Co.* 1880. (Through Book and News Co.)

The work of Dr. Foster has quite recently been reviewed in our pages, and we can only call attention to the fact that Henry C. Lea's Son & Co. have also now published an edition with notes by an American Editor. These notes are chiefly anatomical and histological and do not, we think, materially enhance the value of the book.

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#### BOOKS AND PAMPHLETS RECEIVED.

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THE BROMIDE OF ETHYL AS AN ANÆSTHETIC. By T. Marion Sims, M. D., LL.D. (Read before the N. Y. Academy of Medicine, March 18th, 1880.) With discussion on the same by Drs. Levis, (Phila.) Squibb, Dalton, Post, Piffard, Little, Wylie and Roberts, (Philadelphia.)

FURTHER CONTRIBUTIONS TO THE STUDY OF FRACTURES OF THE INFERIOR EXTREMITIES OF THE RADIUS, DIFFERENTIATION OF LONGITUDINAL AND TRANSVERSE FRACTURES AND THE CAUSES WHICH PRODUCE THEM. By L. L. Pilcher, M. D., Brooklyn, N. Y.

THE IRRITABLE BLADDER IN THE FEMALE. By L. S. Oppenheimer, M. D. Reprint from the *Louisville Medical News*, June 12, 1880.

HEALTH AND HEALTHY HOMES. A Guide to Domestic Hygiene. By Geo. Wilson, M. A., M. D., Medical Officer of Health for Mid-Warwickshire Sanitary District; etc.; with Notes and Additions, by J. G. Richardson, M. D., Professor of Hygiene in the University of Pennsylvania, etc. *Philadelphia: Presley Blakiston.* 1880. 12mo; pp. 313, Cloth, \$3.50. (Through the Hugh R. Hildreth Printing Company.)

LESSONS IN GYNECOLOGY. By William Goodell, A. M., M. D., Professor of Clinical Gynecology in the University of Pennsylvania, etc. With Ninety-two Illustrations. Second Edition. *Philadelphia: D. G. Brinton.* 1880. 8vo.; pp. 454. Cloth, \$4.00. (Through the Hugh R. Hildreth Printing Company.)

CHIRURGIE ANTISEPTIQUE. Principes Modes d'Application et Résultats du Pansement de Lister. Par Le Dr. Just Lucas Championnière, Chirurgien de la Maternité de l'Hopital Cochin etc., etc. Deuxième Edition Complètement Refendue, avec 15 figures dans le texte. *Paris: Libraire J. B. Baillière et Fils.* 1880.

CONTRIBUTIONS TO GYNECOLOGY No. X. I. FIBRO-SARCOMATOUS TUMOR OF THE UTERUS. OPERATION—RECOVERY. II. CANCER OF THE RECTUM. EXCISION—RECOVERY. By John Byrne, M. D., M. R. C. S. E., etc., etc. Reprint from the *Annals of the Anat. and Surg. Soc.* Brooklyn. 1880.

ON DIVISION OF THE SPHINCTER ANI MUSCLES, AS A THERAPEUTIC MEASURE. By Charles B. Kelsey, M. D., Surgeon to the East-Side Infirmary for Diseases of the Rectum (Reprint from the *New York Medical Journal*, June, 1880.) *New York: D. Appleton & Company.*

KOLPO-CYSTOTOMY BY ELECTRO-CAUTERY, WITH REMARKS ON OTHER METHODS OF OPERATING. By John Byrne, M. D., M. R. C. S. E., etc. etc. Reprint from Vol. iv. *Gynecological Transactions.* 1880.

TRANSACTIONS OF THE AMERICAN GYNECOLOGICAL SOCIETY, VOLUME 4, FOR THE YEAR 1879. *Boston: Houghton, Mifflin & Co. The Riverside Press, Cambridge.* 1880.

THE WHITE MOUNTAIN VILLAGE OF BETHLEHEM, AS A RESORT FOR HEALTH AND PLEASURE. *Boston: Rand, Avery & Co.* 1880.

REFLEX CARDIAC GANGLIOPATHY WITH HEREDITARY DIATHESIS. By C. H. Hughes, M. D., St. Louis.

THE MEDICO-LEGAL ASPECT OF CEREBRAL LOCALIZATION AND APHASIA. By C. H. Hughes, M. D., St. Louis.

SALIVATION IN THE INSANE. By E. W. Saunders, M. D., St. Louis.

WHAT SHALL BE DONE WITH THE INEBRIATE? By Gordon W. Russell, M. D., Hartford, Conn.

Reprints from the *Alienist and Neurologist*.

FORTY-FOURTH ANNUAL ANNOUNCEMENT OF THE MEDICAL DEPARTMENT, AND THE THIRTY-FIFTH OF THE LAW DEPARTMENT OF THE UNIVERSITY OF LOUISVILLE. Session of 1880-81.

THE AMERICAN MEDICAL COLLEGE ASSOCIATION. Fourth Annual Meeting held at New York City, May 31st and June 1st, 1880. *Detroit: Post and Tribune Job Printing Company, Printers.* 1880.

THE MANAGEMENT OF CHILDREN IN SICKNESS AND HEALTH, A BOOK FOR MOTHERS. By Amie M. Hale, M. D. *Philadelphia: Presley Blakiston.* 1880. 12mo., pp. 110. Cloth, 50 cents (Through Hugh R. Hildreth Printing Company.)

ELECTRICITY IN MEDICINE AND SURGERY, WITH CASES TO ILLUSTRATE. By John J. Caldwell, M. D., Baltimore, Md. 8vo.; pp. 42. Paper, 25 cents.

THE NEW YORK ALMANAC FOR 1880. Edited by Jas. M. Hudnut. *New York: Francis Hart & Co.*

ANNUAL ANNOUNCEMENT OF TRINITY MEDICAL SCHOOL. *Toronto: Dudley & Burns, Printers.* 1880.

## TRANSLATIONS.

## ESCAPE OF BILE INTO PERITONEAL CAVITY WITHOUT SYMPTOMS OF PERITONITIS.

*Dr. Richard, Medecin-major.*

An Arab aged about 35 years, entered the military hospital at Phillippsville, January 24th, 1880. He was emaciated and very feeble. He stated that his abdomen had commenced to swell two months before, and that within five days the swelling had much augmented. His condition was as follows: a considerable abdominal swelling; no fever nor pain; pulse 70; daily passage of solid and colored feces; appetite; no vomiting. During the first weeks in the hospital the swelling rapidly increased; and February 7th paracentesis was demanded by the great dyspnoea. 13.500 kil. (29.75 lbs.) were drawn off of a liquid intensely yellow, flocculent, of a faint odor and bitter taste, and which tinged the cloth deeply yellow; its reaction slightly alkaline; density 1.028. It contained albumen in large quantity, but produced no coagulum on standing—chemical analysis detected a large proportion of bile. It was suspected from the presence of bile, and absence of symptoms of irritation, that an enormously dilated gall bladder had been tapped.

The abdominal enlargement was rapidly reproduced; and Feb. 16th a second operation was required; 8.500 kil. (18.73 lbs.) were obtained of a liquid similar to the first, but a little more turbid, and Feb. 22d, at a third operation, 5.800 kil. (12.78 lbs.) like the other liquids, but this time a reddish tinge was noticed. There had been latterly a little bilious diarrhea, abdomen a little painful on the right side but scarcely aggravated by percussion. Upon the third puncture the pain increased as well as the dyspnoea and weakness. Feb. 24th, patient died.

*Post-mortem.*—On opening the abdomen there escaped about five litres (4.5 qts.) of liquid like the last obtained. The entire

peritoneal cavity is lined with a delicate fibrous membrane, translucent, elastic, colored yellow by the bile, forming a layer 1 mm. in thickness which readily peels off in strips. It holds the intestinal coils in one mass, though otherwise they are readily separated. In front of the intestines lies a great irregular, uneven mass, the epiploon filled with a great number of hydatid cysts, of which about twenty are nearly the size of an egg, while the largest are as large as an orange. This mass extends to the pelvis where it is firmly attached to the upper part of the bladder and the vesico-rectal cul-de-sac. The cysts are contained within the tissues of the omentum, and not merely attached. One cyst of the size of an egg lies within the folds of the descending meso-colon; another smaller one, covered with a false membrane, is fixed upon the external face of the spleen capsule.

The liver is distorted, voluminous, and weighs 2950 grms, (6 lbs. 8 oz). Its upper surface is covered with the false membrane. Its entire left lobe is transformed into an hydatid cyst of the size of a fetal head at term, tense and resistant. Another cyst, as large as an orange and equally as tense, occupies the place of the small lobe (lob. spig.); it extends towards the right and compresses the gall bladder, which is almost empty, containing only a little mucus and yellowish bile.

Close to the left extremity of the transverse fissure is a distinct cystic cavity, but empty and collapsed; it presents anteriorly an ulcerated opening that admits the tip of the little finger and communicates with the peritoneal cavity. Its interior is tinged with bile and has the appearance of an hydatid cyst in process of regression. Its base is in contact with the liver tissue. Upon dissection it is found that two biliary ducts of the third order and passing into a common trunk, freely open into this cyst. The bile evidently flowed directly from the bile ducts into the cyst, and thence into the peritoneal cavity. Parenchyma of right lobe normal. The most of the hydatid cysts are in a living condition.—*Gaz. Heb.*, April 30, '80.

BATTEY'S OPERATION AND HYSTERIA.

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Dr. James Israel read a paper before the Berlin Medical Society, January 14, 1880, wherein he pointed out the possibility that the ovaries may be sometimes removed for the relief of symptoms, purely hysterical in nature, and which might have been met successfully by simple measures. He described at large a case upon which he based his remarks.

The patient, 23 years old, had menstruated at 15. The menses then ceased for two years, when they returned and were regular. Simultaneously with the reappearance of the menstrual flow, all food taken was vomited; this, at first, was confined to the menstrual epochs, but later occurred also during the intervals, whenever food was taken, especially liquid food. Also at the same time with the vomiting, there appeared severe pains in the region of the left ovary, and violent palpitation of the heart. These symptoms, continually aggravated, led to such debility, that even speech cost the patient great exertion.

After the disease had lasted one and one-half years, the patient consulted physicians in Koenigsberg, who prescribed tonics and gave local treatment, but all without result. She was finally advised to allow the ovaries to be removed. Unwilling to submit to this operation, she visited other authorities in various localities, besides taking the "baths." Her condition meanwhile becoming such, that at one period the vomiting would occur upon the street, and the weakness became excessive. Refusing ovariectomy, amputation of the cervix was proposed and effected, but without avail. The stomach was treated with electricity and otherwise; no good result. After ten weeks stay at Franzenbad, there was a remission of symptoms, and she recovered somewhat. Unhappily, this relief was not of long duration, and the vomiting, ovarian pains, and palpitation, all reappeared, with increased violence. She then fell into my hands, at the Jewish Hospital, Nov. 18, 1879. Seven physicians had urged upon her castration as her only hope.

I found patient in following condition: Color of skin and mucous membrane, pale; adipose well developed; lungs, heart

and kidneys sound; region of the stomach some distended, and sensitive upon pressure. Excessive pain was complained of when pressure was made over the left ovary. By vaginal examination, absence of cervix uteri; no anomaly of the body of uterus; left ovary very painful upon palpation, mobile, neither in size nor in consistency abnormal. The right ovary was a little sensitive, but larger and harder than the left; abnormally approximated to the uterus, and connected with it by a dense cord, that could easily be felt. Two observations of the menstruation failed to detect any change in the patient's condition.

I put her on strict regimen, withholding as much as possible liquid food. This proving fruitless, the usual drugs affecting reflex action were given, and as a last resort Carlsbad water—all useless.

I now declared to my patient that nothing was left but ovariectomy, and explained at length the whole procedure and its consequences. She expressed herself as most anxious for surgical interference. Accordingly chloroform was administered and I carried out my operation.

During the first three days, there was pain in the whole body, spontaneous, and also greatly exacerbated upon the slightest touch. At the same time, until the second day, there was retention of urine, then the urine was voided spontaneously, but with pain and effort. All these symptoms ceased after three days. A free vomiting of greenish matter appeared during the first twenty-four hours, (perhaps from the chloroform). After two days some of the food would be regurgitated, but this lessened gradually until the eighth day, when it ceased entirely, although patient ate at will. The ovarian pain, spontaneous, as well as that upon pressure, disappeared, and she felt that she was cured. She has remained, at last accounts, (March 15th), free from vomiting and ovarian pains.

This is a case of pure and pronounced hysteria, since the only operation performed upon her by me was an *incision into the skin*, while under the anesthetic. Her mind had been filled with the idea that castration would cure here, and nothing but that would suffice. I carried out the deception in the after treatment, as though she had been actually operated upon, and thus insured the mental impression.

The case undoubtedly exhibited symptoms which would have



called for ovariectomy, according to the generally received rules. The right ovary presented the signs of chronic oophoritis and peri-oophoritis; the left ovary was exceedingly painful upon the lightest pressure, and from it proceeded spontaneous pains of a neuralgic character. There was also a marked reflex symptom, the persistent and excessive vomiting.—*Berlin. Klin. Woch.*, April 26, '80.

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#### SECRETION OF FAT BY THE LIVER.

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The liver produces a variety of fat differing from ordinary fats by its readiness of oxidation to serve for nutritive changes. This fat is, like glycogen, the result of the reduction of albuminoid substances. The production of fat in the liver is quite similar to that of milk in the mammæ. It is a veritable secretion. Its activity is in indirect ratio to the oxidations of the organism. Everything that tends to limit these oxidations, augments the production of fat in the liver, (pulmonary lesions, debilitating affections, anemia and cachexia). In these cases the liver ends by undergoing fatty infiltration. When under the influence of debilitating causes, the needs of the organism increase, the liver cannot suffice for these needs and the fat-forming function diminishes. The albuminoid substances, reduced in the liver, produce no more fat, but a product less fit for combustion, the amyloid substance.

This conception of the pathology of the amyloid degeneration, is not consistent, at first appearance, with the fact that certain organs may be affected with amyloid degeneration before the liver. Neumann responds to this objection, by saying that the liver, disturbed in its functions, can give rise to morbid products, which, being taken into the blood, infiltrate the tissues with which they are in contact, especially the walls of the small vessels. So is explained the generalization of amyloid degeneration in the principal organs of the economy.—*Jour. de Méd. de Bordeaux. La. Presse. Méd. Belge*, Feb. 1, '80.

CONFLUENT ERUPTION OF VACCINIA UPON PARTS AFFECTED  
BY ECZEMA.

Dr. Padiou reports the case of an infant, aged 8 months, whom he vaccinated with bovine virus. At the same time he vaccinated twelve other infants and revaccinated seventy adults, in none of whom were there any unusual symptoms.

On the sixth day after the inoculation, at the same time in which five pustules developed upon the arm at the point of insertion of the virus, there appeared upon the face and scalp a confluent eruption of vaccinal pustules, exactly limited to the parts which were the seat of the eczema; not a single pustule upon the rest of the body.

At the same time, most serious general symptoms were manifested, intense fever, hurried and anxious respiration, threatenings of suffocation, incessant vomiting and colliquative diarrhea.

These accidents persisted with a threatening intensity during eight days, until the dessication of the pustules, when they subsided quite suddenly.

In the mother, eight days after the vaccination of the child, there was developed upon the middle of the right cheek, a vaccinal pustule, which, in a few days, assumed enormous dimensions. Two days afterwards, a second, then a third pustule, but of ordinary dimensions, appeared also upon this cheek. Finally, seventeen days later, appeared another pustule upon the free edge of the lower lid of the right side, then two other enormous pustules, one at the point and the other at the base of the tongue. Quite severe general symptoms accompanied the eruption.

The nurse also had a large vaccinal pustule upon the free edge of the lower lid on the left side, toward the inner angle of the eye.

This observation shows the possibility of a vaccinal eruption extending to all the parts which are the seat of an eczema, and seems to contra-indicate vaccination in children affected with this trouble.

It seems also to prove the possibility of the inoculation of vaccinia through the skin of the face, in spite of its perfect integrity. The mother had no solution of continuity, no scratch upon her face, but frequently laid the head of the infant against her cheek, to quiet and soothe him.—*Gazette des Hôpitaux, Annales de Tocologie*, June, '80.

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NATURAL DELIVERY IN A CASE OF EXTENSIVE CANCER  
OF THE OS.

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Obstetrical and Gynecological Society of Berlin, January 13, 1880: Dr. Schroeder, President, reported a case of natural delivery under extraordinary conditions.<sup>1</sup> The amniotic fluid escaped before the pains began, then for five days occasional vigorous pains, which, however, effected but little dilatation. There seemed to be no other recourse than the Cesarean section, but, as the child was certainly dead, the doctor was not willing to perform that operation. With the bent finger he attempted to remove the cancerous masses, and succeeded so well that finally the delivery was accomplished. There was but little hemorrhage during the delivery and afterwards, but little fever subsequently, though the patient died three weeks after the delivery.

Dr. Schroeder adopted this procedure in consequence of a previous experience, where he had observed spontaneous expulsion of the fetus, in spite of an enormous cancerous infiltration about the cervix.—*Berlin. Klin. Woch.*, April 26, '80.

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<sup>1</sup> Both lips of the os, and the pelvic connective tissue as well, were extensively affected with cancer.

## REPORTS ON PROGRESS.

## SURGERY.

**Antiseptic Baths for Phlegmonous Inflammations of the Hand.**—VERNEUL calls attention to a treatment found successful in phlegmonous inflammations of the hand which are usually so very painful. He reports three cases. A phlegmon of the palm of the hand had been opened by another physician, but the pain, fever and swelling continued and increased. The hand and fore-arm were plunged into a warm antiseptic bath, when in a few hours, relief was obtained and cure was effected without further surgical interference. A young man suffering from whitlows on the thumb of the right hand and the index finger of the left, was completely relieved of the pain by the use of the antiseptic bath. The third patient had a boil upon the back of his hand and phlegmonous inflammation of the palm. The pain was so intense that he had not slept for two nights. The hand was placed in a warm antiseptic bath for an hour, when the pain ceased as by magic. The baths were used twice a day for about an hour or an hour and a half; and the relief continued.

He does not claim that this will entirely obviate the use of the knife, but that it will frequently do so, that it will shorten the course of the affection and relieve the intolerable suffering of the patient. Further he claims that if it be necessary to make incisions, it will be in a region that is disinfected, and much less reaction will be provoked. The antiseptic bath consists of a one per cent. solution of carbolic acid.—*Abeille Médicale. La Presse Méd. Belge*, April 4, '80.

**Nerve Stretching in Sciatica.**—BRAMWELL, of Perth, reports five successful cases of the treatment of sciatica by stretching the nerve. He says that it is in cases of rheumatic inflammation of the sciatic nerve from exposure to wet and cold, that nerve stretching proves most efficacious. He does not claim to understand the nature of the effect produced; has found that the operation is tolerably certain to succeed when one feels adhesions giving way while stretching the nerve.

The nerve is generally sought for between the great trochanter and the tuberosity of the ischium; but it is more easily found in another region where it may also be stretched more efficiently.

He recommends the plan of Dr. Bell, of Edinburgh. Make a straight incision four inches long in the middle of the thigh, on its posterior aspect; cut through the skin, fat and fascia; separate the hamstring muscles with the finger, and the sciatic nerve will be easily found on the inner side of the biceps and somewhat overlapped by that muscle. Its sheath being opened by a touch of the bistoury, it is now raised on a blunt hook, then caught by

the finger, and the whole leg lifted off the table. The wound is then brought together by wire sutures, a drainage tube inserted, and a layer of lint soaked in carbolic oil (1 to 12) placed over it. As may well be supposed, there is rarely union by the first intention.—*Brit. Med. Jour.*, June 19, '80.

**Chian Turpentine in Cancer.**—MARSDEN, and his associates in the Cancer Hospital, have been testing Chian turpentine extensively in cases of cancer of the uterus, breast, tongue, etc., but so far without satisfactory results. As far as time will allow of a judgment, they are of the opinion that it neither cures nor arrests cancer. They are still using it in some cases in the hope of obtaining some satisfactory results.—*Brit. Med. Jour.*, June 19, '80.

**Paracentesis of Pulmonary Cavities.**—At a recent meeting of the Royal Medical and Chirurgical Society, DRs. POWELL and LYELL reported a case in which they had made a paracentesis of a cavity situated in the lower lobe of the right lung. The cough and expectoration, which latter had been very profuse and extremely fetid, at once almost entirely ceased. The patient died fifty days after the operation, which, they believe, had been postponed too long. They advocate the puncture of chronic basis cavities in suitable cases, but disapprove of interference with apex cavities, as these are usually efficiently drained through the bronchial tubes. They advise the use of a large trocar in preference to the knife; they would choose the centre of the cavity rather than its lowest point, when the cavity is in the posterior part of the lung. They do not favor making openings into acute basis abscesses.—*Brit. Med. Jour.*, June 19, '80.

**Fibroid of Uterus.**—DR. W. S. ROSS reported to the Vanderburgh County Medical Society the case of a woman, 45 years old, the mother of one child, now 20 years old. She had been losing blood from the uterus for many years, which she had attributed to the "turn of life." Last spring while washing, she strained herself in lifting a tub of water, and felt something give way and come down into the vagina.

Examination sometime afterward showed this to be a pedunculated fibroid. The pedicle was divided by means of an ecraseur, and the tumor which was about the size of a fetal head was extracted by means of obstetric forceps. The general condition of the patient was bad, but she recovered under treatment, and now enjoys reasonable health.—*Atlanta Med. and Surg. Jour.*, May '80.

**Oblique Section of Skin in Surgical Operations.**—JOHN H. PACKARD urges the advantage of making oblique instead of perpendicular section of the skin in surgical operations, claiming that by this method scars are much smaller and sometimes invisible, and that union of the edges of skin takes place more rapidly. The knife used should be sharp and the beveling as long as possible.—*Med. Gazette*, June 5, '80.

**Surgical Treatment of Epistaxis.**—THURSTON depends upon the well-known fact that liquid injected into one nostril returns by the other, and in cases of epistaxis, introduces the nozzle of a syringe into the nostril not bleeding, and holds it firmly. A stream of cold water, thrown in thus, washes out all the clots from the bleeding nostril, and often arrests the bleeding. If not efficient for this purpose, he uses a dilute solution of perchloride of iron.—*Brit. Med. Jour.*, June 5, '80.

## MEDICINE.

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**Dyspepsia of Women with Uterine Affections.**—Taking account of diathesis, dyspepsia, whatever be the form of it, is admirably treated in lymphatic temperaments by means of the bromurated tincture of iodine.

R.	Tr. iodine.	1 grm.	
	Potass. brom.,	4 "	
	Syr. toltan.,	300 "	M. Sig.

A desertspoonful before each meal. In the strumous it is better to employ the iodurated tincture.

In arthritic subjects, sulphur with magnesia is that to which we should give the preference.

R.	Sulphur. sublimat,	2 grm.	
	Magnes. calcinat.,	4 "	
			M. Div. in chart no. x.

The solution of arseniate of soda, one to ten thousand, should be used in the dyspepsia of those of herpetic diathesis, affected with uterine diseases.

R.	Sodæ arseniat.,	10 centigram.
	Aquæ font,	1 litre.

M. Sig. A desertspoonful in the middle of each meal. The constipation which is generally present in these cases, should be combated at the same time.—*Rev. Méd-Chi. des Mal. des Fem., La Presse. Méd. Belge.,* Feb. 8. '80.

**Interstitial Hepatitis.**—GUITERAS questions the correctness of the prevalent notion that cirrhosis of the liver depends upon cicatricial contraction. He says it is by no means certain that cirrhosis of the liver is preceded by a general enlargement of the organ or that hyperplastic hepatitis is ever followed by contraction of the organ.

That the individual bands of fibrous tissue that are found in a cirrhotic liver, have been preceded by groups of embryonal connective tissue cells, there can be no doubt; it could not be otherwise. But this does not signify that the small, puckered organ is preceded by a large swollen one.—*Medical Times,* June 5, '80.

**Metaphosphoric Acid.**—W. C. GRIGG pronounces metaphosphoric acid a much more delicate test for albumen than nitric acid. The acid should be freshly made and dissolved without heat. A piece of about the size of a pea is to be dissolved in a drachm of distilled water. The urine may be added to the solution or *vice versa*. If there be a trace of albumen, the urine will immediately become turbid and of a milky white color.—*Brit. Med. Jour.,* May, '80.

## THERAPEUTICS.

**Pilocarpin in Asthma.**—BERKART recommends the administration of pilocarpin in attacks of asthma. "The powerful revolution which pilocarpine produces in the distribution of the blood, must necessarily have a very beneficial influence in some forms of asthma; for, by attracting a large volume of blood to the skin and to the salivary glands, and by diminishing its volume through the copious perspiration and salivation, the congested internal organs are relieved in a corresponding degree."

Within a few minutes there is marked improvement both in subjective symptoms and physical signs. Alarming symptoms may be developed in cases where there is fatty degeneration of the heart, but these will soon subside spontaneously, or may be relieved at once by a subcutaneous injection of 1-120th or 1-60th grain of atropin. The dose of pilocarpin should not exceed one-third of a grain. Berkart never gives more than ten drops of a two per cent. solution. During the action of the drug the patient should preserve the recumbent posture—which the almost immediate relief will enable him to do—and he should be carefully watched until the effect has passed off. It is well, also, not to use pilocarpin soon after the patient's meals.—*Brit. Med. Jour.*, June 19, '80.

**Benzoic Acid in Rheumatism.**—SENATOR has employed this remedy in forty-six cases of polyarticular rheumatism. From a clinical point of view it much resembles salicylic acid. Salkowski attributes to it the same antiputrescent and stronger antifermentative properties. In order not to irritate the primæ viæ, moderate doses are to be given at first: 10 to 12 grammes, (2 1-2 to 3 drachms) of benzoic acid; or better, 12 to 15 grammes, (3 to 3 3-4 drachms) of benzoate of soda. The acid was given as a powder in wafers or capsules; the benzoate in 100 to 140 grammes, (3 to 4 oz.), of an aromatic draught with or without syrup.

It may be considered a specific for rheumatism, though in a less degree than salicylic acid. As a rule the latter is more prompt in its action, though in some cases where that failed, the benzoic acid succeeded. No relapses nor cardiac complications have been observed. Benzoic acid seems to have no tendency to irritate the stomach or bowels.—*Geneeskund Cour. der Nederl., La. Presse Méd. Belge.*, April 25, '80.

**Chloride of Calcium in Phthisis.**—SAWYER calls chloride of calcium his favorite drug in the treatment of phthisis. He gives ten grains dissolved in a drachm of water and mixed with a drachm of glycerine in a wineglassful of milk, twice daily, after meals. He thinks that it tends to check night-sweats, to cause increase of weight, and to dry up pulmonary lesions. He gives other remedies at the same time, as may be indicated, but finds better results from the combination with this drug than from any other.—*Brit. Med. Jour.*, June 5, '80.

Treatment for Catarrh of Bronchi or Throat.—HAGER uses the following formula, by means of which an acute catarrh may be shortened and relieved, if not entirely aborted.

R.	Quinid. sulph.,	
	Cinchonid. sulph.,	aa. grs. ix.
	Pulv. tragac.	“ xij.
	Pulv. althææ rad.,	“ v.
	Pulv. gentianæ	“ vj.
	Pulv. santali rub.,	“ ij.
	Glycerinæ,	“ vj.
	Ac. mur.,	“ vj.

M. Div. in Pill. xxiv. Sig. Five or six pills at bed-time, and three pills every two hours during the day. When the first symptoms of a cold appear, take six pills, then two every hour during the day, and five to ten pills during the last two hours, before going to bed. If this treatment is commenced promptly, he finds it to give very prompt relief.—*Pharm. Centralbl. Drug Circular.*

*Actea Racemosa* in Rheumatism.—C. H. JONES recommends *actea racemosa*, (snakeroot), for the relief of pain in acute or chronic rheumatism, and thinks that it is of far more therapeutic value, than it is generally accredited with.—*Southern Clinic*, June, '80. ED.

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## DERMATOLOGY.

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General Exfoliative Dermatitis.—JAMIESON, in the course of a valuable article on this rare disease, of which he reports six cases, sums up the result of his experience as follows: 1. That there is a peculiar form of superficial inflammation of the skin, characterized by persistent hyperemia, and cuticular exfoliation, not much impairing the general health, unless of long duration; distinct from eczema; resembling erysipelas migrans in spreading from its margin; chronic, rebellious to treatment, tending to recur, and sometimes ending fatally. 2. That an allied, if not identical, condition may be met with in an acute form, when it is related with much probability to pemphigus foliaceus. 3. That the exfoliation of laminae of cuticle is due to slight, but continuous, exudations into the upper layers of the cuticle. 4. That some altered condition of the spinal and sympathetic nervous systems is the main factor in its production. 5. That it is not favorably influenced by arsenic. The writer considers the best treatment, especially in its chronic forms, is to soothe and protect the skin by means of vaseline inunctions; to unload the congested vessels by free diuresis by alkalies, and particularly by digitalis; when this has been effected, to administer full doses of perchloride of iron, or small ones of carbolic acid, both of which drugs diminish cutaneous hyperemia.—*Edin. Med. Jour.*, April, '80.



**Sebaceous Cysts in the Sole of the Foot.**—CAMERON observes that it is generally stated that sebaceous glands are absent from palm and sole, but that he has seen two cases of diseased glands in the latter situation. A strong, healthy man consulted him for a dense, resisting cyst, the size of a marble, placed under the skin of the plantar surface of the fifth metatarsal bone, the skin over it being red, painful and adherent. Upon incision and evulsion, it proved to be an ordinary enlarged sebaceous cyst, containing fatty, pultaceous matter. In another case, there was a history of a small, painful swelling on the sole, which gradually enlarged, became painful and burst, and finally formed an ulcer.—*Indian Med. Gaz.*, May; *Med. Times and Gaz.*, June 12, '80.

**Spontaneous Disappearance of Morphœa.**—HUTCHINSON, at a meeting of the London Pathological Society, related the following case. The patient was a young woman, aged 20, who a year ago was brought to him suffering with well marked patches of morphœa. These patches were placed irregularly, but corresponded with definite areas of nerve distribution. At the time he took accurate notes of the case. Now, only twelve months after, they have all completely disappeared, the skin merely showing a little staining and thickening. He further stated that the fact of the disappearance of morphœa was well known, but that this was a typical case, and likewise showed how rapid this disappearance might be. BAKER related a somewhat similar case, where the disappearance was attributed, by the patient, to a hemorrhage from the bowels.—*Lancet*, April 24, '80.

**Pilocarpin in Skin Diseases.**—PICK gives the result of his experience with pilocarpin, in various skin diseases, as follows: After a two-weeks course of pilocarpin in a case of alopecia areata, which had existed six months, there appeared fine, white lanugo, and at the end of twelve weeks the growth of hair was restored. In ten cases of alopecia pityroides, the result of the treatment was favorable. The writer concludes that the remedy may be depended upon to restore the growth of hair, in cases where there is no strong hereditary tendency to baldness. (Consult COURIER, Vol. II., p. 356). In a case of chronic intractable urticaria, a cure was effected with one-tenth grain dose of the drug, twice daily. No effect was observed from its use in psoriasis; acute eczema was aggravated, while the chronic form was apparently benefited under its administration. In pruritus cutaneus, and particularly in pruritus vulvæ, good results were obtained.—*Vierteljahr. f. Derm. u. Syph.*, Heft 1, 1880.

**Treatment of Ringworm.**—COTTLE treats ringworm of the scalp by painting the most obstinately affected portions with linimentum crotonis, and subsequently applying an ointment or lotion of salicylic acid, twice or thrice daily. If the first application of the croton oil fail to promote copious eruption, the application should be repeated. The salicylic acid should be prescribed in the proportion of ten to forty grains to the ounce of the base selected, lard, vaseline, etc.—*Brit. Med. Jour.*, May 29, '80.

**Arsenic in Skin Diseases.**—MORRIS, in a paper read before the London Medical Society, makes the important point, that to get the full therapeutic effect of arsenic in skin diseases, it should be given uncombined with other drugs.—*Lancet*, April 10-17, '80.

**Papillary Growths of Nervous Distribution.**—MACKENZIE and CROCKER, have reported cases of this affection. One case (Crocker's) occurred in a boy of 15 years, the subject of pseudo-hypertropic paralysis. In this patient the lesions were limited to the left half of the body, and were most marked on the extensor surfaces. They consisted of an aggregation of light fawn-colored lenticular masses, the largest one-twelfth of an inch in diameter; but some were mere dots. The raised part of each mass was made of epithelium, which could be easily scraped off by the nail; and then the exposed part was slightly below the level of the sound skin, and with a lens could be seen to be granular, like the granulations of a wound on a small scale, and quite dry. These were evidently enlarged papillæ. MACKENZIE's patient was a boy, aged 16, of fair complexion, light brown hair, and grey eyes. The papillæ are, for the most part, flat-topped, but their summit is irregular and warty looking; they are shiny, of pinkish-red color, with little or no scab, as a rule. They are sometimes solitary, and sometimes aggregated into large patches. A few red spots were noticed when the child was a few weeks old, and were much increased in number at the third or fourth month. They were at one time very irritable and itched very much. Some years ago the spots left the thigh, but reappeared about a year ago. In this case the eruption was situated along the course of the genito-crural, ilio-inguinal, small sciatic, and internal and cutaneous middle nerves of the right upper extremity. In CROCKER's patient, the lesions followed the same general distribution, but were more extensive. The eruption in both instances was limited to the lateral half of the body. MACKENZIE suggests that the affection of the nerves, upon which the eruption depended, was connected with a morbid condition of the spinal cord, from which the nerves arose. (We have observed one case of this disease, which will be shortly published.—REP.)—*Med. Times and Gaz.*, April 24, and June 12, '80.

W. A. HARDAWAY.

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## OBSTETRICS AND GYNECOLOGY.

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**Inversion of the Uterus.**—Dr. B. P. GOOD reported to the Cincinnati Medical Society, a case seen in consultation with Dr. Kramer in which remarkable distension of the uterus, with fetid gas, occurred during the progress of labor. Discharges of gas from the vagina caused a sound that could be heard all through the room. The presentation was by the breech, and delivery was effected by the blunt hook. The abdomen of the child was distended to double the normal size. The occipito-mental circumference of the head measured eighteen inches. From meatus to meatus, over the scalp, measured thirteen inches. The bones of the head could be moved about as if in a bag. After a few minutes it seemed that the placenta was

about to be expelled from the vagina. The cord was so much decomposed that it was broken by slight traction. The woman was requested to make an expulsive effort, which caused the whole mass to be discharged; and a complete inversion of the uterus was found to have taken place. The uterus was cleansed of all particles of placenta, and small rolls of epidermis from the child, were picked off. It was then returned, and afterwards remained above the pubes and well contracted. Patient recovered with no serious complications.—*Ibid.*

**Premature Labor Induced by Pilocarpin.**—LUCIEN WILMART reports in *La Presse Médicale Belge.*, Feb. 15, '80, the case of a woman with a pelvis so contracted as to render impossible the delivery of a child at term, and in whom the operation of embryotomy had been twice performed. It was decided to induce premature labor in her next pregnancy, at the end of seven and one-half months. The period having arrived, he determined to test the oxytocic powers of pilocarpin.

The patient was about thirty-five years old. She was thin, of low stature, her figure distorted, her complexion faded, her hands shriveled. The cardio-pulmonary apparatus was affected with grave alterations, an important point.

Sept. 15, 9 A. M.—Two centigrammes of the chlorhydrate of pilocarpin were injected subcutaneously. Scarcely ten minutes had passed when the patient experienced a sensation of general heat. The face, shoulders, belly and thighs assumed a rosy hue, and were covered with a profuse sweat. The pulse beat regularly, only slightly accelerated. The respiration was not affected at all. The nervous system manifested nothing noteworthy. Some vomiting of mucus announced the end of the effect, which passed off gradually. About one o'clock, P. M., the same injection was repeated, and also at four and nine. The successive phenomena were the same. At this time the woman had felt no true pains, but there was sufficient dilatation to admit the finger into the internal orifice easily.

During the second day the injections were continued, and pains in the loins appeared, while the dilatation of the os reached the size of a two franc piece. The third day there was less vomiting, and the dilatation progressed. About ten o'clock P. M., the waters broke, and an hour later, a dead child was born. The recovery of the mother was rapid.

**Inversion of the Uterus.**—W. H. MATCHETT reports a case seen in consultation, where, before his arrival, the patient had died from post-partum hemorrhage. The account given by the practitioner in attendance, and the examination of the cadaver, showed that, in attempting to remove an adherent placenta, the attendant had completely inverted the uterus, and had then exerted his best endeavors to pull that away.—*Obstet. Gazette*, June, '80.

E. M. NELSON.

## SOCIETY PROCEEDINGS.

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### ST. LOUIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY.

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Stated Meeting, May 27th, 1880. Dr. L. Ch. Boisliniere, President, in the Chair.

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#### PERITONEAL CYSTS.

*Dr. Engelmann.*—Mr. President, I have here quite a unique specimen. While performing the operation of ovariectomy, after the incision had been made into the peritoneal cavity, a few cysts slipped out into the opening. As small cysts are not likely to appear in the peritoneal cavity, we supposed these were either intestinal coils, or that we had cut through a cyst wall with the first incision, and that the small cysts had come from the interior. Dr. Prewitt put them back once or twice, I think; still they reappeared. Then he pulled at them and the more he pulled, the longer they became; we thought it was becoming dangerous, so I tucked them back again. Afterwards they came out again and I tied one or two of them.

When I had removed the tumors we found a few of the stringy pedicles, and, I think, one or two other cysts of the same kind in the peritoneal cavity. I followed the pedicles to the upper surface of the liver near the diaphragm and tied them. They are not cysts of the liver. They are cysts of the peritoneal covering of the liver, an appearance which I have never before seen.

After I had removed the tumor we thought it best to remove these also. They were filled with a thin serous fluid. They are cysts originating in the peritoneal structure.

*Dr. Maughs.*—Some of you may remember the case occurring at the female hospital, of the woman who presented a tumor of the anterior fornix—quite visible—it was a large cyst. I think it was interstitial. We pushed it up several times; finally we called in Dr. Sims, thinking that his superior knowledge might

aid us, and he diagnosed that it was a peritoneal cyst. We drew off about a wine-glassful of fluid from it. Of course we could not tell where the pedicle was attached; it may have been attached further up.

*Dr. Engelmann.*—Here is an ovary—from a case of Battey's operation, a most fortunate one. It contains a very small cyst. The ovary is very slightly enlarged. It was removed on account of a dislocation, which occurred from a fall from a window.

*Dr. Ford.*—With regard to the specimen which Dr. Engelmann presents, I will say, that during an ovariectomy in 1874, we found the pedicle of a large polycystic tumor, quite short, filled with small cysts, so that it was with difficulty that I put on the clamp between the tumor and the uterus, so that to divide the pedicle, I had to adopt the method of tying the main arteries with carbolized silk, and I had difficulty in cutting it off, to avoid these cysts. About the pedicle of the tumor there were from fifty to one hundred cysts, almost as large as a pea. One of the cysts was six inches long, pyriform. This appeared to be a cyst of the broad ligament. Some of these cysts occur in consequence of the friction of the parts, or of the tumor against the peritoneum in any part of it. The constant friction causes a hyper-secretion from the peritoneum, which results in these cysts. I think it is a very important point to leave none of these cysts behind. I recall to mind a case in which Dr. Logan and myself operated, in which the tumor developed again; and I always suspected that it was a cyst of this kind that caused it. I consider that the recurrence was due to the filling of one or more of these little cysts left behind. It is not at all unlikely that the inflammation which occurred after the operation, would not be adequate to cause their destruction.

*Dr. Maughs* reported a case of vaginal enterocele, occurring between the neck of the uterus and the bladder. Finally, it became so elongated that the patient became alarmed. It developed until it passed through the vulva, so that there was a pendulous white body visible. I suggested the performance of Sim's operation of elytrorrhaphy. The woman had become thoroughly alarmed, and although I told both her and her husband, that it was a dangerous operation, she consented to its performance. We denuded the edges, or rather the walls of the cavity through which it protruded, and made an incision so

as to bring them together with silver sutures. Having first pushed the tumor into the cavity through the opening, we proceeded to denude the mucous membrane, so as not to open the peritoneal cavity. This part of the operation was quite interesting, as we could distinctly see the circulation in the small blood vessels. This woman suffered from no particular symptoms, although she was an invalid.

*Dr. Prewitt.*—Mr. President, I want to say in reference to these cysts, they had a curious connection with the tumor. When they first presented themselves, I supposed they came from the cavity of the tumor. It was a curious complication of things. When we opened the abdominal cavity, the bladder lay right in the opening, narrowly escaping incision. With these complications, it was a question whether the cyst had been opened and these had escaped from it. As I examined them, however, I saw that they came from somewhere about the pedicle of the tumor; afterwards we found that they came from the upper portion of the liver, near the diaphragm. I don't know that I tried the point, but it occurred to me that if I had taken up one of these tubes, the fluid would flow back towards the pedicle. I suppose it would. I don't recollect that we tried the experiment. Dr. Ford says he found a tumor probably of the same character, originating from the peritoneum. The point is, do they have any connection, or does the existence of a tumor in the abdominal cavity lead to the development of these, or might they have existed independently of the tumor in the abdominal cavity? I have never seen any thing of the kind, and never heard of anything of the kind occurring with ovarian tumor, heretofore.

The tumor reminded me very much, of a melon with a rind and central portion, a colloid substance, which would not run through Wells' large trocar. I never saw a tumor like it. The patient recovered.

*Dr. Engelmann.*—I don't think these cysts have any connection with the tumor, especially with ovarian tumor. Certainly, if they had been in the lower part of the abdominal cavity, we might have supposed that friction would have produced inflammation, but these occur so high up that there is no possible chance of friction.

## UMBILICAL HEMORRHAGE.

*Dr. Prewitt.*—I had, in April, a hemorrhage in a new-born babe, where the child bled to death from the umbilicus. I delivered him on the fifth of the month, and on the thirteenth I was sent for to see him. I found the child showing, already, some evidence of considerable loss of blood. I applied lint, saturated with a solution of persulphate of iron—diluting it at first. As soon as I found that did not stop the hemorrhage, I applied it full strength. That did no good. I then took a roll of lint, and saturated it with the persulphate, drew the walls of the abdomen over this roll of lint, and fastened it firmly with adhesive plasters. In the evening I found it still flowing. I then sat down by the child, and with my thumb in the umbilical opening, maintained an accurate pressure. It did not bleed so long as I kept this up, which was for an hour or an hour and a half. Then I instructed a lady to keep up this pressure, but she did not do it with accuracy, and it bled in spite of her. I took a thimble that pretty accurately fitted the place, pressed it in and fastened it with adhesive plasters. This prevented the hemorrhage for a while, but any little movement of the body immediately permitted the oozing of blood. I went back in the evening intending to put a few stitches through and through, and draw it together so it could not bleed, but I found the child moribund, so that it was useless to do anything. There was evidence of jaundice, which had changed the skin to a deep orange, greenish color.

*Dr. Robinson.*—I have found plaster of Paris, of service in such cases. I have stopped the hemorrhage in several cases where I have applied it.

*Dr. Prewitt.*—I have never seen this suggestion made, but it strikes me as being a very excellent one, and likely to prove successful in a case of this kind. We could put the plaster of Paris all over the umbilical surface, so as to entirely block up those little tubes. In this case there was simply no effort at coagulation. The vessels remained open tubes; the blood ran like water. There was not the slightest effort at coagulation. I think probably the plaster of Paris would have stopped the hemorrhage, but as inflammatory action had taken place, even if cicatrization had occurred, I don't think it would have saved the life of the child.

*Dr. Barret.*—Mr. President, I had a case of this kind, in which the child had been bleeding for hours from the navel. Plaster of Paris stopped the hemorrhage completely.

*Dr. Ford.*—Mr. President, in a case of this kind, I think I should use collodion.

*Dr. Robinson.*—Plaster of Paris is equally effective. It is much used for bleeding of the gums, the bleeding after drawing a tooth, for instance. The use of plaster of Paris is not a new idea at all.

*Dr.* ————— These cases of hemorrhage from the umbilicus, which occur in children, are not inflammatory, at least I have seen three or four cases, and I did not consider them inflammatory. The hemorrhage generally comes on several days after the birth of the child, and does not seem to come from any vessel; it oozes from the surface everywhere—due, seemingly to some change in the blood; so far as my observation extends, the stoppage of the hemorrhage does not save the life of the child. I never have seen a case get well. In one or two cases, I have seen it tried, by ligaturing the mass of tissue around the navel, but it merely prevented the child bleeding to death. They die whether the blood is stopped or not. I think Dr. Prewitt is right, that the child would have died anyhow. I think, in a great part, the condition of the child is indicated by this jaundice. The destruction of the gall duct would provoke this icteroid condition, and cause the hemorrhage.

#### ANESTHETICS IN LABOR.

*Dr. Boisliniere.*—Mr. President, I wish to state a case, in order to bring about an expression of the views of the members on the subject of anesthetics in labor. The case was that of a young lady, a married woman, who had a very tedious labor, owing to an occipito-posterior position. As usual in these cases, dilatation was very slow, and also, as is usual in these cases of occipito-posterior positions, there was an early rupture of the membranes before dilatation. During this slow dilatation, I gave the patient an enema of laudanum and chloral. She took, by enemata at half hour intervals, forty grains of chloral, with half a teaspoonful of laudanum, three times; when the os was sufficiently dilated, as she had been eighteen hours already in labor, I concluded to apply the forceps, which I did. I then gave her chloroform—a friend gave it to her, a cautious, capable person. Half an ounce was given in the course of



half an hour; when, suddenly respiration ceased and blood rushed out of the mouth and nose. There was a convulsive movement, and then the tongue was drawn in. I opened all the windows, dashed cold water in her face, and pulled her tongue out. She then began to breathe very rapidly and convulsively; she was within the death circle. She would have died in half a minute. She was cyanotic, blood rushing out of the nose and mouth. As soon as respiration was reëstablished, I completed the labor, and no bad symptoms followed.

This is the question: whether these large doses of chloral, administered by the rectum, did not render the chloroform more effectual? The theory has been advanced that chloral is transformed into chloroform in the blood; it is also denied by some German authorities. The theory is not proved, at any rate, so that it remains an hypothesis.

The question is, did the administration of chloral, in forty grain doses, three times before chloroform was given produce that effect? It came very near being fatal. There was, as I said, a cyanotic condition of the face, the tongue drawn in, the teeth clenched, respiration had almost ceased, the pulse feeble, and altogether these were certainly very bad symptoms.

It has been stated that anesthesia has never proved fatal in labor, but it would certainly have been fatal in this case, if I had not been very expeditious and very fortunate.

*Dr. G. A. Moses.*—There have been fatal cases reported, recently.

*Dr. Coles.*—In 1871, I think it was, I wrote a paper reviewing the subject of anesthesia. The only reliable statistics at that time, were those collected by the Medico-Chirurgical Society of Great Britain, and they had collected, I think, one hundred and ten fatal cases—this included dental operations, etc. These statistics seemed to have been collected with looseness, as they mention one or two fatal cases in labor, but there is no proof that they tried to find out the circumstances under which these cases had occurred. It is only said these cases had been reported. Whether they had been simply reported in some newspaper, was not known. I wrote to Dr. Squibb in New York, about the time of the preparation of my paper, in regard to this subject, especially in regard to a case that I saw reported in a medical journal, and he wrote me that the case I referred to occurred in Brooklyn, and that it was a case

in which the midwife had mismanaged a shoulder presentation. Morphine had been used before chloroform was administered. I don't think it was a case which could be said to have resulted from anesthesia. I could not find any cases of death from anesthesia, in labor, but I am well satisfied, from my own observation and experience, that such a thing is possible. I must confess that every time I give chloroform, I give it with greater fear and foreboding. Some six or eight years ago, I administered chloroform to a lady, and gave it with the greatest care, too. In the case to which I refer, the chloroform was administered carefully, when the woman became perfectly pallid and pulseless for a few minutes, after which she rallied. After that I ventured to use chloroform again. I put some more on the handkerchief, and she went through a very tedious labor without any bad symptoms.

Dr. Simpson states that it is not an unusual thing for a woman to be affected that way when she first takes it. I think it is wonderful that there have not been more deaths reported from the use of anesthetics, in labor. I take the position, and in this matter I think I anticipated Dr. Barnes, that during pregnancy there is a slight hypertrophy of certain nerve cells, in the spinal column, but especially of those cells that give off fibres that are connected with the uterus; and that, perhaps, one reason why the woman is not so much affected is, because the nervous system has become toned up, so that it is not so much surprised by the use of anesthetics. The majority of cases in which death occurs from anesthesia, are in strong, healthy men, who, it would be supposed, could stand chloroform. So, also, it is true, that the majority of deaths occur during the performance of some slight surgical operation, for some slight ailment; not in persons with heart disease. In pregnant women the nervous system has a long, preliminary toning up, to be prepared for the great shock which is to be endured.

According to Dr. Sims', there is another reason why anesthesia might not be injurious in labor, that is, during the expulsive efforts, which produce cerebral congestion. Chloroform reverses this condition, and there is a lack of blood in the brain. His idea is to hold the patient by the legs, head down, to allow the blood to gravitate towards the brain in all cases of chloroformic syncope.

*Dr. Maughs.*—The great majority of deaths from anesthetics occur during surgical operations for some trifling ailment, I think, and one reason why deaths during labor are so seldom heard of, is the imperfect way in which chloroform is administered. Some ten or twelve years ago I was called in to a case of delivery in a strong Irish woman. There was a shoulder presentation, and the attending physician requested me to assist in turning. We turned the child, and he had just brought the child down into the vagina, when she placed her foot against his neck and pushed him over, chair and all. I said “we will stop that,” and began to administer chloroform when she became quite black in the face, in fact, she was almost in articulo mortis. No pulse, respiration had ceased, and her lips were black.

We dashed cold water in her face, and then opened all the windows and doors. She rallied and the child was born. In this instance nothing but two drachms of chloroform—less than two drachms was administered without any chloral, morphia, or laudanum, and the woman came very near dying.

There is nothing in labor to prevent a woman dying under the influence of anesthesia.

*Dr. Gehrung.*—Mr. President, I think we could avoid some evil effects of chloroform in labor, by the use of ergot. We can frequently use ergot with advantage. If chloroform causes anemia of the brain, ergot on the other hand causes contraction of the capillaries. I am really astonished we have not had more accidents than have been reported. I have had my attention called to this subject recently by a case, not at term, but a miscarriage at the fifth month. The lady wished me to use chloroform; the circumstances indicated the use of ergot, as the head was protruding, to stimulate the relaxed womb. All went well until about an hour after the labor, when I was sent for hurriedly and found the patient almost in a collapse, suffering from very severe pain in the region of the heart, but more particularly in the stomach. I had some misgivings during the use of chloroform and ergot together, so that my attention was directed to the subject. I did not find any symptoms of increased pulse, or any febrile condition, so I simply ordered some brandy, and two teaspoonfuls relieved the pain before anything else could be done. Whether the use of ergot and chloroform caused this condition I cannot tell, but it seems probable to me that it did.

*Dr. Robinson.*—This is a very important discussion, and I would like to hear the views of every member of the Society present with regard to the advantages and disadvantages of the use of anesthetics during labor, *first*, because it is desirable in many cases to relieve the intensity of the pain; *second*, because we all, who have had any experience, know the great advantage to be derived from chloroform in certain difficult complications; and, in the third place, because it becomes a question sometimes whether the physician's services are to be retained or not. One of the very first questions asked is "Are you willing to give me chloroform?" Only three days ago a lady sent for me and told me that an old physician in this city positively refused to give her anesthetics under any circumstances, declaring that he had never given anesthetics in labor. She put the question to me, whether I was willing to give them and I told her I used anesthetics whenever I thought they were indicated. That was the best answer I could give her. I have used anesthetics very extensively in my practice, with the greatest care. I have a wholesome fear of them. I never use chloroform. I find ether answers every purpose and is harmless. Whether it really diminishes the pain or merely acts on the imagination, I cannot say. The only objection to it is, that it intoxicates like an alcoholic stimulant. When the pain becomes extremely severe at the termination of the second stage, I think the patient may have sulphuric ether or chloroform if she desires it, on account of the changed condition of the brain—the congested condition. I recognize the truth of what Dr. Maughs says; we have the greatest mortality in the administration of anesthetics from the ordinary surgical practice, but where the patient dies from very small doses of chloroform, I think exceptional cases. So far as my experience goes, the greatest objection to chloroform or ether and chloroform, is the disposition to hemorrhage. It is a very reasonable objection, because there has been extreme relaxation produced and the contractility of the womb must certainly be diminished. It certainly has the effect of diminishing the expulsive contractions; and, therefore, subsequent contractility of the womb, which ought to be well established, is prevented.

*Dr. Boisliniere.*—Will you inform me what is the advantage of using sulphuric ether?

*Dr. Robinson.*—It is, without this last objection, on account

of its stimulating properties. In instrumental labor I think there is an objection to the use of anesthetics—the application of forceps—because it is desirable to have the coöperation of the woman, in my opinion, so as to have certain indications where we are to use traction, which we lose when we administer chloroform. I suppose, Mr. President, you recollect the case that I had several years ago when you resuscitated the infant; I believe you saved the life of that child by your vigorous efforts. I was in hot water in that case. There was a contracted pelvis. I applied the forceps at the superior straight and delivered the child. That patient did not take any anesthetic at all. She stood the operation remarkably well. I seldom use anesthetics if I can possibly do without it, in the use of instruments, for the reason that I want the coöperation of the woman for the indication when or when not to use traction. I believe, however, in many cases the use of anesthetics is desirable, for example, in case of rigidity of the perineum.

*Dr. G. A. Moses.*—I agree with Dr. Maughs, in so far that a patient is as likely to die from anesthesia in labor, as under any other circumstances. It has been my fortune to administer chloroform ever since I was a student, first at the hospital here, and during the war, and I suppose I have administered it since then as often as any other physician present. It had never been my fortune to see a death result, until I had become so thoroughly satisfied that with proper precaution no ill effects would occur, that I never hesitated to administer it at any time and anywhere, unless I was satisfied there was some existing lesion of the circulatory or respiratory apparatus that rendered it improper; but two years ago at the hospital, a negro woman was lying upon a table with her breast exposed about to be operated on for cancer. She had been operated on four or five years before. Dr. Gregory asked her if she had taken chloroform at that time and she said she had. I examined her and found no evidence of any disease contraindicating; so I began giving the chloroform with the ordinary precaution. She gradually came kindly under its influence. I told the doctor he could go ahead with the operation. He made one incision in the skin when she gave a little gasp and died. Her condition up to that second, had been just as favorable as any case I had ever seen. A post-mortem examination revealed no trace whatever of any disease that might have caused death—noth-

ing but cerebral anemia. The heart was healthy, lungs healthy. There was no evident cause for her death. I administered chloroform in a case of labor. It was administered very carefully, yet the first few whiffs produced the ordinary symptoms of threatened death, and it was necessary to adopt some very active measures to revive the patient. Recently, there have been three or four recorded cases of death from anesthesia in labor. I think the reason we do not have more cases is because it is administered in such an imperfect manner. Generally, a few whiffs are given at the time of pain, and unless some actual active procedure is necessary, in which the physician requires the administration of a large dose, it is given more to amuse than anything else. It is the habit of most physicians to place the chloroform to the nose when the respiration is very imperfectly performed, so that scarcely a whiff is gotten.

*Dr. S. G. Moses.*—I have been using chloroform almost ever since it was introduced. It has been my habit to use it, but not to complete anesthesia. I don't think one physician in a hundred brings the patient under its complete influence. I think it useful in preventing, in a great measure, the shock produced by severe and long continued labors. I am in the habit of using a mixture of chloroform and ether, half and half. I have never seen a fatal post-partum hemorrhage follow the use of chloroform in ordinary cases of labor. I give ergot in almost every case, to produce contraction of the uterus and prevent after-pains. I believe, if the uterus is thoroughly contracted, you have the minimum of after-pains. The great proportion of deaths from chloroform, are from dental operations and slight surgical operations. I have never seen a bad result from the use of chloroform.

## ST. LOUIS MEDICO-CHIRURGICAL SOCIETY.

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Stated Meeting, March 8th, 1880. Dr. Robinson in the Chair.

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## INCARCERATED INTESTINE.

*Dr. N. B. Carson* presented a specimen, taken from a patient in whom it was found on making an autopsy, that a loop of intestine had slipped beneath a firm band of adhesive lymph, and had thus been strangulated. Several bands of lymph were found, the result of old inflammatory processes in the peritoneum.

*Dr. Glasgow* gave the history of the case, saying that the man came under his care at the Sisters' Hospital for what seemed a trivial affection associated with constipation. A pill was given him; and the next morning he reported having had an attack of colic with most intense pain; and morphia was administered hypodermically which relieved the pain. About five P. M. the pain returned, and repeated doses of morphia hypodermically seemed to have no effect at all. This condition continued for two days, paroxysms of severe pain alternating with periods of comparative ease. During the first part of this time there was repeatedly, vomiting of bilious matter. Later there was retching without anything being thrown up. The attacks of severe pain continued to the time of his death. He had had a similar attack four years before.

*Dr. C. A. Todd.*—Such a case is very interesting, with reference to the question of the propriety of a surgical operation to relieve the obstruction.

*Dr. S. G. Moses.*—I have seen, as every man who has arrived at my age must have seen, a number of cases which presented somewhat the same symptoms as this case presented. A young married lady, aged about twenty-four years, and apparently in good health, the wife of an intimate friend of mine, had been married about two or three months, when she fell into my care for what at first appeared to be an attack of indigestion. She had eaten supper, and about five or six hours afterwards was attacked with colicky pains. After vomiting she was much

relieved. I supposed it to be a simple attack of indigestion and gave a cathartic which failed to operate, but was vomited after a lapse of about six hours. An emetic which was administered emptied the lower bowels of a large quantity of fecal matter, apparently relieving all the symptoms. The tongue was normal in its condition. On the following morning, she seemed to gain her appetite, and ate some light food (a cup of tea and toast). About four hours after eating, she was taken with another violent attack of vomiting, accompanied with great pain. Of course the ordinary means were used, warm fomentations, cupping, and a cathartic. She retained this some time, when the paroxysms appeared to pass off. Four or five hours after she was free from pain. This condition went on until paroxysms of pain and vomiting became very frequent.

I would observe here, by the use of enemata she had a fecal operation. The vomiting had never at any time been stercoraceous; it simply appeared to be the ordinary secretion of the stomach, with the bile and the food she had taken.

Finally, I called in Dr. Lane, a man of great experience and great observation for the day in which he lived. He advised that she should take calomel and opium in small doses. She had, as he expected, some fecal operations. I am satisfied that nothing passed the constriction of the intestine. I called his attention to it, and he advised me to give her seven grains of calomel every three hours, until she had taken three doses, which apparently cleared the stomach for the time being. In four or five hours vomiting recommenced, and finally she succumbed.

I had inquired particularly into her history, and learned that she had been treated for neuralgia of the bowels; had several attacks at different periods of her life; that some years before, perhaps four or five, she had an attack of what was called neuralgia of the stomach; as it is, there is no doubt that it was peritonitis. The post-mortem examination presented something like this specimen, a band of perhaps a quarter of an inch in width, about two or three inches in length; and into this band a loop of intestine had passed, and was entirely strangulated. This loop of intestine was just at the upper portion of the ileum, accounting for the fact that no stercoraceous matter was vomited at any time. The lower portion of the bowels was empty. At the time, nothing could possibly have passed



through it. I supposed this condition was produced by the first attack of peritonitis, which was relieved by the treatment at the time.

A case occurred two or three years ago, presenting all these symptoms. The young man had violent cramps and vomiting for days, not for one day, but for days; and his temperature at one time fell so low, that I thought he would die. Care was taken in that particular case not to give purgatives. I gave him only one tablespoonful of sweet oil, and after that time he threw up an immense quantity—I am not exaggerating when I say half a basin full. He had decided appetite and great thirst, which was indulged, as he drank freely of various liquids, champagne, etc., which after a short period regurgitated, mixed with stercoraceous matter so marked that it was extremely offensive. This lasted two or three weeks. He recovered entirely, and has had no recurrence of the attack.

*Dr. Robinson.*—What Dr. Moses says is very important with regard to correct diagnosis in these cases, and it is extremely important, as well as interesting, to get the detailed histories and post-mortems. As pertaining to that question of diagnosis, with a view of further questions of surgical operation, I would ask Dr. Prewitt if he can recollect the main points in a post-mortem he made of a gentleman we had both seen during last summer; and what he does not remember of the history of the case, perhaps I may be able to supply.

*Dr. Prewitt.*—I was called to the case to which the president refers, last summer. I was sent for in the absence of Dr. Robinson, with the statement that he had hemorrhage of the bowels. When I got to the house, I found a gentleman, perhaps forty-five years of age, quite emaciated. I found he had had considerable pain about the bowels, that there were enlarged coils of intestine which were perceptible; and that his condition was a very bad one. I learned, on making inquiry into the history of the case, that some years before he had had an attack of peritonitis, and that after that, he had been constantly troubled with colicky pains about the bowels. His bowels were difficult to move, and this attack came on with more than usual pain, obstinate constipation, etc., and followed by bloody stools. I made a diagnosis of obstruction of the small intestine from old peritoneal adhesions, told his wife that the prognosis of course was very bad; that he would probably die; that at

the point of immediate obstruction, ulceration was going on, and that the case was liable to prove fatal, as it did. On making a post-mortem, we found the large intestine empty, while the small intestines were matted together by old adhesions. On the left side especially where he had complained of more than usual tenderness, we found quite a band of adhesions across the intestines, evidently such obstruction as accounted for the immediate symptoms. Would observe, as Dr. Moses says, the important point in this case is the diagnosis. Usually, there is a great deal of doubt as to the obstruction, as to the exact character of the obstruction, and yet pathological anatomy throws a vast deal of light upon these cases. We can, as a rule, make an approximate diagnosis, if we recall the fact that we have two classes of cases of obstruction of the bowels, acute and chronic; that the acute obstructions are usually attributable to twist, to internal strangulation and internal hernia, to bands and to intussusceptions; that the symptoms and the history of these cases correspond to hernia precisely. The symptoms of acute obstruction are without any history that leads up to it, whereas the chronic cases have always a history. They come on gradually, they have given trouble generally for a long time by a series of characteristic symptoms.

Chronic obstructions of the bowels may occur either in the large or small intestines. When in the large bowel it is mostly due to one of two causes, cancer encroaching upon the calibre of the bowels, or ulceration followed by contraction. In the small bowel, chronic obstruction is usually caused by some inflammatory or cancerous matting together of the coils of intestine. These conditions are generally pretty readily recognized. In the large bowel, the stricture, from whatever cause, is mostly in the lower portion—the sigmoid flexure or rectum. As a consequence, the most prominent symptom is, difficulty in defecation—while there is alteration in the character of the stools—mucus, blood, or pus, one or all, being present at times. Where the trouble is in the small bowel, there is difficulty in getting the bowels to move, great irregularity in their action, constant colicky pains, etc., due to the interference with the peristaltic action from the matting together of the coils of intestine. When the bowels do move, however, the stools are perfectly natural, well moulded and healthy.

Take the case referred to by Dr. Moses. The young lady

had complained of neuralgia of the bowels. The neuralgia was simply the colicky pains, which indicated the obstruction which existed there. She had probably had peritonitis, which had glued together the small intestines, thus interfering with the peristaltic action, and there was consequent difficulty in the passage of the contents through, but when through she was relieved. So it was in the case referred to by me. This gentleman had been constantly troubled with colicky pains, irregular action of the bowels, but had healthy stools when his bowels did act. When seen by me, there was distention of the small intestines, with visible peristalsis, blood in the stools, nausea and great prostration. The chronic obstruction had now become acute, and there was, no doubt, strangulation and ulceration of the mucous membrane, at the point of greatest constriction. Taking into consideration the history of a previous attack of peritonitis, the constant recurrence of colicky pains, the irregular action of the bowels, the perfectly natural stools, with the symptoms existing when seen by me, I made a diagnosis of chronic obstruction of the small intestines, with acute symptoms supervening. I gave a most unfavorable prognosis. The patient died and a postmortem verified the diagnosis. The colon was collapsed, but healthy throughout, while the small intestines were all matted together.

The greatest trouble seemed to be at the point where the patient complained of most pain, somewhere in the left lumbar region, where a large fibrous band, stretching from right to left, and from below upwards, seemed to be the special cause of constriction of a portion of the small intestine in that region.

We have here a result not unlikely to occur at some time, when greater obstruction than usual takes place. This is followed by increased distension of the bowel above; and this very distension again serves to render more difficult the passage of fecal matter onwards, and in turn causes greater pressure about the point of greatest constriction, tending to ulceration, to gangrene or collapse and death. Any distension of the abdomen under such circumstances, aggravates the local congestion. Hence the caution necessary in the use of enemata or inflation, when obstruction from any other cause than intussusception exists.

I recollect a case of acute obstruction that occurred to me

some years ago, where I thought it possible intussusception might be the cause. I resorted to inflation, and the patient rapidly grew worse as the abdomen became tense. It proved to be a case of twist of the bowels, and of course as the abdomen was distended, the strangulation became greater. I was less familiar with the symptoms of intussusception then, and I think I should not fall into such an error now. These symptoms (of intussusception) are very characteristic, and are not likely to be mistaken by those familiar with them.

It is only in cases where you have a definite, fixed, limited obstruction, at some point, that you can hope for any relief by operation. Where the intestines are matted together, you can not hope to operate with any prospect of relieving the patient. In cases of chronic obstruction of the large bowel, colotomy at a point above the seat of the constriction, in the left or right lumbar region, is our only resource.

*Dr. Robinson.*—I was called to see this gentleman first, for an affection of the ankle-joint and the instep, which he supposed was rheumatism. I told him after I had examined it, that he had injured his foot. In five or six days he prepared to go to Washington, and the omnibus had actually come to take him away, when he was suddenly taken with violent pain in the intestines—colicky pain—and sent for me. I went to see him; found him suffering great agony and was compelled to administer morphine subcutaneously, to relieve him. This pain returned during the night, and the next day and night he suffered a great deal. He had frequent injections of morphine. All this time, from twenty-four to thirty-six hours, there was no action of the bowels. There appeared to be an obstruction, and with the assistance of another physician, also of the United States Navy, I injected a large quantity of fluid into the bowels, and this, with a stimulating enema, produced several actions, which appeared to be satisfactory. The pain and constipation were accompanied also with vomiting, most of the time; but at no time was there any stercoraceous matter. He complained, mostly, of pain in the left hypochondriac region. I could not make out whether it was the large or small intestine. At any rate, after three or four days of suffering, the pain subsided, and he appeared to have recovered from this obstruction, for he continued to have two or three actions during the day, and was able to dress himself. On the last

morning I saw him, he was lying upon a settee in his room, apparently comfortable, taking nourishment. He was preparing to go to Washington that day, which was about four or five days after his first attack. I myself was taken sick; and that very evening he sent up to my house, saying that he had hemorrhage from the bowels. I requested that they send for Dr. Prewitt. I had no consultation with him. The presumption in my mind was, that he had inflammation, and subsequently ulceration of the mucous membrane of the intestine. He died next morning. I made my diagnosis, that there was an obstruction, that there had been peritonitis and obstruction in the large or small intestine, I could not make out which. I was rather inclined to the belief that it was in the large intestine, because the obstruction seemed to be relieved by the injection. We had pushed into the large intestine a long tube something over a yard long, which succeeded in bringing away a considerable amount of fecal matter, which seemed to justify the conclusion, being followed as it was by subsequent spontaneous discharges from the bowels, that the large intestine was the seat of obstruction.

The hemorrhage seemed to have been from a point in the small intestine, which was constricted by a band of adhesions, so that the caliber of the intestine was very much diminished. There was a decided elevation of temperature, indicating some inflammatory action in the intestine.

To illustrate how much the human system will bear, even when we open extensively the abdominal cavity, and interfere with the continuity of the intestine, I will mention the case of an insane individual who, with a dull knife, ripped open his abdomen, drew several feet of the small intestine out, cut off the piece and threw it away. The physician in attendance sewed the ends of the intestine together, leaving out the portion that had been excised, and the individual got well. You will find that case related in the *Charleston Medical and Surgical Journal*, about twenty years ago. I recall another case, illustrating how far the obstruction may go or how long it may last, and yet the individual recover. While I was attending clinics, in Paris, twenty odd years ago, there was an old woman who had an obstruction of the bowels, and had had no passage of fecal matter for certainly twelve days, if not more. She had had great pain in the right iliac region, about the caput cæcum,

and her abdomen was enormously distended. The tympanitis seemed to indicate general peritonitis. That, however, subsided to a great extent, and yet constipation persisted. The doctor made an incision, and drew away by means of scoops, an enormous amount of fecal matter. The inflammation had been extensive and at that point there was adhesion to the abdominal wall. For about ten days fecal matter continued to pass through the artificial opening; but this gradually grew smaller and smaller, and, she had finally, an evacuation through the ordinary passage. The wound closed up, and she recovered completely.

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Stated Meeting, May 10, 1880, Dr. Lemoine in the Chair.

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*Dr. Ford* read a paper on "The Treatment of the Cystitis attendant upon the Senile Hypertrophy of the Prostate Gland."

#### PECULIAR EAR TROUBLE.

*Dr. Todd.*—A man called on me yesterday, who complains that, for four years, he has been greatly annoyed by a crackling sound in the right ear, every time he moves his head. Upon examination, I noticed a contraction of the sterno-cleido-mastoid muscle. I heard the noise quite distinctly at the distance of a foot from him, and he says it can sometimes be heard many feet off. By placing the stethoscope over the mastoid process, I heard it very distinctly. It also is to be heard at the anterior nares. With the contraction of the sterno-mastoid there is also spasmodic action of the velum palati. The patient is of a decidedly nervous temperament, with a strong tendency to hypochondriasis.

There is no question about the presence of the noise, as it can be heard quite distinctly.

The patient said he had never had any pain in the place, but this noise drives him crazy—he is really desperate, and willing to submit to almost anything, in order to get relief.

I examined it very carefully. He hears it only when he moves his head. Of course no very serious operative interference is justifiable.

*Dr. Prewitt.*—The only case at all analogous to this of Dr. Todd's, that has come to my notice, was that of a young man who applied to me some months ago, with the idea that there was a bullet somewhere here, (indicating in the left side of his head in front of the ear), which moved on the inclination of the head. He had received a bullet wound in the cheek, the bullet evidently having impinged against the skull, and remained there. He claimed that it moved when he moved his head. He came up, I think, from Arkansas, with the view of having it removed, or at least having an operation performed for the purpose of removing it. At times there was a sound which I could hear. He said it was the bullet which made the noise, and seemed to think it inside the skull. I could not believe this. But from the insensibility and convulsions occurring at the time of the injury, the bullet no doubt impinged upon the skull, and may have become encysted at the point of lodgement, in such a way as to permit of movement.

The bullet struck about an inch before the ear. He was insensible for some time after the shot was fired, and there was evidence of brain injury at the time. It is very possible that some other physician present may have seen him. I was not very eager to cut down into the ear. He was so anxious to have something done, it is very probable he may have applied to some other physician for relief.

*Dr. Spencer.*—I am unable to throw any light upon this subject brought before the Society. It is a very singular coincidence, however, that I have had to-day, a patient whose case is very similar to this one of Dr. Prewitt's. (For full report, see page 90.)

*Dr. Todd.*—I would state further, as to this case, that the noise came on gradually. It began four years ago. The man took a bad cold. He was perfectly well, and had no such trouble before that time. He says that sometimes the noise is so loud, as to be heard twenty feet away, but I think this is an exaggeration. He said the sound was quite weak yesterday, and I could hear it distinctly a foot off. He stated that when he was quite young, there was a large suture between the parietal and temporal bones, a depression there when he was two years

of age, so that his parents were very cautious about any one touching him about the head.

#### DISEASED PLACENTA.

*Dr. Boisliniere.*—I will call your attention for a few moments to a case of so-called fatty degeneration of the placenta. The specimen here presented is from a lady of apparently very good health; the father, also, apparently in good health.

The remarkable fact in this case is, that this is the fifth time this accident has happened to the same patient. The first time she was attended by another physician, and the child was born dead after the fifth month. The other times I attended her; twice the children were born under six months.

At her fourth pregnancy, I determined upon trying some constitutional means to arrest this result, if possible. Although the father (I did not put the question to the mother) denied positively any syphilitic infection, and neither presented any syphilitic manifestations, I put both parents under a treatment at first by the bichloride of mercury, and iodide of potassium, more or less continuously for five months, and after this period put the mother on chlorate of potash and the tincture of iron.

After the third accident, I suspected the death of the child might have been the consequence of some inflammatory condition of the mucous membrane of the uterus. On examination I found that some chronic inflammation existed. There was endo-metritis, in a moderate degree, and some uterine catarrh. I treated this condition for some time, and finally cured the endo-metritis. I then put the mother on this alterative treatment of bichloride of mercury, followed by a course of chlorate of potash and iron. This death of the placenta, or placental phthisis, took place by degrees, I think, and may have been the result of chronic placentitis. The child, as a consequence, received less and less blood from this cirrhused placenta.

Under this alterative treatment, I carried the child along until the end of the sixth month, at which time it seemed to be very lively. I hoped to be able to reach the end of the seventh month, and then to induce premature labor and save the child. I carried it along very nearly to the beginning of the seventh month.

At that time, the movements were quite perceptible, when



suddenly an accident happened which frightened the mother very greatly, a runaway accident. The carriage in which one of her friends was riding was overturned in her presence. She felt the shock very much and sent for me. From that time on, I could feel the strength of the child's heart beats decreasing. The child was dying by degrees. The examination, day after day, showed that the feeble heart beats were becoming feebler; and, near the end of the seventh month, about six months and three quarters, the lady became in labor and the child was born dead.

I examined the placenta in this case with great care. It presented an entirely changed appearance; the placental structure, the cotyledon structure was quite smooth, yellow and homogeneous, and it presented a semi-fibrous or stearoid appearance with a few disseminated small clots, which pointed to a previously apoplectic condition of the placenta, or placentitis. There was no placental tissue left, and the child had probably ceased to exist simultaneously with the changes in the placental structure. I succeeded in saving this child for almost seven months, when this accident, above referred to, happened; and that shock defeated all my hopes.

At the next pregnancy, which is this one, this lady thought she would conceal her pregnancy from me, and for some time she said nothing of it. So, she went on for five months of pregnancy without being treated. The result of which is this product before you.

The placenta again presented the above described change in structure with also a few blood spots or small clots upon it; and a yellow coloration due perhaps to a process analogous to the formation of the corpus luteum.

A remarkable fact about this last child, was that there was hydrocephalus and some degree of ascites present. The child's abdomen was considerably swollen. This is a very interesting subject, and made even more so to me, as I hear from Dr. Moses that he has noticed this appearance in the child in some cases. Perhaps this morbid change in the fetus is of more frequent occurrence than is supposed, and suggests the possibility of peritonitis in the child, being the cause rather than the effect of the pathological changes in the placenta, and the question arises—how is it that the child gets along apparently well for five or six months, and then gradually ceases to grow, becomes

feebler, the heart ceases to beat, and the child is born dead, with this change in the placenta. This is a subject that should be investigated, as the pathology of this condition is very difficult to explain.

Another interesting fact also, is that some of those morbid conditions of the placenta and fetus are liable to recur in successive pregnancies in the same women. This is, however, in consonance with a very curious and interesting general law in intra-uterine pathology.

My plan for the next time is to put both these parents on an alterative treatment, because I think that this morbid change takes place very soon after the formation of the placenta, and it is to be noted that these morbid placentaë are not only changed in structure, but are also more or less atrophied.

*Dr. Engelmann.*—This case is an extremely interesting one, and made still more so by the very thorough history which Dr. Boisliniere gives us. There is a possibility, that the accident is due to syphilitic taint, although it is usual in case of syphilis of the father, which would probably exist here, that each miscarriage occurs a little later than the one preceding; each ovum is carried more nearly to term. I have always observed that the mother miscarries at first perhaps, at the end of the third or fourth month; then in five or six months, and finally near term, then she may be delivered of a dead child at term, or the child lives a few minutes, the next one a few weeks. Each time she miscarries at a later stage. Here we have a history of miscarriages at about the same time. We have a history of uterine disease, or supposed uterine disease, previous to the miscarriage. The effect, here, I think, is due to the most ordinary affection of the placenta, and one which is very frequently the cause of miscarriages. The placenta appears to be very small. I do not take it to be a case of fatty degeneration. I think it is more likely to be fibrous. We very frequently find a similar placenta in labor at term, with the firm, thick, whitish border; sometimes there are thick, whitish spots; sometimes the border or portions of the border are thick, white and hard, in consequence of local inflammation, while here the entire organ seems to have been affected, and this has probably occurred, at successive periods, so that no child has been able to survive. It is, of course, want of nourishment which causes the child's death. The death of the child

is the consequence of this change in the placenta. It is this inflammation and the consequent degeneration of the placenta, which is itself a consequence of local uterine disease, that has brought about the death of the fetus and the miscarriage, but I don't think, from the history of the case, that it is syphilitic.

If syphilis had been in the case, the woman would have miscarried at an earlier period, and would have carried the children longer each time. Furthermore, the husband has every reason in the world for acknowledging the fact, if it has been so. I think it is proper to try the treatment Dr. Boisliniere proposes, the treatment of the mother; the uterine treatment, the tonic treatment, and anti-syphilitic treatment if the doctor will. It is, however, a case of fibrous degeneration, arising from a local inflammation, and not the result of specific infection.

*Dr. Prewitt.*—I would like to ask Drs. Boisliniere and Engelmann, what the cause of the degeneration of that placenta is. If it is the result of uterine disease, how are we to treat it? If we are to understand it to be the result of uterine disease, is the metritis going on all the time during pregnancy, or is it something which originates in the placenta, independently of its attachment to the uterus? How are we to prevent this condition of things? I am particularly interested, as I have a patient with a history something like that which Dr. Boisliniere presents. It is a lady who has had several miscarriages. I might say, also, that she has borne two or three children during her earlier married life, who lived to be several years of age, and died from different causes. She is now very anxious to bear children. She had several miscarriages, at various periods—at two or three months, for instance. After some uterine treatment, she carried the children a longer time, (about six months). I thought the labor was premature, on account of some diseased condition of the placenta. One of the children lived some hours after birth. The miscarriages came on at about the same time.

I would like to say, in regard to my case, there is no reason to suspect syphilis, so far as the mother or father is concerned.

Stated Meeting, May 24th 1880, Dr. Pollak in the chair.

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STRANGE SOUNDS IN THE EAR.

*Dr. Spencer.*—Mr. President, I have a very interesting case to present. I have obtained the consent of the gentleman of whom I spoke at the last meeting, to be present this evening. This gentleman on the 27th of November, 1878, went out with a sheriff's posse to make an arrest; the party was ambuscaded and he received a number of shots, one in the shoulder, one in the forearm, one in the hand, causing the loss of the third finger, one in the thigh, one in the leg—in all eight shots. There was one shot which entered the head on the right side, at a point three quarters of an inch below the floor of the meatus, and seven-eighths of an inch in front—actual measure—from the central point in the floor of the meatus just in front of the tragus, nearly on a line with the external auditory canal: This shot passed entirely through the head—entering on one side of the head and passing out on the other. At the time of the injury, he experienced no inconvenience so far as the hearing was concerned, no disturbance in the ear; but a few days after the injury, a noise began in the ear, which has continued ever since. It can be heard very easily by means of the diagnostic tube; it was supposed that this deafness was caused by this injury. Two months after the injury, he applied to Dr. Pope, of New Orleans, for treatment, who referred his deafness to the injury. I think it is rather due to cold which he contracted from lying on the ground. Falling from the horse which he had been riding, he lay on the ground; it was a very cold day, and after the shot, he remained on the cold wet ground for a couple of hours, until he became blue up to his thighs; but there was no deafness. This deafness came on gradually, not being observed until two months after the injury. There is certainly great deafness, chronic catarrh and inflammation of the middle ear.

*Dr. Pollak.*—Was he unconscious after the shot?

*Dr. Spencer.*—Yes sir. He was afterwards removed, by his friends, to the city where he received surgical attention. There

was no arterial hemorrhage so far as I can make out from the history I get from him. There was no dizziness or vomiting. The noise may be caused by some deflection of the bone, some fibrous depression or aneurism. The noise we have here is a continuous bruit, as you will all perceive.

*Dr. Todd.*—What is the appearance of the drum?

*Dr. Spencer.*—There is nothing peculiar in its appearance. There is chronic catarrh and inflammation of the middle ear. So far as the deafness is concerned, I will state that under treatment it has improved somewhat. The right side, where he was affected at first, has improved, and now he is troubled more with the left side.

Discussion of Dr. Ford's paper on

THE TREATMENT OF THE CYSTITIS ATTENDANT UPON SENILE  
HYPERTROPHY OF THE PROSTATE.

*Dr. Todd.*—There is one point, Mr. President, that I would like to ask Dr. Ford about. I think it is quite interesting, physiologically. If I recollect rightly, Dr. Ford said that in one or more cases in which he punctured the bladder through the rectum, this artificial opening became eventually subject to the patient's voluntary control.

*Dr. Ford.*—I did not so state in regard to the cases on which I operated. I merely said I believed it was possible that the patient should acquire a certain amount of control over the passage of urine through the vesico-rectal fistula. In reports of cases I have lately perused, I have noticed an account of a patient's acquiring a great deal of control—it is said absolute control—over the passage. I think it is possible that the fibres interlace with each other in such a way that a certain amount of voluntary control may be acquired. I have never seen a case strictly of this kind. I would say, however, that after the first week or so after a rectal puncture, no constant trickling into the rectum occurs in these cases. The bladder always fills up to a certain point, and when reflex irritation becomes adequate to induce its contraction, the urine passes into the rectum. This occurs probably every two or three hours.

*Dr. Carson.*—I think Dr. Ford is right. I have a case, a very interesting one, at the hospital, a man who fell through the joists of a new building, and a splinter passed through the bladder into the rectum causing a recto-vesical fistula. This

patient does not have a constant trickling into his rectum. Whenever he passes water it passes through the rectum.

*Dr. Ford.*—I might state further that the urine ceases after some time to cause irritation of the rectum. Forty-eight hours after a puncture and withdrawal of the cannula, urine will pass through the opening. At first the urine will be fetid and irritating and thus may cause ulceration around the fistulous orifice, but the urine soon becomes clear and unirritating.

*Dr. Todd.*—Does it cause any irritation of the bowels?

*Dr. Ford.*—The bowels after some time become quite tolerant of the presence of the urine. A slight irritation occurs at first, no doubt, because the urine is more or less putrescent. The cystitis, however, soon becomes diminished, and as the irritation of the bladder subsides, the urine becomes more healthy. As soon as this occurs the irritability of the rectum ceases. Fresh healthy urine does not cause irritation, but when putrid it irritates the mucous membrane with which it may be in contact.

*Dr. Michel.*—Do you think that a recto-vesical puncture is preferable to the use of the catheter?

*Dr. Ford.*—The catheter will cause additional irritation of the bladder. Peritonitis and inflammation of the cellular tissue, occasionally attend upon puncture of the rectum, but I do not regard it as a dangerous procedure.

*Dr. Hardaway.*—Mr. President, I have something here I wish to present. Here is a preparation calculated to take the place of the ordinary green soap, so commonly used in skin diseases. It is almost impossible to get a good article of green soap. What we usually get is of a very poor character, highly adulterated. My attention was called to this some time ago, by an article in the *New York Medical Record*, from the pen of Dr. George Henry Fox. The preparation is called "*Sapo Olivæ Preparatus*." It serves all the purposes of the ordinary green soap—is equally efficacious, and, in addition, has the advantages of perfect uniformity, and being entirely free from disagreeable odor.

Here is a preparation of this soap and alcohol. I have often described a shampoo made of green soap and alcohol. It is excellent for the treatment of various conditions of the scalp, especially dandruff; it makes one of the most admirable shampoos, but this preparation is infinitely better, as the ordinary

preparation of green soap and alcohol has such an offensive odor. A preparation of this strength can be made by combining four ounces of "the soap," with four ounces of cologne. It makes a perfectly clear solution of most agreeable odor. This soap is made of olive oil and potash; the exact proportion I don't know. I obtained this from Mr. Good.

*Dr. Moses.*—Mr. President, I have here also a specimen obtained from Mr. Good, a specimen of chian turpentine, so much spoken of in connection with the treatment of cancer of the uterus. It is simply gum turpentine, as it oozes from the trees without distillation—simply the gum.

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## NOTES AND ITEMS.

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ARRANGEMENTS have been made for binding the volumes of the COURIER, which, we think, will be satisfactory. See COURIER Advertisements, p. vi.

UNITED STATES POSTAL LAWS.—The attention of our subscribers is called to the following resumé of the United States laws, concerning the relation of subscriber and publishers.

Bills were sent out in the April number. We hereby tender our thanks to all who have promptly responded. We would politely call the attention of the others to the fact that they are delinquent; and hope that they will manifest their appreciation of our efforts, by a prompt payment of the subscription due.

1. A postmaster is required to give notice *by letter* (returning a paper does not answer the law) when a subscriber does not take his paper out of the office, and state the reasons for its not being taken. Any neglect to do so makes the postmaster *responsible* to the publishers for payment.

2. Any person who takes a paper from the post office, whether directed to his name or another, or whether he has subscribed or not, is responsible for the pay.

3. If a person order his paper discontinued, he must pay all arrearages, or

the publisher may continue to send it until payment is made, and collect the whole amount, *whether it be taken from the office or not*. There can be no legal discontinuance until the payment is made.

4. If the subscriber orders his paper to be stopped at a certain time, and the publisher continues to send, the subscriber is bound to pay for it *if he takes it out of the post office*. The law proceeds upon the ground that a man must pay for what he uses.

5. The courts have decided that refusing to take a newspaper and periodical from the post office, or removing and leaving them uncalled for, is *prima facie* evidence of intentional fraud.

EPIDEMIC IN BERKSHIRE COUNTY, MASS.—The *Boston Medical and Surgical Journal*, of June 24th, contains a condensed account of an epidemic, of the nature of cholera morbus, which first appeared at the town of Adams, in the western part of the State, and then extended to four adjoining towns. The first account, as given in the daily press, were, of course, much exaggerated.

“The first cases occurred on Tuesday evening, in the center of the village, among the best residences; but soon the other part of the town were affected and few families escaped. Wednesday morning found the whole town sick. Those who were attacked Tuesday evening were, some of them, out on Wednesday, and most of the rest were well by Thursday; a few cases lasted three days. All recovered, though many continued weak from the effects. Many new cases occurred on Wednesday, and a few on Thursday and Friday.”

The symptoms were those of a very sudden and severe attack of cholera morbus, accompanied with great weakness. Simple remedies, chalk, camphor, bismuth, readily controlled the symptoms. Dr. Holmes reports that he gave no opiates at all.

The physicians estimate the number of cases at five or six hundred. The disease occurred among the farmers as well as among the factory employees.

The same disease appeared within a few days in other towns adjoining. No local cause for the outbreak has been discovered, though carefully sought for: the water supply is excellent, and no article of food has been found to which the trouble could be referred. The local physicians are disposed to refer the outbreak to some peculiar atmospheric condition. The course of the epidemic was from west to east and south-east.



THE free baths are very popular in New York, being visited by 6,000 to 7,000 men and boys daily. The boys enjoy the bathing so much, that after taking a bath, they make themselves dirty again as soon as possible, and go to another bath to repeat the process.

The attendants have to be on their guard constantly to prevent this imposition, as the capacity of the baths are limited, and one person bathing repeatedly would prevent others from having the opportunity of bathing at all. Various devices have been adopted, such as examining the boy's hair to see if it is wet from a previous bath; but the most ingenious expedient that we have heard of, is that of feeling the boy's nose to see whether it is cold or not, the inference being that if the nose is cold, it is from the effect of a bath having lowered the general temperature.

The daily papers have reported cholera cases developed in Cincinnati. Dr. T. C. Minor, Health Officer, writes to the National Board of Health, that while the mortality for the week ending, June 15th, was unusually high, and there were some cases of cholera morbus, which cases in the time of epidemic would be undistinguishable from true cholera, there is nothing of the nature of epidemic cholera prevailing in that city now.

THE polar expedition of Dr. Howgate, has sailed under the American flag upon its voyage of exploration. We are gratified to find a St. Louis medical graduate among the savants of the ship's company, Dr. Octave Pavy, of the Missouri Medical College. The doctor is also a member of the St. Louis Academy of Science, before which body he has explained the nature and objects of the expedition.

MRS. Mary Putnam Jacobi, M. D., who, as well as her husband, ranks among the prominent medical practitioners, of New York City, was recently refused admission to a seaside hotel, near the metropolis, on the ground that no Jews are admitted to that hotel.

FOUR Sanitary guard-boats are being put in readiness for use on the Mississippi river, in carrying on the campaign against yellow fever. The boats are swift propellers, and are arranged to be readily converted into hospitals.

JAPANESE OBSTETRIC PRACTICE.—After having obtained a pretended reduction of irregular presentations by abdominal massage, the physician makes the patient arise; he places his shoulder against the chest of the woman, and makes her pass her arms around his neck. He then clasps her knees between his own, so that she is well supported, and practices a lateral massage with the hands, starting from the seventh cervical vertebra, from above downwards, snapping his fingers to distract the woman's attention. Finally, he rubs with the palm of his hand from behind forward, the buttocks and thighs, sixty to seventy times, and this every morning from the fifth month. We may add that Japanese practitioners are generally aged.—*Fr. Médicale. La Presse. Méd. Belge.*, Feb. 15, '80.

At the semi-annual meeting of the Medical Journal Association, the following gentlemen were elected to membership: Dr. H. Greiner and H. Tuholske, St. Louis; Dr. E. R. Du Val, Fort Smith, Ark.

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## OBITUARIES.

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ALFRED SWAYNE TAYLOR, M. D., F. R. S. This distinguished English Toxicologist died in London, May 27th, in the twenty-fourth year of his age. For many years, Dr. Taylor was the highest authority on medical jurisprudence in England; and through the medium of his published works, he enjoyed no less reputation in this country. His manuals on "Medical Jurisprudence" and on "Poisons," are well known to both the legal and medical professions.

S. M. BRADLEY, a distinguished English surgeon died at Ramsgate, May 27th, of acute pericarditis occurring in a relapse from rheumatism which was at first relieved by the salicylate of soda treatment.

ST. LOUIS  
COURIER OF MEDICINE

—AND—  
COLLATERAL SCIENCES.

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ORIGINAL ARTICLES.

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ARTIFICIAL INFLATION AS A REMEDIAL AGENT  
IN DISEASES OF THE LUNGS.

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BY W. Y. GADBURY, M. D., YAZOO CITY, MISS.

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*(Read by Dr. J. Solis Cohen, M. D., before the Am. Med. Ass. in New York,  
June, 1883.)*

**T**HE great uncertainty attending the introduction of new discoveries in the medical profession, impresses me with diffidence and distrust of my own judgment, and has delayed for a year the public announcement of a remedy which seems to possess more than ordinary merit. Even now, after assurances from a distinguished source, I am disposed to withhold much that I would like to say in its favor. I allude to artificial inflation of the lungs as a remedial agent in disease. It occurred to me after reading a history of the use of condensed and rarified air, that it was expensive and inconvenient, and the intervals were too long to accomplish the desired effect. I then sought for an instrument which could be used at the discretion of the patient, and one that would be in reach of the poorer

classes. One was improvised by removing the spray tubes from a Richardson hand-ball and bulb atomizer, and inserting in place of the spray tubes a mouth tube. After repeated trials on myself, I became satisfied that fresh air could be forced into the lungs in the following manner: Insert the mouth tube into the mouth with the left hand, take a deep inspiration, and with the fingers of the same hand close the lips and nostrils, and work the hand ball rapidly with the right hand, so long as the patient can bear it. In a healthy subject, the operation is painless, and may be prolonged for a minute or more, but to a person with diseased lungs it is at first disagreeable, though not painful; and the patient complains that he cannot force in much air. However, practice soon enables him to pump the air freely into the lungs and for a longer period each day.

After frequent use it affords great comfort to those who suffer from a feeling of suffocation, and have diminished capacity of these organs. In the fall of 1878, I determined to try the remedy. The first case presented itself on the 12th of February, 1879, after having gone through with a course of cod liver oil without benefit. The following is the history recorded at the time:

Mr. Wm. Lamb, aged 32 years, carpenter, has been losing flesh twelve months; weight, in health, 147 lbs.; can trace no family taint. Now weighs 114; has suffered with short breath and pain in the side for three months. Condition now—pulse, 110; respiration, 36; temperature, 102°; hectic flush and fever; harrassing cough; muco-purulent expectoration, containing cheesy matter. Careful exploration of chest, revealed tubercular deposit in both lungs, and cavities were suspected, though not positively demonstrated; has night sweats and sleeps badly. He was taught the use of the instrument, and directed to use it every two hours. February 16th—has used inflation faithfully but has gained nothing discernible. Dr. J. P. Moore, of this city, examined the patient carefully, and several times subsequently, and fully concurred with me in the diagnosis. 18th—pulse, 100; respiration, 30; temperature,

101 ; cough and expectoration increased ; sleeps but little. 19th—pulse, 100 ; respiration, 30 ; temperature,  $99\frac{1}{2}^{\circ}$  ; dullness distinct over apices of lungs on percussion. 20th—pulse, 106 ; respiration, 36 ; temperature,  $101\frac{1}{4}^{\circ}$  ; has pain in left side and sleeps but little. Ordered five grains morphine to be divided into ten powders ; one to be taken at night. 21st—pulse, 100 ; respiration, 32 ; weight same, 114 pounds ; sleeps better ; gaining strength ; spends nearly all his time inflating his lungs. 24th—pulse, 100 ; respiration, 32 ; weight, 118 ; works some every day and feels better. March 1st.—He has become quite dextrous in using the instrument, and inflates his lungs every half hour during the day, and whenever he is awake at night. Ordered to the country, with directions to use all the milk he can take, and to work in open air constantly when not fatigued.

Before leaving the city, Dr. R. L. Dunn, of this place, examined him and pronounced his case one of phthisis. March 20th.—Returned to city after an absence of twenty days much improved ; pulse, 95 ; respiration, 27 ; gaining strength and appetite.

April 5th.—Returned after an absence of fifteen days. Pulse, 86 ; respiration, 24 ; weight, 123 pounds ; a gain of nine pounds since February 12th. Improving in every respect ; works most of the day ; carries the pump in his bosom and uses it almost unremittingly ; expresses great confidence in its efficacy ; has taken the ten morphine powders but no other medicines. No cough, pain or fever.

April 17th.—Absent twelve days ; reports himself as feeling well and able to work all day ; weight, 131 pounds.

April 28th.—Absent thirteen days ; reports rapid improvement ; pulse, 76 ; respiration, 24 ; weight 136 pounds ; apparently well. May 22d—reports himself well ; weight, 142 pounds ; gets full wages at his trade. Returned his inflator, badly worn from use.

Lamb continued well, and left the city during the following winter. This man had youth, vigor of constitution, and good digestion, all favorable to restoration of health ; but his improvement was so rapid under inflation, and his re-

covery so perfect, from a condition usually considered hopeless, that I am induced to believe that he would have died without it. And as no other agent was employed, the recovery must be attributed to inflation alone. That cavities existed in his lungs, was evident from the cheesy, mucopurulent expectorations; but they were not positively demonstrated by exploration.

April 12th, 1879.—John Moyer, 56 years, asked the privilege of using inflation. He had been sick three years; had large cavities in his lungs, fever and night sweats; much emaciated; normal weight, 144 pounds, now 118. His case was hopeless, but he was instructed to use inflation. Pulse, 104; respiration, 32; temperature, 102°. 18th—used inflation six days, and feels better; less pain and more sleep than before using the instrument. Pulse, 92; respiration, 26; less fever, better digestion, and more strength. He inflated his lungs often, and stated that he could not talk freely without first cleansing the matter from his lungs, which sometimes had to be repeated several times before his voice could be distinctly heard. It gave him much relief from suffocation, and afforded comfort during the night. He stated that often during the night, he awoke with an oppression and difficulty of breathing, which would be immediately relieved by inflating his lungs. His strength and appetite improved, and he was enabled to pass through a long, hot summer without confinement to bed, and with comparative freedom from pain and dyspnoea. Some time during the winter he left here for Philadelphia, forgetting his inflator. On his arrival at his northern home, he immediately wrote for it, saying that he would suffocate without it. His death was reported this spring.

Charles Bracey, colored, aged 40, had pneumonia, and now has gangrenous abscess, with extensive deposit of tubercles. Having no hope for his recovery, I allowed inflation as an experiment. At the expiration of a week, the offensive odor was nearly relieved, and his fever had abated. No permanent improvement resulted, and he died

in about two months. This case is related to show that inflation will, to some extent, disinfect diseased lung tissue.

Cases having received the benefit of internal medication are excluded from this paper for obvious reasons; but the subjoined extract from a letter written by Dr. B. R. Holmes, an intelligent and experienced physician, is worthy of consideration:

YAZOO COUNTY, Miss., April 1st, 1880.

DR. W. Y. GADBURY:

*Dear Sir*—My wife, aged 49, has been suffering for many months with cough, pains in the left lung; expectorating from six to ten ounces of pus every night; has evening fevers followed by profuse sweats; no appetite, but a loathing for food; constipation; loss of sleep, and chills recurring monthly. In January last she was examined by two highly cultivated physicians, who diagnosed her case as consumption; one of them asserted the existence of a large cavity in the left lung. She has dyspepsia, a disease hereditary in her family; has lost flesh rapidly. She has taken the usual remedies, such as malt, cod liver oil, quinine, iron, podophyllin, etc. After several weeks use of these remedies, pain developed itself in the right lung, just under the third and fourth ribs. About this time I consulted you, as I had lost all hope. You kindly offered me your lung inflator, urging a persistent use of the instrument, saying that it would require some time to develop marked effects.

The first effect of inflation was increased cough, followed by large expectoration. After the lungs were freed by forced expectoration, she could inflate without expectoration, and with but little pain. At first, inflation caused exquisite pain, but at the end of a week she complained much less; nor has she suffered with the right lung since relieved, thus confining the disease to the left lung. I find her now with marked improvement, and have abandoned all drugs. Am using at this time, London porter as a tonic and appetizer. Could I prevail on my wife to make more

constant use of inflation, I honestly believe her life would be prolonged. As she is now in Yazoo City, I beg that you will see and convince her of the necessity of constantly using inflation. I feel certain that it has eradicated the pain in the right lung, which was constant and acute before using the pump. It forces expectoration until the cavities are cleansed, after which it dilates the torpid air cells, and gives motion to the vessels about the cavities, which the unaided muscles could not do. She is improving in strength and appetite; can sleep sweetly the better part of the night. In the day she is able to attend to her household duties and her dairy. I am not vain enough to suppose her relieved or cured of consumption by my management of her case; but, thanks to an all-wise Providence, I think she will be spared to me yet a few years. Her fever and sweats are not prostrating, and she expectorates but little, has more appetite and better digestion.

I must again thank you for the air pump, from which I hope so much, based on the evident improvement in my wife's case, which I honestly believe has been accomplished by the not assiduous use of your lung inflator.

Very respectfully,

B. R. HOLMES.

May 1st, 1880—Mrs. Holmes continues to improve. The history of this case corresponds with my own observation. From the relief afforded to the right lung, and the improvement of the general health, it is reasonable to infer that if inflation had been adopted in the early stage of the deposit, and persistently used, the disease would have been arrested.

The result of Lamb's case, the first mentioned in this paper, was an agreeable surprise, and seemed hardly credible. I accordingly wrote to Dr. J. Solis Cohen, on the 5th of May, 1879, detailing my plan of treatment by inflation, and requested him to institute experiments to determine its value. He has kindly performed that duty, and now consents to make known his views, which will settle the question of its utility and range of application. While observ-



ing the effects of inflation, the following notes were written, and are submitted to the profession for consideration:

Inflation forces fresh air into the lungs, expanding unused capillary tubes and air cells; displaces the residual air and noxious gases; excites cough and expectoration, which removes morbid secretions at once, thereby lessening the danger of infection from unhealthy accumulation, and obviates the necessity for expectorant medicines, which often disturb the digestive organs; oxygenates the blood; promotes absorption; relieves dyspnœa; gives impetus to pulmonary circulation; reduces temperature in fever, and dessicates the fluids in the air passages.

Beneficial effects may be derived from it in croup, diphtheria, bronchitis, asthma, tuberculosis, whooping cough, asphyxia, chloroform poisoning, shock, foreign bodies in the air passages, and many other obstructive lesions of the pulmonary organs.

By inflation, vapors and gases may be introduced into the air passages, and it is believed that experiments in this line will open a new field of usefulness, and brighten hopes for the hapless sufferer from croup and diphtheria.

A recent distressing case of membranous croup suggested to my mind the propriety of inflating the lungs through a large aspirating needle or curved trocar passed into the trachea as a substitute for tracheotomy, or to prolong life until that operation could be performed; and it occurred to me also that foreign bodies in the larynx and trachea could be expelled by the same operation.

An inflator for such purposes should have two hand balls, so as to force into the lungs a sufficient quantity of air to substitute what would be taken in by the inspiratory act. Expiration would necessarily follow inflation from the elasticity of the thoracic walls, through an orifice too small to permit inspiration. The internal pressure of a large volume of atmosphere upon the strictured larynx would render it more patulous, and probably detach and expel any false membrane present. The main difficulty would be in preserving the natural rythm of the respira-

tory movement. This simple and harmless operation would be justifiable in chloroform poisoning, asphyxia from drowning and other causes. The instrument may be made small enough to be carried in the pocket.

The instrument I have used is imperfect. It should have a shield to close the mouth and nostrils, and a much larger and more elastic air-bulb.

The economic advantage of inflation especially commends it to the poorer classes, and its harmless nature and prompt action suggest the propriety of using it as a substitute for medicinal expectorants in cases of enfeebled digestion and irritable stomach. It is hoped that its use in persons with weak lungs may assist in developing these organs, and perhaps operate as a preventive of tubercular deposit. It is not urged as a remedy for tuberculosis, for all such are justly chargeable with suspicion, and the burden of proof in their favor must be submitted to many generations; but the faithful physician should never cease to contend with it so long as there is hope of success.

YAZOO CITY, June 24, 1880.

*Editors Courier* :—

My paper on Artificial Inflation of the Lungs was written hurriedly for the American Medical Association, and many points were deferred for a future publication. I desire to warn physicians who use inflation, not to allow patients to forcibly inflate their lungs in the erect posture, as it often disturbs the central circulation.

Since writing the report I use a steel spring nasal compressor to close the nostrils, and find it quite convenient.

W. Y. GADBURY.

Dr. J. Solis Cohen in a paper published in the *Medical and Surgical Reporter*, says:

As mentioned in the last edition of my little treatise on "Inhalation," I have long sought for an apparatus applicable to the convenient administration of inspirations of condensed air. All the available apparatus that I have seen are so bulky as to practically confine the treatment to the

office of the practitioner, to the great consumption of his time, and to the corresponding expense of the patient; circumstances which necessarily limit resort to this valuable therapeutic agent. The apparatus of Waldenburg, figured and described in the volume referred to, is very satisfactory, and, in the cheap form constructed for the clinical room of the laryngoscopic department of Jefferson Medical College Hospital, is not beyond the reach of patients in quite moderate circumstances; but it is by no means a portable instrument. And until a portable instrument is constructed at a moderate cost, this method of treatment is not likely to make much progress in America, despite the favor that has been awarded it in Europe.

It was with great pleasure, therefore, that about a year ago I received a letter from my esteemed friend, Dr. W. Y. Gadbury, of Yazoo City, Mississippi, detailing me a plan he had adopted successfully in a number of instances, and requesting me to avail myself of my better facilities for encountering suitable cases, to put his plan to the crucial test from which he was debarred by lack of proximity to a large medical centre.

Dr. Gadbury employs the rubber compressor of the hand-ball atomizer; and his plan is as follows:

The patient, having dilated his lungs to their greatest capacity by a forced voluntary inspiration, immediately compresses the nasal passages with one hand, while he places the tube of the compressor between his lips with the other, then closes the lips gently upon it, and rapidly works the compressor. A few squeezes pump an intermittent current of compressed air into the lungs; and as soon as the distention becomes unpleasant, or the need of an expiratory movement is required, the instrument is withdrawn, to be replaced and re-employed in the same manner a few moments subsequently; the operation being repeated four or five times in succession.

I have given this plan a trial during the past year, in my private practice, and in the clinical practice of the hospitals with which I am connected; and am in a position to

estimate its value and capabilities. It cannot be safely employed in all the cases in which insufflations of compressed air, as supplied from the apparatus of Waldenburg and others, are applicable; but it has a sufficiently wide range of utility to commend it to professional attention; and in a certain class of cases, to which allusion will be made presently, it is of greater service than the bulky machines adverted to.

In patients liable to hemoptysis, or other hemorrhages, and in certain cardiac and visceral disorders, the intrathoracic compression, if left to the patient, is apt to be too powerfully exercised, and thus to be absolutely detrimental; and it is to the hands of patients that the instrument is to be confided. It is seldom safe to employ compressed air with a pressure exceeding from one-sixtieth to one-thirtieth of an atmosphere, and quite delicate handling of the ball-compressor is requisite to keep within this limit, while the size of the compressor prevents access of air in large volume, or at constant pressure. Thus, for general purposes, this plan, unmodified, cannot supersede the use of more complicated appliances.

There is one use of the Gadbury method, however, to which I desire to call the attention of the profession prominently; and that is its employment as a mechanical expectorant. Time and again I have placed the little compressor in the hands of a patient with bronchioles and air cells clogged with mucus and pus, to see its use immediately followed by copious expectoration, to the great comfort of the patient. The process is repeated until it ceases to be followed by expectoration, and there is absolute or relative relief from the desire to cough, until re-accumulation indicates a renewal of the procedure at intervals of a couple of hours, or longer, according to circumstances. I have frequently availed myself of this method of clearing the air passages previous to careful physical examinations, when abundance of moist râles were present, and have been better able to estimate the actual conditions of the respiratory organs on auscultation afterward. Hence, in

chronic bronchitis, of whatever origin, compressed air can be employed with advantage in this way, to discharge the mucous accumulations from the air passages, and spare them much of the topical irritation to which they are otherwise subjected. In a few instances I have seen chronic bronchitis relieved by the use of this method, without any medication whatever, and far more rapidly and effectually than follows the administration of medicinal expectorants, which are too often coupled with the disadvantage of interference with the processes of nutrition by their nauseant influence upon the alimentary tract.

The physical action of this mechanical expectorant is simple. The hyper-distention of the air-cells permits the access of air under pressure to points beside and beyond the masses of mucus clinging to the walls of the bronchioles and alveoli, and excites effective cough, which removes the partially detached masses. Several of my consumptive patients clear their passages out at bedtime in the manner indicated, and secure a good night's rest, free from disturbance by cough, without the administration of opiates. When they rise to dress, they clear the parts of the accumulation over night in like manner, and attack their breakfast with relish. Some individuals have little or no occasion to expectorate during the intervals, and can pursue their vocations, relieved of the frequent and recurring plague of an annoying and harrassing cough. The therapeutic advantage of an agent capable of doing this much, is incontestable; and it is for the purpose of drawing attention to this simple and inexpensive contrivance, and of having its merits tested on an extended scale, that this article has been written.<sup>1</sup>

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<sup>1</sup> Dr. Cohen presents the above as a preliminary article, to be followed, as leisure permits, with a description of the adaptation of a blow-pipe contrivance for the same and similar purposes, and some remarks on the pathological conditions in which it may be resorted to with prospect of advantage.

## THE LEGAL RESPONSIBILITY OF PHYSICIANS.

BY EVERETT W. PATTISON, ST. LOUIS.

WHAT legal responsibility is incurred in undertaking the treatment of a disease or an injury? This is a question of deep interest to the profession. It is often as perplexing as it is important. Suits for malpractice occur with sufficient frequency to give cause for anxiety. In many parts of the country they have become so common as no longer to excite comment. A man meets with an accident. A leg is broken and badly crushed. The surgeon is hastily summoned. On his arrival he hesitates between his desire to save the limb and fear lest he may lose the patient. A decision is finally made, and months of anxious and sedulous care follow. The patient finally rises from his bed to make his way to a lawyer. He sues the surgeon, in case amputation was resorted to, because he did not save the limb. If the limb has been saved, he claims damages because it is an inch shorter than the other, or because ankylosis has ensued, or because there has been sloughing of the parts, or because a sore was not healed in three weeks instead of as many months. That this is no overdrawn statement, one or two instances will show.

In Massachusetts, a woman cut her thumb while paring apples, making a slight incision, from which the blood oozed, but did not drop. Next day the thumb and arm began to swell, and the patient was troubled with nausea. A physician was sent for, and began at once to treat the patient for felon, opening the thumb, bathing the arm in sugar-of-lead-water, bandaging, etc. The felon proved a serious one, and the recovery slow, and the result was a stiffening of the fingers. Some time after her recovery she learned from another physician that it was possible to re-

cover damages from the one who had treated her hand; and forthwith a suit was commenced, and the physician was plunged into long and expensive litigation. The plaintiff failed to obtain a judgment, but the trouble and loss of time and money to the physician, and the injury to his reputation, were most serious.

A surgeon in Maine was still more unfortunate. A judgment for two thousand dollars was obtained against him because an amputation made by him would, as the sequel showed, have been better made two or three inches higher up. The Supreme Court, in reviewing the case, observed that the evidence tended to show that the limb could not have been saved in any event, and that the removal of the thigh bone, which had been subsequently performed, could not have been prevented, even had the amputation been made at a higher point. Yet the court refused to set the verdict aside except on the ground of excessive damages; and on the plaintiff remitting five hundred dollars, allowed it to stand. So the surgeon was actually forced to pay fifteen hundred dollars because he didn't do that which there was at the time no reason to suppose that he ought to do, and which, if he had done it, would have been unavailing.

The liability of a professional man, whether lawyer or doctor, depends upon his contract. And between the attorney and his client, the physician and his patient, a contract always exists. True, there is seldom any formal agreement; though to such a course there would be no legal objection, however it might be viewed ethically. The law allows any contract to be made which is not in itself immoral, or *contra bonos mores*. And if the physician sees fit to enter into a special arrangement whereby he warrants a cure, or the surgeon guarantees to heal a wound or restore a fractured limb to a perfect state, such contract is valid, and he will be held to a performance of it.

Few professional men, however, are willing to assume such responsibility. As a rule they would decline to enter into any formal agreement with their patients or clients.

Yet, in the absence of an express understanding, the law itself makes a contract between the parties. This is called an implied contract. The moment the relation of attorney and client, or that of physician and patient, is established, that instant the law steps in and defines what each undertakes to do for the other. The implied obligation of the patient is to strictly follow the directions of the physician, and to pay him for his services a reasonable compensation. What are the correlative obligations assumed by the physician?

And, first, it may be well to state what he does not undertake to do. He does not agree that there shall be no failure to cure. In the absence of a special contract to that effect, he is not a warrantor nor an insurer. He never stipulates for success at all events, and he is never to be tried by the event.<sup>1</sup> Nor does he stipulate for absolute knowledge. He must be guided by what is probably true, and is not to be held responsible for his ignorance of the absolute truth, which is not known.<sup>2</sup> Especially does this apply to the physician's knowledge of the constitution, temperament, habits of life and previous illnesses of the patient. While his best judgment must be exercised in such cases, he is excusable in law for untoward results arising from the peculiar condition or temperament of the patient, of which he had no knowledge, provided all reasonable and proper efforts are made to possess himself of such knowledge. He is not answerable for consequences which he could not foresee, which are not the ordinary or probable result of what he did.

So, in the language of Judge Hare, of Philadelphia, "If a medical practitioner resorts to the acknowledged proper sources of information—if he sits at the feet of masters of high reputation, does as they have taught him—he has done

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1. *Leighton vs. Sargent*, 27 N. H., 460. In this and the following references I do not give all the authorities for the principle stated. It has been my aim to select some one leading case out of the numerous decisions bearing upon each point.

2. *Bogle vs. Winslow*, 5 Phil., 136.



his duty, and should not be made answerable for the evils that may result from errors in the instruction which he has received. Medical opinion varies from time to time. What is taught at one period may be discovered to be erroneous at another. But he who acts according to the best known authority is a skillful practitioner, although that authority should lead him in some respects wrong. He will then have done all that he can, all that it is given man to do, and may leave the result without self-reproach in the hands of a higher power."<sup>1</sup>

What, then, is the contract which the law implies on the part of one who offers his services to the community generally, or to any individual, as a physician or surgeon? Succinctly stated, it is this. He undertakes:

1. That he possesses that reasonable degree of learning and skill which is ordinarily possessed by the members of his profession, and which is ordinarily regarded by the community and by those conversant with the profession as necessary and sufficient to qualify him to engage therein.

2. That he will use reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge to accomplish the purposes for which he is employed.

3. That he will use his best judgment in the exertion of his skill, in the application of his knowledge, and in the exercise of his care.<sup>2</sup>

The skill required is not the highest degree which the most learned might acquire;<sup>3</sup> nor, according to a decision in an earlier case, is it requisite that the care and skill should be proportionate to the character of the injury treated, and the physician is not to be held liable if he does not treat a severe injury with such skill as its severity reasonably demands.<sup>4</sup> On the other hand he cannot escape

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1. *Bogle vs. Winslow, ubi supra.*

2. *Leighton vs. Sargent*, 27 N. H., 460.

3. *Barnes vs. Means*, 82 Ill., 379.

4. *Utley vs. Burns*, 70 Ill., 162.

by showing that he is not grossly incompetent, and that he has not been guilty of gross negligence. The skill required is average skill. The care and diligence to be exercised are such as an ordinarily prudent man would exercise in such matters.

And, as is remarked above, the standard of skill does not vary with the case. Whether the same is true as to the care and diligence required may be doubted, though such a doctrine is apparently supported by the high authority above mentioned.<sup>1</sup> Only ordinary care is demanded. But what in one case would be extraordinary care, in another would be gross negligence. The conduct of an artist might manifest due care, if applied to hewing out a rough model in wood, while it could only be characterized as carelessness if he were engaged in carving a statue from Parian marble. So what would be due care in the case of a mere cut or an abrasion, might be gross negligence in the treatment of a compound, comminuted fracture.

It is not easy to define accurately the standard of skill. The Supreme Court of Vermont uses this language :

“The ordinary expression is ordinary skill. That means such skill as doctors in the same general neighborhood, in the same general lines of practice ordinarily have and exercise in like cases. If a doctor does in a case what the average class of doctors are accustomed to do and would do in such a case, then he exercises what is meant by ordinary skill in a given case. If he exercises such skill then he is not liable for lack of skill, because the law only requires of him that he should exercise ordinary skill, such as the average of doctors like himself are accustomed to exercise in like cases. If he exercise such skill, then he is not liable for lack of skill, even if injury occurs that might have been prevented if the doctor had possessed and exercised greater skill. A doctor is not bound to be more skilful or more learned or more competent than the average

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1. *Utley vs. Burns, ubi supra.*

class of doctors, unless he holds himself out as having extraordinary skill.”<sup>1</sup>

The Supreme Court of Iowa holds that the true measure of skill and diligence is “that ordinarily exercised in the profession by the members thereof as a body; that is, the average of the reasonable skill and diligence ordinarily exercised by the profession as a whole. Not that exercised by the thoroughly educated, nor yet that exercised by the moderately educated, nor merely of the well educated, but the average of the thorough, the well and the moderate—all, in education, skill, diligence, etc.”<sup>2</sup>

Nevertheless, the determination of the extent of any particular physician’s responsibility is necessarily affected by a consideration of his opportunities for improvement, and for a practical and experimental use of his requirements. The average skill must necessarily vary in different parts of the country and even of the same state. The same degree of skill would not be looked for in country towns, and sparsely settled districts, as in populous cities. In the former, the surgeon, however well informed in theory, is seldom called upon to perform difficult operations in surgery, and lacks the opportunity for daily observation and practice which large cities afford. The degree of skill required of a practitioner in such a locality is the average degree of skill possessed and exercised by the profession in such localities generally.<sup>3</sup> It is not sufficient that his skill be equal to that ordinarily exercised in his profession in the particular locality in which he practices.<sup>4</sup> For there may be none in that particular locality possessing the requisite skill.

The Supreme Court of Massachusetts in a late case<sup>5</sup> held that, in determining whether a proper degree of skill was

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1. *Hathorn vs. Richmond*, 48 Vermont, 557.

2. *Smothers vs. Hanks*, 34 Iowa, 286.

3. See, on this point, *Shearm. and Redf. on Neg.*, §436.

4. *Gramm vs. Boener*, 56 Ind., 497.

5. *Small vs. Howard*. 1 Am Law Review [N.S.] 328

shown, regard should be had to the improvements in, and the advanced state of, the profession at the time. And this is evidently the correct view, though it is disapproved by the Supreme Court of Iowa in a case decided in 1872.<sup>1</sup> This latter case was, however, decided by a divided court, Chief Justice Beck in a strong dissenting opinion taking the same view as that held by the Massachusetts court.

The third element which enters into this implied contract, is the use of the judgment. This does not mean an absolute freedom from errors of judgment.<sup>2</sup> There may be responsibility, even where there is no neglect, if the error of judgment be so gross as to be inconsistent with the use of that degree of skill that it is the duty of every physician and surgeon to bring to the treatment of a case, according to the standard above indicated.<sup>3</sup> But he should be charged with the consequences of mere errors, only when such errors could not have arisen, except from want of reasonable skill, or from neglect.<sup>4</sup> It is not sufficient, therefore, to show that the physician has not treated his patient in that mode, nor used those measures, which, in the opinion of others, even of medical men, the case required. Nor is the failure of a course of treatment evidence of an error in judgment, any more than of want of skill or care.<sup>5</sup>

It seems that the surgeon may, as tending to show that he possesses the requisite skill, introduce evidence that he has received a good medical and surgical education, that he has attended a course of instruction in surgery at a medical school of high reputation, and has otherwise received good, scientific tuition in surgery.<sup>6</sup> Manifestly such evidence is not conclusive. For, after all, the question is not what he is able to do, or what his education

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1. *Smothers vs. Hanks*, 34 Iowa, 286.

2. *Leighton vs. Sargent*, 27 N. H., 460.

3. *West vs. Martin*, 31 Mo., 378.

4. *Leighton vs. Sargent*, *ubi supra*.

5. *Wood vs. Clapp*, 4 Sneed, 67.

6. *Leighton vs. Sargent*, *ubi supra*.

should have prepared him to do ; but what did he do ; what skill did he display in the particular instance. Still, as a man will generally use such skill as he possesses, the fact that he has acquired skill in his profession affords a presumption, in the absence of rebutting proof, that he exercised proper skill in the particular case.<sup>1</sup>

It has been already stated that one of the obligations devolving upon the patient is to comply strictly with the physician's directions. And if a cure is not effected, or injury results, the practitioner will escape liability if it appear that a lack of attention by the patient to such directions, substantially interfered with the treatment, or substantially contributed to the injury. It may also be shown that neglect or carelessness of any character on the part of the patient substantially contributed to the adverse result.<sup>2</sup> But the burden is on the practitioner to show such acts, and that they substantially contributed to the injury.<sup>3</sup>

It may happen that a patient insists upon the performance of some surgical operation which the surgeon thinks unnecessary. In such case a serious question presents itself—one which may well cause the surgeon to hesitate. With his duty in such a dilemma viewed from a purely ethical standpoint this article has nothing to do. With the legal bearing of the question, and the course which will relieve from legal liability, we are alone concerned. His first duty is to advise against the operation. And should he proceed to perform it, without expressing any opinion as to its necessity or propriety, the patient would be justified in presuming that in the surgeon's opinion the operation was proper. But suppose the patient insists. Then, if he is of mature years and sound mind, and is advised that the surgeon considers the operation unnecessary or improper, he cannot hold the latter responsible. He relies upon his own judgment, and not upon that of his profes-

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1. *Bogle vs. Winslow*, 5 Phil., 136.

2. *West vs. Martin*, 31 Mo., 379.

3. *Gramm vs. Bæner*, *ubi supra*.

sional adviser; and the consequences he alone must bear.

The following instance of this kind occurred in Indiana:<sup>1</sup>

Dr. Gramm was called to set the arm and leg of one Bœner, which had been broken, and performed the operation. Some weeks afterward, the bones of the arm being slightly out of place, either from having become displaced or from not having been accurately adjusted originally, Bœner asked the surgeon to rebreak it. He at first refused. The patient repeated the request again and again. Dr. Gramm advised against it; said it would be of no use; that it had better be left alone, and that he ought not to think of it. Notwithstanding all this the patient stated positively that he wanted it rebroken. Thereupon the doctor complied, rebroke the arm and adjusted the bone more accurately. Bœner lost the use of his arm, and brought an action against the surgeon, based partly upon his action in rebreaking the arm. At the trial the court told the jury in effect that the surgeon was not justified by the mere request of the patient in doing an act that would imperil the limb, and that if he did it, he was answerable for the consequences. The Supreme Court reversed the judgment, declaring the law to be as already stated above.

The practitioner may feel that but an uncertain standard is presented for his guidance. He would fain have something more reliable; a sure indication when he is within the rule, and secure from vexatious and losing litigation. But, unsatisfactory as it may be, no other standard is offered. It is the same as that by which the lawyer, and the follower of every other profession is to be tried. The difficulty is not in the rule. It is in the application of it. Nor would it be easy to suggest a better. So long as men are fallible, so long may the question whether a professional man has in any given case come up to the standard, be decided differently by different juries. And the physician is not the only litigant who has occasion to lament the incomprehensible conclusions of the twelve. No path of absolute

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1. *Ibid.*

safety can be pointed out. Yet to him who keeps abreast with the spirit of progress, who carefully avails himself of the best methods, and adopts all well-tested improvements, while absolute immunity from law-suits cannot be promised him, there is little danger of any disastrous consequences.

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## CASES FROM PRACTICE.

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### DISPLACED SPLEEN MISTAKEN FOR SUB-PERITONEAL FIBROID OF UTERUS.

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BY P. V. SCHENCK, M. D. *Surgeon in Charge Female Hospital, St. Louis.*

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Perfection in diagnosis is a desideratum of our profession. The indication of the progress of our science is the great advance made in this respect. The abdomen is the location which has been the most wrapped in mystery; but we are deciphering the language of the symptoms there revealed, so that we are becoming enabled to see that, as Gooch advises, not women's words, but their bellies, should be believed.

It is easier to say what the abdominal tumor is not, than what it is. To tell what it is, requires a sensitive and well trained ear, a practiced eye, a delicate sense of touch—the tracing from cause to effect. Proper diagnosis is the foundation upon which all successful treatment rests. Differential diagnosis in abdominal examinations has a social and moral scope outside of the scientific. Abdominal surgery has increased immensely the weight of such diagnosis. .

It is not singular that many and sad mistakes have been made, such, for instance, as the celebrated one where Mademoiselle Jauvrin, of Berlin, was sued for concealed pregnancy and child murder, when she was in fact suffering from ovarian dropsy. Gooch relates a case brought to the table for ovariectomy, and postponed to the next operating day; but before it recurred she was delivered of a child. Dubois tells us where

a friend of his delivered a clinical lecture on ovarian tumor. The patient was taken from the room, and soon delivered of an infant. Baker Brown reports that he has seen three cases sent to St. Mary's Hospital in one day by different medical men, where pregnancy had been mistaken for ovarian tumor. Sir James Simpson reports where a female with enlarged abdomen, was supposed by several gentlemen to have ovarian tumor. They all concurred in the propriety and necessity for the performing of the operation of ovariectomy. The day was fixed, and everything prepared, when, fortunately, the patient saved herself all the horrors and danger of the operation by giving birth to a child. Dr. Kammerer, of New York, has reported a case operated on for ovarian tumor, which proved to be a uterine fibro-myoma. Spencer Wells says that there are more than one hundred cases on record where the abdomen has been opened to remove an ovarian tumor, when the operator discovered it was uterine. Last autumn I saw one of the ablest ovariectomists this country possesses, open an abdomen in order to perform ovariectomy, and finding he had a spongy fibroid of the womb, close the incision.

The diagnosis of cystic fibromata of the uterus by means, of physical examination alone, is impossible. Péan and Spiegelberg both acknowledge this. They are generally taken for ovarian tumors, and their true nature discovered only when the abdomen is opened. Robinson reports a case where a large omental hernia, complicated with abdominal dropsy, was mistaken by several medical men for extra-uterine pregnancy. Dr. King, of New York, reports a case as having been treated in Chicago for a fibroid of the womb, in St. Louis, for a tumor of the ovary; in New York city, the operation of ovariectomy was about to be performed upon her, when, upon careful examination, the tumor proved to be a misplaced spleen.

The case which it is desired to report, is connected with that abnormal growth of the womb, known as fibroids—that condition which Baillie has called hard tubercles; Hooper, sub-cartilagenous growths; Virchow and Kolb, myomatæ; Broca, hystero-ma. One calls them fibrous, another fibroid, and another fibromata.

A correct diagnosis of these tumors is essential. True, we have the authority of Bayle and Lobstein, confirmed by that of Cruveilhier and Lebert, that they never become malignant;



yet McClintock and Braun have told us they are the most frequent of all the organic diseases of the uterus. Bayle says that twenty per cent. of all women dying after thirty-five years of age, have uterine fibroids; and Kolb states that of those who die after fifty years, forty per cent. are thus affected. King informs us that there is no organ in the body more prone to exhibit a superfluous growth of connective tissue than the uterus.

Add to their common occurrence, the size they attain. Dupuytren reports one at twenty-five pounds, Courty one at fifty, while Walter has recorded one at seventy-five pounds. Then again superadd the ill-effects they produce. As soon as they surpass the size of a pigeon's egg, they cause uterine dislocations. One-third of those who have them, become invalids; the pleasures of life cease, and existence is burdensome; married life is made unhappy, as fibroids are often followed with sterility; and even when pregnancy is associated with them, they grow more rapidly, acquiring a size, as Cazeaux has reported, in four months, as large as in the non-pregnant condition it would have taken several years to attain. Another point is the tendency they have to produce hemorrhage. Existing as parasites in the uterine walls, they stimulate uterine contraction, so much so that the womb has become inverted in its effort to expel a tumor.

But, say some, how can a dislocated spleen be mistaken for a uterine fibroid, since a tumor at the fundus is more discernible than any other by palpation through the abdominal walls? But under all circumstances the diagnosis by external manipulation, presents great difficulties. He who expects in all fibroids to find the hardness like wood, the irregularities of outline, the unequal and bosselated surface as constant symptoms, will be mistaken—likewise will he be mistaken if he expects in all cases, to find the indication of the presence of the spleen in its normal position so marked as to be beyond question. Many a practitioner has had cases where the spleen was so small that the most careful percussion failed to elicit manifestations of its presence.

CASE.—Jennie H., aged 21, native of Indiana, married, was a patient in this hospital five times during the years of 1877, '78 and '79. The history of her case is one of special interest. Between July 1876 and the date of death, she was either under

the charge of, or examined by most of the prominent physicians of this city; part of the time she resided in the family of a physician; her case was pointed out as a typical one of uterine fibroid; and by nearly all she was treated by the use of ergot, given either epidermically, hypodermically, or by the mouth.

In July, 1876, she had small-pox, from which she recovered. November 7th she was attacked with diarrhea. When she was admitted here, she had colitis and peritonitis; the abdomen was so sensitive and tympanitic that no internal organs could be traced. Still that there was a tumor of considerable size was apparent to the eye.

Examination per vaginam showed there was some endocervicitis; but a large weight was felt pressing down on the anterior and left vaginal walls. She said that this tumor was enlarging, and she had noticed it for several months. She did not desire treatment for that, as she had been under the care of a physician outside, and she had the medicine with her. In one bottle was contained the muriated tincture of iron, and in the other, the fluid extract of ergot; of the former she took twenty drops, twice a day; of the latter, she took half a teaspoonful, three times a day. Her case was diagnosed "Suspected fibroid tumor, dysentery with peritonitis." After a period of one month, she was discharged "improved."

Her second admission was on account of an acute affection for which she remained but a few days; no minute examination was made.

The third time she was admitted, she was suffering from metrorrhagia, severe pains over the abdomen, sacral pains, headache and nausea; the tumor was very marked; the womb of normal depth, with a slight left lateral displacement; the os was eroded. The tumor was attached to, or seemed to be a part of the womb; when it was moved, the womb moved also, as could be distinctly felt with the finger of the other hand placed on the os uteri. On consultation, the diagnosis of fibroid tumor of the womb was made.

The fourth time she was admitted, she again desired to be treated only for her cough. Upon examination of her chest, the lungs were found to be tuberculous, and the left lung had already commenced to break down. She left here improved as far as her strength was concerned; but in one month after-

wards she was readmitted, suffering from phthisis pulmonalis. Her condition had become much worse; both of the lungs had cavities. On examining the chest carefully, we found that where before we had thought the spleen was located, as dullness indicated, it was now clear; and that she had emaciated rapidly and greatly, so that where it was impracticable to examine before, it was now plain.

We diagnosed the tumor to be a displaced spleen fastened in some manner to the womb. Three months afterwards she died, and a post-mortem made by Dr. Pharr, my senior assistant, fourteen hours after death, revealed as follows: Rigor mortis not well marked; emaciation great; some ascites; spleen dislocated; capsule complete; color normal. There was chronic-peritonitis, local over spleen in its abnormal location. There were firm bands attached to the capsule holding down the spleen; the bulk of spleen was in the left inguinal region, covering the fundus uteri which fitted in the hilum; the spleen extended into right inguinal region; veins of mesentery, much enlarged, full of dark blood; the colon very much contracted, about the size of the index finger; the walls thickened and congested; uterus and ovaries normal; the walls of the abdomen normal. Liver hypertrophied; position, normal left lobe extending far over in left hypogastrium. The lungs were filled with tubercles, large cavities in each being near apex. Spleen weighed thirteen ounces.

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## ABSCESS OF BRAIN.

BY EUGENE F. HAUCK, M. D., ST. LOUIS.

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E. M.; age, 45; married; hard drinker; admitted to City Hospital June 30th, 11.30 A. M., in a semi-conscious condition; would answer questions put to him now and then, but with great difficulty in articulation; deglutition was also difficult; right arm, thigh and leg paralyzed, with some degree of rigidity; facial nerve not involved; pupils dilated, not fully, however; tongue dry; pulse, 90. No anesthesia on affected side; temperature slightly less than on left side. July 1st, 9 A. M.—

He is less rational than yesterday; pupils react on exposure to light; pulse, 72, and regular; extremities on right side paralyzed; no rigidity to-day. Abscess of brain was diagnosed, but exact location was not positively determined. 5 P. M.—Totally unconscious, recognizing no one; constantly mumbles inarticulately; breathing somewhat labored. July 2d, 9 A. M.—Breathing somewhat labored; purulent looking fluid passing from both nostrils with each expiration; now and then from mouth also; frothy material now and then from mouth. A few seconds before death pupils were *entirely* contracted and rigid. There were a few spasmodic gasps, and abundant discharge of purulent fluid from nostrils and mouth; the face and ears became cyanosed; the pupils rapidly dilated; the pulse disappeared. Death took place at 9.45 A. M. The necropsy, which had to be performed in a hurry, examination of the brain alone being allowed, showed consistency about normal, considerable congestion, slight effusion into lateral ventricles, and an oval abscess cavity in the frontal lobe of the left hemisphere, involving the external and posterior portions of second and third frontal convolutions. The boundaries were irregular, one side appearing as if cut out by a concave chisel, whilst the other was covered by an opaque membrane (probably thickened arachnoid and pia mater), which enclosed several small blood vessels. The brain tissue around this was, if abnormal, indurated to a slight extent only. Nothing else abnormal was found in the brain.

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#### ENTERO-UTERINE FISTULA—RECOVERY.

A. T. EINBECK, M. D., HOLSTEIN, MO.

Ida K—, 12 years of age; had never menstruated; was attacked with peritonitis, December 15th, 1879. Her general health had always been good, except that last spring she had an attack of double pneumonia, from which she recovered after four weeks. The peritonitis was of a mild form, and I have nothing to report concerning it, except that the patient was constipated on the second day, but was relieved by an in-

jection of soap and water. Made my last visit December 13th, when I found patient fast improving.

December 27.—Has so far recovered that she can walk from sleeping room to the kitchen.

December 29th.—During the absence of her mother in the kitchen, patient climbed on the step-ladder which leads to the garret, to get some hazelnuts. Unfortunately the ladder slipped, and the patient fell about ten feet to the floor in the kitchen. Her mother found her in a comatose condition, placed her in bed, washed her, when she soon came to herself and complained only of headache. This was in the evening, and the following night she began to complain of pain in the hypogastric region, which became so intense towards morning, that her father sent for me.

December 30th.—On my arrival, patient complained of a little headache, nausea and a little pain in the hypogastric region. Her bowels had not moved since the day before. Pulse, 81; temperature, normal; bowels were moved by an injection; nausea relieved by mustard poultice; if necessary, one-tenth of a grain of sulphate of morphine should be given.

December 21st.—Did not see patient to-day, but her father reports that she is "all right again." She has rested well without taking any of the morphine powders. No other medicine was prescribed.

January 9th, 1880.—Heard from patient to-day. She is doing very well; but a very little pain is felt again in the hypogastric region.

January 12th.—Complains of a little pain yet, but is up and going about.

January 19th.—Patient is well; taking out-door exercise; no more pain felt in the hypogastric region.

January 21st.—In passing, I made a call. Found patient well and hearty. Her mother stated that her appetite was good, bowels regular, and daily out-door exercise was taken. No more pain was felt in the hypogastric region, but since early this morning she had felt a little "back-ache." A very few streaks of blood were noticed on her shirt by her mother; thinks that she is menstruating. About one hour after I saw the patient, a very sudden discharge of feces, blood and pus took place from the vagina. I saw her soon after this occurred, and found her in a prostrated condition. Noticed very little

pus and a few clots of blood, hard feces and a large quantity of watery fluid of a peculiar yellowish color and of yeasty smell. Had to abstain from closer examination on account of weakness of patient and of not having the instruments with me.

January 22d.—Patient about the same as yesterday. Ordered antiseptic injections, and postponed examination. No more pus and blood were discharged; feces and yellow fluid of yeasty odor continued.

January 23d.—Discharge of hard feces from vagina somewhat less; the thin yellowish looking fluid still continued; noticed no pus or blood. Patient feels a little stronger and consented to an examination, which was made without positive result. No opening in the vaginal wall could be detected. The uterus was found in position. On account of the extreme narrowness of the parts, it was very difficult to make a positive diagnosis.

January 24th.—Her health about the same; pulse, 82; temperature, normal; vaginal discharge has been less for the last twenty-four hours. Ordered a tonic pill three times a day and milk and farinaceous diet.

January 27th.—Vaginal discharge continued, very little hard feces have passed from the vagina for the last 24 hours. The pills ordered on the 24th inst., have passed undissolved from the vagina. Examined patient to-day; but as before, on account of the extreme smallness of the parts, I could not exactly ascertain the seat of the injury. But judging from the vaginal discharge of a peculiar strong yeasty odor, and the pills being also found undissolved in the vagina, during the examination, there could be no mistake that a communication with the small intestines was present. Pills discontinued; diet as before; antiseptic injections continued.

January 28th.—Heard from patient to-day; health improving; vaginal discharge less; was sitting up in rocking chair.

February 5th.—Visited patient to-day; health has been steadily improving; vaginal discharge is less; hard feces have not passed from vagina for the last five or six days; a very small quantity of the yellow discharge still continues.

February 11th.—Bowels regular and no vaginal discharge at all since Feb. 6th, (reported by her father.) Diet still continued; injections, ditto.

February 13th.—A little fecal matter, semifluid, well mod-

eled, passed from vagina once to-day accompanied with a few very small clots of blood and about a tea-spoonful of pus; otherwise improving.

February 18th.—Vaginal discharge has stopped entirely bowels are regular; temperature and pulse, normal; health, improving; diet and injections continued.

February 23d.—A small clot of blood and some pus passed from vagina to-day; no discharge from vagina since last report, (Feb. 18th.) Health improving.

February 27th.—A very little yellow discharge from the vagina again to-day. Besides, has had two regular passages of hard feces; has a very good appetite; walks about the house.

As her general health had so much improved that patient could be taken to St. Louis, I proposed to her father, to take her there and consult Dr. Hodgen. In consequence of my proposition, patient left for St. Louis March 1st, and returned from there again March 5th. Dr. Hodgen has examined the case, and thinks that there is an opening between the small intestines (supposed jejunum) and the uterus. A probe was passed  $2\frac{1}{2}$  inches into the uterus without meeting obstruction. The os uteri is large and patulous. Since the patient has returned from St. Louis, the discharge from vagina has entirely ceased. The diet and the injections were continued for about six weeks, and patient is now enjoying good health, and is as stout as before. She goes to school again, and besides, assists her mother in her general house work. She may now (June 22d, 1880,) safely be pronounced "*cured.*"

[Dr. Hodgen states in connection with this case, that by means of a urethral speculum he could see the mouth of the uterus which was patulous, and could discover no opening in the vagina.—ED.]

## THE SUBSTITUTION OF A LEAD PLATE FOR A PORTION OF THE FRONTAL BONE.

By M. H. Post, M. D., St. Louis.

The following case is one of interest from its rarity, and from its unexpected, favorable result. When I took the case under consideration, I was unable to find a record of any similar case; and I hope my desire to help some professional brother in a similar strait, is a sufficient excuse for presenting the following account:

Some two years ago, while assistant physician to the St. Louis Female Hospital, a patient came under my immediate charge, suffering with tertiary syphilis. She had passed through the preceding stages, and during part of the time had suffered great pain, and had acquired the opium habit, at times taking as much as a drachm of morphine a day. One night, while under the influence of morphine, she struck her head against a nail (this is the account given me, but I think it doubtful, as there are a number of scars on her forehead), which resulted in necrosis of the bone.

When she came under my treatment, she had several gummata, and an ulcer upon her forehead, exposing the bone. She was put on as large doses of potassium iodide as she could bear. She was cured of the morphine habit; and the necrosed bone, separating from the living bone, was removed. After being in the hospital for a number of months, she recovered, and was discharged.

During the month of April, 1879, the woman came to my office to know if I would not do something to improve her personal appearance. At that time her health was good; but there was a deep depression near the center of her forehead, where the loss of bone had occurred. The depression was about  $\frac{1}{6}$  inch deep,  $\frac{3}{4}$  inch in its transverse axis,  $\frac{7}{8}$  inch in its vertical axis; approximately rectangular. It was noticeable at some distance, and was too low down to be covered with her hair. She wished me to fill it up in some way. I tried to dissuade her, telling her that any thing introduced beneath the skin would irritate, and ultimately ulcerate out, making a



larger scar than the original one. I consulted with several medical gentlemen about the case, and they all advised me to leave it alone; and I was very sorry when the patient reappeared. I told her the chances were nine out of ten against success; but she insisted, and agreed to take the risk. Accordingly, June 24th, 1879, with the assistance of Dr. McCandless and Dr. F. Glasgow, I performed the operation. The day previous I took a cast of the depression in plaster of Paris, from which I made a lead plate. My reasons for using lead were that the tolerance of bullets in the body seemed to teach that lead is innocuous; lead was much cheaper than silver, and at the last moment could be cut into a new shape, if necessary. The patient had been taking potassium iodide for some days.

As soon as the patient was anesthetized, I made a horizontal incision about half an inch above the upper margin of the depression; through this cut I dissected up the skin and scar tissue, keeping close to the bone. When the depression was reached, there was considerable difficulty, as the scar tissue was extremely thin, and firmly adherent to the bone. The dissection having been accomplished, the lead plate was slipped in, and the horizontal incision sewed up. The knives used and the plate were immersed in a weak solution of carbolic acid in water. The plate weighed a drachm and a half. The wound was dressed with cold water dressings. There was considerable redness and heat following the operation, and considerable serum was effused about the plate, so much that twice I drew it off with a hypodermic syringe. The case progressed favorably, and I find in my note book, "July 28th, the forehead is smooth, and there are no signs of inflammation."

A bandage was worn about the forehead for some time to keep the plate from moving about, and it also was pleasant to the patient, as it seemed to relieve a sense of weight which the plate produced. This has been given up, and there are no signs of the foreign body doing any harm, it having been tolerated for over a year.

There are three points particularly to be borne in mind—1st, the plate lies on bone; 2d, it is covered by scar tissue; and, 3d, the scar tissue is not more than  $\frac{1}{16}$  inch thick.

I saw the patient to-day (June 30th, 1880); the plate was in place, giving no trouble, and was filling its purpose so well, that I found myself examining the wrong portion of the forehead.

## EDITORIAL.

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## THE TANNER FAST.

The newspaper world has been much occupied with Tanner's proposition to pass forty days without food; the lack of other matter during the dull season of the year, has made this exhibition in New York City a piece of good fortune to the daily press, which devotes columns to the latest manifestations, with all possible commentations, notes and addenda. The profession in New York, at the outset, refused to take charge of Tanner, he being unknown and possibly a mere trickster, desirous of notoriety and hopeful of "gate money." In view of past experience, this supposition was reasonable, and no responsible physician has the time to devote to the rigid and constant surveillance day and night, of a cunning imposter skilled in his trade. But, granting Tanner to be an honest man, with remarkable confidence in his vital powers, and a humane desire to prove that prolonged fasting is not necessarily fatal, his undertaking becomes one of only moderate interest. The press, with its usual zeal, has unearthed a number of cases of prolonged fasting that have not appeared in works of science, and which, if capable of positive authentication, would be of medical interest. In all these cases of local wonder there is reason to suspect trickery, especially when the subjects are females. In Great Britain it will be remembered that, not long since, a "fasting" girl, when put under strict and absolute supervision, starved to death and without complaint. The value of Tanner's exhibition is to be estimated after due consideration of the circumstances. What is he to determine? The fasting of

a sick person is altogether another affair; the system is stricken by a consuming disorder, the fevered pulse indicates an unnaturally rapid destruction of the tissues, the mind is affected; under these conditions rigid fasting but accelerates the too speedy tissue waste, and while the physician accepts the direction of Nature and does not urge food, he nevertheless will not refuse any light and appropriate nourishment as it may be craved. The compulsory fasting of men cut off from supplies in mines, or upon the march, or shipwrecked, is altogether different from Tanner's. Such unfortunates labor under intense mental excitement; they struggle against their fate until exhausted nature succumbs; they perish more from prostration than from the mere deprivation of food. Tanner, by reason of the warmth of the summer atmosphere, abstention from exercise, and freedom from mental worry, saves his energies; he also takes water, which is well known to prolong life in the absence of food. The exhibition, then, can claim at the utmost only a moderate degree of scientific interest, supposing it to be a perfectly honest one, and the subject a man of integrity. Perhaps some enthusiast in our ranks may be moved to "tempt Providence," and with the accurate deliberation of a scientist binding himself down in the cause of humanity, Prometheus-like, to be a prey to devouring pangs of starvation, invite his fellows to witness a transcendent vivisection. One good thing the public may derive from Tanner, and that is the knowledge that three or more hearty meals daily are not a necessity. The hard worker necessarily must be well fed, but there are multitudes who have not the same excuse for such indulgence. In America excellent and savory food is so abundant, that the temptation to over-eating is universal. That dyspepsia is a "national disease" is not altogether due to the use of tobacco and spirits; our too seductive markets are responsible as well.

The idea may occur that starvation might be a good method of treatment in some cases—Compel the body to use up its own reserved stores and then feed upon itself, searching out every available molecule of albuminoids and hydro-carbons, reducing the aggregate weight of the tissues to the last degree compatible with restoration. Such a course would afford a

skeleton system to be re clothed with a fresh and consequently unimpaired tissue material—a sort of new birth, or reduction of Kant's metaphysical theory to actual visible practice. We all know the unwonted elasticity, the rejuvenation that blesses a fortunate convalescence in a good constitution after a severe but not too extended illness. Such an experience is almost worth a sickness, if it come at a perfectly convenient time. The violent fever denotes rapid tissue destruction, and at the same time the system refusing food, an extensive reduction of the body ensues; but the brevity of the attack leaves the inherent vigor untouched, and prepared to assimilate food with rapidity and effect. It is, however, a question whether the unremitting mental strain necessary for self-control required by such a method of treatment, could be commonly borne, or would not altogether negative the treatment.



#### ANALGESIA BY RAPID AND FORCIBLE RES- PIRATION.

To escape suffering pain, to avoid giving pain, are points of interest and importance to both patient and surgeon. There are many minor surgical operations, such as the extraction of teeth, the opening of abscesses, etc., which are of such brief duration that surgeons are reluctant to incur the risk of chloroform or the annoyance of ether, and which are yet attended with very great, sometimes intense pain. Especially in dental practice nitrous oxide gas has been used quite extensively, and with great satisfaction, but the facilities for its administration are not always at hand.

At a recent meeting of the Philadelphia County Medical Society, Dr. Benjamin Lee brought before the society the results of some observations and experiments which he had made upon the subject of analgesia induced by forcible and rapid respiration. From his paper published in the *Philadelphia*

*Medical Times*, we gather the following facts concerning the subject:

His attention was first called to the subject by the report of a servant who had been sent to Dr. Bonwill, a well-known dentist of Philadelphia.

She said that "Dr. Bonwill had pulled her tooth and did not hurt a bit," that "he had made her breathe as fast as ever she could, and before she knew it the tooth was out." There was no pain, although she perceived the jerk, when the tooth was extracted.

Not long after this, he had occasion to open an abscess in the perineum of a young man about twenty-five years old, rather delicate and decidedly nervous. After the young man had made rapid inspirations for about three-quarters of a minute, the doctor made an incision about an inch long and evacuated several ounces of pus. He continued the rapid breathing for at least a half minute longer, and was surprised to find that the operation was completed. He had felt nothing except a sensation of pressure upon the tumor. A fistulous communication with the urethra appeared in a couple of days, and it became necessary, ultimately, to lay open this fistula. Two bridges, each an inch broad, were divided with scissors on a grooved director; and by the same method perfect freedom from pain was secured, although the operation was, of course, much longer than the former one.

In another case where he lanced a felon, there was not the same success. The patient's nerves were completely unstrung from the intense and protracted pain which she had undergone; and she could not be made to breathe with sufficient force and rapidity to secure the desired effect.

In another case also of an hyperesthetic, hysterical lady, in whom he attempted to inject a pile with carbolic acid, the rapid respiration failed to produce analgesia.

Two members of Dr. Lee's family have had teeth drawn by Dr. Bonwill while they were under the effect of the rapid breathing. One of them spoke of a sensation of giddiness produced by the rapid respiration.

Dr. Lee does not undertake to explain how this effect is pro-

duced, whether it is a form of hypnotism or the result of a modification of the cerebral circulation, brought about by the respiratory act. He merely brings forward the result of his observations thus far, believing that they show that by a continuance of rapid and forcible respirations for a certain length of time, it is possible "to induce such a condition of the nervous system that pain shall not be appreciated by the sensorium."

Dr. Bonwill has made use of this mode of securing freedom from pain in dental surgery for several years past, and especially during the last five years. He informs his patients that they will be fully conscious of all that occurs, and perceive every touch, but will feel no pain if they keep up the inhalations energetically and steadily during the whole operation.

The inhalations must be at the rate of one hundred a minute. It is very difficult for a person to breathe more than one hundred times a minute, and "*for the minute following the completion of the operation the subject will not breathe more than once or twice.* Very few have force enough left to raise hand or foot." Dr. Bonwill claims that the results of his experience are such that there is no longer any necessity for chloroform, ether, or nitrous oxide in the *dental* office for the purpose of extracting teeth or deadening sensitive dentine.

Drs. Garretson and Hewson have made use of this system of rapid respiration in connection with the usual anesthetics in major operations where time is needed, and find a much smaller quantity of the drug to suffice than when it is given in the usual way.

Dr. Hewson makes use of the rapid breathing to the exclusion of drug anesthetics in midwifery practice.

Dr. Bonwill's theory of the effect of the rapid respiration is: First. That there is diversion of the will-force in the act of forced respiration at the rate of one hundred per minute, which involves such concentrated effort that ordinary pain would make no impression while this abstraction is kept up.

Second. That there is a speedy effect due to the excess of carbonic acid set free from the tissues by the rapid respiration.

Third. That hyperemia is caused by the rapid respiration retarding the flow of blood from the brain.

In the discussion of the papers of Drs. Lee and Bonwill, Dr. Hewson stated that he constantly employs this method of securing analgesia in minor surgical operations in his office. He does not accept the explanation of Dr. Bonwill, at least so far as the second point is concerned. He claims that the blood is less thoroughly oxygenated with one hundred respirations per minute than with the usual number.

Several other members of the society stated the results of their observations. Dr. Kite stated that "at first there is a decided sense of exhilaration during rapid breathing, just as from ether, then the senses become confused, there is blurring of sight, peculiar buzzing in the ears, and more or less vertigo."

Further observation and investigation are necessary to determine the scope as well as the *modus agendi* of rapid respiration in causing analgesia, but if it shall prove as efficient in the practice of the many as it had done with Drs. Lee and Bonwill, it will be a very valuable discovery.

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## ON THE DIAGNOSIS AND TREATMENT OF PHTHISIS.

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In a paper read before the Philadelphia County Medical Society, Dr. Carl Seiler draws attention to certain diagnostic changes taking place in the larynx in the earlier and later stages of phthisis. He states that the mucous membrane of the larynx affords a positive index to the condition of the lungs, even in cases where percussion and auscultation give negative results. He believes that the changes in color and shape of the larynx are so characteristic that when once they have been seen, they will always be recognised. He describes these changes to be, first, a peculiar ashy-gray discoloration of the mucous membrane of the pharynx and larynx, a characteristic appearance quite different from that of anemia.

Secondly, they consist in a peculiar swelling of certain parts of the larynx, especially of the arytenoid cartilages and

epiglottis, which differs materially in shape and appearance from ordinary edema of the parts. The arytenoid cartilages, either on one side or the other, or on both sides, assume the shape of a pear, the largest amount of swelling being near the inter-arytenoid commissure, while it tapers off in the line of the ary-epiglottic folds. Usually this pyriform swelling is noticed on the side of the lung most affected, but this is not always true. Less frequently a turban-like swelling of the crest of the epiglottis is seen, which at the same time assumes a horseshoe bend. Dr. Seiler states that the pyriform swelling of the arytenoid cartilages may exist previous to the affection of the lung, but that when the epiglottis is affected, there is certainly breaking down of the lung.

He describes the microscopical examination of these swellings as revealing an infiltration of the sub-mucous tissue by masses of small cells, with a tendency to the formation of depôts with cheesy centres and an hypertrophy of the glands and follicles, so as to amount almost to an edematous growth.

In the diagnosis of the earliest stage of phthisis, great stress is laid on the *pitch* of the percussion note—and the suggestion is made that even where physicians have not an accurate ear for musical tone, they can make use of a xylophone and so determine variations of pitch of the percussion sound at different localities of the thoracic cavity, and by recording the pitch as determined by this instrument, can observe its change as the disease advances or improves.

He advocates, in the treatment of phthisis, slightly stimulant inhalations combined with the use of fatty articles both internally and externally. In giving the directions for inhaling, he says, any available vessel may be used, as a tea-pôt, a funnel placed over a cup, or an inhaling bottle—these should contain hot water, to which may be added tar, balsam of tolu or similar substances—a deep inspiration should be taken so as to fill all the available space in the lung, and then the breath should be held as long as possible. The effect of these forcible inhalations is to force a small quantity of air into the obstructed air-cells and thus to allow the discharge of the debris, the result of the pathological process. The idea is somewhat similar



to that advanced by Dr. Gadbury and endorsed by Dr. J. Solis Cohen, at the late meeting of the American Medical Association. [See page 97, this number.]

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### ON THE INTERNAL USE OF WATER FOR THE SICK.

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Dr. J. Forsyth Meigs, has recently published an interesting brochure upon the subject of administering water internally to the sick. The doctor prefaces his remarks with the statement, "I learned from him, (Dr. Meigs, Sr.,) early in my career, that it was rarely wise for the physician to refuse water to a thirsty patient." Abundant illustrations are given from the records and from private practice to enforce the truth expressed in that admonition. It is always grateful to note in the profession an advance in the direction of rendering honor to Nature and respect to her intimations, rather than a rigid adherence to old dogmas. Physiology has accomplished much in these later days of active and successful research, in the way of infusing a better knowledge of the needs of our bodies in disease as well as health; physicians now, animated with a more distinct knowledge of the phenomena of tissue life, are less inclined to dogmatise in practice, and are on the alert to watch for the indications of the *Vis Medicatrix*.

This brochure of Dr. Meigs is one of the publications of the times, aiming at the alleviation of one of the greatest torments of the sick, that of enforced thirst; it bases its argument upon the plain teachings of physiology. We now know that the sensation of thirst, like that of hunger, for ordinary food and for oxygen, is not localized in any one organ or part of the body, it is a cry from all the tissues throughout for aliment; it is a demand too imperative and vital to be neglected or treated with open disregard. Who cannot recall the suffer-

ings of a sick room, when the greatest possible boon, a cup of cold water, was remorselessly denied, although the hot dry skin, the parched mouth and cracking lips, the wearying restlessness eloquently plead with the entreating voice? when the fevered dreams brought the gurgle and rush of pure flowing water, and every thought became concentrated upon that one overpowering want, a drink of cold water? This book of Dr. Meigs is an acceptable peace-offering to those long days and nights of torment. The doctor calls attention to a fact, that needs to be borne in mind. Infants may seriously suffer from thirst without its being noted; he also advises the administration of water even in cases of cholera-infantum, diarrhea, and indigestion of young children. Practice has made great advance in the indulgence of the sick in respect to the use of water; bathing and sponging, together with free use of water and ice internally, rob the sick room of much that up to within a few years made it a terror to the nurse as well as unnecessarily painful to the patient.



#### VIVISECTION—THE ENGLISH INSPECTORS REPORT.

In the last number of the *COURIER* notice was taken of the various repressive measures adopted or recommended in this country and Europe, in regard to vivisection. The German Government, after the exact and thorough inquiry characteristic of that nation, has decided that such method of investigation is indispensable in educational institutions. Virchow, before the imperial commission, declared that since Great Britain passed the infamous bill, restrictive of vivisection, *no physiological work of any importance whatever*, has been accomplished in that country.

The London *Lancet*, (June 26, 1880,) gives a synopsis of the report of the inspectors under the Vivisection Act for the year 1879. It appears from the report that the total number of experiments performed in England and Wales was 270, of which number there were about twenty-five "in which there is reason to believe that any material suffering was caused." Of these, however, "fifteen were cases in which disease followed the inoculation of infectious matter, but in which no painful operation was performed; and ten were experiments upon as many frogs, in which an incision of the skin was required for the introduction beneath it of a medicinal substance." The quotations are from the inspector's report.

The *Lancet* very reasonably asks, If the suffering in the latter case (frogs) is to be described as "material," we should be interested to learn the inspector's idea of suffering, which may be described as "trifling." There were thirty-six licenses to vivisect issued in England and Wales, but no less than ten were not used. In Ireland out of eight licenses four were not used. In England and Wales no less than thirteen licenses are no longer in force. The *Lancet* pointedly remarks that the reasons for this should have been stated in the report. One of the lapsed licenses is that of the professor of physiology at Cambridge.

The *Lancet* sums up the impediments to study and original research under the Vivisection Act as follows: "An investigator has the opportunity and leisure to carry on a set of important experiments and applies for a license. So long a delay elapses before the license is obtained that the opportunity is past, the leisure gone; the license is for a limited time, and has expired before the opportunity recurs." Fancy an eminent student absorbed in his round of duties, but spurred on in his labors by the sense of the inestimable value of their results to the cause of humanity, pursuing an involved and difficult subject of research,—fancy such an one brought to a sudden halt to petition for a license that shall allow him for a certain length of time, to perform such and such experiments, upon such and such animals, with or without anesthetics, under condition of killing or not killing. An irascible experi-

menter under such trying circumstances would be apt to reply to Her Majesty's commissioner in a manner unbecoming a loyal subject.

At a late session in London of the International Association for the Total Suppression of Vivisection, one of the inevitable "noble lords" proposed a resolution demanding the total abolition of the practice of vivisection on the somewhat peculiar ground that it was scientifically useless; another *more* noble lord, a marquis, seconding the resolution. One of the speakers, who must have been a *most* noble lord, complained that on the question of vivisection, the press was entirely under the influence of the men of science. This whole English business savors strong of the Pickwickian, and we have difficulty, while reading, in preventing the celebrated Sergeant Buzfuzz and his peers from holding the court.

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PURE WINE.

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The German Government, investigating the state of the wine production in Baden, found that although for several successive years the vintage had been defective, the vintners were producing an *increased* quantity of the "finest wines." It was also discovered that large quantities of spirit had been imported into Baden. This raised suspicion, and the police have seized upon a great number of casks of supposed genuine wine, to be analyzed by the public officer. One firm, it appears, has been doing business to the amount of 500,000 marks since the beginning of the present year, and the police are in possession of evidence that it has purchased at least 300,000 marks' worth of foreign spirit. Such information will strike terror to the souls of lovers of hock. It has long been believed that American whisky has been sent to France, to be returned as best cognac, etc. In the south of France, the town of Cette has the unenviable reputation of manufacturing so-called wines on a large

scale, and its proximity to the wine-growing localities, both Spanish and French, give it special facilities. The French state that to export wine safely to America it must be treated with alcohol, otherwise it will spoil before consumed, a convenient theory, at all events—one that will cover a good deal of poor whisky in the shape of an adulterant. It is worthy of mention in this connection, that the Italian Government, viewing with well-founded apprehension the large importation of cotton seed oil, proposes to lay upon it a heavy duty, to protect the olive oil interest.

It is a matter of serious regret that pure foreign wine is so difficult to procure. It would be laughable were it not too embarrassing, to note the abundance of "foreign" wines that is offered in every small town in the United States, when it is well known that the special wine-growing districts are incapable of supplying a limited European demand. Those who have drunk the *popular* wines of Europe upon their native soil, know what really pure wine is like; of a truth it maketh the heart of man glad, and reveals the reason of the enthusiastic praise of the ancients, in whose times whisky and logwood etc., etc., were still in the womb of the malignant Future. For the convalescent or invalid, genuine wine is an invaluable medicine; but to prescribe at random sherry, claret, hock, champagne for the feeble system or rallying strength, is to deliver the patient over to the mercenaries who "make" but do not grow wine; the distinction between the two methods of production should be well borne in mind by the physician.

Our native wines do not as yet replace the foreign. The California product is apt to be too heavy; it seems to be charged with alcohol. Missouri wine has a good reputation, but still the delicacy of the Rhine and Bordeaux brands is not satisfactorily approached. However regrettable the fact, still it must be said that the physician in America cannot prescribe wine as freely as his practice demands. It is not safe to allow patients at will to purchase that stimulant.

### A BREAK IN AN IMPORTANT SEWER.

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A disaster to the local system of drainage work, which occurred in the early part of July, is deserving of notice on account of its gravity and the possible ill effect it may have on the public health here. The accident referred to is a break at two places in the line of Mill Creek sewer, where the work crosses the bed of what was in former times known as Chouteau's pond. The sewer is 15 feet high and 20 feet wide in the clear, built of stone, with a flat bottom composed of timbers. It drains about 6,000 acres, including some of the most populous portions of the city, receiving both the house-waste and rain-fall of that area, and is so situated that it has no relieving or intercepting channels. Sudden and very heavy falls of rain July 1 and 2, taxed its capacity to the utmost, and resulted in a weakening of the foundations of the arch, with a consequent sinking of the masonry for a distance at one place of more than 200 lineal feet, the alluvial deposit, or pond sediment affording, as the result shows, an unreliable foundation for such a structure, with the weight of superincumbent earth, exposed as it is at any hour, to the crucial test of sudden and impetuous floods.

The sinking of the body of the work, with the coincident thrusting upward and breaking of the timbers forming the floor, very greatly narrowed the caliber of the conduit, and seriously interfered with the cloacal functions of the sewer. The prosecution of the work of repair, which was promptly undertaken, will necessitate the upturning of large quantities of humid soil, charged with many impurities, together with free exposure of the interior of the sewer, as the work of rebuilding goes on. There is imperative need that the work be pushed rapidly forward; but nevertheless it must arouse a feeling of concern for the public health, when it is remembered that the heats of midsummer are not yet over, with an approaching autumn that threatens perhaps more than the usual amount of

malarial complication from rank vegetation, and recent river overflow and paludal submersion.

The proximity of these breaks to populous localities—to the Union depot, city jail, etc., must render them objects of solicitous attention on the part of those charged with the care of the general health, as the openings will effect a wholesale ventilation of the immense waste-carrier right in the heart of the city.

The necessity of prompt action in the matter was early recognized by the Health Commissioner, and the experiment of disinfecting and deodorizing the sewer and sewage has been undertaken. The task is one of no mean proportions, however, and the result, as regards successful issue, will be watched with considerable interest.

The effect of the sewer emanations, either alone or as coöperating with other morbid causes, on the ascertained morbidity types and mortality returns of the circumjacent territory, will be not devoid of interest, and will be carefully noted by competent observers. It is not anticipated that the health of the men engaged in repairing the break will be seriously affected, as a majority of them are inured to such work. The mishap, rather, will serve more as a test of the resisting powers of those exposed to the miasm who are not accustomed to it, at a season when febrile affections are likely to be most rife.

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## COMMUNICATIONS.

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2631 OLIVE STREET, July 26th, 1880.

*Messrs. Editors*—DEAR SIRS: In the July number of the COURIER, in the report of the Obstetrical and Gynecological Society, page 73, I observe that I have been reported to say the contrary of what I have said. First repeating the principle misquotation, I will attempt to state what I really said:

“Mr. President, I think we could *avoid* some of the evil effects of chloroform in labor, by the use of ergot. We can frequently use ergot to advantage.”

What I have said is this: "I think that we might perhaps *attribute* some of the evil effects of chloroform in labor to the simultaneous use of ergot, chloroform causing anemia of the brain (so its deleterious action is explained by some), and ergot causing contraction of the capillaries. It would appear from *a priori* reasoning, that this also causes anemia of the eccentric capillary system, and consequently increases the dangers to which the use of chloroform exposes. Despite the frequent administration of the two agents simultaneously, no accident, so far as I am aware, has been reported. My attention was called to this subject about two years ago, when I thought I observed such evil results of the combined use of chloroform and ergot—not in a case of labor at term, but in a miscarriage at the fifth month of pregnancy, the subject of which was an anemic lady of hysterical temperament.

The lady and her husband imperatively demanded the administration of chloroform, while future developments in the case demanded the use of ergot. The labor was short and everything progressed satisfactorily. About an hour after labor I was sent for hurriedly. I found the patient almost in collapse, complaining of an intolerable pain in the heart and stomach. The heart beat violently and convulsively; no elevation of temperature; the face cold. The time being altogether too short for the development of inflammatory troubles, and remembering the misgivings I had had when administering chloroform and ergot in such an anemic subject, I came to the conclusion that this depression was the result of the use of the above mentioned agents. Some brandy being at hand I gave her at once a tablespoonful (not a teaspoonful as reported) and repeated the dose in five minutes. This at once relieved the pain and depression before anything else could be done.

I should like to hear the opinion of the members present whether or not my surmises were correct, and why it is that such results do not occur more frequently.

EUG. C. GEHRUNG, M. D.



## BOOK REVIEWS AND NOTICES.

MAN'S MORAL NATURE. An Essay by RICHARD MAURICE BUCKE, M. D., Medical Superintendent of the Asylum for the Insane, London, Ontario. *New York: G. P. Putnam's Sons. Toronto, Ont.: Willing & Williamson. 1879. pp. 200.*

In these pages the learned Superintendent of the Asylum at London, has given a most interesting discussion upon that "function" of man which makes him what he is in the social scale—angel or brute. The author is certainly a lover of his race, and has studied devotedly all the better parts of human nature, setting before his readers in most agreeable if not conclusive manner, his thoughts upon the origin and development of the moral nature.

From many interesting coincidences as to physical development, longevity, and capacity for resistance against oppressive and repressive surroundings, as associated or contrasted with moral excellence or debasement, the probable conclusion is suggested that the moral nature of man is the result of the functional office of the great sympathetic nervous system. It has before been advanced that this great nerve was the seat of the soul, and the present monograph is perhaps to the same purpose. Evolution, natural selection and the survival of the fittest, find full support in the arguments adduced, and the entire reasoning is in perfect accord with the advanced, liberal, and to our view, reasonable teachings of the day.

The little book is indeed full of instruction and inducement to accept "condition of the whole matter," whether or not we accept the anatomical premises, which for our part we consider reasonable and not capable of disproof, while to the contrary, many curious facts seem to point very directly to the doctor's conception as to the "physical basis" of this element of life and happiness. The conclusion is, (to quote) "Love all things—not because it is your duty to do so, but because all things are worthy of your love. Hate nothing. Fear nothing. Have

absolute faith. Whoso will do this, is wise; he is more than wise—he is happy.” Good doctrine, and lessons worth learning, so that we cordially advise the labor-weary practitioner to rest his mind by granting it the intellectual feast presented in so happy a shape. M.

HEALTH AND HEALTHY HOMES. A Guide to Domestic Hygiene. By GEO WILSON, M. A., M. D., Medical Officer of Health for Midwarwickshire Sanitary District, etc. With notes and additions, by J. G. RICHARDSON, M. D., Professor of Hygiene in the University of Pennsylvania, etc. *Philadelphia: Presley Blakiston, 1880.* 12mo, pp. 313, cloth \$1.50. (Through the Hugh R. Hildreth Printing Company.)

During the last few years the subject of hygiene has received more careful attention from the medical profession than ever before; and, as a result, there has developed a more intelligent interest in these matters among the laity. The surest indication of this is found in the large number of books treating upon hygiene, that have been brought out by different publishers.

Among those that have been prepared for the general public, we have seen none that so fully satisfies the requirements as the volume of Dr. Wilson.

When it is considered that at least one-fourth of the annual mortality is the result of diseases which may be considered preventable by the observance of the laws of health, it is evident that too great importance can scarcely be given to this subject.

Following the introduction, chapter II, “The Human Body,” gives a condensed statement of important facts in physiology; chapter III, “Causes of Disease,” treats of hereditary influence, self-induced and social causes and material, local and communicable causes of disease; chapter IV considers “Food and Diet,” choice of articles of diet, mode of preparation, etc.; chapter V deals with “Cleanliness and Clothing;” chapter VI, with “Exercise, Recreation and Training;” chapter VII discusses “The Home and its Surroundings,” and chapter VIII “Infectious Diseases and their Prevention.”

Dr. Wilson has thoroughly considered his subject during years of experience and observation as an officer of health, and he has given us a work free from crude theories, and which commands the confidence of the reader.

A TREATISE ON FOREIGN BODIES IN SURGICAL PRACTICE. By ALFRED POULET, M. D., Adjutant Surgeon Major, Inspector of the School for Military Medicine at Val de Grace. 8vo. *New York: Wm. Wood & Co.* [Through C. C. Pease, St. Louis, Gen'l Agent Wm. Wood & Co.]

This treatise is in two volumes of about 300 pages each. It constitutes a part of Wood's Library of Medical Authors for 1880.

The author, as he says, "has undertaken a work which has no analogue in our classical literature. He has collated the observations of surgeons on foreign bodies as found recorded in the details of cases related in the medical literature of journals and books.

The first volume is devoted to the consideration of foreign bodies in the intestinal tract, but before entering upon its special province, we find in Part I, a discussion of foreign bodies in general, in which he gives as defining a foreign body the following: "By foreign bodies in surgery, are meant abnormal, solid, or fluid substances which have entered the body from without, which have penetrated the organism, or become fixed to its surface, and which by their presence or mechanical action modify the conditions of existence of the parts." A calculous concretion, an accumulated exudation or secretion, although foreign to the functions and normal condition of a part, is thus properly excluded from the list. It may act as a foreign body, but is not so considered. The author then gives his classification of foreign bodies and discusses the etiology, nature, manner of introduction and the fate of those bodies.

He then enters systematically upon the consideration of foreign bodies of pharynx, esophagus, stomach, intestine and rectum.

He enters upon each subject in the same systematic manner, going regularly through the prescribed plan, considering the nature of the body, the symptoms it induces, the complications likely to arise, the diagnosis, prognosis and treatment. This exhaustive consideration of each subject in all of its phases, makes the work unnecessarily verbose. This, I think, is the great fault of the work, and yet it is a fault which may be readily excused, because the author has evidently been very faithful in his endeavors to present all of recorded value in the history of illustrative cases. It is evidently a book which cost

the author much labor and time. He has endeavored to make it a complete book, and has, I think, lessened its value to many medical men by making it too diffuse. It is historical in its minute details of methods of procedure therapeutic and operative, and in its recital of cases with the names of operators.

Nearly one-half of the second volume is devoted to foreign bodies in the genito-urinary organs. The nature of these bodies is extremely varied, and will illustrate something of the morbid condition which is the source of the most frequent origin of this class of foreign bodies. In his list of foreign bodies found in the bladder, we find pins, pen holders, whalebones, shoemakers awls, glass balls, sealing wax, hair pins, fork with four prongs, leather, bones, watch chain, etc.

The second volume also treats of foreign bodies in the air passages, the ear and nose, and the glandular canals.

The volumes contain illustrations of instruments used and bodies extracted.

H. H. M.

TRANSACTIONS OF THE INDIANA STATE MEDICAL SOCIETY, 1880. Thirteenth Annual Session. *Indianapolis: Carlton & Hollenbeck, Printers and Binders.* 1880.

The first volume of State Medical Society Transactions for 1880, comes to us from Indiana. It is well printed on good paper, and contains a number of papers of considerable interest.

The President, Dr. J. R. Weist, in his annual address, discusses some of the "Problems in Relation to the Prevention of Disease." He shows the importance of the adoption by the State of such measures as shall, as far as possible, protect the citizens from the suffering and loss that result from the prevalence of epidemics, and urges the organization of a State Board of Health, to coöperate with the National Board.

He speaks of the influence of heredity in the production of disease, and the effect of unsanitary environment even upon those who inherit no taint; and closes with a consideration of some of the injurious effects upon health produced by defects in our system of school education.

Dr. W. Commons read a paper entitled "Ergot, its Use and Abuse."

He says that the action of ergot is prompt, uniform, and specific, and causes contraction of circular muscular fiber, and a diminution of the caliber of tubular structures. He does not consider it a parturient in any sense, but believes that it is much

more likely to interfere with and retard delivery, than to promote it. He uses it in obstetric practice, solely to secure contraction of the uterus at the conclusion of the labor. It seems to us that the ground which he takes is extreme, and that while ergot may be given in such a manner as to most seriously complicate labor, it may also be used in such a way as to render valuable service in this process.

An interesting medico-legal paper is that by Dr. Van Vorhis, entitled "Expert Evidence; What it is."

Besides the address of the President, there are three papers dealing with topics in connection with sanitary science—"Harmony and Associated Action in Connection with State Medicine," by Dr. J. D. Gatch; "Public Hygiene and Synteretic Jurisprudence," by Dr. J. W. Hervey, and "Sanitary Survey of Indianapolis," by Dr. T. M. Stevens.

The Committee on Publication are to be complimented on the promptness with which their work has been completed, and the very creditable appearance of the volume.

TREATISE ON THERAPEUTICS, translated by D. F. LINCOLN, M. D. from French of A. Trousseau and H. Pidoux. Ninth edition, revised and enlarged, with assistance of Constantine Paul. Vol. II. *New York: William Wood & Company, 1880. 8vo., pp. 299.*

This translation of the celebrated work of Trousseau and Pidoux, will be of interest in the Library of Standard Medical Authors, on account of the just renown, as a therapist and clinician, of the principal author, M. A. Trousseau. By omitting pharmaceutical details, the physiological action of drugs, and some sections that seemed to be of less value, the translator has abridged the work more than one-half, and it constitutes three volumes of "Woods' Library for 1880."

The chapters are numbered continuously through the three volumes. In volume II are contained chapter V, Antiphlogistic Treatment; chapter VI, Evacuants; chapter VII, Musculo-motor Excitants, or Excito-motors; chapter VIII, Narcotics.

THE PRACTITIONER'S REFERENCE BOOK. By RICHARD J. DUNGLISON, A. M., M. D., Editor Dunglison's "Medical Dictionary," etc., etc. Second edition revised and enlarged. *Philadelphia: Lindsay and Blakeston. 1880. 8vo.; pp. 476. Cloth. (Through Hugh R. Hildret: Printing Company.)*

This book contains a great deal of useful information collated from various sources, tables of weights and measures, comparison of the metric and other systems, tables of solubility,

abbreviations, specific gravity, posological tables, diagnostic tables, directions for writing prescriptions, for examining urine, for restoring the apparently drowned, for using the hypodermic syringe, the thermometer, the galvanic battery, for making post-mortem examinations, etc., etc., etc. The present edition is about fifty per cent. larger than the first.

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### BOOKS AND PAMPHLETS RECEIVED.

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THE SURGERY, SURGICAL PATHOLOGY AND SURGICAL ANATOMY OF THE FEMALE PELVIC ORGANS. In a series of Plates taken from Nature, with Commentaries, Notes and Cases by Henry Savage, M. D., London, Fellow of the Royal College of Surgeons of England, etc. Third Edition, Revised and greatly extended; 32 plates and 22 wood engravings with special illustrations of the operations on vesico-vaginal fistula, ovariectomy and perineal operations. *New York: Wm. Wood & Co., 1880.* (Through C. C. Pease, Agt. St. Louis.)

ANNOUNCEMENT of the Medical Department of the University of Pennsylvania for the one hundred and fifteenth annual session, 1880-81, and List of Graduates at the Commencement held March 15th, 1880. *Philadelphia: Collins, Printer. 1880.*

SYMPATHETIC AFFECTIONS OF THE EYE, by C. J. Lundy, M. D., Prof. of Clin. Dis. of the Eye, etc., Michigan College of Medicine, Detroit, etc., etc. Reprinted from *Leonard's Ill. Med. Jour.* July, 1880.

DIABETIC CATARACT, IRITIS, ETC. A Clinical Lecture delivered at the Michigan College of Medicine, by C. J. Lundy, M. D., Prof. Clinical Diseases of the Eye, etc. Reprinted from the *Mich. Med. News.* June 10, 1880.

TRANSACTIONS of the Medical Society of the State of Tennessee at its Forty-seventh Annual Meeting, 1880. Nashville, Tenn. Printed at "*The American*" Steam Book and Job Office. 1880.

A REPLY TO CRITICISMS ON "THE PROBLEMS OF INSANITY" with Remarks on the Gosling Case. Delivered before the New York Medico-Legal Society, April 16, 1880. By Geo. M. Beard, A. M., M. D., Member of the New York Medico-Legal Society, etc., etc.

MINUTES OF THE TWENTY-FOURTH AND TWENTY-FIFTH ANNUAL MEETINGS OF THE STATE MEDICAL SOCIETY OF KENTUCKY, 1879 and 1880, Louisville, Ky. *Printed by Jno. P. Morton & Company.* 1880.

TRANSACTIONS OF THE MEDICAL AND SURGICAL FACULTY OF THE STATE OF MARYLAND. Eighty-second Annual Session. Held at Baltimore, Md., April, 1880.

SIXTH ANNUAL ANNOUNCEMENT OF THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF TENNESSEE. Nashville Medical College, Session of 1880-81.

THE HISTOLOGY OF THE BLOOD VESSELS. By Edmund C. Wendt, M. D., New York. Reprinted from the *New York Medical Journal*. July, 1880. *New York: D. Appleton & Co.* 1880.

MICHIGAN COLLEGE OF MEDICINE, DETROIT MICHIGAN. Announcement for Session of 1880-81. *Post and Tribune Job Printing Company.*

MEDICAL COLLEGE OF OHIO, CINCINNATI. Founded 1819. Sixtieth Annual Catalogue and Announcement. Session of 1880-81.

WHAT CONSTITUTES A DISCOVERY IN SCIENCE? By Geo. M. Beard, A. M., M. D. *New York: 1880.* 8vo, pp. 7, paper.

THE DETROIT MEDICAL COLLEGE, DETROIT, MICH. Thirtieth Annual Announcement and Catalogue. 1880-81.

SECOND ANNUAL ANNOUNCEMENT of the College of Physicians and Surgeons of St. Joseph, Missouri. 1880.

## TRANSLATIONS.

## BROMIDE OF POTASH IN SPASM OF THE GLOTTIS.

*Dr. A. Joffroy, Revue Men. Med. Chir. No. 10, 1879.*

It is frequently observed that children who have been successfully tracheotomized, and who exhibit no trace of diphtheritic lesion, rapidly succumb to spasmodic closure of the glottis upon removal of the cannula. It is true, the spasm does not constitute the only danger; vegetations, infolding of the trachea, may produce the same results. Spasm of the glottis in some cases appears during convalescence, when the cannula is allowed to be removed for a few hours at a time. If the spasm does not persist, it is without serious consequences; but if it continue during several months, it becomes a grave complication, exposing the child to the dangers of bronchial and pulmonary disease through the necessary retention of the cannula. The laryngeal mucous membrane is abnormally sensitive before complete recovery, it is more excitable; if at this time the cannula be removed, the larynx becoming active again, the reflex action which produces the muscular contractions is exaggerated, and the regular contraction becomes spasmodic.

Dr. Joffroy, remembering that potas. bromid. greatly diminishes reflex sensibility of the throat, concluded to experiment with the drug in the case above described. His success in two cases he gives as follows:

Case 1—Child of 4 years operated upon July 20; complete recovery, but it was not possible to remove the cannula up to August 14. From this date 2 grammes pot. brom. was given, and August 16 the cannula was removed without bad results, and cicatrization proceeded regularly. The pot. brom. was continued for a week.

Case 2—Child of 4 years, operated upon July 26. Up to August 14 condition excellent, but spasm of the glottis occurred upon each attempt at removing the cannula. On the 14th, pot. brom. 2 grammes in solution. August 16, removed cannula



without complications. The bromide was continued eight days.

The presence of bronchitis would contra-indicate the bromide, as it diminishes the action of the bronchial tubes, and facilitates congestion.—*Gaz. Heb.*, June 18, 1880.

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#### VEGETABLE PEPSIN.

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For some time scientific attention has been drawn to the fruit of the South American papaya tree (*carica papaya*), and the peculiar properties of its juice. The tree attains the height of about 20 feet, and shoots straight up, without branches, bearing upon its apex a bunch of long narrow leaves, between which the blossoms appear. Staminate and pistillate flowers never occur together; hence, on account of its varying appearance the tree is called by the natives Papaya or Mancai.

The fruit is oval,  $1\frac{1}{2}$  inch in diameter; it is eaten both raw and cooked. Its interesting peculiarity is that the juice is capable of digesting, or at least softening the toughest and hardest meat so that it can be eaten, and this within a short time. This property the natives take advantage of, in the preparation of their dried fish and strips of flesh. The digestive power of the fruit is so great, that when eaten too freely alone, not finding material in the stomach for the exercise of its peculiar activity, it attacks the mucous membrane of the alimentary canal itself.

Meat washed in water containing a little of the juice, and afterwards boiled or baked, becomes completely disintegrated into its fibres.

Roy evaporated some of the juice, and pulverized the residue. This powder some time afterwards was found to possess the same digestive property when dissolved in water; flesh, albumen, and gelatinous substances being acted upon, but not starch.

Wittmack lately has thoroughly investigated the subject, and established the following: The juice resembles pepsin in its action; the addition of a free acid is not necessary for this activity. It is also more energetic when exposed to a higher temperature. The filtered juice differs from pepsin in that it

gives no precipitate on boiling—that it is precipitated by hydrarg. chloride, iodine, and all mineral salts; on the contrary, like pepsin, it gives a precipitate with neutral plumb. acetat., while cup. sulphat. and ferr. perchlorid. have no such effect.—*Deutsch-Amerik, Apothekerzeitung, Wiener Med. Woch.*, June 21, 1880.

## REPORTS ON PROGRESS.

### SURGERY.

**Sudden and Transient Swelling of the Lips.**—Within the last few years, during the service of Dr. T. B. Curtis as surgeon to out-patients at the Massachusetts General Hospital, certain patients have presented themselves with an affection for which there is no diagnostic term, a nondescript and nameless ailment, not described in any text-book. This condition of things has led Dr. Curtis to contribute an interesting article with the above title. The affection presents for consideration in most cases but one symptom, namely, a sudden, transient, circumscribed, painless swelling of the lip. The onset seems to take place mostly in the night; the swelling is in most cases very great, occupying the entire upper lip, or the lower lip, or both, and gradually fading away, without distinct limit upon the cheek. The lip so affected is enlarged in every way, greatly thickened and elongated. Its consistency is hard and firm. There is little or no tenderness, and pressure does not cause pitting. The swollen lip stands stiffly out rendering the sufferer at once hideous and ridiculous. Another uncomfortable result is a continual overflow of saliva. The patient is alarmed by the suddenness of the attack and by the conspicuous character of the deformity.

The most important office of the physician consists in dispelling the needless alarm of the patient, since the swelling may be expected to disappear spontaneously in a few hours or at the latest in a day or two. That the physician may be able to render this service he must be prepared to recognise the affection and foretell its issue, and Dr. Curtis states that the object of his remarks upon this ephemeral swelling has been mainly to impart the familiarity which breeds contempt. Investigation has thrown no light upon the etiology of the affection. In regard to the pathology, the writer attributes the disturbance to an acute reticular lymphangitis.—*Boston Med. and Surg. Jour.*, June 10, '80.

**Catheterism of Larynx.**—When the ordinary means of producing artificial respiration fail to give a satisfactory result, catheterism of the larynx, as a means of resuscitating the asphyxiated, is much more certain than any

other method of exciting respiration. Dr. W. M. Polk reports a case where, under the use of the Schultz, Marshall Hall, and Sylvester methods, the child had become virtually dead, eyes fixed and glazed, the entire surface of the body cold and cyanosed; at this point, a catheter being passed through the larynx, the lungs were inflated and emptied regularly, and in a few minutes voluntary respiration was restored. The writer urges that with a stiff instrument the procedure is so simple and so certain that it should be given more prominence than it has hitherto enjoyed. To show its superiority to any effort at filling the lungs by merely blowing into the child's mouth, he appeals to the well known fact that most of the air under that method goes into the stomach and very little into the lungs.

He gives details of the procedure as follows:

In the adult or child with teeth, fix the jaws open by means of a cork, seize the tongue with a tenaculum or other instrument, draw it well out, and hand to an assistant. Pass the index finger of the left hand well down into the mouth, find the epiglottis, go beneath it, and place the finger over the laryngeal opening. Take a stiff catheter, No. 8, or No. 10, with the right hand, and using the left index finger as a guide, pass the instrument into the larynx. Be sure that the eyes of the instrument are well below the vocal chords. With the arms of the patient extended, the operator now inflates the lungs through the catheter. The arms are next brought down and the chest compressed; this procedure is to be continued with regularity. There is one point to be observed: In the adult the larynx is often at such a depth that the index finger cannot reach the laryngeal opening; in that case some one should seize the larynx from the outside and thrust it up, by which the opening is brought within easy reach of the finger.—*N. Y. Med. Rec.*, June 19, '60.

**Skin-Grafting.**—At the Chambers Street Hospital in New York, they have been very successful in skin-grafting, and publish their peculiar method as follows: The grafts were taken by picking up the superficial skin, down to and including the papillary layer, so as just to show dottings of blood, and snipping it off with sharp scissors. Size of graft as large as the head of a two inch pin. The raw surface of the graft was laid on the granulating surface and covered with rubber tissue dipped in a solution of thymol, of which the dressing consisted.

A number of grafts were taken from amputated arms and legs as long as four hours after the operation, and invariably took well. The grafts placed near the edges grew most rapidly; grafts grow from a proliferation of their own cells; each graft has a maximum of growth, usually about the size of a five cent silver piece, then the edges grow sluggish and cease to advance. The new skin has very little tendency to the contraction usually seen in cicatrices. The largest number of grafts planted at any one time was 228; of these only five failed to take.—*New York Med. Record*, July, '80.

**The Treatment of Pott's Disease by the Plaster of Paris Jacket.**—After three years experience in the use of the jacket in two hospitals and in private practice, Dr. E. H. Bradford gives his conclusions as follows:

(1) Plaster jackets are efficient in Pott's disease when the caries is below the level of the middle of the scapula.

(2) The efficiency is not due to fixation alone, nor to extension, but to fix-

ation in an improved position. This improved position is usually obtained by suspension, but also in many cases by recumbency.

(3) The treatment by plaster jacket requires care in the application of the bandage. A poor plaster jacket will do harm, deceiving patient and physician.

**Arsenic in Tetanus.**—DR. C. C. FIELD, of Massachusetts, pays his compliments to Dr. Hodgen, of St. Louis, acknowledging a valuable suggestion through the press as to the use of arsenic in tetanus. Dr. Field's case lasted seven weeks and terminated favorably; the first administration of Fowler's solution subcutaneously was followed by marked improvement; on omitting the medicine, the symptoms returned. The solution was again prescribed and continued to the end. There were no tonic spasms after the solution was resumed, and the rigidity of the muscles began to relax at once.—*Boston Med. and Surg. Jour.*, June 3, '80.

**Incomplete Ovariectomies.**—DR. CAZIN reports a case in which he was obliged to leave a very large unilocular cyst within the abdominal cavity; the wound was kept wide open with care, a carbolic acid wash used, and a dressing of antiseptic gauze employed. On the 28th day the elimination of the superficial sloughs was completed with very little suppuration. Dr. Cazin then, without refreshing the edges of the abdominal wound, tried to obtain immediate secondary union. The intestine by its distention held the posterior face of the cyst wall against the anterior face which was firmly adherent to the wall of the abdomen; the union of the two was rapid and complete, and the whole wound had healed on the fiftieth day after the operation. Dr. Cazin insists upon the fatality observed in cases of this kind, and attributes his success to the caustic action of the carbolic acid, retarding suppuration, to the small amount of suppuration in this case, to the care he observed in keeping the abdominal wound wide open instead of closing it at his predecessors have done, who content themselves with placing a drainage tube in the lower angle of the wound, and finally to his employment of immediate secondary union which was remarkable for ease of execution, rapidity of result, and complete harmlessness.—*L'Union Médicale*, June 17, '80.

**Oophorectomy for Fibrous Tumor of the Uterus.**—DR. M. D. MANN reported to the New York Obstetrical Society the case of a woman, 44 years old, where the uterus was occupied by several fibroids and extended considerably above the umbilicus; there was also a large polypoid growth deep in the uterine cavity, while the cervix was simply a dense fibrous mass and yielded very little to a tent. After consultation with Dr. Baker, of Boston, Dr. Mundé, of New York, and Dr. Wainwright, of Hartford, it was decided that the only chance for prolonging the patient's life was to remove the ovaries and bring on the menopause. The operation was accordingly done; the ovaries were found adherent to the surface of the tumor, but were removed without profuse hemorrhage. Pacquelin's cautery was used, and antiseptic precautions observed. The death of the patient occurred on the second day. At the autopsy the condition of the cervix was such—surrounded by and filled with a dense fibrous growth—that, in Dr. Mann's opinion, it would have been impossible to remove the polypus during life; or to have removed the uterus at the operation as a pedicle, could not have been formed of the cervix.—*New York Med. Jour.*, July, '80.

## MEDICINE.

**Small-Pox.**—THE mortality from small-pox can be better taught by figures than in any other way. The following are taken from the statistics of the small-pox hospital in London:

Mortality among those who have been vaccinated, 6.56 in 100 persons; and in those who have particularly good cicatrices, 2.52 in 100 persons; in the unvaccinated, taken as a whole, young and old, the mortality in the London hospital is 37 in 100. But in the discrete small-pox, the mortality is only four per cent., of the slightly confluent, eight per cent., of the confluent small-pox, fifty per cent. In children not yet one year old, all die; it is the same with persons over sixty, if they have not been partially protected by vaccination; pregnant women rarely recover.

In the experience which I have had in the New York Hospital, which lasted two years, I saw quite a number of cases that were admitted for fever, which turned out to be small-pox and were sent to the small-pox hospital; and of all these cases, not one left the small-pox behind it. No person who assisted the patient to get into the carriage, or to get to the hospital, took the disease; no patient lying along side of him took it. The superintendent of the hospital testified to the same effect, and said that there had been but one case in which the contagion had been left behind, and that was a case of the hemorrhagic variety, in which the diagnosis could not be made until the third or fourth day. The same is true of Bellevue hospital. All cases that I have observed there, received in the belief that they had fever and afterwards sent to the small-pox hospital, have not left the disease behind them, if they were sent away at the time of the beginning of the umbilication of the pustule. My conviction is strong, that up to that time there are no emanations from the body that will poison another person.—Lecture by Alonzo Clark, M. D., *N. Y. Med. Record*.

**Singular Case of Malarial Fever.**—DR. J. P. WALKER, in his report to the Cincinnati Medical Society, mentions a case of malarial fever where the usual order of symptoms was reversed. He found a three-years-old boy in profuse perspiration, the bed clothes, especially the pillow being saturated. There was no indication of febrile disturbance. This was the third evening that excessive sweating had returned at the same hour, followed by high fever, even by delirium, continuing about two hours, when the child would pass into an uneasy sleep, waking in the morning free from fever. The intermission was perfect, the attack returning at 8 P. M. This case presented a perfectly reversed order in a malarial attack, except the cold stage after the fever, which was not perceptible. The patient recovered under the use of quinine, after having suffered in a similar manner five nights at the usual hour.—*Cincinnati Lancet and Clinic*.

**Traumatic Abscess of Liver.**—These cases are so rare, that I was unwilling to admit that the liver was implicated until the examination of the dis-

charge under the microscope proved the existence of liver-cells. According to statistics this cause of hepatic abscess is very rare. There is nothing in the character of the external wound that would indicate the extent of the lesion. It is a large, irregularly shaped trauma, freely covered with pus. But when the discharge is examined microscopically, it is found to contain pigment and liver-cells; and we have here the same proof of their origin, that we get in the sputa, where a hepatic abscess bursts into the lung. Ordinarily, as in this case, we are aided in the recognition of an abscess of the liver by the cachexia and general prostration. Here is profound cachexia and palor, whence I suspect we have to deal not only with abscess of the liver but also as a result of the prolonged suppuration, with amyloid degeneration in addition.

The treatment does not resolve itself simply into relieving pain and sustaining strength. Amyloid degeneration, if it has not occurred, must finally ensue from this prolonged suppuration. It has been noticed in a series of experiments in the treatment of tuberculosis by the benzoates of soda and magnesia, that notwithstanding the fact that suppuration had existed in some of them for years, no case thus treated had amyloid degeneration. With our present knowledge of this curious process, we are forced to look upon it as a product of blood poisoning; hence the efficacy of the benzoates, the salicylates, etc.

I think it would be advisable in these cases, to make a trial of these new remedies. They are said to combat the infectious principle in the blood; but the blood must be almost saturated with the remedy to secure perfect prophylaxis. One may begin with a half teaspoonful of the salt, dissolved in a wineglassful of water three times a day, and gradually increase to a tablespoonful or two per day. Further than this we should use thick hot poultices, and administer freely, alcohol, milk and eggs. If, under this treatment, the pus does not freely escape, we should use the aspirator.—(Lecture of Prof. Jas. T. Whittaker, Cincinnati.) *N. Y. Med. Rec.*

**Poisoning from External Application of Carbolic Acid.**—DR. COMEGYS PAUL reports a case of poisoning by external use of carbolic acid. A young convict complained of the great discomfort caused by a crop of herpes upon the right side, extending from the nipple to the axilla. The part was painted with a concentrated solution of carbolic acid which entirely relieved the pain. It was then dressed with vaseline. Two days afterwards he asked to have the acid again applied. Within twenty minutes after this was done, he became faint and dizzy, very weak in the legs, and exhibited all the signs of a general collapse. This condition continued about half an hour, when he gradually revived. The surface covered by the acid was not more than five square inches, and the second application came in contact with only a partially denuded cuticle of smaller extent.—*Phil. Med. Times.*

**Rare Cases of Hydatids.**—DR. THOMAS, of Adelaide, reports an interesting case of hydatid cyst of the lung with the following history. The patient was a phthisical looking boy, nine years old; he was very thin, but less so in the face than the body. About two years previously he had expectorated a little blood after a long ride on horseback. During July he had complained for some weeks of shortness of breath with some wheezing and a slight

cough. One morning as he was about dressing, he was suddenly seized with intense dyspnea. He became blue in the face, struggled for breath, and implored his mother not to let him die. A large quantity of watery fluid was expectorated; later in the day small quantities of blood were expectorated, especially if he attempted to lie on his back. The next day signs of double pneumonia were discovered, the right lung being more severely affected than the left. There was considerable functional disturbance of the heart. The attack was so violent and the air passages so obstructed by frothy, blood-stained mucus, that sudden death was expected. About the third day the sputa assumed the ordinary rusty color of pneumonia, and at the expiration of a week had become muco-purulent. He recovered from this attack and has since suffered from cough and expectoration; the sputa is said to vary greatly in amount, and to have at times an offensive odor. An examination made November 3d, showed no physical signs. Expansion generally good on left side; on the right side it is deficient, especially in the infra-clavicular region.

**Percussion.** Normal resonance on the whole left lung; on the right side anteriorly, there is general dullness, less apparent about the nipple and the right acromial angle; there is a general sense of resistance to the finger. On the right side posteriorly, diminished resonance over supra-spinous region; absolute dullness over infra-spinous with normal resonance below the scapular; the inter-scapular region is resonant.

**Auscultation.** Over the left lung, back and front, there is puerile respiration; at the acromial angle the respiration is interrupted with a harsh expiration; over the right lung anteriorly there is cavernous respiration with whispered pectoriloquy in the supra- and infra-clavicular regions, audible as low as the nipples; below this the respiratory sounds are weak; posteriorly in the inter-scapular regions the respiration is loud and interrupted with harsh prolonged expiration. Sternal region normal.

Heart's apex located in fifth space, fully one-half inch to left of mammary line.

On November 17th, he expectorated "a piece of skin about as large as a crown piece" and on the next day, after an emetic, he expectorated with a great struggle a large quantity of skin; there was no blood, but a good deal of filthy matter. The cough ceased in about a week after this last piece of cyst was expectorated and the boy grew strong and well.

**A Case of Renal Hydatids.**—DR. WOOD of Melbourne, reports the case of a woman 64 years old, who noticed a tumor growing in the left side of the abdomen and which was gradually increasing in size, but without pain or detriment to her general health. Seventeen months previously a hydatid cyst had been removed from her left thigh; otherwise her general health was good.

A rounded semi-elastic tumor was discovered in the abdomen, occupying the left lumbar region and the adjacent part of the umbilical and hypochondriac region. There was circumscribed dullness over the tumor, which was slightly movable but did not alter its position with change of posture; it did not extend downward into the pelvis.

The tumor was aspirated and thirty-seven ounces of colorless hydatid fluid was drawn off. There was no albumen, but chloride of sodium was found in

abundance. Specific gravity 1006. Microscopically, blue crystals of indigo were seen along with clusters of echinococcus scolices, with the usual suckers and hooklets, growing on delicate stalks from portions of finely granular endo-cyst.

Pain, with slight vomiting followed the operation; this subsided in a few days and the patient was discharged well.

**Hydatid Cyst of Lung.**—Dr. COLIN HENDERSON, Ararat Hospital, reports:

Edward F—, æt. 42; sawyer, a well-built man, whose mother died of consumption; had always had good health himself till September, 1877, was then in hospital, spitting blood and mucus. This ceased, but returned again during January. In April, '78, he had pain in upper third of right lung; dullness on percussion; large crepitations; mucous sputa tinged with blood; cough; night sweats and loss of weight; liver somewhat enlarged. Bromide of potassium and kamela were given internally. He improved and left the hospital June, 1878. Re-admitted during October with return of same symptoms, and received the same treatment. Two days after admission, he expectorated large quantities of blood and mucus mixed with shreds of the cyst walls of hydatids. He improved rapidly and left the hospital November 12th, completely cured.

**Hydatid Cyst of the Bladder.**—The following case is reported by Dr. W. E. Hearne, of Inglewood Hospital:

J. B—, æt. 40; a farmer; having been thrown from his horse, July 16, was stunned but soon recovered consciousness. He was unable to pass water and was brought to the hospital. He complained of slight general pain over the abdomen, not increased by pressure; his breathing was hurried and his face had an anxious expression; his temperature was normal, and his pulse full and slow; bladder not distended. A hot bath with fomentations relieved him, and in a few days he seemed completely restored.

On the afternoon of the 19th of June I was called and found him much flushed with a hot, dry skin; pulse 100; temperature 101–2°. He complained of great pain over lower abdomen, increased by pressure; and he was lying on his back with his knees drawn up. Twelve leeches were applied to the abdomen followed by hot fomentations, and one-grain doses of opium were given every hour. During the night the temperature rose, the pain became intense and the pulse went up to 120, very small. Persistent vomiting set in and he died at half past ten the next morning.

Post-mortem examination showed in the abdominal cavity one and a half pints of serous fluid with shreds of lymph floating in it. The visceral and parietal layers of the peritoneum were in patches of a vivid red color and were glued together in places by recent lymph. Firmly attached to the fundus of the bladder was found a collapsed hydatid cyst about the size of a turkey egg. There was no rupture of the bladder, as was shown by injecting it with water.—*Australian Med. Journal.*



## THERAPEUTICS.

**Improved Lunar Caustic.**—SAWOSTIZKI melts together five parts of nitrate of silver and one of nitrate of lead, and moulds in sticks like the ordinary caustics. These sticks may be readily sharpened with a knife, and are much less readily broken than the pure nitrate of silver sticks.

**Castor Oil Emulsion.**—Castor oil may be quite thoroughly disguised by making into an emulsion, as follows:

R. Ol. Ricini	℥i.
Tinct. cardamom. comp.	℥iv.
Ol. gaultheriæ	gtt. iv.
Pulv. acaciæ	
Pulv. sach. alb.	aa. ℥ij.
Aq. cinnam.	q. s. ad. ℥iv.
Misce secundem artem.	

[*Boston Med. and Surg. Jour.*, May 21, 1880.]

**Suberin for Chapped Nipples.**—An impalpable cork powder, under the name of suberin, is recommended in the treatment of chapped nipples. After washing the nipple, the powder is dusted on, and then a piece of gold-beater's skin applied. When the child is to be nursed, the nipple is washed clean, and the gold beater's skin replaced. Punctures made with a needle through this skin allow the milk to pass through freely, and the nipple is protected from chafing in nursing. After the nursing the powder is applied again, and covered with the skin as before.—[*Boston Med. and Surg. Jour.*, May 27, 1880.]

**Tartrate of Morphia** is particularly advantageous for hypodermic injection, on account of its ready solubility. It passes quickly out of the system, and the after-effects are less unpleasant than those of the muriate or acetate. It causes little smarting or irritation when thus administered, and the solution never clogs the finest needles.—[*Phil. Med. Times*, May 8, 1880.]

**Jamaica Dogwood in Neuralgia.**—M. FORD has found the effect of Jamaica dogwood to be very prompt and satisfactory in the relief of cranial neuralgia, and also in a case of sick headache. He used the fluid extract in doses of two drachms. Not only was the pain at the time speedily relieved, but the patients were free from any return of the suffering than they had been at any time before for several years.—[*Louisville Med. News*, June 19, 1880.]

**Jamaica Dogwood in Insomnia.**—ROGERS recommends the fluid extract of Jamaica dogwood in the treatment of insomnia. He has used it with success in cases where chloral and the bromides had failed.—[*Louisville Medical News*, June 17, 1880.]

**Clover Tea for Cancer.**—The *Louisville Medical News* calls attention to the fact that the pain of cancer is often greatly relieved by the use of tea made from the blossoms of the red clover. "The tea should be made as tea is

made for the table, strained and taken before meals and at bed time, about a quart daily." We have known personally of the clover tea being used with advantage for the relief of the pain of cancer, and cases have been reported where growths of the nature of epithelioma disappeared under its use.

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## OBSTETRICS AND GYNECOLOGY.

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**Morphine in Puerperal Eclampsia.**—C. C. P. CLARK says that he has never seen opium, properly used, fail to ward off eclampsia when it seemed to be threatened; that he has many times seen it obviously and at once put a stop to the paroxysms after they had been commenced; and that he has never known a patient to die of this disease when that medicine had been administered in season, in sufficient quantities, and in the proper manner.

When premonitory symptoms of eclampsia appear, continuous or paroxysmal pain in the head, alteration and figments of the senses, especially of sight, mental dullness and ataxy, a countenance expressive of suffering and apprehension, an irresolute and incapable manner, and complaint of indefinable distress, he orders two to three grains of opium per diem with full confidence that convulsions will be warded off. He does not ignore eliminants but does not trust to them alone or chiefly.

When the convulsions have appeared, he says, the patient "should have forthwith injected into her arm a grain and a half of morphine *by weight*." "Should the paroxysm return any time after two hours, this dose should be repeated. And if she be in labor, she should have another dose after eight hours any way."

He asserts that a comatose or half-comatose condition is no contra-indication to such use of morphine; and he urges that this course be pursued unhesitatingly unless the patient be obviously moribund; and has the greatest confidence that morphine so used will succeed in all cases where the brain has not already sustained irreparable injury by a long succession of paroxysms, or by a few of great violence.—*Am. Jour. of Obstetrics*, July, '80.

**Prevention of Lacerated Perineum.**—B. E. MOSSMAN advocates artificial dilatation of the perineal structures before the head reaches the floor of the pelvis, in order to prevent laceration. He claims that his method has never failed, in uncomplicated labor in normal primiparæ to prevent rending so much as even the mucous membrane covering the inner sides of the fourchette.

He anoints the external parts and the vagina as far as the finger will go, with melted lard with extract of belladonna; and if the first stage of labor occupies one or two hours, he makes two or three such applications. As soon as the womb has dilated sufficiently so that the cervix is safe against laceration, he begins at once artificial dilatation of the perineum. He applies the belladonna ointment freely, and then places one or two fingers within the vagina, making pressure lightly but continuously downward and forward.

When the head descends so as to press upon the perineum, he removes the fingers from the vagina, and introducing them into the rectum and placing the thumb upon the occiput of the child, pulls the perineum forward and upward, and presses the head upward under the pubes whenever a pain comes on, Goodell's method of protecting the perineum.

When the pain ceases and the head recedes, he applies the dilating force with the fingers in the vagina as before, alternating the pressure from within with the forward traction during the pain, and retarding the expulsion of the head until the dilatation is sufficient to allow the escape of the head without laceration.

He thinks that it is very rare that shoulders cause laceration after the head has safely passed.—*Ibid.*

**Recurrence of Puerperal Fever.**—E. P. BERNARDY believes that an attack of puerperal fever predisposes to subsequent attacks, and reports a series of cases in which six patients had between them fifteen attacks of puerperal fever in twenty-three pregnancies.—*Ibid.*

**Hour-glass Contraction of the Uterus.**—C. C. LEE reported to the Obstetrical Society of New York, a case where in the third stage of labor the placenta seemed to be completely adherent. No tractions were made upon the cord, but after waiting fifteen or twenty minutes, and no contractions having occurred, he introduced his finger into the uterus and found an hour-glass contraction. After ten or fifteen minutes, with considerable uterine pain, the uterus relaxed and the placenta came away readily.—*Ibid*

**Transverse Presentation.**—F. C. TERRILL reports a case in which an irregular practitioner had attempted to deliver a woman of a child presenting by the shoulder, by pulling with all his force upon the protruding arm. The hand and arm were greatly lacerated, the skin being stripped down from the shoulder to the wrist, the muscles torn so that only a small portion of the subscapularis and a few fibres of the trapezius remained intact. The mother's external genitals were much bruised and swollen. Chloroform was administered and podalic version performed without any difficulty. The woman died on the third day, of puerperal peritonitis.—*Phys. and Surg.*, July '80.

**Extra-Uterine Pregnancy.**—W. O. ROBERTS reported to the Kentucky State Medical Society a case of gastrotomy in extra-uterine pregnancy. A dead fetus, of near six months development, was removed a few days after the sac had opened into the bowel. The patient was greatly exhausted and had a temperature of 103° at the time when the operation was performed. Strict antiseptic precautions were observed. The drainage tube was removed on the fifth day; the placenta came away on the eighth. At the time of the report, twenty days had elapsed and convalescence was satisfactorily established.—*N. Y. Med. Rec.*, June 19, '80. E. M. N.

## SOCIETY MEETINGS.

## ST. LOUIS MEDICO-CHIRURGICAL SOCIETY.

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Stated Meeting April 26. Dr. Prewitt in the Chair.

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## IMPERFECT SEXUAL DEVELOPMENTS.

*Dr. Moses.*—I have an interesting case to report; it is one of imperfect sexual development. About ten days ago a patient came to the hospital in the hope that some surgical procedure might relieve him. He was examined by Dr. Gregory and myself. The trouble was that he was obliged to sit down to urinate. The patient, to all appearance, was a man of medium height, of good muscular development. He lacked the general rotundity of the female form. The muscles were well developed and hard. His face was covered with an abundance of beard, and indeed the body was covered with hair where it is usual. The development of the chest was masculine. The whole peculiarity consisted in the development of the sexual parts. Upon an examination of these, the main features were those of a female. In the proper place for the penis, was an organ, perfect in development, except that there was no urethra. The organ was not very large, and the prepuce did not quite cover the gland. Below this organ the development was apparently that of a female. The labia majora and nymphæ were perfectly formed; the vulvar opening was that of a female. The vagina had the shape of the ordinary vagina except that it ended in a cul-de-sac. On the catheter being passed into the bladder, the length of the urethra was found to be about that of the female urethra. The finger passed into the rectum detected neither uterus or ovaries. The finger could be passed without any obstruction as high as could be reached from one side to the other, and there was no body that offered more resistance than an intestinal coil.

He had practiced self pollution by the ordinary operation,

mere friction of the penile organ. He said there was a discharge of yellow globules. He had noticed this twice. I think he wanted to marry—wanted to marry a woman—and inquired very earnestly whether we could not possibly remedy the deformity. We answered very decidedly that we could not.

*Dr. Moses.*—Several years ago I met a case very similar to this, except that the penis was perfect, the urethra being complete; and the vagina was not nearly the same depth, a shallow cul-de-sac. In that case the labia seemed developed imperfectly. There were no testicles perceptible. Most likely there were abdominal testes.

*Dr. Carson.*—The voice of the patient seen at the hospital was that of a man, not a deep voice, however. His whole figure was masculine. I will state, in connection with this case, that last fall I saw the counterpart in a child several months of age. It was brought here for operation, which a physician in the country had recommended. The genital organs described by Dr. Moses were present in this child. The penis, if we may so call it, was well developed—all the parts being well developed except the urethra. There was a vagina, apparently, as in this other case. The child was otherwise remarkably well developed. We cannot tell what sex the child would represent in an advanced period of life.

*Dr. Briggs.*—I would like to ask Dr. Carson what was the shape of this clitoris or penis, in the case described by Dr. Moses?

*Dr. Carson.*—It was of the ordinary shape. It was about three inches in length and, from the description of the man during erection, must have been nearly four inches in length. He represented it as long as his finger.

*Dr. Prewitt.*—The question whether it is a man or a woman, is identical with the question whether testicles or ovaries are present. The development of the female form and voice is due to the presence of ovaries; the development of the male figure is due to the presence of testicles.

*Dr. Moses.*—My impression is that this is a man. I think he has abdominal testicles.

*Dr. Carson.*—He thought from the size of the penis, that, if he were to marry, he could manage matters to the satisfaction of all parties concerned, and with some chance of reproduc-

tion. He thought that the discharge, of yellowish globules which followed the act of masturbation were emissions of semen. He had masturbated quite frequently; never had had connection with a woman, had never attempted it. He was sometimes in female society and became excited, much as a male does. All his inclinations were those of the male.

*Dr. Robinson.*—He is a white man?

*Dr. Carson.*—Yes sir, and a very well appearing individual. He dresses well and walks firmly. He presents a very respectable appearance. To see him walk, no one would suppose there was any malformation in development.

*Dr. Ford.*—I should think the examination of the seminal emission under the microscope would be legitimate.

*Dr. Carson.*—I asked him to send me some if he ever had any more emissions, and he promised to do so.

#### RETAINED PLACENTA.

*Dr. Briggs.*—A few weeks ago I was called to see a woman, the mother of two or three children, who had been deserted by her husband some sixteen months before, at which time, or shortly after, she had twins. I found her in bed, in a very weak condition, and exceedingly pale. My first impression was that possibly she had been feeding those children and neglecting herself, that probably starvation was the trouble. That theory failed however. She was a well fleshed woman, well rounded. At any rate she seemed anxious and depressed. Once or twice I asked with regard to any difficulty of the womb, but she answered, no! I had plenty of food furnished, and determined to see what effect a tonic would have.

After six or eight days, she did not seem to improve. I then put some very direct questions, and discovered that there was a little discharge from the womb—just a little blood. I made an examination and found a mass of placenta protruding through the os uteri. After considerable trouble, I managed to get it all away. Although the first had no odor, the last was quite putrid. The woman had had a miscarriage about five or six days before I saw her. Her worthless husband had visited her in December, and she was ashamed of having been obliged to entertain him; and hushed the matter up.

*Dr. Carson.*—Was the miscarriage natural or induced?

*Dr. Briggs.*—I had no reason to suppose it was induced. She

was a hard working woman, under great mental depression and it was quite natural she should have a miscarriage.

SYPHILITIC APHASIA.

*Dr. Carson.*—Mr. Chairman, I wish to report a case that may interest the gentlemen present to-night. In 1871 a gentleman consulted me who had some time before contracted syphilis. He had been treated in New York before coming to St. Louis. After his arrival here, his habits were very irregular, and after a time secondary manifestations appeared. He became impatient under treatment, and in the spring of 1871, went to Hot Springs, to try the treatment as administered there. He returned to St. Louis very much reduced in strength, but with no sign of the disease present, nor did any sign of the disease appear at any time within the four years following. Last February, one year ago, I think it was, he came to me with what appeared to be an ulcer within the urethra. I thought the attack was nothing more than a chancroid or simple ulcer following an impure connection. Taking his previous history into consideration, I was led to this opinion. It did not yield readily to treatment, and in due course of time, one of the inguinal glands enlarged to about the size of an almond. After the lapse of several weeks secondary symptoms appeared. These yielded readily to treatment—mercurial and afterwards iodide of potash. The patient again became impatient and discontinued all treatment.

Last October, after a protracted spree, he noticed that he saw double. I again put him on iodide of potash. He continued the use of the medicine a short time, and again gave it up. About Christmas he began to suffer pain in the left eye. Dr. Hodgen then saw him while he was suffering very severely, during my absence from the city, and prescribed for him. Upon my return I saw him again, and recommended iodide of potash in increasing doses, which he took for some time. He improved somewhat. He suffered very severe nocturnal pains. Acting upon my advice, he went to Hot Springs again. I advised him to go because he had been so successfully treated before, and he had great confidence in the efficacy of the springs, and would the more willingly resume the necessary treatment. About the first of February he went to the springs and remained one month. The bathing did not agree with him

as, after leaving the bath, he would become chilly and remain so during the whole afternoon. Although the weather was quite warm he had to have a fire in his room and was obliged to retire and get under blankets to keep warm. All this time he was taking large and increasing doses of iodide of potash. Two weeks after reaching the springs he was taking two hundred and some odd grains a day. In the latter part of February, the last Wednesday in February, he had in the afternoon what he supposed was a chill, followed by nausea, and this nausea lasted through the next day and for several days after. On the following Sunday he returned to St. Louis, and on the first Wednesday after, when on his way to my office, he was again taken with a disagreeable feeling, followed by nausea and a chilly sensation. Reaching my office he laid down on the bed, and soon after threw up all the stomach contained. This condition lasted for two or three days. He then suffered severe headache, with a dull, uncomfortable feeling about the head, and particularly beneath the left eye. He also complained of tingling sensations in the feet and tips of the fingers. These symptoms had been present in the latter part of December, during his first attack. While lying upon my bed, I thought he was going to be paralyzed. It became difficult for him to articulate, and he seemed for a short time to lose all control of the muscles of one side of the body. Although well acquainted with me, being as familiar with my name as with that of his brother, he said: I can't recall your name—I don't know you. I see you, but for the life of me, I cannot call your name to mind. When I called it over to him, he seemed to have forgotten it. When suffering so much about the head he was very irritable, would take no medicine, so we applied pads of iodide of potash, in hopes that enough would be absorbed to be of some benefit. After two or three days he seemed to improve under this treatment. The following Sunday, however, he had another attack similar to the one already mentioned. In this attack all the previous symptoms were present, except the aphasia. He had the tingling sensation in the tips of the fingers, loss of power of speech. Again these symptoms passed off and he became comfortable.

For the next several days he remained passive, lying in bed, speaking to no one except when spoken to, and apparently unconscious of all surroundings, except when aroused. He had



passed from a very irritable condition, to a perfectly passive one. We got him to take medicine, commencing with twenty-five grains of iodide of potash, three times a day, with daily mercurial inunctions. This we continued daily, increasing the potash five grains, until he was taking upwards of three hundred grains a day. Under this treatment he rapidly improved. The double vision began to be less marked, and the appetite increased.

There is one thing I neglected to mention. Last January, a year ago, he received a fall, striking upon the back of the head. This was followed by some pain and a small abscess, which I opened, and the discharge of a small quantity of pus followed. The great difficulty we have had, was to get him to take medicine for any length of time. He invariably discontinued its use so soon as all disagreeable symptoms subsided.

*Dr. Robinson*—Do you remember in what direction the left eye deviated?

*Dr. Carson*.—The divergence was upwards. He has improved so much as to be able to draw the margin of the pupil below the lower lid, which was not the case before.

*Dr. Hodgen*.—The impression I had of the case was, that it was probably a disturbance of the fourth nerve, and not the third, though I don't remember the direction of the divergence.

*Dr. Carson*.—I thought that at first, but after you left I examined it more particularly, and I think it is the third.

[*Dr. Carson* states that since the time when this case was presented to the Society, the patient has had another similar attack following a protracted spree. The aphasia was very marked, and lasted until he had again been brought under the influence of iodide of potassium. He is now in the East, spending some time at the seashore, bathing, yachting, and leading a regular life, and all the alarming symptoms have wholly disappeared.—ED.]

Stated Meeting, June 14th, 1880—Dr. Baumgarten in the chair.

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MALIGNANT DISEASE ASSOCIATED WITH SYPHILIS.

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*Dr. Tuholske*—Mr. President, I have here a specimen to present. I am very sorry I was not able to do so two weeks ago, since I have been unfortunate enough to make an unsuccessful experiment with it. It has been stated that a fluid called *Wickersheim's* has the power of preserving specimens placed in it. It has been claimed that specimens would retain their normal condition—a thing which is very desirable. I state this because the specimen is changed—decidedly lessened in value as a specimen. There is enough left, however, to show the extent of the lesions. This specimen is a leg which I removed about three weeks ago. The man is about sixty years of age. In 1870 I treated him. He then had the ordinary form of tertiary syphilis; the periosteal troubles about the clavicle, sternum and other parts of the body. The same patient called about three years afterwards; he then had some gummatous tumors. He finally got well, after a good deal of destruction of the parts involved. A year and a half ago I was called to see the same patient. I found a gummatous tumor which had begun near the margin of the foot. It was then about the size of a silver dollar. I prescribed iodide of potassium. I didn't see him again until late in the fall, when he told me the swelling had healed up, but he had a great deal of trouble with the scar that followed it. It presented nothing very characteristic then. I put him on anti-syphilitic treatment, prescribing large doses of iodide of potassium, some mercury, and cod liver oil. The patient didn't get on very well. After months of unsuccessful treatment, it dawned upon me that the sore might be malignant in its nature. Dr. Prewitt was kind enough to see the patient with me, and pronounced it malignant in character. This foot does not now show the condition in which it was, as large pieces of flesh have dropped out from these margins. The healing process had apparently ceased. The pain at first was nocturnal, but towards the last two months of his sickness it changed, and he suffered both day and night.

I gave him very large doses of iodide of potassium, and also large doses of morphine. The patient was in very poor and reduced circumstances; he had been laid up a year and a half, and, I thought it absolutely necessary to give him a chance to get about and earn his living, so I cut off the leg. I afterwards had the specimen examined by Dr. Baumgarten. I have taken off the leg rather high up, since the skin seemed to be involved considerably above this place. There had been much pain in the tibia above this tumor, and I was afraid that if I cut very near the tumor there would soon be a recurrence. The patient is not a good subject for operation; he is over sixty years of age, and is suffering from asthma and a large rupture. He is in poor circumstances, confined to his bed in a room that is not a very good one; living at Eighth and Carr, a neighborhood not celebrated for its healthfulness. He has been getting on very well, however. I tried to treat him antiseptically, and succeeded locally, but could not procure anything like a general antiseptis. It is about three weeks since I amputated the leg, and the trunk has healed very nicely; the flaps are almost united everywhere, and he is now in rather a good condition. Some time after the amputation the muscles of the leg were subject to frequent spasmodic contractions, to such an extent as to jerk the leg right off the pillow on which it was resting. This gave him a great deal of pain, but it did not interfere with the healing process.

*Dr. Gregory.*—Doctor, what do you mean when you say you administered large doses of iodide of potassium?

*Dr. Tuholske.*—I gave him as much as two ounces and a half a week. I gave him as much as two hundred and fifty to three hundred grains a day. I thought at first, after prescribing several doses, that, as he got his medicine in fluid form it might not have been full strength. I therefore prescribed iodide of potassium in bulk.

*Dr. Pollak.*—How much above the surface was the tumor?

*Dr. Tuholske.*—An inch and a quarter.

*Dr. Gregory.*—There was no syphilitic manifestation about the man prior to or in conjunction with this tumor?

*Dr. Tuholske.*—There had been no syphilitic manifestation for two years. A year and a half ago, when I saw the patient, there was this large swelling, which, however, healed up, leaving a very thin cicatrix. I didn't see the patient again for quite a

number of months, until after this ulceration had commenced. The tumor was very painful indeed.

*Dr. Gregory.*—What do you expect to accomplish by this amputation?

*Dr. Tuholske.*—To enable him to get around, and prevent him from starving.

*Dr. Baumgarten.*—I would like to say that I am by no means sure that the diagnosis of spindle-cell sarcoma is correct. The specimen which I received for microscopical investigation was rather unfavorable. It was taken from the very midst of the tumor and therefore had in its character a good deal of cicatricial tissue. I should much prefer to examine a specimen from near the healthy parts of the skin. The specimen I received contained not a trace of epithelium; it was rather more of a cicatricial nature, or rather it was cicatricial tissue of the scirrhus structure, something between a small spindle-cell sarcoma and a new connective tissue, in structure. I found some portions undergoing fatty degeneration.

*Dr. Prewitt.*—I think, Mr. President, this is an exceedingly interesting case, taking into consideration the history of it. When I saw the tumor with Dr. Tuholske, it did not present the characteristics of a syphilitic ulcer. It had the outgrowths which are so characteristic of epithelial growths. I suggested to Dr. Tuholske that in all probability there was just such a mass of growing tissue in the central part of the ulcer, as we find so often in these epithelial growths, such as I have never seen in syphilitic ulcers. It may have been a syphilitic lesion primarily; and degenerative changes, so to speak, have occurred subsequently. I saw a case of this character a few months ago. A man, 58 years old, had had ulcers on the leg for fifteen years. They healed once but broke out again. There were sprouting growths that resembled very closely epithelial ulceration. They refused to heal, and the man was greatly reduced. It was evident that he would die, unless something was done. This case was at the city hospital, and I suggested to Dr. Dean the advisability of amputating the leg. The glands about the saphenous opening, had already become involved, which was affirmative of degenerative change in the ulceration, and the microscope confirmed the diagnosis; but, independent of the diagnosis of malignant degeneration in this case presented by Dr. Tuholske,

I think amputation was justifiable, because it refused to heal under vigorous anti-syphilitic treatment. The man was utterly unfitted for getting around—utterly unable to make a living; whereas, if he survived the amputation, there was no reason why the power of locomotion should not be restored, so that he could at least earn a living for himself.

The term, “large doses of iodide potass.,” is very indefinite, because what one practitioner regards as a large dose, would not be so considered by another. Some physicians think fifteen or twenty grains a large dose. My rule is to give to the point of toleration. I gave a patient at St. John’s Hospital, 960 grains a day, and it was not until I had given an ounce a day that there was any improvement. The increase was continued until it reached, as stated, two ounces per day.

*Dr. Gregory.*—You are rather governed by the effect upon the disease then? That is what you mean by toleration? You mean until you see improvement in the patient?

*Dr. Prewitt.*—I give the patient as much as the stomach will tolerate, or until marked improvement is manifest. It is not tolerated by all patients alike. What is a dose with one patient, and what he will take without any physiological disturbance, another cannot tolerate. I remember a case of a patient on whom the very smallest dose, a quarter of a grain had a very decided effect. My rule is to keep enlarging the dose, so long as the stomach tolerates it, unless I find it unnecessary to increase it further. The interesting point in the case is, that these old syphilitic ulcers may undergo these degenerative changes, and present characteristics which are altogether foreign to syphilis.

*Dr. Todd.*—I would like to ask if syphilitic patients bear iodide of potassium better than non-syphilitic?

*Dr. Prewitt.*—I think they do. Yes, sir.

*Dr. Leete.*—I wish to ask, in regard to the case at the City Hospital, if an examination was made at any part of the tumor to determine whether it was cancerous or not?

*Dr. Prewitt.*—I think there was a microscopic examination made, and it was found to present epithelial cells. I felt positive it would prove so in this case, as it did. Epithelial ulcers generally present very marked characteristics when they have existed for any length of time; an outgrowth which looks like a huge mass of granulations in the centre, with irregular depressions and elevations.

I saw at St. John's Hospital, about twelve months ago, the penis of a man who had had syphilis, and had been treated for syphilis. When I saw him, he had an ulcer on the penis, of such a character that I was convinced, at the first inspection, it was epithelial; but I gave him the benefit of the doubt, and prescribed iodide of potassium, in large doses, and a general tonic treatment; but it didn't make the slightest impression on the local trouble, and at last he had to have the penis amputated.

#### OVARIOTOMY.

*Dr. Gregory.*—I have had four ovariectomies this year. Three were successful. I can't say they were particularly favorable cases, or, in fact, I don't know but what the most favorable cases of ovariectomy are those which in the end prove most unfavorable. That is my opinion, founded on my limited observation. My favorable cases have turned out to be fatal cases, and those cases which by common consent were considered bad cases, have recovered, so that I really don't know what to call a good case. Three of these were cases in which the patients had suffered for months from the tumors. They had suffered pain from pressure; they had suffered more or less disturbance of the functions from the encroachment of the tumor upon the adjacent organs.

In one case, although the tumor was large, yet the patient never complained of pain from the tumor, although the tumor pressed seemingly into every recess of the abdominal space. I recollect when I called to see the patient, she came tripping down the stairs to meet me in the parlor. I recollect feeling surprised at the seeming agility of this patient, and I remarked that she seemed to move about as if she had nothing the matter with her, and she told me that she had suffered very little. She complained of no disturbances of functions, and so far as I could see she was perfectly healthy. The tumor had existed for two years, and had grown considerably during the last twelve months. I saw the patient about twelve months before the operation.

On the day of the operation on this particular patient of whom I am now speaking, I took aside a gentleman who had come to assist with the operation, and said to him: There are two points in this case; one, I have not tapped the patient; it is usual to

tap these patients; I have made it rather the rule where there was but one cyst to tap. I don't know whether it is a good rule or not; but after I have tapped a cyst I usually feel that my diagnosis is clearer than where this operation is not performed. I suppose it to be ovarian. The other point in the case is the perfect health of the patient. I really dislike to operate in a case where the functions are not in some measure disturbed—in a large measure I make it a rule that at least there should be some feeling of pressure—some sense on the part of the patient that the presence of the tumor is a burden—something that she is anxious to get rid of because it offends her, and disturbs her functions. He said: "Doctor, I think that is a good point in the case." I recollect this was his reply: "I think that is a good point in the case." But had this patient, when she consulted me, said: "Now, doctor, is this a favorable time to be operated on? Would you advise me to be operated on now, or had I better wait?" I should have said, Wait. But she didn't give me the opportunity. She came to be operated upon, and nothing but an operation would satisfy her. She was very determined. She was operated on and died in less than forty-eight hours, seemingly of diffuse peritonitis.

Now, this was a patient in perfect health. It was in all respects a favorable case—no sign of adhesions in any direction. The ordinary abdominal incision was made. The tumor seemed to be packed tightly into the abdominal space, and we extended the incision. Although there was a number of cysts, it was removed without difficulty from the recesses of the abdominal cavity, into which it had pressed. A large portion of it was solid. There was a number of proliferous cysts, some very large cysts, which were tapped, and of course the tumor was materially reduced; but, notwithstanding this reduction, the tumor was large.

As to the treatment of the pedicle, in this case, I included it in the wound. The pedicle was tied with a strong silk thread, which had been properly carbolized. There were three ligatures in the pedicle; and then I cut off the pedicle about an inch from the ligatures, and this portion was simply tucked into the wound. There didn't seem to be much tension. In the other cases the pedicle was allowed to fall loosely in the abdominal cavity. So that in the three successful cases the pedicle was tied and allowed to fall loosely, and in the one un-

successful case it was included in the wound. The patient complained of a sense of tension, and I regret very much that I did not allow the pedicle to drop into the cavity of the pelvis. It is the only thing I regret in the case. In one of the cases operated on, the tumor weighed eighty pounds. She never had a temperature that reached above a hundred.

*Dr. Prewitt.*—How old was she?

*Dr. Gregory.*—She was 52 or 53 years old. In one case the adhesions were extensive. The adhesions were readily broken down. One patient, who recovered, had a single cyst; that was the one I just referred to, in which there were extensive adhesions; the other two had what is called multilocular cysts, and their mass was so large that the abdominal incision in each case was very long, extending above the umbilicus, and in one case almost to the ensiform cartilage.

I feel that the successful result in these cases, is largely due to the very methodical preparation made, for which I am indebted to Dr. Carson. Every possible precaution was taken in the way of the preparation of the room, preparation of the bed clothes, and clothing of the patient. The precautions regarding the room were taken some time before the operation. The wound was dressed each time with what is called antiseptic precaution, and under vapor. It is not worth while detailing these precautions. I will only say, every precaution of which we have any account, was taken, and the details in the minutest particulars carried out from the beginning to the end of the cases. Now, I have never yet been an enthusiastic advocate of what is called "antiseptic surgery." We all believe in antiseptic surgery, of course; but whether the method as practiced is the best, I have never felt certain. I feel assured, however, that it enforces cleanliness. Certainly its cleanliness recommends it. It seems to me that, taking it all in all, there is much that is good in it.

I must say that I cannot join with those surgeons who advise early operations. My observation, although very limited—and I hope I have put my opinions forward modestly—has convinced me that it is advisable to wait until the system begins to complain of the tumor. For two years I have had under my observation a young lady; two years ago this summer she was very anxious to be operated upon; but I dissuaded her. She taught in one of the public schools. She is teaching at pres-



ent. The tumor has not grown any for the last six months, and she does not feel much pressure, but she is anxious to get rid of the deformity. I have encouraged her to wait. I have two other cases, also, under observation, one for a year and a half. This patient is waiting and is perfectly willing to wait, in fact she prefers to wait. The other patient, of whom I spoke, is anxious to be operated upon; her object is to get rid of the deformity. I feel sure, so far as my judgment is concerned, that it is better to wait. I am in favor of waiting until the patient is unable to get around comfortably, until she feels that something must be done.

*Dr. Pollak.*—What is your reason for waiting?

*Dr. Gregory.*—Because I have operated on cysts called favorable cases, that have turned out badly. I have operated early when everybody said, "If this case does not turn out well, I feel that I have no judgment," and they terminated badly.

I recollect a case which we operated on several years ago—Dr. Maughs was present at the operation—in which I did not put my finger into the abdominal cavity at all. After making an incision, the cyst was tapped, and after its collapse, it started out itself; we simply beckoned it out, as it were. This patient died in a short time from diffuse peritonitis. This woman came to me from a distant part—western part—of the city and she walked, to engage me to perform the operation. She was as active as she ever had been. My limited observation tells me that those patients get well best who have been complaining the longest.

*Dr. Maughs.*—Mr. President, I think it has got to be the rule with ovariologists, not to operate until the patient suffers great inconvenience from the tumor. They make it a rule to wait until there is a disturbance of the functions. It is an operation that may kill the patient, while it may never have to be performed, as the tumor may be discharged through the fallopian tubes, or otherwise, and the patient get well; and should it be necessary to operate, it is believed that if the patient has suffered long from the presence of the tumor, the peritoneum itself, in the presence of the tumor, undergoes change, so that it is less liable to become inflamed than if the patient is vigorous and healthy, and no change has taken place. Treatment and operation of these growths has been

reduced to an operation of minor surgery. While in New York I saw Dr. Thomas operate in a case of ovarian tumor. It was a case of monocystic tumor in the left ovary. He made the abdominal incision, tapped and drew it out, amputated it, and closed the abdominal cavity, and was in his buggy going to read a paper before the medical society, in twenty minutes. This was a large dermoid cyst. This was removed, the pedicle ligatured, and dropped in the abdominal cavity.

This distinguished gynecologist has operated eighty consecutive times successfully. While I was in New York, he received letters from three or four cases, in which he had operated successfully. He has had one recent case which proved fatal, but the patient was in such a condition that there wasn't the least hope of her living, unless the operation was performed, and even then there was little hope of benefit. The solicitations of the patient at last overcame the doctor's objections, and the operation was performed, under the most desperate circumstances, the patient living a few days.

*Dr. Prewitt.*—Were there any adhesions in the dermoid cyst?

*Dr. Maughs.*—No; he passed the point of the knife all around the tumor, and there were no adhesions in any direction. He operated under the antiseptic treatment, using the spray all the time. The temperature of the room was near 90°.

*Dr. Prewitt.*—I think, Mr. President, when Dr. Gregory says that the favorable cases are not the successful cases, that if he means by that, that those cases where there are no adhesions, etc., are favorable cases, and that they are more likely to be unsuccessful than when there are adhesions, I think that it is a mistaken view. If he means to say that an early operation, before any inconvenience has resulted from the tumor, in a case in which there are no adhesions, in which the tumor is readily removed, is less likely to prove fortunate than one where there are extensive adhesions I think he is in error. I think Keith takes the view that where the tumor is without adhesions, the patient is more likely to get well than in those complicated cases where they occur, and when he speaks of favorable cases, he speaks in the sense that there are no adhesions, that the tumor is readily removed, etc.

*Dr. Gregory.*—I mean, Doctor, that those cases which have been considered most favorable have, in my practice, proved most unfortunate.

*Dr. Prewitt.*—I understand that.

*Dr. Gregory.*—Again, I know that it is a very common idea, I do not know how well grounded it is, that when the adhesions are very extensive the patients are most likely to recover. The reason assigned is that the peritoneum is changed—that it is less natural and consequently less affected by exposure than it is when it is perfectly natural. I believe this is a common idea. Whether it is well grounded or not I cannot say—I am not prepared to say. Certainly those cases which were most unfavorable seem most likely to get well from my observation.

*Dr. Montgomery.*—Are you in favor of any preparatory treatment a week or two before operating? I think Dr. Morgan has mentioned it and Dr. Atlee in a lecture or short address some time since, said he did not attribute his success, in these cases, to his skill or dexterity as a surgeon, so much as to the preparatory treatment before operation. He never operated without a treatment of that kind two or three weeks before.

*Dr. Gregory.*—I can only say in regard to the matter of preparatory treatment, I simply give a purgative of castor oil two or three days before operation.

*Dr. Carson.*—Dr. Atlee, when he was here, told me he did not give his patients any preparatory treatment before operation. He simply gave some mild aperient, castor oil, a day or two before operation, and then put them on light diet.

*Dr. Prewitt.*—I have a case of ovarian tumor at St. John's Hospital. It is a cystic tumor with some solid elements. It is in the right ovary. About four weeks ago she became paralyzed in the lower extremities. There is an involvement of the sphincters. She has an idea that the paralysis is due to the presence of the tumor, but I cannot suppose there is any connection between them. This is not hysterical paralysis, of course, because the sphincters are involved. She has bed sores as well.

#### MISTAKEN DIAGNOSES.

*Dr. Papin.*—I had a very remarkable case sent to me from the country. The family physician gave me a full history of the case in a long letter. He had diagnosed a cystic degeneration of the right ovary, with probably a malignant development in the body of the womb itself.

I made a digital examination, and then by mere touch made an examination of the cancerous degeneration of the body.

She had not menstruated for six months, She said there was a very uncomfortable feeling in the right side, immediately under the liver. After making a thorough digital examination of the left lateral region, I used the stethoscope over the *cystic degeneration*, and found it was a baby. It was simply a case of sixteen years sterility; and, as the woman was 44 years of age, she supposed she had passed the menopause. This is not a single case in its character. A very prominent physician sent me an ovarian tumor, and the woman proved to be within two or three weeks of her confinement. I was so impressed with the idea that it was a cyst of the ovary, that I could hardly make up my mind that it was really a baby's head. It was not until two weeks afterward, when the woman was confined that I found the truth in the case.

*Dr. Maughs.*—A distinguished New York surgeon performed the operation of tapping a cyst, and drew off the liquor amnii in the last month of pregnancy; and a distinguished ovari-otomist was only saved from accident by premature labor coming on between the time he saw the patient and the day set for the operation. I saw a much more remarkable case in this city; a lady, forty-one or two years of age, noticeably enlarged in the abdomen. She consulted the family physician, and he told her to make herself easy, as it was simply the change of life. But he finally concluded it was an ovarian tumor, and decided to operate. Before doing so, however, he asked me to see the patient. When I saw her she was walking across the room with much difficulty. She was very large. I examined the patient and found her to be in the last stage of pregnancy. She subsequently gave birth to a child at full term.

*Dr. Papin.*—Some years ago a woman came to me, who was about thirty years of age, but had never felt the symptoms of menstruation. She had a greatly distended abdomen; and there was also a great deal of milk in her breasts. Making a careful examination, I found that she had no ovaries, and no womb. She was very large, the abdomen was tympanitic in last degree. I gave her four compound cathartic pills which brought it down at once.

I have surmised that she must have been manipulating her breasts in trying to discover if milk was coming, which finally excited the secretion. That, of course, was nothing new. The secretion has been known to occur in men. This was a

very remarkable case. I have seen four or five women without wombs, or with but rudimentary wombs, but they had ovaries; and about the time of menstruation, had horrible tortures; but this woman had neither ovaries nor womb, and yet to all appearances, she was a perfectly formed woman.

## LACERATION OF URETHRA.

*Dr. Prewitt.*—Mr. President, I wish to report a case which may be of some interest to the Society. On Monday evening, about six o'clock, I was called to see a young man who had, about four o'clock, fallen from a ladder, and across a window sill, striking the perineum. There was quite profuse bleeding from the penis for a while, and as there was no external wound, it was evident that the urethra had been lacerated. I first tried to introduce a silver catheter, and failed; I then took a soft gum catheter, and after bending it to the proper curve, with gentle manipulations succeeded in passing it into the bladder. The water flowed freely, but during the night he got it out. I reintroduced it the next morning with little trouble, and retained it during the day, but the next night it came out again, although it was tied. I was a very soft catheter, and the least effort pushed it out. I introduced it the third time, and the following night it came out again. Next day I attempted to introduce it and failed; although I was very gentle in manipulating it, it excited a considerable flow of blood. I concluded to take the risk and let him pass water. Half an hour or an hour after I saw him, he did pass water; and, in half an hour or an hour, had a most intense rigor. I saw him, perhaps, an hour after the rigor set in; he then had a temperature of  $105\frac{3}{10}^{\circ}$ , and very great prostration. I did not attempt to pass the instrument again, but concluded to do so next morning. During the night he passed water again, and again had rigor, and high fever. He sent for me in the night and I determined if he had another chill, to perform external urethrotomy, so as to allow a free flow of urine. On the next morning he passed urine without any chill, and has continued to pass water since, without any bad symptoms following.

*Dr. Gregory.*—Did you give him quinine?

*Dr. Prewitt.*—I gave a large dose of quinine, and directed him to take a quarter of a grain of morphine, and ten grains of quinine, half an hour before he allowed the water to pass again, which he did.

*Dr. Pollak.*—Is there any inflammation?

*Dr. Prewitt.*—There is no evidence of it. There is still a little blood, occasionally, from the urethra, especially after the flow of urine.

(This patient recovered, without further unpleasant symptoms but has neglected to report for treatment, to prevent the formation of traumatic stricture, as urged to do.)



Stated Meeting, June 28, 1880, Dr. Todd in the chair.

#### DRY TREATMENT OF OTITIS MEDIA PURULENTA.<sup>1</sup>

*Dr. Todd.*—As I have recently been very much interested in this subject, I will state that I am glad to know that Dr. Spencer is following a treatment parallel with my own. In fact I had made this treatment the subject of a paper which I had hoped to read before the State Association, but as I was not able to be present, I sent the paper which was mentioned by title only.

The doctor's remarks should certainly be taken to heart by the general practitioner. The ear is very greatly endangered sometimes by the treatment that is now in fashion. Formerly the practice was not to check the discharge, but to let it run on until it stopped of itself. Now the risk is taken in a somewhat different way, and the ear is subjected to various washes. If any one will look into the ear after it has been in a state of suppuration for some little time, he will notice a macerated appearance. This is the first thing that will strike one. The discharge bathes the mucous membrane, the membranes of the tympanum and external auditory canal, until they present a macerated appearance; and, as Dr. Spencer very well remarks, the more desirable plan of treatment is not so much to wash it out as to dry it, and for this purpose I use powdered borax, and with good results. Washing the ear and the use of

<sup>1</sup> Dr. Spencer's paper on this subject, printed in the July number of the *American Journal of Otology*, will be given to our readers next month.—ED.

ear drops, tend to produce a macerated state, exactly what we want to relieve. I have almost ceased giving ear drops to patients. Once in a while only, I wash out the ear and cleanse it with absorbent cotton. Every possible care is taken to avoid introducing fluid into the ear. I have met with the most delightful results in this treatment. I have used the powdered borax in almost indefinite quantities, often filling the canal of the ear half full. The results have been most gratifying.

*Dr. Pollak.*—What do you put the powdered borax in with ?

*Dr. Todd.*—I puff it in with a suitable tube. The borax acts as an absorbent, readily takes up the discharge and helps to dry up the tissues. This is exactly what we want. It also discourages suppuration. A wonderful change will sometimes be effected in a single day. I have been astonished at the effect on the macerated tissue of the external ear and membrana tympani. The membranes will sometimes look quite natural in twenty-four hours time.

*Dr. Fischel.*—Do you use this treatment in cases that have become chronic ?

*Dr. Todd.*—Yes. We have especially happy results in such cases. Cleanse the ear thoroughly with the absorbent cotton—wipe it out thoroughly and insufflate the borax. I have a case of a child now who had a discharge for several years—one or two years—it was a bad case, the perforation healed in a short time, less than a month. I have seen the child only twice a week, which is certainly a very favorable result.

*Dr. Pollak.*—Do you use borax or boracic acid ?

*Dr. Todd.*—I use powdered borax. I would like to call the attention of the members to a recent discovery of Pasteur, in which he advances the germ theory to account for puerperal septicemia. He claims that the discharge in puerperal disease furnishes a nidus for germs. He suggests that the discharge can be relieved by the use of powdered boracic acid, which can be safely used. He suggests the use of boracic acid on cotton tampons to prevent the discharge generating bodies which may be absorbed and thereby poison the body. He uses this merely for its antiseptic effects—local antiseptic effects. I think in these cases of suppuration it might be well to give medicine internally. Sulphide of calcium has a remarkable effect on suppuration. It should be used in small doses, one-twentieth to one-tenth of a grain every two hours.

## SULPHIDE OF CALCIUM.

*Dr. Baumgarten.*—I would like to have Dr. Todd report a case in which he used sulphide of calcium.

*Dr. Todd.*—I had two notable cases this spring, one a boy about eleven years old, who was suffering very intense pain from suppuration of one of his ears, consequent upon measles. There was a great deal of swelling about the ear. The glands were swelled and excessively painful. There was much discharge. I gave this preparation freely, it relieved the pain. The result was very marked.

*Dr. Carson.*—I would like to ask Dr. Todd what doses he gives.

*Dr. Todd.*—I give children one-twentieth of a grain, and adults one-tenth of a grain every two hours.

*Dr. Spencer.*—Mr. President, I would say I have heard much of the good accomplished with sulphide of calcium; but although I have used it in many cases, I have met with no success whatever. I cannot say it hastened suppuration, or prevented it in any way, or hastened results in those cases where suppuration had begun. I have used it very freely.

*Dr. Todd.*—Perhaps you used it too freely.

*Dr. Glasgow.*—Mr. President, I must say that my experience does not correspond with that of Dr. Spencer in the use of sulphide of calcium, especially in suppurative cases. I think it prevents suppuration and cuts short the disease. I am fully satisfied of its beneficial effect in three or four cases. One case in particular I remember. I was called to see a priest who was suffering intense pain from tonsillitis. He had not been able to swallow for about two days. The tonsils were very large and much inflamed, so much so that I deemed lancing them advisable, but he would not consent, so I put him on sulphide of calcium, a quarter of a grain every two hours. The next day the tonsils were not so red. I cannot say they were any smaller, but there was considerably less pain. I again suggested the knife, but he said: "Wait." I kept up the sulphide of calcium. I saw him the next day. The swelling of the tonsils had gone down a great deal, and I discharged the case in two days afterwards. Now I think that was a pretty rapid cure. I say the whole took place within four or probably five days. In those cases where suppuration has not taken



place, the sulphide of calcium prevents suppuration. In regard to its use in enlarged glands, I would say, I use it in these cases with a good deal of confidence. A patient came to me some two weeks ago, who had been under treatment for two years by various physicians, with an enormous enlargement of the glands of the neck. The various masses of glands were enlarged in long chains running down the sides of the neck. These masses were very hard and tense. I put the girl on sulphide of calcium, one-quarter of a grain every three hours. This was three weeks ago. I saw her to-day and the glands were diminished fully one-half. The first effect was to soften the glands so that I could distinguish the different glands of the chain. She had been under treatment for two years, under different physicians, who had used iodine without the slightest effect.

*Dr. Spencer.*—Dr. Glasgow, in this case of tonsillitis, where you used sulphide of calcium, did you use any other treatment? Did you make any topical application?

*Dr. Glasgow.*—I made no topical application. I used an old woman's remedy, however, simple yeast, such as you get from the brewery.

*Dr. Carson.*—The weight of evidence seems to be against me in the use of sulphide of calcium. I had a case somewhat similar to that of Dr. Glasgow. A man had tonsillitis with inflammation so very great that he could barely open his mouth. As it was impossible to make any application, although not expecting much benefit, as I had tried it on two or three other occasions without success, I ordered sulphide of calcium, one-quarter of a grain every two hours—and the patient received no benefit at all. I increased the dose to one-half a grain every three hours, but it did not benefit him. In this case the inflammation was longer and the suffering greater than in any case of the kind I have ever seen. I also used sulphide of calcium in the case of a patient with abscess of the thigh, and this patient derived no benefit whatever from the use of it. It ran the same course that any other severe abscess of the same part would have done. It seemed to influence it in no way whatever. I have used it in several other cases, in none of which did it exert any more influence than so much water.

*Dr. Spencer.*—I have used sulphide of calcium myself, and I put my experience with that of Dr. Sexton, of New York. A

year ago the *American Journal of Otology* spoke of the treatment of furuncular inflammation by the use of sulphide of calcium, and recommended that it be given a fair trial. I have used it in forty-five cases of furuncular inflammation together with suppurative process in the middle ear, and I declare, sir, that I cannot see that in any instance, it ever shortened a case or influenced it in any way whatever. I was not willing to rely upon it, but at the time I continued the treatment which I had always been accustomed to in these cases. I don't think the sulphide of calcium influenced the termination of the cases, either by hastening or retarding them.

*Dr. Carson.*—I now call to mind a case of furuncular trouble, similar to the one Dr. Glasgow mentioned. This gentleman was a martyr to furuncular eruptions on the back of the neck, and suffered great pain, sometimes for weeks at a time. When I heard of the sulphide of calcium being used in these cases, I concluded that at last I had found something which would benefit this patient, and I was really selfish enough to wish he might be afflicted again, in order that I might try this vaunted remedy. Well, it did return, and I tried the sulphide of calcium, but it had no effect whatever. I increased the dose from one-quarter to one-half a grain, every two hours, but one after another of these small furuncles appeared and took their usual course in spite of the drug.

*Dr. Glasgow.*—Possibly the drug was not pure. I will say this, that during the session of the National Association, this subject was discussed at great length, and sulphide of calcium was universally admitted, by men at the very head of the profession, from the different states, to have a wonderful effect. They all united in extolling its merits. The general expression asserted its virtue in suppurative, and especially in furuncular processes. This case of tonsillitis that I quoted, is simply one, but I have had several so marked, that I am fully confident of the virtue of sulphide of calcium.

*Dr. Todd.*—We cannot always get sulphide of calcium in St. Louis. Very few druggists have it.

*Dr. Hardaway.*—An article that appeared in the *Lancet*, several years ago, on the sulphides, by Dr. Ringer, first induced me to make use of this group of remedies, in the suppurative processes. Ringer states that they appear to possess the property of preventing and arresting suppuration. Thus in in-

inflammation threatening to end in suppuration, they reduce the inflammation, and avert the formation of pus. But after the formation of pus, he declares, the influence of the sulphides on the suppurative process is still more conspicuous; then they hasten maturation considerably, while, at the same time, they diminish and circumscribe the inflammation, promote the passage of the pus to the surface, and the evacuation of the abscess. This is almost literally the statement of Ringer, as found in his hand-book of therapeutics; and I must confess that my own experience goes far towards confirming the claims he has made for the sulphides. I have used the sulphide of *calcium* exclusively, and nearly always in the form of powder, rubbed up with sugar of milk. It has seemed to me that the pills are not so trustworthy. I have prescribed the sulphide of calcium quite extensively in dermatological practice, and while I am not now prepared to enter into the details of cases, I feel quite safe in stating that the drug has acted most favorably in carbuncle, furuncle, some forms of acne, etc. Again, for some unaccountable reason, some cases have failed to be benefited by it; but such is my general confidence in the remedy, that I always resort to it in appropriate instances. I have never found it to do the least good in bubo, although I observe that Dr. Otis, as the result of a series of careful observations, testifies to its efficacy. It may be appropriate to state, in this connection, the apparently exceptional results obtained by me with the hyposulphites, in small-pox. I will acknowledge at once, that of all diseases, small-pox is the most difficult upon which, to base any therapeutical conclusions, owing, of course, to the modifying influence of previous vaccination. Theoretically, we would expect that a group of drugs influencing the suppurative process, would favorably influence the secondary fever of variola, lessen the formation of pus, and, consequently, markedly decrease the pitting. These results the bold administration of the hyposulphite of sodium, has seemed to accomplish. I was in the habit of giving from ten to twenty grains of the hyposulphite of sodium in syrup of wild cherry, every one or two hours. One other fact in regard to the sulphides. I believe that their property of hastening suppuration, is much more pronounced than their ability to prevent it; at any rate it is a property much more susceptible of demonstration. Suppurative processes, affecting gland-

ular structures, seem most suitable for the exhibition of the sulphides.

LOCAL APPLICATIONS, CHLORATE OF POTASH.

*Dr. Leete.*—I would like to ask Dr. Glasgow if I understand him rightly, that he does not value local applications in acute tonsillitis?

*Dr. Glasgow.*—Yes sir.

*Dr. Carson.*—I will state that although my use of this drug has been unfortunate, I have ample opportunity for trying it, of giving it a fair test, and if there is any gentleman who wishes to try it and will furnish the drug, I will furnish a case.

*Dr. Glasgow.*—I don't think either Dr. Carson or Dr. Spencer can speak authoritatively on this subject. If they had used it as it is recommended, in the powdered form, and had obtained a reliable article, then their experience would be of value.

*Dr. Leete.*—In connection with what has been said of the topical application of borax or boracic acid, and of its influence on suppurating or ulcerating surfaces, I would like to call attention to what every one knows. About 1864 or 1865, Polli gave to the profession the result of an extended observation made in the use of the hyposulphites. He experimented with two dogs—taking those as nearly as possible of the same weight and condition, and pumping into the veins of each of the animals septic matter, and having placed before them each food and drink, placing hyposulphite of soda in the water of one. The one that got no remedy rapidly sickened and died in a typhoid condition. The other one was sick but recovered. A few months ago I saw that he had made a similar experiment with borax or boracic acid, I am not certain which, and with a like result. I think these results are very interesting. Of course we don't know exactly how the poison in these cases is propagated, or to what degree the suppuration proceeds; but it is a very interesting fact that the borax has been found so valuable after close examination.

In the treatment of tonsillitis, I have to say that I have from the very first found topical applications useful, or else I have been deceived very much. In the course of my experience in the army, I very frequently had to deal with severe cases of tonsillitis, and I very often got favorable results from topical

applications. I scratched the tonsil gently with the point of a knife, so as to let out a small quantity of blood, giving the patient immediately a warm water gargle, to encourage the bleeding. The relief was instantaneous and remarkable. I sometimes used a large sized probang either saturated with hydrochloric acid, or what I think about as good, warm water. I succeeded this with crystals of the chlorate of potash. The use of the knife or probang is disagreeable to the patient. I have used crystals of chlorate of potash quite frequently during the past winter; and the patients invariably reported marked relief within a very brief space of time—within a very few hours.

*Dr. Briggs.*—I have been very much pleased with this discussion. I have a case now on which I shall use this remedy. It is the case of a person in the lower ranks of life, who is annoyed with a swelling in the neck so that it interferes with the poisoning of the head. I remember some five or six years ago I had a case of swelling of the glands of the neck, in the only daughter of persons of wealth. If it had gone on to suppuration, she would almost inevitably have been scarred, and as she was a very pretty young lady about six years of age, all my energies were directed to a treatment which would result in a resolution or discussion of it. At one time I used a very strong application, and I am satisfied that if I had not done so, pus would have formed.

I wish to ask *Dr. Glasgow* if in the case he mentions there was suppurative ulceration, or whether he felt sure pus was formed?

*Dr. Glasgow.*—I call it a case of probable suppurative tonsillitis, from the fact that it presented all the appearances of tonsillitis before suppuration. The man had severe, intense throbbing pain, and this throbbing pain is evidence of suppuration, of the tonsils especially, when conjoined with the peculiar touch, which, I admit, is very deceptive. He had, also, the general constitutional symptoms, fever, great mental and physical prostration.

I said I did not make any local application. I did not consider water a local application. Hot water, I think, is universally used in this class of cases; but a patient with acute tonsillitis cannot gargle—cannot get water back over the tonsils. The use of water is universal, but it is better in the shape of a hot spray. You may use simple water, or chlorate

of potash water, but I don't think there is any virtue in chlorate of potash to relieve these cases. Hot water is most gratifying, and would give all the sensations of relief which Dr. Leete ascribes to chlorate of potash.

*Dr. Leete.*—I didn't say I used hot water in my cases, except where I had scarified the tonsil; then I used warm water to encourage the bleeding. I do not give chlorate of potash in water, but in crystals taken into the mouth to be dissolved in the saliva. Whether it gains strength by mixture with the saliva or not, I don't know.

*Dr. Fischel.*—The doubt was whether the case was one of suppurative tonsillitis, or not. According to my experience, I am inclined to think that cases of suppurative tonsillitis are not so very rare. I think they ought to be very good cases for testing the sulphide of calcium. The remarks of Dr. Glasgow, called to my mind a case that I had, in which the glandular swelling had existed for five years. The suppuration of one of the glands was considerable. I tried the sulphide of calcium a great while, and I am sure I got a pure article, but without effect. I recall another case, in which the glandular swelling was of unusual size—without any exaggeration, as large as my fist; in this case I tried the sulphide of calcium some time without benefit. I afterwards used iodide of potash in exceedingly large doses, giving sixty grains, three times a day, with quite remarkable effect.

*Dr. Hardaway.*—I think it is a mistake to suppose that the sulphides are indicated in the reduction of chronically enlarged glands. I do not remember that Ringer makes any such claims for them. The tendency to pus formation or the presence of pus itself, seems to be the essential factor in the therapeutics of the sulphides.

*Dr. Leete.*—With regard to the topical application, and application of chlorate of potash, I have had a large experience in the case of old chronic ulcers, while in the army; and I have seen nothing else so beneficial to the patient, in regard to keeping granulating surfaces in a wholesome, healthy condition. When I left the service at Pennsylvania Hospital, the surgeon in charge said to the surgeon who came on duty next, that he had seen more old suppurating ulcers healed up in the hospital, during the three months which I had been there, than ever before had been healed in that hospital, and he gave me the

credit of the success. Now, in the entire treatment, nothing cut so large a figure in the healing process, as a solution of chlorate of potash, varying from three to six grains to a fluid ounce of distilled water, applied to the ulcerating surfaces. It is a poison if taken in very large doses.

*Dr. Baumgarten.*—I have given an ounce of it without producing any poisonous effects. It is hardly a poison in the usual acceptation of the term. I use it in diphtheria, and in internal suppuration, especially of the bladder. I have seen very good results from its use in large doses. I have given an ounce of it, actually, without any inconvenience to the stomach generally. Then it had a decided effect, which was not produced by any other remedy, on the bladder and kidneys.

*Dr. Hardaway* exhibited a pair of impermeable, film rubber gloves. He considered them much superior to the thick, uncomfortable kind generally sold. These film gloves could not only be used to advantage in skin affections, but were particularly useful in chemical manipulations, post-mortem examinations, etc. Mr. Good, the druggist, had procured them for him from London.

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## SELECTIONS.

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### THE HIPPOCRATIC OATH.

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At the request of several readers, we copy here the celebrated "Hippocratic oath," as it is given in the "Practitioner's Reference Book."—[Ed.]

I swear by Apollo the physician, and Æsculapius, and Health and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by

precept, lecture, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this oath, may the reverse be my lot!

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### SAWYER'S SPLINT.

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[By the courtesy of the editors of the *Chicago Medical Journal and Examiner* we are enabled to present our readers with the illustrations accompanying the description of Dr. Sawyer's splint, taken from the valuable paper of Drs. E. W. Lee and Ch. Fenger in the July number of that journal.—ED.]

The splint is a modification, or rather an extension of the well known Hodgens' anterior splint, employed in fractures of the femur, etc. The outlining frame-work was constructed of five-eighths inch iron, while the cross-bars arching over the limb and body, as hereafter described, were of three-eighths inch iron.



The five-eighths iron bar constituting the main framework of the splint, commenced at the lower border of the axillary space on the side of the affected limb and was extended downwards to a point six inches below the foot, being moulded so as to correspond, with approximate accuracy, to the outline of the body. Below the foot the bar made a square turn, extending horizontally inward about four inches; thence turning squarely again and running up the inner aspect of the affected limb to the groin. From this point it arched across the opposite groin in an oblique direction corresponding with the inguinal fold and at the anterior superior spinous process of the opposite ilium, took another and final turn, ascending along the opposite side of the body to its termination at the lower border of the axillary space. Arching across the limb and body, and connecting the two branches or "legs" of this framework, were five cross pieces at the following points: first, at the upper extremity of the splint; second, extending obliquely from a point six inches below the upper extremity on the affected side to the angle of the splint corresponding to the anterior superior spinous process of the opposite side; third, at a point corresponding to the inner and lower extremity of the fixed arch across the opposite groin; fourth, at the lower third of the thigh; and fifth, at the lower third of the leg. Of these arches all but the third terminated on either side in a hook for the purpose of suspending the apparatus. There was a slight bend in the splint corresponding to the knee-joint, so as to allow of limited flexion, and another at the upper end of the femur, where it was bent upward at an angle of perhaps  $20^{\circ}$ .

This apparatus was applied after the manner of a Hodgen's splint. Adhesive straps were applied to the limb as high up as the lower third of the thigh, being secured to the limb by a roller. These straps were attached at their lower extremities to a "stirrup block," which was in turn fixed to the lower end of the splint by means of a short piece of elastic tubing.

The limb and body were supported by broad strips of muslin passing underneath and secured by pins on either side to the framework of the splint.

The apparatus was suspended by two sets of cords as follows: 1. Four being converged from the four lower hooks already mentioned to a point some distance above the limb, were attached to a line dropped from a pulley in the ceiling, a

little below the foot of the bed, the degree of obliquity in the direction of this line varying with the amount of extension desired. 2. Four cords converging from the four upper hooks to a point a few inches above the body, were attached to a line dropped directly downward from the ceiling, a set of compound pulleys intervening for convenience in elevating the body. For convenience in dressing the limb, a block was removed from the mattress corresponding to the location of the wound. This could be replaced when not dressing.

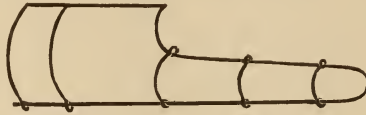


Fig. 3 shows the iron frame of Sawyer's Splint.

Dr. Sawyer's splint proved in this first case—a boy of seventeen years of age—a most excellent and convenient help in the after-treatment. When the dressing was renewed, the patient hoisted himself with the upper system of pulleys, an assistant raising the limb by the lower set of pulleys; the straps covering the wound were removed after withdrawing the block in the mattress and the wound was easily gotten at.

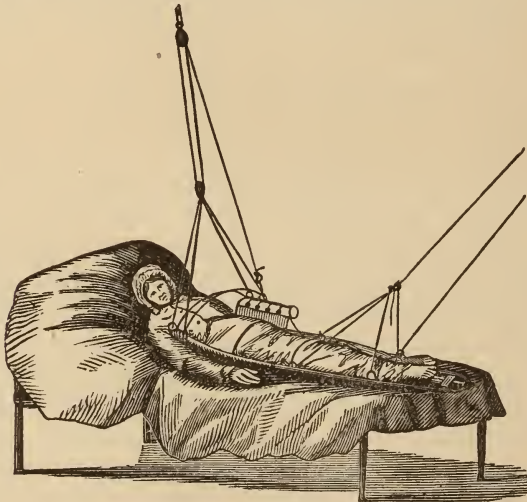


Fig. 4 shows the splint applied to the excised hip.

An important point in the after-treatment, if we would carry out all the details of the antiseptic method, is this: We must

be in no hurry, but must have ample time to cleanse every part of the wound, wash out the tubes, etc., without fear of tiring the patient or causing him to get nervous or suffer pain. Therefore it is necessary to have the whole body of the patient easily suspended and high enough to enable the surgeon to get free access to the wound from below, to operate the atomizer and to change the bed clothes. To accomplish this, Dr. Lee devised a movable suspension frame, with straps, to support the patient during the shifting of the dressing.

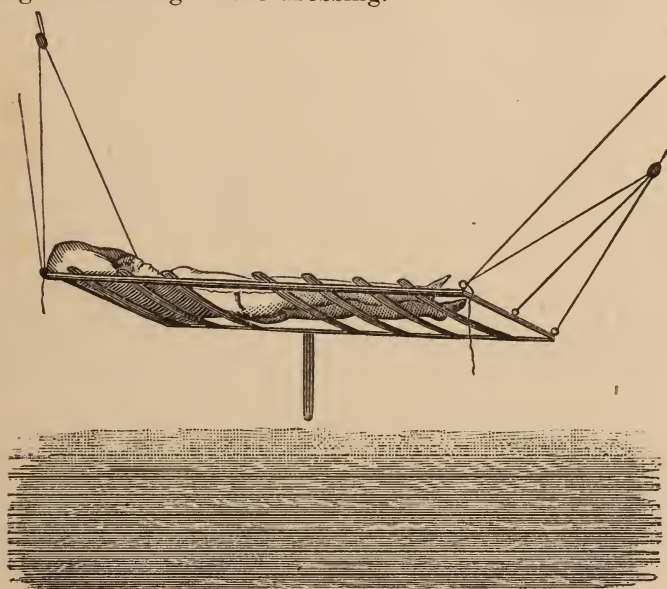


Fig. 6.

Fig. 5 shows Lee's frame for dressing of excisions of hip-joint. It consists of a wooden frame six feet long, two and a half feet wide, with cross straps four inches wide and four inches apart. Each corner has a strong iron hook for attaching a suspension rope.

The center of each of the end pieces bears another hook for fixing the end of the rope after the apparatus is hoisted.

The mode of operating is as follows: The patient is first hoisted in Sawyer's splint five to ten inches above the bed. Lee's frame is placed on the bed beneath, when the patient is lowered upon it. The ropes are then adjusted to the frame and this is raised up two feet, bearing patient, Sawyer's splint

and all, and fixed in this position. The patient has a pillow under his head and is perfectly comfortable.

The bed is then taken away. The straps in Sawyer's splint covering the Lister dressing are unbuttoned and removed. Next the straps in Lee's frame covering the wound are removed. The antiseptic dressing is then accessible, is easily removed and the wound cleansed, under the spray. The bed is refreshed and the new antiseptic dressing in all its layers is prepared and laid upon the bed in the proper place, when the bed is brought under the patient and he is let down upon the dressing, the application of which is completed by bringing around the body the ends of the many-tailed bandage that holds the dressing firmly to the part.

The straps of the splint are readjusted and the patient hoisted by this away from the wood frame which is now removed, and the patient is again lowered on the bed and the dressing is finished.

The description of this dressing and the apparatus may make it appear complicated and unpractical. But if you could see the dressing made upon these little patients and see them, as we often have seen them, laugh, chatter and make fun during the whole of the tedious performance, which otherwise must be tiresome and painful, you would not entertain such an opinion of it.

The apparatus already described,

1. Permits defecation, dressing the wound, changing the bed clothes, etc., without moving the patient; it lifts the patient without moving him.

2. It can easily be kept perfectly clean.

3. It is inexpensive.

NOTES AND ITEMS.

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THE COURIER.—Having now fairly entered upon the second half of the second year of its existence, its supporters are to be congratulated upon the success so far attained. We have a journal of attractive appearance, and a good supply of excellent material, and the pledged support of a large number of the leading men not only of St. Louis, but of adjoining cities and states, who are stockholders in the Association. Our subscription list has increased fifty per cent. during the first half of the year; and we are constantly receiving this best evidence that the COURIER is commending itself to the profession, in the addition of new names to the list.

Let our friends continue kindly to exert their influence for us during the latter months of the year when physicians are making out their list of journals for subscription, and the number of our readers can easily be doubled.

We shall be glad to receive from our readers any well considered suggestions as to the best means of extending the influence of the COURIER so that it may the more perfectly attain its object, to be *the* journal of the central Mississippi Valley.

The COURIER was started upon the conviction of many of the profession that such a journal was needed in the West, and a stock company was formed by members of the profession for the purpose of supplying this need.

The COURIER is carried on by the profession, and for the profession, and expects the support of the profession, so long as it shall prove worthy of such support.

We desire to call the attention of our readers to the position of the COURIER upon the subject of advertising. We have made it a point to admit no advertisement to our pages which we cannot fully commend as trustworthy. We wish it to be understood that the *houses* whose advertisements we publish, can be depended upon for honesty and reliability, and that preparations so advertised have been found to be of real

merit by our own experience and that of men in whose judgment we have complete confidence.

We, therefore, shall not introduce into the body of the *COURIER*, editorially or otherwise, articles written in the interest of special preparations.

It will be to the interest of our readers to note the advertising pages of the *COURIER* and observe changes that appear from time to time and new advertisements; and we hope that they will do us the favor to mention that they have seen the advertisement in our pages when they correspond with these houses.

THE Fourth Annual Meeting of the *American Dermatological Association* will be held in the Ocean House, Newport, R. I., on the 31st of August, and the 1st and 2d of September.

ARTHUR VAN HARLINGEN, M. D., Secretary.

DR. CHISHOLM, of New Concord, Ohio, suggests the following "to prevent yellow fever":

R. Major Gen. Butler.

Men.

Brooms, picks, shovels, etc.

Lime, salt and carbolic acid.

Bromo-chloralum  $\bar{a}\bar{a}$ . q. s.

S. Apply frequently and often.—*Ohio Med. Jour.*, June, 1880.

GROWTH OF HAIR.—Prof. Moleschott has ascertained by experiments upon eleven persons during a year, that the average growth of the human hair amounts to twenty centigrammes a day. The hair grows more rapidly in summer than in winter. Frequent cutting of the hair stimulates its growth.—*Lond. Med. Rec.*, Apr. 15, '80.

A LAW REGULATING THE PRACTICE OF MEDICINE has been enacted in New York State. All physicians desiring to practice medicine there are required to present their diplomas and register at the County Clerk's office.

DURING last year eighty-one books and pamphlets, and three hundred and sixty-seven journal articles on the subject of insanity were published.

**KENTUCKY TAKES THE LEAD.**—At the last meeting of the Kentucky State Medical Society, a resolution was adopted by which the Society discontinued the publication of a volume of Transactions, simply publishing the minutes in pamphlet form. Papers read before the society may be printed in the regular medical journals selected by their authors.

A resolution was also offered and laid over for consideration at the next meeting, providing for the creation of a prize-essay fund by the appropriation to this purpose of the money heretofore used for printing the transactions.

This is a move in the right direction, and we congratulate the profession in Kentucky upon the position which they have taken.

**THE COLORADO STATE MEDICAL ASSOCIATION** held their annual meeting in Denver, June 29th and 30th, and July 1st. The officers for the following year are F. J. Bancroft, M. D., President; S. E. Solly, M. D., Colorado Springs, First Vice-President; I. H. Dougan, M. D., Leadville, Second Vice-President; Jessie Hawe, M. D., Greeley, Third Vice-President; Dr. Warren, Denver, Permanent Secretary; A. W. Adams, M. D., Colorado Springs, Recording Secretary; B. Johnson, M. D., Assistant Recording Secretary.

Dr. C. C. Lathrop who had served as Permanent Secretary for four years, resigned on account of impaired health. In accepting his resignation, the association rendered him a vote of thanks for efficient service.

The new *Rocky Mountain Medical Review* was endorsed by a vote of the association.

**HOW VIVISECTION CONCERNS EVERY CITIZEN**, is the title of an article by Lewis S. Pilcher, M. D., which appeared in the *Christian Advocate* of July 8th. It is a very able reply to Dr. Leffingwell's paper in the *July Scribner*. It ought to be read by every one who has read Dr. Leffingwell's paper.

**WHY CARBOLIC ACID TURNS RED.**—Hager concludes from the result of repeated careful experiments, that the nitrate of ammonia contained in the air is the cause of the change of color in carbolic acid, and that, therefore, it should be kept in closely stoppered bottles.—*Druggist's Circular and Chem. Gaz.*

**THE BRITISH MEDICAL ASSOCIATION** will hold its forty-eighth annual meeting at Cambridge, August 13, 1880.

It is stated in the *Medical Times and Gazette*, that at the approaching meeting of the British Medical Association, at Cambridge, the University will grant the degree of Doctor of Laws, an honor of the most distinguished kind, upon the following medical men: Gross, of Philadelphia, (already a D. C. L. of Oxford); Broca and Brown Sequard, of Paris; Chauveau, of Lyons; Donders, of Utrecht; and Jenner, Gull, Burrows, Bowman, Haughton, Lister, O'Conor (President of the Association) Simon and Wood, of Great Britain and Ireland.

FROG POISON.—The natives of Colombia poison the arrows which they use in their blow-guns with an acrid yellow liquid, which exudes from the skin of a peculiar frog which is found in the *tierra templada*, between 1,500 and 2,000 metres above the level of the sea. The Indians protect their hands with leaves when they catch the frog. They suspend it by the hind legs over a fire. A yellowish, acrid liquid is then exuded into which the arrow-tips are dipped. The effects produced by this poison are reported to be identical with those of curare, being innocuous when taken by the mouth, but speedily fatal when introduced into the blood. No antidote is known.—*Die Natur. New Remedies*, July, '80.

SOLUTION OF SALICYLIC ACID.—Wm. Springer says that carbonic acid water, seltzer and vichy water readily dissolve salicylic acid. The latter, containing an excess of alkaline carbonates is generally preferable. The acid should be put in the glass first, and mixed thoroughly with a small quantity of the water, and then the glass filled and drunk at once.—*Louisville Med. News*, May 1, '80.

REMARKABLE OBESITY.—F. B. Smith, of Covnetry, Mass., has a patient, a lad of fourteen years, who during the past year has increased in weight half a pound a day, and now weighs two hundred and eighty-four pounds. He has an inordinate appetite and eats eagerly all food that falls in his way, even raw meat. The intervals between meals are spent principally in sleeping. He complains of nothing but hunger and appears to be in good health otherwise.—*Boston Med. and Sur. Jour.*, May, '80.

THE American Medical Association Library contains 3,258 volumes according to the report of the Librarian at the last meeting.



ST. LOUIS  
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- AND -

COLLATERAL SCIENCES.

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No. 3.

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ORIGINAL ARTICLES

PUERPERAL FEVER.

*Read by DR. GEO. O. FEAGAN, before the La Fayette County Medical Society, which met in Higginsville, Mo., May 3d, 1880.*

WE may define puerperal fever, as any fever having its origin a few days before, during, or a few days after labor, whether inflammatory or non-inflammatory, which may endanger life. This definition, as I believe to be the case with all others, must be qualified. Thus malarial fever, as a rule, may be regarded as an incident, though the question of its correlation is now being suggested by some observers. Phlegmasia dolens makes its appearance, as a rule, not earlier than ten days after labor; and pelvic peritonitis and pelvic cellulitis are local inflammations, which can usually be easily differentiated. In a recent article by Dr. G. M. B. Maughs, of St. Louis, we are informed that this disease was well described by Hippocrates 2,300 years ago, and yet it appears to have attracted but little definite attention until about the year 1740, at which time its ravages were so alarming as to awake the most serious consideration of the whole medical world. For the next hundred

years following this period, medical men, though warring with the dreadful enemy, appear to have been completely at sea, compassless not only in reference to its character, but its treatment also. Indeed, the approach to definiteness in the pathology, and consequently the development of rational treatment appear to have been made in the last quarter of a century. When I entered the profession, ten years ago, though much had been written and published in the journals and in pamphlet form, there was no monograph in print upon the subject of the puerperal diseases in the English language, Barker's excellent book, which appeared in January, 1874, being a pioneer in this direction.

We first inquire as to the nature or pathology of puerperal fever, and the consideration of this question necessarily involves the discussion of its cause. Upon this part of our subject, as might be expected, there is much diversity of opinion; and here I must add in truth, as well as to render myself consistent, that I do believe that there is much that is true in each and every one of these opinions or theories, and that it is the exclusive adoption of them, and not the opinions or theories themselves, that are at fault. The first theory, which we will call the localist, regards the fever and general symptoms as secondary or symptomatic of a primary inflammation of some one or more of the organs engaged in the process of parturition, or tissues contiguous to these organs. Now, it will readily be seen that this theory well covers all the idiopathic inflammations which may and do occur in childbed. It would apparently, if not really, include all those cases in which some one or more of the organs are the seat of inflammation at the time of, or from the time of the initial fever movement. In order to invalidate this exclusive and narrow theory, we have only to recall the fact that puerperal fever often exists for several days before there is any proof of the presence of a local inflammation, or still stronger, all those cases in which the autopsy gives no evidence of inflammatory action, though death is the result of puerperal fever. It is impossible to state all the arguments *pro* and *con*, and only the most salient are pointed out.

Then there are those who regard puerperal fever as analogous to traumatic or surgical fever. This is the septicemia and pyemia, of which we have heard so much lately. Those who take hold upon this theory of the disease, regard every case as the result of septic or purulent absorption, and hence, as might be expected, their treatment is biased, and impressed by this view of the diseased condition. It is now accepted that in every case of labor, however normal and easy, there are tears and abrasions in the metro-vaginal tract. Now, as a rule, these injuries granulate before the discharges become septic. But if, from any cause, whether moral or physical, the vital powers be depressed, then granulation is retarded, and putridity is hastened. That very many cases of puerperal fever are produced in this way, and manifest the characteristics which these conditions evolve, cannot be successfully disputed. Many of our most eminent observers take this exclusive view, and even assert that if the septic material is obtained from sources extraneous to the patient, it is absorbed in the same manner, and produces the same or approximately the same condition. Some of the advocates of the theory of septicemia go so far as to assert that there is no such thing as milk fever, but that what is termed milk fever is but the exponent of a small septic absorption. This reminds me that I recently read in an English journal that no physician, however great his experience or acute his observation, could certainly assert in the height of milk fever, that it might not turn out to be puerperal fever. I, for one, was glad to see this, for I never did know as much about milk fever as my old lady friends; and I am free to confess that fever of any kind in a child-bed patient, has acted less like a sedative on my nervous system, as experience has accumulated. We all know that the loss of blood predisposes to fever; and this, to some extent, is confirmatory of this belief, for the blood is in a condition to drink up everything after a hemorrhage; and here comes in again the fact which we have alluded to above, that the depression, as the result of the blood loss, retards granulation, and increases the tendency to a septic condition of the lochia.

Acute practitioners avoid much purgation on this score, because, as they say, absorption is stimulated by the depletion of a purgative. Goodell, of Philadelphia, I believe, is the author of this suggestion.

Admitting that septicemia is a reality, and that a large percentage of puerperal fever has its origin in this way, yet there are very many cases which it is impossible to explain on this hypothesis. Thus, I have seen cases of puerperal fever which had their origin at the very beginning of labor, if not before. Playfair, one of the most prominent advocates of this theory, with a candor which is ever praiseworthy, admits that it is impossible to satisfactorily explain every case of puerperal fever as septicemia. Then, in taking leave of septicemia for the present; at least, we say that it is a factor, and a very important one, too, in that fearful entity, puerperal fever.

A third class regard puerperal fever as a primary blood disease, developed, like, other zymotic diseases, by epidemic, endemic, and contagious influences. They hold, that in this disease, a modification of the general organism occurs antecedent to the local lesions, which are consequently secondary; in short, that it is an essential fever, in the sense that typhus fever is essential. Now, the first part of this proposition we recognize and believe. That there is a primary change in the organism, and probably resulting from influences that are imponderable, all analogy goes to prove. But when it comes to an essential fever that is peculiar to women, it may well be questioned. Is it not the condition of the subject that is peculiar or essential, and not the fever? Barker, of New York, stands as the most prominent advocate of this theory; and he describes septicemia, pyemia, and the idiopathic inflammations when they occur in the puerperal woman, as separate and distinct pathological conditions. In the latter opinion I believe he is correct, for I do think that I have seen peritonitis in the puerperal woman which was idiopathic, and not puerperal in character.

A fourth class of observers include under the term puer-

peral fever, all of the zymotic diseases when they occur in the puerperal woman, also septicemia and pyemia, and all the primary inflammations occurring under the same condition. They do not reject a primary vitiation of the blood, but term the disease a puerperal fever, whatever may be the specific nature of the primary poison. The most eminent men of Great Britain cling to this theory, Playfair being a notable exception. The only objection to be urged against this theory is the inclusion of the few cases of idiopathic sthenic metritis or peritonitis or metro-peritonitis or even of pneumonia or pleurisy, which may, and undoubtedly do occur in the puerperal woman, and yet are not impressed by the puerperal state except by the fatigue which is incurred during labor. The above is, in a nutshell, the view we take of child-bed fever, and further on we will have occasion to refer to it again.

A fifth class regard the diphtheritic process in the genitals of lying-in women as the only essential element in puerperal fever. I have seen the diphtheritic patches on the vulva and in the vagina of patients in the lying-in wards of Bellevue Hospital, but this was regarded only as an incident of a dyscrasia. The Germans take this view of the disease; but they apply the term diphtheritic with so much more latitude than we do, that we are scarcely capable of discussing this theory.

Then there is the French author, Hervieux, who says there is a puerperal poison, and that each and every inflammation following the effect of this poison is a distinct entity. I have followed Barker in giving you the prominent theories of the day. It is not necessary to go over again and recapitulate what we have already said in reference to this apparent discrepancy of view among medical men, upon a subject so important, and which so nearly affects us as practitioners. I say apparent discrepancy, for I believe that the differences are largely in words and not in facts.

We say, then, that child-bed fever is a correlated, pathological condition. To explain, a patient, who under ordi-

nary circumstances would have any of the zymotic diseases, as erysipelas, typhoid fever, etc., would in child-bed, have child-bed fever. It has been observed that a child-bed patient, exposed to erysipelas, will most likely die of child-bed fever, for this condition produces the most malignant type of the fever, whilst the child will die of erysipelas. The poison which produces puerperal fever may be autogenetic, *i. e.*, the lochia becoming putrid, are absorbed, or hetero-genetic, *i. e.*, absorbed from sources extraneous to the patient. The former is septicemia proper, and is the less fatal of the two. I have not alluded to the condition known as puerperal phlebitis, from the simple fact that I have never been able to make out this peculiar form of puerperal fever, though I cannot doubt that those who have had great experience can do so. Barker describes it separately, and I infer that he regards it as distinct.

This brings us to the symptomatology and diagnosis. There is no pathognomonic symptom of puerperal fever. In very many cases it is insidious in the extreme. This is not insisted on by the authorities so far as I am aware; but from a sad experience I am deeply impressed with the truth of this observation. The symptoms vary very materially, not only in different localities and different years, but in the same locality and the same year. In a large majority of cases the first symptoms are manifested between the first and third day after labor. I have seen it present at the beginning of labor, and Barker states that he has seen it put in an appearance a day or two before labor. The same author says that it rarely begins after the fifth, and he has never seen it after the eighth day. Barker goes on to say "that during an epidemic, an experienced physician can remark the haggard countenance, the trembling lips, the paleness of the cheeks, the wandering eyes, the vague answers, and the air of undefined suffering before the appearance of other symptoms, and before the patient makes any complaint." For myself, having suspected puerperal fever so often when it did not make its appearance at all, and having been called to so

many cases where I least looked for it, I am forced in candor to admit, that I can say nothing from personal experience upon these points.

The first symptom usually is a chill, but this may be overlooked unless strict enquiry is made in reference to it. The chill rarely occurs a second time; and good authorities say that when it does so, we may strongly suspect a complication of suppurative phlebitis or pyemia. Theoretically, I would regard suppurative phlebitis as but the forerunner of pyemia. Following the chill there are more or less ill-defined abdominal pains; but, as there is more or less uterine tenderness in nearly every case, this is not a pronounced symptom for some days, or until near the approach of death. I have seen the tympanitis appear and disappear several times in favorable cases; this disappearance of tympanitis usually followed a free action from the bowels. Whilst we are always glad to see the abdomen natural in appearance, we must not be the less watchful and apprehensive on this account. It is said that abdominal pain is seldom present in auto-genetic septicemia. Of this I can say nothing. The temperature is elevated from three to seven degrees, and the oscillations are much increased when the septicemic or pyemic type of the disease is present. The pulse ranges from 110 to 150, and varies in character according to the stage, progress, etc., of the fever. Individuality has as much influence over this symptom as any other in the course of the disease. In metritis uncomplicated, the pulse and temperature bear an apparently abnormal relation. Thus the pulse in pure uncomplicated metritis, will range from 85 to 105, whilst the temperature will run up to  $102\frac{3}{4}^{\circ}$  to  $103\frac{1}{2}^{\circ}$ . The former symptom is not serious, apparently; the latter certainly indicates the absolute necessity of close watching. The respirations per minute are increased to 24 or 30 in ordinary cases; if they are hurried, shallow and labored, it is always one of the worst symptoms. Thoracic complications are not necessary in order to produce this bad breathing. A catch or stop in breathing in this, as in most all other diseases,

is ominous of evil. The tongue is more often moist than dry; and is often indented by the teeth: it may become dry and cracked, though I regard this as exceptional. A very heavy coat I have invariably observed to indicate a severe case, and I have learned to expect other bad symptoms from this one, even where they were deferred more than twenty four hours.

The cerebral symptoms are extremely variable, all the way from the mildest form to extreme mania. The latter is always the very worst of symptoms. I have seen a few fatal cases in which the mind was perfectly clear, and the patients always expressed themselves as doing well, apprehensive of no evil, even when death was only a few hours distant. One case I can never forget, a splendid young woman, cultivated in the highest degree, and married only ten months before. She was seen by Dr. J. B. Wood in consultation. After a close examination, it was only too evident that she could only live a few hours at most. The patient, though perfectly clear in her mind, was all unconscious of her sad condition. When I entered the room that evening, her first and hurried words were, "Doctor, breathe for me." When informed that she must soon die, she looked up and asked excitedly, "Is it possible?" In that look there was more than words can express. She was reconciled to her condition in another moment, expressed her hope without a fear for the future, exacted no promise of husband or friends, and passed away as quietly as a babe into its earthly sleep.

The patients I have seen in this condition declare that they are doing quite well, seem to appreciate the attention of friends but wonder at their solicitude. In the *American Journal of Medical Science*, January, 1875, the lamented Parry describes this condition in his own graphic way. He says: "In other and by far the largest number of cases, the patients manifested a most singular apathy in regard to their condition, though their minds remained perfectly clear. Day after day we would go to their bedsides, be received with a cheerful, happy smile and the quiet assur-



ance that they were well and had neither ache nor pain. All examinations were submitted to quietly, as a part of our routine work, or else with wondering, incredulous thankfulness at what they deemed unnecessary caution. All this was when they were being consumed by a fever, when the blood was coursing in heated torrents through every artery and vein, when dissolution had already set its cold seal upon their foreheads, when the apathy was already deepening into stupor and the stupor into death. It was the most curious and the saddest mental condition which we ever witnessed. Human hopes, human loves and human desires were not destroyed; but the unfortunate victim sank away from them as unconsciously as a happy child sinks to sleep, but, alas, unlike the child, hers was the sleep that is to be eternal." It appears from this that the mental condition which we have seen a few times was characteristic of the class of cases which Parry describes.

Vomiting is a common symptom, though not of much import unless excessive; then the matters ejected are dark green or grass green, and, if accompanied by hiccough, it is always a bad symptom. Barker says that a moderate diarrhea toward the close of the disease is favorable. Parry, speaking of diarrhea in the epidemic which he describes, says that it was present in fatal cases. When the stools are involuntary, they are usually muddy in appearance, or dark and tarry, and we often wonder where the amount that is discharged comes from, as it is so large. The lochia often furnish no evidence either of the character or presence of the disease. They may diminish or quite disappear a few days after the disease begins, or may continue quite natural or become purulent and quite offensive, or may be sanguinolent. Hemorrhage is exceptional, though it may occur. As a rule, lactation is interfered with; but in a small number of cases Barker says, he has seen the function perfect throughout the attack. The same author speaks of the reëstablishment of lactation after recovery as quite exceptional. I had one such case last November.

In the peritoneal variety of the disease, there may be pain and distension, but it must be well borne in mind that intense peritonitis may be present without the least symptom of it. This peculiarity is not confined to child-bed patients; for the disease that is ordinarily termed inflammation of the bowels is often latent when idiopathic; and its insidiousness and difficulty of diagnosis, coupled with the tendency to fatality, has taught me to dread it as one of the most dreadful diseases. If metritis be present, there is pain on pressure, over the hypogastrium, and on taking a long breath, the involution is retarded, and the lochia are suppressed unless acute endometritis is present, when they are purulent and horribly offensive. The entrance to the room or approach to the bedside is often sufficient to notify us of the presence of this latter condition. It is asserted on good authority, that a cord-like feel is present on the side of the uterus in uterine phlebitis. Of this I know nothing. The symptoms which answer to what the older practitioners term typhoid, constitute septicemia in the recently published accounts. The recurrent chills, followed by the profuse and drenching perspirations, the suppuration in the articulations, the purulent collections in the great cavities, etc., indicate pyemia.

Puerperal fever sometimes produces its effects quickly, and I have seen death occur on the third to the fifth day. Some authors speak of recoveries equally as rapid. This I have never seen. It is a decided rule that recoveries are slow; and I have seen a few cases in which more than a year intervened before convalescence was perfect. We can conceive of cases in which the health may be completely broken. I am not advised in reference to the development of tuberculosis and allied conditions upon the debris of child-bed fever; but the absence of teaching in reference to it leads me to believe it uncommon.

I shall not attempt to go over the symptoms which would lead us to expect a recovery, for these are too obvious to require mention. The decided falling of the temperature, unless it lasts at least twenty-four hours and is accompa-

nied by a correspondingly favorable turn of the other symptoms, is not to be regarded as decidedly favorable. External suppurations have been regarded as favorable, as has herpes labialis.

Now, in regard to treatment, I have said that the rational treatment has been methodized in the last quarter of a century. So late as 1858, Fordyce Barker favored the treatment of puerperal fever by means of emetics, purgatives, and diuretics. We cannot look upon such treatment to-day as much less than murderous. Good practitioners have remarked, that if they were limited to one remedy, they would select opium in preference to all others. My experience agrees fully with the large preponderance of medical testimony, that it is simply impossible to treat puerperal fever in most any of its forms without the bold, yet judicious use of opium. The point is, to keep your patient sufficiently narcotized to allay all pain, procure sleep and throw the opium glamour over the patient, making her not only forgetful of present trouble and dangerous probabilities, but hopeful and bright in reference to the future. Opium is indicated especially in the peritoneal variety of the disease. In regard to the quantity of the remedy to be given, it must be given for effect, and patients are very variable in their susceptibility to it. As a rule, the subcutaneous injection of sulphate of morphia  $\frac{1}{3}$  to  $\frac{1}{2}$  grain, combined with sulphate of atropia  $\frac{1}{75}$  to  $\frac{1}{50}$  grain, is the best mode of administration, or the deodorized tincture of opium combined with tincture of belladonna may be given internally. Barker favors the use of suppositories of the extract of opium. This I have never used.

Now, although the books say but little, if anything, about it, there is a class of patients who do not bear opium in sufficient quantities to be of any benefit. I think, if we will examine closely, we will find the kidneys at fault in these cases; and, from a limited, though a pointed experience, I am satisfied it ought to be looked to in every case. I will cite two cases. In September last, Dr. Chas. Smith attended a case of labor, natural in every respect, except

that more than ordinary nervousness was present. Dr. Smith left the patient comfortable, but had hardly arrived at his office before he was sent for, the messenger saying that Mrs. F—— was having fits. He found that she had had one convulsion, and immediately put the patient under the influence of chloral hydrate and bromide of potassium. No more convulsions occurred, but fever immediately made its appearance; and in a few days the peritoneum became implicated. He now prescribed opium, but found that it acted badly. I now saw the patient and insisted on the use of opium. Against Dr. Smith's protest I injected subcutaneously  $\frac{1}{2}$  grain of sulphate of morphia with  $\frac{1}{60}$  grain of sulphate of atropia. The patient immediately became very restless, stertorous breathing and delirium quickly followed; it was quite evident that opium did not suit the case, and chloral hydrate and bromide of potassium with hyosciamus were substituted with benefit; and the patient made a good and prompt recovery. Dr. Smith had noticed that the kidneys were very deficient in their action.

I was called to see Mrs. J. G—— on the 12th of last December and found her in labor. She was confined in ten hours, the labor being natural in every respect. When it was complete her temperature was  $101\frac{1}{2}^{\circ}$ ; and she gave a history of irregular fever for over one month. Metritis was present on the third day after accouchement. I prescribed opium with the same bad effect as in the above case. I now substituted the chloral, bromide of potassium, hyosciamus and belladonna, with but little better results. I was called hurriedly to see her about the fifth day after I had seen her the first time, and found her comatose. The nurse informed me that the kidneys had not acted for some hours. I immediately introduced the catheter and was dismayed to find no urine in the bladder. The temperature was now  $106^{\circ}$ ; skin hot and dry; (it had been profusely moist) the hot corn bath was ordered. The pulse was 125 and very weak, and she could not swallow. I gave syringe-ful after syringe-ful of whisky subcutaneously. Tincture

of *nux vomica* and tincture of belladonna, ten drops each were also given until the muscles began to twitch, and the pupils began to dilate. In about one hour profuse diaphoresis came on, and the mind was almost clear. The catheter was now introduced and four ounces of urine was drawn off. After this, whisky was principally relied on to procure sleep. The patient recovered. Drs. S. W. Brown and Chas. Smith saw this patient with me, and gave valuable advice and assistance. I say, opium is the great remedy in child-bed fever, but watch the kidneys.

The vascular sedatives are important remedies in the treatment of this fever, *veratrum viride* and *aconite* being the principal ones in use. They have here, as in other conditions, almost superseded the drawing of blood. Blood-letting is the absolute destruction of power; these remedies simply abrogate for the time, but if properly handled, do not destroy. And here we remark, that whilst Playfair and Barker differ so widely in reference to pathology, (theoretically I mean) their treatment is almost identical. The former employs *aconite* whilst the latter adheres to *veratrum*. The pulse must be the guide, and experience alone can point out when to give and when to withhold these sedatives. As Barker justly and truly says, they will reduce the pulse of over-action, but not the pulse of debility; in the latter condition, *digitalis* is the great remedy. Reduce the strong pulse to 70 or 80 with the *veratrum* or *aconite*; as debility comes on, combine the *digitalis* with them, and, as debility increases, leave off the former and push the latter.

Alcoholic stimulants come in here, and you will often find it impossible to either reduce the pulse or increase its volume or regularity until they are given in heroic doses. I recently had a case of puerperal fever in which I gave from half a pint to a pint of proof spirits every twenty-four hours for fifteen days; and I verily believe that if not thus boldly given, the patient would have succumbed, so fearful was the poison. Then do not be afraid of whisky. In health it may increase the temperature, but in disease the condition is changed.

Next in importance stands quinine. At first it should be given in large doses, say one, two or even three scruples in twenty-four hours, in two, three, four or five doses as the caprice of the attendant may indicate. Later, it may be given as a tonic and in small doses. The mineral acids are advised by good authority, and phosphoric acid is given as a nerve restorative. If the perspiration be profuse and debilitating, we have no remedy superior to oxide of zinc in two grain doses every four to six hours. Atropia or belladonna meets the same indications. In great debility the nux vomica is one of the best spinal stimulants. Emetics are not indicated. Purgatives are to be avoided as a very decided rule. If the bowels can be moved in the beginning, well and good, if not, let them alone; active purgation is to be scrupulously avoided; and the practice of moving the bowels every day or every other day will surely bring harm. Barker puts the case well when he says "if there be excessive bilious vomiting, give ten grains of calomel rubbed up with bicarbonate of soda, and you will get the smoothest action it is possible to get from any purgative. If this fails, use an enema; if this fails, let it alone, for it is useless to tug away at a paralyzed organ; harm and not good will result from attempting something that is impossible.

We have attended cases in which we have seen the tympanitis disappear, apparently the result of a free action from the bowels. The tympanitis usually returned in greater or less degree in from six to twelve hours. The question naturally suggests itself, why not keep the tympanitis in check by means of purgation, if this be the case? We answer, that, as a rule, the presence of the tympanitis will do less harm than the effect of a purgative, and only in those cases in which the bowels act of their own accord, or by the gentlest assistance, does the tympanitis pass off as a result of the bowels acting. You can rest well assured that, if violent means are used to move the bowels, not only the tympanitis but all the other symptoms will be surely and fatally aggravated. We here follow nature, possibly

lead her if the utmost circumspection is used. Maughs speaks of having seen puerperal fever caused by excessive purgation, the result of an over-dose of castor oil. Ptyalism need not be feared from the use of mercury as above indicated. The constitutional effect of mercury is not desirable in the treatment of puerperal fever in any of its forms, although it has been advised by so great an authority as Harvieux. When the temperature is very high, say up to  $106^{\circ}$ , and you are satisfied that everything in the shape of ordinary remedies has failed to reduce it, apply cold to the abdomen, and if the temperature still continues high, apply it to the whole body. It is strongly advised by competent authority to use alcohol to the surface freely in cases of high temperature. I have no experience on this part of our therapeutics; but, if we know that our patient must die without it, whilst as a rule I do not advise the remedy, I would certainly give the unfortunate the benefit of the doubt. In many cases, opium will relieve pain but will not produce sleep; on the contrary, it brings about a peculiar wakefulness. In this condition the combination of ten grains of chloral hydrate with twenty to thirty grains of bromide of potassium and thirty drops of tincture of hyosciamus, repeated every hour, will give the happiest results. Local applications in the shape of turpentine stupes over the entire abdomen, are of the very highest importance and should never be neglected. I have in some cases covered the stupe with a hot hop poultice with the very happiest result. I once covered the stupe with hot ashes and obtained a large blister over the entire abdomen.

The nutrition is of supreme importance, and here we must try to anticipate the coming depression and sustain the vital powers through the trying ordeal. In case we have local indurations about the pelvic cavity, the fly blister is superior to everything else in the way of a resolvent. It is usually necessary to repeat them, and this is done so soon as the patient can bear it. These indurations show themselves after the acute symptoms have disappeared.

I have said nothing about uterine or even vaginal injec-

tions up to this time. If we read Playfair alone, we will conclude that not only vaginal but uterine injections should be used as a matter of course. Maughs takes the same view; and, if I understand him aright, the uterine injections are to be used whether the infection be hetero- or auto-genetic. Barker favors them, but Parry, who describes a form of hetero-genetic puerperal fever, is doubtful even of the propriety of vaginal much less uterine injections; indeed he states that in his opinion, they do harm; and he finally abandoned their use. I believe that the preponderance of medical testimony is decidedly opposed to intra-uterine injections. I will cite a case in actual practice, in order to show you the cases in which uterine injections are not only admissible but are absolutely demanded. In the practice of Dr. Chas. Smith, last December, I saw a case in point. The patient, the wife of Wm. A., "colored," miscarried at about the sixth month. The placenta was firmly adherent in all its parts, and as the cervix was firmly contracted it was impossible to detach and remove it. The patient gave the history of placentitis one month before. I advised Dr. Smith to watch the patient closely, and promised if there were fever or fetor, to assist him on the next day. In less than twelve hours both were present. I now saw the patient with Dr. Smith, and Dr. Jno. F. Yancey was added to the consultation. We decided to dilate the cervix and remove the placenta as far as possible. We made the effort to introduce Barnes' dilators; but as an acute anteflexion existed, we were forced to place the patient on the table, and, after introducing Sims' speculum, we succeeded in dilating the cervix as far as was necessary and prudent. It was found impossible to remove any considerable portion of the placenta. The patient became delirious whilst upon the table, and we washed out the uterus by means of a Davidson syringe, using warm water and carbolic acid, one part carbolic acid to twenty of water. The patient was put to bed after this, and opium and quinine and the vascular sedatives were prescribed, no purgatives. Turpentine stupes were freely and assidu-



ously applied. The uterus was washed out four or five times in twenty-four hours. No trouble was found in introducing the female nozzle of a Davidson syringe. The patient always expressed herself as feeling better after the washing out, and even went so far as to call for its use on more than one occasion. The fever was also observed to bear a relation to the promptness of the uterine injections. A prompt recovery followed. The placenta came away piecemeal, and within a month or six weeks the patient was convalescent. Now can we doubt the presence of septic absorption and the immediate bearing of the local washings in cutting off the dose of poison? My experience is, that when the placenta is left in the uterus and comes away by softening, if the patient recovers, there is a long and tedious convalescence, with a miserable dyscrasia lasting from one to two years. I recently had a case of hetero-genetic fever in which the lochia were somewhat offensive. I used vaginal injections. After the offensive discharge was relieved, I continued the wash because it appeared to relieve local heat. But if you know you have a case of hetero-infection, and there is no bad smell from the lochia, and the wash tires and annoys the patient, producing restlessness, and debility, then not even the vaginal wash is indicated.

There is one other point which should have been mentioned before, and that is in reference to the management of the third stage of labor. Care should be taken to follow the uterus down, and all shreds, clots, etc., should be most carefully removed. The uterus ought to be carefully kneaded for at least one hour after the child is born. It is scarcely necessary to go into the reasons why this treatment is necessary. The hygienic influences should be the most favorable, and the accoucheur's hands should be subjected to the most careful ablutions in carbolic acid water.

There are two remedies which I have failed to name. I refer to the ferric chloride and potassium chlorate. They are often valuable even in the early stage of some cases; as a rule they suit the latter stages. They are best given

combined in glycerine. In order to treat child-bed fever successfully, the physician should never leave the house of the patient for more than an hour or so at any time during the presence of any dangerous symptoms, in fact it is best and safest to err on the safe side, and be close at hand even if the patient appears to be doing well. I learned this from Fordyce Baker, and since I adopted his advice, I have had cases recover, such as invariably died before I followed him. In the last year I have been assiduously and intelligently assisted by my friend, Dr. Chas. Smith; and Dr. Jno. B. Wood saw most of the cases in consultation. The little details are important, and as physicians, I do believe that we are all to a greater or less degree negligent in this particular. The morale of the patient must be carefully guarded, and dispirited and whispering nurses are to be excluded from the room. Nor is it advisable to be all the time pointedly speaking of the favorable condition of the patient; it is much better to leave this impression by looks and words, which are indirect, thus showing that we do not even deem it necessary to give assurance of good condition and favorable tendency. This must be left to the sagacity of the attendant, and each individual case must be decided upon its own merits. The physician must command the situation absolutely. Hesitation on his part often leads to disaster, and nothing more surely portends evil than demoralization about the sick. They look to us for support, and it is as imperatively our duty to give it, as it is to prescribe a remedy. Finally, the closest attention, the keenest discrimination, the boldest, yet greatest discretion in the use of therapeutic means, and an influence of the attending physician over the patient are prerequisites in order that this, one of the most formidable pathological conditions, be met successfully. A large per centage of severe cases at best are lost, and there is not another class of patients which commands more fully the heart of the conscientious doctor than this.

INTRA-UTERINE INJECTIONS, POST-PARTUM—  
DEATH.

BY T. F. PREWITT, M. D., ST. LOUIS.

*[Read before the St. Louis Obstetrical and Gynecological Society, May 20, 1880.]*

IT will be remembered, that at the last meeting of this Society, I presented the outlines of a case of septic fever, following parturition, in which I resorted to the use of intra-uterine injections with the most startling effects; the case eventually proving fatal. As stated at that time, I have not been able to divest my mind of the impression that the injections were, in part at least, responsible for the result.

Let me again recapitulate the chief points. Mrs. S—aged about 28, mother of three or four children, was taken in labor January 12th, 1880. The labor progressed very well until thorough dilatation had taken place and the head had become engaged in the pelvis, rotation being pretty well completed. During a strong expulsive pain, while my index finger rested upon the head, a sudden sound was heard and felt, resembling closely the “pop” of a champagne bottle, muffled by its position in the abdomen. The woman observed it as well, and cried out, “oh what was that gave way in my back.” Fearing rupture of the uterus, I placed my left hand over the fundus, while with the index finger of the right I watched anxiously for any indications of the head receding, intending to apply the forceps and deliver immediately, if such should be the case. Labor progressed however, uninterruptedly, and the child was delivered after a few more vigorous pains. About the third day the patient had chilly sensations at intervals, with fever, ranging on the fourth as high as 104° F. There was no evidence of peritoneal inflammation. Believing

this high temperature to be due to septic absorption, and thinking it advisable to resort to intra-uterine injections, I prepared a solution of carbolic acid not exceeding one per cent., which was used with an ordinary fountain syringe, consisting of an India rubber bag to be hung up, with a long rubber tube attached, with the ordinary metal nozzle for vaginal injections at its extremity, having a central opening not exceeding  $\frac{1}{8}$  inch in diameter, which must be considered as representing the size of the stream used. The water was quite warm. Immediately upon the commencement of the flow the woman complained of an agonizing pain *in the head*, the right hand was thrown up to the head with convulsive distortions of the fingers. The injection was stopped; no especial pain was complained of about the abdomen, but the intense pain of the head continued; a severe rigor set in with depression of the pulse and some disturbance of respiration. A hypodermic injection of morphine relieved these symptoms to a very great extent, and the next day the pulse had risen to nearly or quite its normal volume, while the temperature had fallen to 101 F. Having kept no minutes of the case, I have to rely upon my memory. Still her condition was not satisfactory in every respect. The expression of the face betrayed some anxiety, and the respiration was not just what it should be, a little faster than normal and too shallow, while occasional chilly sensations suggested further septic absorption. About the 8th or 9th day the rigors, which had continued to occur at intervals, and the fever induced me to resort again to the intra-uterine injection. Having had patients complain not unfrequently of swimming in the head, etc., after the use of the hot water douche, and thinking the high temperature of the water might have had something to do with the symptoms following the first injection, I was careful to have the water in this instance but little above blood heat. This was followed by precisely the same train of symptoms, the cry of pain in the head, the clutching at the head and convulsive distortion of the fingers, the depressed circulation, the protracted

rigor, the disturbed respiration; only all these were intensified. It was at this stage that my friend, Dr. Bauduy, saw the case, and so feeble was the pulse that he could not perceive it. The mental hebetude, approaching stupor, following this, was greater than in the first instance, and articulation was less distinct; soon after the injection there was expelled from the womb a clot undergoing decomposition, and quite offensive. Rigors of considerable severity occurred at intervals. She remained in this lethargic state for three days, when, after an injection used by the nurse, which she stated was intra-uterine, the same symptoms recurred a third time, and the patient died on the night of the 13th day.

As I believe this case to have been no less instructive than unfortunate, and as I feel that the subject has not received the consideration at the hands of this society which its importance deserves, I have thought it proper to present the case in a somewhat more detailed form, and to offer some remarks upon the subject of intra-uterine injections post-partum. While the use of intra-uterine injections is not new, an occasional obstetrician having been found bold enough to resort to them in the past, yet we all know that within the memory of many of us, all intra-uterine manipulations were regarded as extremely hazardous, and the teaching of the schools in this respect was tempered with a caution that bordered upon timidity. The uterus was regarded as a "*noli me tangere*," that resented, often in an inexplicable way, the incautious interference of the accoucheur. The temerity of modern gynecologists has changed all this, and no organ of the body is hacked and dragged around, drenched and prodded so indiscriminately and, for the most part, with so much impunity as this. But now and then it resorts to its old tricks, so much dreaded by our fathers, of resenting in unexpected ways, the temerity of the practitioner. Manipulations of daily performance, operations apparently too trival to cause uneasiness, have been followed by fatal results, and even "the court that sits after death," is not able, always, to say

why the patient died. But our subject now is intra-uterine injections, post-partum, and we propose to glance at the alleged dangers connected with their use.

1. The danger most dreaded and upon which most stress has been laid, seems to have been the introduction of air and its entrance into the general circulation.

2 Detachment of thrombi from the uterine sinuses, their forcible propulsion along the vessels into the general current, and consequent embolism.

3. Forcing of fluid through the Fallopian tubes into the peritoneum, giving rise to peritonitis.

4. Systemic poisoning by absorption of agents used in solution, as carbolic acid.

5. Lastly—shock, pure and simple.

Let us consider these dangers *seriatim*, as possible causes of the symptoms in the case I have presented.

Some of the earlier advocates of intra-uterine injections (Grunewald about 1840, Winckel, Bischoff in Bâle, Haase and Beinlich in the Berlin charité and Münster, *Obstetrical Journal*, 1878) seemed to fear only the injection of air, and special precautions were taken by Schulein and others to avoid this much dreaded danger. It will not be claimed, I think, by the most apprehensive, that the mere entrance of air into the womb could give rise to any immediate danger, or that it would find its way into the uterine sinuses of itself. To accomplish its entrances into the veins and the general circulation, there must be a "*vis a fronte*" or a "*vis a tergo*." This is illustrated by the manner in which air enters the veins in operations about the neck and axilla. In stretching the tissues by pulling upon a tumor during its dissection, for instance, the mouths of the veins are rendered patulous, and at the moment of inspiration when a vacuum is created in the chest, the needed *vis a fronte* is furnished and air rushes in. The patulous condition of the veins themselves would never do it, since the eddyings of the blood-current back through the cut veins would prevent its passage into the general circulation. Again, if the point of a hypodermic syringe which contained air should

be thrust into a vein and the piston pushed home, or, as might happen with Aveling's transfusion apparatus, if air should be permitted to remain in the bulbs, unquestionably it would be forced along the vessel and follow the current, because it could not do otherwise. Here, though, we have the required *vis a tergo*. But would it be possible to force air into the uterine sinuses and veins by filling the cavity of the womb with it, *four days after delivery*, when the contraction of the organ had so greatly altered the directness of these channels, closed them against the further escape of blood, and when, according to the generally accepted view, their mouths were already blocked by thrombi? I doubt whether air could, under these circumstances be forced into these vessels, if pumped into the uterus with no means of escape. It is infinitely less probable, that the small amount of air in the lower extremity of a fountain syringe, propelled by a fall of not more than two feet of water—a pressure less than the blood current itself—through an opening not exceeding an eighth of an inch in diameter with free opportunity of escape, would find its way into the venous sinuses four days and eight days respectively, after delivery. For it must be borne in mind that the symptoms were precisely similar in each instance, and whatever may have been the accident in the first place, it was repeated in the second.

The question of embolism demands more consideration, but I think can be excluded with no less certainty, admitting the existence of a condition of thrombosis of the uterine sinuses and veins adjacent, it does not seem possible that so feeble a stream of water as was used in this case, could, *per se*, dislodge a recently formed thrombus from the mouth of a sinus and drive it into the circulation. I can conceive it possible that the sudden contraction of the uterus, excited by the introduction of a current of hot, medicated fluid into its cavity, might have such an effect, just as the rude manipulation of the femoral vessels in phlegmasia dolens might detach fragments of even a recent thrombus, and send them on into the circulation. But

would not that be a rather far-fetched hypothesis to explain a possible embolism? Besides, what reason is there to suppose such thrombosis existed? According to Hervieux, endorsed by Fordyce Barker, the uterine sinuses are not closed by thrombi, but simply by contraction of the uterus itself and, therefore, there are no clots to be dislodged from the mouths of these vessels.

Again, all experience shows that recent thrombi are not easily broken up—fragments are not easily detached. Dr. W. S. Playfair has pretty conclusively shown that pulmonary embolism, the result of puerperal thrombosis, never perhaps, occurs before the nineteenth day after delivery, and usually much later, since the retrograde changes in the clots have not earlier than that produced such softening and disintegration as to permit of detachment of fragments. Whether, indeed, pulmonary embolism ever occurs from thrombosis of the uterine sinuses or uterine plexuses alone, is at least a question of doubt. Certain it is, that, in those cases where this has been known to occur, the embolism has been found to come, not from the uterine sinuses or plexuses, but from the iliac, the femoral, or the veins of the leg below. Thus of twenty-five cases of pulmonary obstruction collected by Playfair, ten only he regarded as due to embolism. In all of these “there were well marked symptoms of phlegmasia dolens, or crural phlebitis, or the veins of the lower extremities contained coagula.” [*Lancet* 1867, Amer. Reprint, page 613.] In none of these in which the date of death is given, did the fatal result occur earlier than the nineteenth day after delivery, and in most at a much later period. In the case I have related, there was no phlegmasia dolens; and had there been, we could not have expected the breaking down of the thrombus at so early a period. Nor were the symptoms those of asphyxia from such a cause. There was no gasping respiration, no struggling for breath. It is true, there was somewhat accelerated respiration in conjunction with feeble heart action; but the pulse rose again within twenty-four hours to very fair volume, and a frequency not exceeding one hundred.



After the second injection and the recurrence of a precisely similar train of symptoms, the pulse was never so good; it continued feeble, and I suspected the formation of heart clot and possibly pulmonary thrombosis, but this, if so, was the effect, not the cause of the condition of my patient. Certainly, the hyperinosis universally admitted to exist in the puerperal state, with the vast quantity of effete material circulating in the blood for some time after delivery, the product of involution, together with the toxic condition present in this case, would favor in a marked degree the occurrence of thrombosis. Whether a rapid precipitation of fibrin may not have taken place in the pulmonary artery, is a most interesting question, but, if so, it was, as I have said, clearly an effect and not a cause.

As to the escape of fluid through the Fallopian tubes, very little can be predicated upon the force of the current in this case, since a stream of water less than  $\frac{1}{8}$  inch in diameter, with a fall of two or three feet, would overcome very little resistance, admitting that the os uteri was not dilated sufficiently to permit of its unobstructed return, or even with the os firmly grasping the tube so as not to permit of any escape. In any event, the danger of forcing fluid through the Fallopian tubes in the post partum state must be greatly exaggerated, since Richter in 3,000 injections used by him in such cases never had such an accident, although he used a large, curved glass tube, for which he claims as an advantage over the formerly employed Nélaton's catheter with small lateral holes, that its widely open point permits its introduction only just within the internal os, whence "*the strong jet of water distends and thoroughly washes out the cavity.*" [*Amer. Jour. Obstet.*, Jan., 1878, page 203.] More than that, he assured himself that, in all these cases, the fluid always escaped readily at the side of the tube.

It will be remembered, that one of the members of this Society suggested that there had been rupture of the uterus, and that the injected fluid had found its way into the peritoneal cavity in this way. Admitting the possible occur-

rence of such rupture, the peritoneal adhesions which must have taken place in the three or four days after its occurrence, and "a fortiori" those a week old would have been more than sufficient to resist so feeble a current. But had such an accident occurred, the peritoneum does not resent in this way the contact of foreign substances. Instead of pain in the head, it would, have caused *abdominal* pain, of which there was no complaint to any extent, and would have been followed possibly by peritonitis, of which there was no evidence, at least in the earlier part of the attack, and of the existence of which I do not feel certain even at the close.

Rheinstäder (*Acute Carbolism by Peritoneal Absorption*, —*Deutsch Med. Wochenschrift*, No. 15, page 191) reports a series of symptoms not unlike those occurring in Mrs. S——'s case, as the result of an injection of a weak solution, less than one per cent., of carbolic acid, several days after enucleation of a fibroid tumor of the uterus. There was clutching of the head with the hands, sudden loss of consciousness, pallor of face, tonic muscular contractions, distension of abdomen, coolness of skin and beginning irregularity of breathing. Under use of irritants the patient was able to swallow in two hours, and consciousness returned in four hours. In the course of the following week purulent vesical catarrh appeared, which he attributed to elimination of great quantities of carbolic acid. He thinks at least 5.0 grams of carbolic acid got into the peritoneal cavity, how, it is not stated, but presumably through the Fallopian tubes.

Whatever may have been the explanation of the symptoms in Rheinstäder's case, I cannot see that it has any bearing upon the case reported by me. I think I have fairly shown that there could have been no escape of fluid into the peritoneal cavity, and, hence, no absorption from that surface, of carbolic acid. I think, therefore, of the alleged dangers in the use of intra-uterine injections we may fairly exclude from any participation in the production of the phenomena in this case, introduction of air into the cir-

culation, pulmonary and cerebral embolism, escape of fluid into the peritoneal cavity and poisoning by absorption of carbolic acid. There remains only shock, and a careful consideration of the subject convinces me that there are ample grounds for attributing all the phenomena to this cause.

Numerous instances are upon record where fatal shock has followed comparatively trivial uterine operations in some cases, and the use of injections in others. In Richter's 3,000 injections he twice had "light hystero-epileptiform attacks follow the injection, without, however, being attended by any evil consequences whatever." A case is reported from Spiegelberg's clinic, where the womb was washed out on the morning of the fifth day after delivery with a one per cent. solution of carbolic acid. About one litre had been injected when the woman turned up her eyes, groaned, became unconscious, pulseless, breathed a few minutes and was dead. Post-mortem gave no clue to the cause of death. [COURIER OF MEDICINE, 1879, Vol. II. page 37.]

Herdegen, who reviews this case, after rejecting the various theories advanced to explain the accident, detachment of a thrombus, entrance of air or fluid into a vein, carbolic acid intoxication, refers to a somewhat similar case of his own, and attributes the accident to reflex action, sudden cessation of the heart's action depending upon the mechanical irritation of the inner surface of the womb. He is evidently, however, not entirely convinced of the correctness of this explanation, "but thinks that in view of the fact, that in all cases reported, the withdrawal of the syringe was followed by a greater or less discharge of fluid blood, the question as to the final cause of these accidents is not yet definitely settled."

W. Fischer in an inaugural thesis at Magdeburg, has collected fifty-four cases of serious accidents from intra-uterine injections in the puerperal and non-puerperal states. He has classified these according to the various reasons assigned as causes of the accidents. [*Centralblatt für Gynacologie* No. 9, 1880, page 207.]

The causes assigned, correspond very closely to those referred to above in this paper. But as the number of cases occurring post-partum is not given, the statistics have only a partial bearing upon the subject under consideration now.

All are familiar with the stress laid upon the dangers incident to the use of injections into the non-gravid uterus. But it has been contended that the objections to their use in these cases, do not apply to the post-partum uterus when used to prevent septic absorption. It will be remembered that their great utility and perfect safety in the latter class of cases under ordinary care, have been strongly urged in this society, and I must confess, that influenced by this strong endorsement, and their advocacy by other high authorities, I have resorted to them on a number of occasions with a feeling of great security as to their harmlessness. The rude awakening brought about by this case has rekindled some of the dread manifest in the teachings of older authorities.

The wide discrepancy in results of gynecologists in the use of injections is something marvellous. Thousands of injections have been practiced by some, not only without a fatal result, but with very little trouble of any kind. While others have always found much trouble to follow them. Whatever ill-effects have followed in these cases, have been largely attributed to the failure to secure free return of the fluid, and Emmet makes the broad statement that "whenever the canal is sufficiently dilated for the free escape of fluids, it may be injected, *not only with impunity, but with benefit.*" (Italics mine.) [*Prin. and Prac. Gynecol.*, page 142.]

Yet upon the preceding page he refers to a case occurring in a western city, where a woman in good general health, died instantly, with nothing more than a slight convulsive movement, after a small quantity of Churchill's iodine had been injected into the undilated canal. "The post-mortem revealed the important fact that no portion of the iodine had passed into the Fallopian tubes nor into the

uterine sinuses." If he refers to the case in the practice of a distinguished surgeon of this city, he might have added, if I am correctly informed, that none had passed beyond the internal os. If such was the case, what influence could the fact of dilatation or non-dilatation have had upon the result?

Noeggerath, however, does not consider that the non-return of the fluid is the cause of the bad symptoms following intra-uterine injections. And the experience of Richter, who so fitted the large, open mouthed, curved glass tube into the internal os, as to at least partially block it up, and to *distend* and wash out the uterine cavity, would seem to confirm this view.

But, admitting that such is the cause of the troubles that follow, will it be contended that we must dilate the post-partum uterus? Is it not, indeed, always sufficiently patulous to permit of free reflux of fluids at the side of an ordinary sized catheter, or the nozzle of a syringe? If this be not admitted, will it be claimed that the object can be attained by the use of the double cannula?

Barnes has but little faith in the utility of this double cannula—at least in the non-puerperal uterus—as the end which should serve for the return current is liable to be choked. And if this be true in the non-gravid state, does it not apply with still greater force in the post-partum, where the very object is to wash out an amount of debris never found in the former. Indeed, Barnes assures us that the observance of all the precepts enjoined upon us, is not an absolute guarantee against accidents. And this is the point of special concern to us as obstetricians and gynecologists.

Nor are we without analogous accidents in the use of injections into other cavities.

It is a well known fact that injections of the pleura in emphysema have not unfrequently been followed by the most alarming symptoms—deathly pallor, slow pulse, gasping respiration, dilated pupils, convulsions, paralysis and even death with nothing revealed by the autopsy to ac-

count for the symptoms. There was neither pulmonary thrombosis nor cerebral embolism. Nor did the nature of the fluid seem to have anything to do with it—it having occurred with plain warm water as often as when other substances were held in solution. If such striking reflex phenomena may occur when the plural cavity is injected, need we be surprised if equally alarming and fatal results follow injections of the uterus, an organ so endowed in its nervous relations, both cerebro-spinal and sympathetic, as to develop widespread reflex phenomena from the most trivial disorders?

In conclusion, I beg leave to submit the following propositions:

1. Intra-uterine injections in puerperal septicemia, while of immense value, are not free from danger, whatever precautions may be taken.

2. Gestation does not modify the susceptibilities of the uterus in such way as to prevent the most profound reflex impressions upon the nervous system upon invasion of its cavity.

3. The admission of air into the uterine sinuses and thence into the general circulation, is of doubtful occurrence under any circumstances, and most improbable after contraction of the organ has taken place. It is, at least, amenable to the Scotch verdict, "not proven."

4. Pulmonary embolism, the result of puerperal thrombosis, occurs only after the retrograde process has softened and led to breaking down of the thrombus—probably not earlier than the nineteenth day after delivery, and usually at a much later period.

5. Puerperal pulmonary emboli, are derived from thrombi in the femoral or iliac veins, or the veins of the leg.

6. The passage of fluid through the Fallopian tubes in the post-partum uterus, is highly improbable, since the cervix is always sufficiently patulous in this condition to permit of its ready reflux, when an ordinary catheter or nozzle of a syringe is used—while the tubes themselves are,

perhaps, never dilated, as occurs in certain non-gravid states.

7. Of all the dangers connected with intra-uterine injections, post-partum shock is most dreaded, because most likely to defy all precautions.



## BLOODSTAINS AS EVIDENCE IN CRIMINAL CASES.

BY CHAS. O. CURTMAN, M. D., ST. LOUIS, MO.

*Read before the St. Louis Medico-Chirurgical Society.*

THE detection of bloodstains on linen or other articles of apparel, has often a melancholy interest to the medical expert and the criminal jurist. In many cases, the decision of court and jury has hinged upon the evidence afforded, or supposed to be afforded, by suspicious stains found upon the clothing or implements used by persons accused of murder. Not very long ago it was imagined by the public and even by members of the profession and enthusiastic admirers of the microscope, that human blood might be positively and easily identified by the microscope. Upon the extension of the scope of utility of the spectroscope, that instrument has also been held by many to be an unerring detective of blood.

But by degrees the illusion in regard to the positive and unassailable results of the microscope has vanished, and at present, (especially since the thorough investigation of the subject by Dr. J. J. Woodward, U. S. A.,) no expert would be found bold enough to assert, in the face of contrary evidence, that he can positively identify *human* blood by any microscopical device. The blood discs of the *dog*, especially, are so nearly of the size and shape of human

blood, that no means, at present known, will discriminate with absolute certainty between the two, even in the fresh state, much less after having been dried and subjected to the methods of preparation necessary for microscopical investigation. The spectroscope does, with great accuracy, reveal the presence of blood, by the absorption bands characteristic of the hemoglobin, but cannot make any distinction between the various blood corpuscles affording the coloring matter.

But even were all of those difficulties successfully overcome, and could the minutest distinctions be made between the different kinds of blood, such evidence would, in many cases, be rendered absolutely nugatory by the doubts thrown upon the source of the blood and its manner of transfer to the stained article by the following facts :

Having been applied to, last winter, to make examinations of suspected bloodstains, the thought occurred to me that there is a possibility of the transfer of human blood by means of predatory insects, such as the mosquito, the bed-bug and similar others. Experiments showed that the crushing of such an insect, loaded with its meal of human blood, will yield a stain of considerable size, much larger than I had anticipated. I then captured some mosquitoes, after they had imbibed their fill of blood, and kept them alive in close confinement. They were then, after different periods of time, crushed and the blood examined, mixed with various menstrua for dilution. In all cases up to forty-eight hours I found a large proportion of the red corpuscles of human blood still unchanged, and quite readily recognizable. I next examined the blood of the mosquito, which had not been permitted to feast on the human subject. The size and color of these corpuscles of mosquito blood are so different from human, that no mistake can possibly arise from this source.

In the last few weeks Dr. E. Evers was kind enough to assist me in a considerable number of micrometric determinations of the human blood taken from the mosquito, after various intervals, and the corpuscles of mosquito



blood proper. The task has been a laborious one, owing to various difficulties, not the least among which was the selection of a proper menstruum for dilution. Glycerine in various dilutions, gave excellent definitions of the human blood corpuscle, but left the margins of that of the mosquito so ill-defined as to make accurate measurements very difficult. After various trials, we found alcohol of about 80 per cent. the best medium for examining mosquito blood, and very fair for the human blood corpuscle, although both shrink somewhat in the alcohol.

Our results<sup>1</sup> are as follows :

Human blood (after imbibition by the mosquito) averages (red corpuscle,) in dilute glycerine, 7.4 micro-millimetres, (or  $\frac{1}{3200}$  inch); in 80 per cent. alcohol, 6.9 micro-millimetres, (or  $\frac{1}{4000}$  inch.)

Mosquito blood averages in dilute glycerine, 1.8 micro-millimetres, (or  $\frac{1}{14000}$  inch); in 80 per cent. alcohol, 1.4 micro-millimetres, (or  $\frac{1}{18000}$  inch.)

The subject appears to me to be of sufficient importance to deserve farther investigation. However much we may regret that another prop is taken from the value of circumstantial evidence, derived from suspicious stains in murder cases, it is best to know and make proper allowance for any weak points of such information. For even if stains should now be fully identified as derived from human blood, the accused may plead in his justification, that they are due to the agency of insects and cannot be allowed to furnish any proof of his guilt.

Since reading the above paper before the Society, investigations with the bedbug (as yet very few in number) appear to show that the imbibed human blood is destroyed far more rapidly in them than in the mosquito. In one individual, after twelve hours, not a trace of the human blood corpuscle could be detected.

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1. These results are the average of more than one hundred careful measurements.

## CASES FROM PRACTICE.

HYDRENCEPHALOCELE—REMOVAL—DEATH FROM  
TETANUS.

BY JNO. T. HODGEN, M. D., ST. LOUIS.

August 2, 1880, I was called to see a child born the day before. Mrs. Carpenter, an intelligent accoucheuse, was in attendance during the delivery. The child was well grown, weighing  $7\frac{1}{2}$  to 8 pounds, well developed and perfect in every respect, except a tumor, which was situated on the back of the head in the median line. The tumor measured ten inches in its circumference, and over its most prominent part from the occiput to the neck, including the pedicle, measured twelve inches. The pedicle, about an inch and a quarter in thickness, connected it with the occiput. The pedicle with about an inch of the border about it was covered with normal skin and hair, the remainder, with a shining membrane, thin and transparent, with numerous bloodvessels traversing it. At the most prominent point this delicate membrane was already becoming sphacelated. The texture seemed loose and the connective tissue edematous. Palpation detected deep fluctuation, which was supposed to be due to the presence of a remaining portion of cerebro-spinal fluid. A careful examination could not find an opening in the bone, though there was apparently a depression at the attachment of the pedicle to the skull.

Persistent, firm pressure on the tumor, did not affect the child in any way, nor did it diminish the size of the tumor.

Believing that the opening into the arachnoid sack had closed, and satisfied that the delicate covering of the tumor would rapidly ulcerate, I determined to remove the tumor.

August 3.—Assisted by Drs. Mudd, Smith and McCandless, and in the presence of Madam Carpenter, the patient being under the influence of chloroform, I made an incision through that part of the tumor covered by normal skin,

and next the pedicle. Carrying it two-thirds the circumference of the tumor, this incision was continued through the edematous connective tissue until the sack was reached. The connective tissue was pushed back from the wall of the sack until near the occiput, a strong ligature was drawn tightly and the pedicle was then severed.

The edematous tissue through which the cut had been made, allowed the serum to drain off freely. There was little bleeding, no vessels requiring ligatures. I found that I had cut through a firm membrane having a serous lining and had thus discharged about three ounces of fluid. This sack had a dense wall not unlike the dura mater. At the point of division the opening in the cyst would admit the little finger.

After the removal of the tumor, I found a deficiency in the bone about the size of the tip of the little finger—this opening seemed closed by a membrane, though of course, this could not be positively determined. The stump was dressed open with a one per cent. solution of carbolic acid.

During the operation, Dr. McCandless, who gave the chloroform, reports the child breathed irregularly; after the operation it was pale, and passed a restless, fretful night.

August 4.—The child frets a good deal.

August 5.—The child has no fever, nurses well, and seems more comfortable.

August 6.—The child is doing well, nurses well; changed the dressing to-day.

August 7.—The child had been fretful all day and last night, could not nurse, would "seize the nipple and bite it," would "cry out and stiffen itself back."

Died at five o'clock A. M., August 7. Probably of Tetanus.

## SCROFULA, WITH POTTS' CURVATURE.

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GEORGE McLEAN, M. D., L. S. A., Lond., Orrick, Mo.

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March 30th, 1879, I was called to see a little girl who had been treated, the father said, by all the doctors in the neighborhood. He had taken her several times to Kansas City for surgical advice, but without any benefit; on the contrary, she appeared to be gradually getting worse. I found the little patient—a pale, delicate, blue-eyed, fair-haired girl, five years of age—seated in a small rocking chair. She seemed greatly deformed—sat “all of a lump,” as it were, and had a very aged appearance. Her body was ill-nourished, head normal size, face rather small and triangular, chin sharp and peaked, chest very narrow and prominent in front, shoulders elevated; the neck appeared wanting, the spine curved. She had good use of her hands and arms; the lower limbs were crooked, the natural curves increased, the legs crossed, right resting on left, which was drawn under right thigh. She could not bear to be moved; cried when lifted in or out of bed, and moaned constantly while riding in a spring buggy.

From the mother, a very intelligent woman, I afterwards obtained the following additional history: They had been married a little over a year when Iona, the subject of our sketch, was born. When three months old she had whooping cough, which lasted a year; then she had ague, from which she had never been permanently relieved. When two years old she complained of pain in her back, and six months later a lump appeared, with increased pain. She had no trouble about her teething. About a year later they took her to Kansas City, to one of those so-called “Institutes,” for surgical advice. There a brace was applied—one of those clumsy, old-time affairs—which rested on the hips, with crutches to support the arms, and weighed about *five pounds!* *Not a word was said about constitutional treatment!* This instrument (of torture) caused great irritation, and increased the pain along the spine, resulting in psoas abscesses, opening in the right and left groin, under Pou-

part's ligaments, and on posterior aspect of the left thigh, all discharging freely when seen. The parents, thinking that they failed to apply it properly, returned with her to the "Institute" upon several occasions, to have the surgeons apply and re-adjust the apparatus. It bore several marks of alteration and supposed improvement, but all to no end or purpose. The poor child fretted and cried so very much, that, fearing convulsions might set in, they threw the instrument aside. They had lost two children—the first a girl eighteen months old; dentition was the supposed cause; and the second, a girl nine days old, cause of death unknown. The mother's family were all healthy, but the father's family were delicate, and all died young; of a large family he was the only one left.<sup>1</sup>

I told them the child's general health might be improved, but whether the limbs would become straight, and she be able to walk, I would not promise.

Appetite pretty good, bowels, in a general way, regular. Mind very active. Ordered syrup of iodide of iron, ten drops in a tablespoonful of water every four hours. Warm sea salt water bathing, with friction every morning. Flannel to be worn next the skin; cream and sugar *ad lib.*

This treatment made a rapid improvement. Two months after diarrhea set in, controlled, however, with gray powder (hyd. c. cret.), compound tragacanth and aromatic powder, of each two grains, every two or three hours. Discontinued the syrup and gave the following:

R. Potas. iodid.	gr. xxxij.
Potas. bromid.	ʒj.
Ferri et potas. tart.	gr. xxxij.
Syr. calcis phos. precipit.	ʒij.

M. Sig. Half a teaspoonful in a tablespoonful of water, *immediately* after meals.

This mixture we continued without any change, as it seemed to agree very well, and produced no unpleasant symptoms whatever. The limbs straightened and became stronger; by the end of June she was able to hobble around on a pair of crutches; in August, could go pretty lively with one crutch, and in September she used a cane, in about a month longer she

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<sup>1</sup> On the first of January, 1880, he was kicked in the side by a horse; pneumonia set in, peritonitis supervened, and on February third he died; had no constitution whatever.

was able to throw that aside also. She complained of pain in the left side when standing; the left lower limb appeared shorter than the right.

On December 4th put on a plaster jacket, as recommended by Dr. Thos. J. Walker, in the *London Lancet*, American edition, p. 158. This was a great improvement; could run and play better, and it did not tire her to stand. April 1st she complained of tightness across the chest, with difficulty of breathing when running. I removed the jacket, and found that she had grown four inches, with marked improvement in every particular; she can run as lively as any of her playmates. Intend to put on another jacket next December. The abscesses have now healed.



## MULTIPLE PAPILLARY TUMORS OF THE LABIAL, BUCCAL AND GLOSSAL MUCOUS MEMBRANE.

BY C. J. MARCH, M. D., CAMDEN, ARK.

Alice N., æt. 9, was brought to my office June 13th, 1880, by her mother, who requested me to examine the interior of the child's mouth, "for," as she said, "there is something growing there." I complied with her request, and on inspection I found a very remarkable state of affairs. The mucous membrane of both lips, from the point where it is reflected on to the gums out to the muco-cutaneous junction, that lining both cheeks, as far back as the second molar tooth, and that covering the anterior half of the dorsum of the tongue, was studded with tumors varying in size from that of a millet seed to that of a large pea. On the labial and buccal mucous membrane the tumors were sessile, and so thickly set that in places they actually crowded one another. On the tongue the papillæ were in various stages of hypertrophy, some being but slightly enlarged, while others had formed quite large pedunculated and slightly lobulated tumors. The epithelium covering the tumors presented its normal appearance. The tumors manifested no tendency to hemorrhage or ulceration. It is proper to state here that the tonsils were hypertrophied also. The affection was

symmetrical, there being as many tumors on one side as on the other. The mother said that about a year before she brought the child to me, she noticed two or three small growths on the mucous membrane of the lower lip; hence the spread of the affection had been quite rapid, as at the time of examination there were not less than 100 tumors of various sizes.

The fact of the hypertrophy being symmetrical, might lead us to suspect a constitutional cause; but I could ascertain no history of syphilitic or other taint which might be assigned as a cause.

In the way of treatment I gave the patient internally five grains of potassium iodide in solution after each meal, and I directed the local application of a saturated solution of sulphate of iron three or four times daily. This treatment has been followed by a prompt disappearance of the tumors.

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## LACERATION OF KIDNEY.

BY J. S. EASTMAN, M. D., SPEARVILLE, KANSAS.

July 11, 1880. Grey, a farmer, was riding one horse and leading another. The horse becoming unmanageable, Grey was violently jerked to the ground. He got up and walked about a half mile to his house. The accident occurred about 9 A. M. On account of pain and passing blood with the urine, messengers were dispatched for physicians. We arrived at 1 P. M.; found him suffering with all the symptoms of shock. Surface cold, clammy, pallor, a small feeble pulse, anxiety of countenance, with pain over left kidney and inguinal region. Neither introduction of catheter, nor finger in rectum, revealed anything. Before our arrival a small chamber half full of blood had been passed with the urine, some clots following.

*Treatment*—Opii pil. gr. j., every three hours. Beef tea, ice, milk and chicken soup for diet.

July 12.—Temperature, 102°; pulse, 98. Slightly tympanitic, urine clear, bowels closed. During the next five days there was seemingly a slight improvement.

July 17.—Temperature,  $100\frac{1}{2}^{\circ}$ ; pulse, 85; tongue, white; slight tympanitis, with pain on pressure; has slight, nervous tremors and shooting pain in lower part of bowels, on left side of abdomen; and bowels have not been moved; urine scant and color of coffee grounds; appetite good and sleep natural. Ordered castor oil, and soap solution for enema.

July 18th., 4 A. M.—Called on account of severe pain and reappearance of blood in the urine. At 5 A. M., more comfortable. The clot in the vessel would weigh about two pounds, serum about ten ounces. Treatment continued same as before.

Up to the 21st, there was but little change, the urine then became clear instead of coffee colored, and was voided without pain. An indurated spot about the size of a silver dollar was detected in the center of left lumbar region, painful on pressure.

July 25.—The only notable change was a gradual loss of strength and less tenderness.

July 28.—Diarrhea; other symptoms about the same. R. Opii pulv. gr. j., every six hours. R. Tinct. Opii ʒj. S. inject every six hours. Give alternately, so as to get one every three hours.

July 29.—No diarrhea, very flatulent, drowsy and very weak; pulse, 120; temperature,  $101\frac{1}{2}^{\circ}$ ; pupils slightly contracted. The indurated spot in lumbar region less tender. Dulness on percussion over left half of left lumbar, lower third of left inguinal, and lower fourth of left hypogastric region, exacerbations of pain. Gave extract of beef and brandy freely.

July 30.—Seemed a little stronger, less stupid.

July 31.—Family reported his condition better, stronger.

August 1.—Eyes sunken, emaciated, pale, sweating, hands cold, clammy, temperature in axilla,  $102^{\circ}$ . Articulates very indistinctly, swallows with difficulty, pulse threadlike, 120. Delirious, attempts to rise, talks incoherently, recognizes no one, excretions pass involuntarily in bed, abdomen very much distended. Dullness a little less perceptible.

August 2.—About noon began to fail, died at 2 P. M.

August 3.—Capt. L. Y. Loring, Assistant Surgeon, U. S. A., Dr. Chouteau and I, opened the abdominal cavity, found the visceral and parietal peritoneum adherent; traces of extensive



inflammation throughout. Left kidney was badly lacerated, a handfull of clots beneath it. Left ureter denuded. Considerable pus in the cavity; the bladder broken down, collapsed; pus burrowing into pelvis and above kidney, so we must have had more or less pyemia and uremia before death.

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## REPORT OF CLINICS.

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CLINIC OF PROF. J. P. KINGSLEY AT ST. JOHN'S HOSPITAL—DISPENSARY OF MISSOURI MEDICAL COLLEGE.

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*Reported by S. Emory Lanphear.*

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CASE I. DIABETES MELLITUS.—May C—, female, age eleven years. At first visit to the hospital, the following history was obtained: For several weeks she could not retain the urine for more than an hour, and the quantity passed was very much increased, amounting to fully one gallon during the night alone. At first it was very clear, but now, upon examination, it is found to be a little colored, having a specific gravity of 1040, and upon the application of the proper tests, an abundance of sugar is proven to be present. She complains of headache every night, restlessness and want of sleep, and a dull, continuous pain in the region of the liver. Thirst sometimes excessive and appetite voracious, yet although enormous quantities of food and drink are taken, she is rapidly becoming emaciated and weak. The treatment adopted consisted in the administration of the iodide and the bromide of potash in five grain doses every four to six hours, and a restriction in regard to diet, all starchy and saccharine articles being excluded.

Twenty-four days later, she made her second appearance at the clinic, but not having adhered very strictly to the rules laid down for her government, the symptoms were about the same. Still passes large quantities of urine containing sugar. Sleeps better; all tenderness over liver disappeared. After this time she made her appearance regularly once a week at the hospital, for about seven weeks, at the expiration of which time, the treatment having been rigidly enforced, she was com-

pletely restored to health, but was advised to continue the animal diet for a considerable time, although the polyuria had entirely disappeared.

CASE II. RHEUMATIC FEVER.—Katie M——, aged two years. Has been sick about one week; attack was sudden, although preceded by a diarrhea; symptoms are: continuous fever, more marked during afternoon, nausea and occasionally vomiting, tongue red and uncoated, anorexia, very restless, and constant demand for water, slight cough, very acute pain in limbs, can not stand upon her feet, but cries out and sinks to the floor; both wrists and both knees swollen, tender, hot and red. Treatment: Salicylate of soda, three grains every four hours. Two days later, returned, much improved; treatment continued, and four days afterwards, was reported well.

CASE III.—On February 10, James D——, aged four years, presented himself at the clinic, having large sores upon the head and face (eczema capitis), lymphatic glands much enlarged and every evidence of scrofulosis. The modern diachylon ointment (consisting of equal parts of lead plaster and vaseline) and the syrup of iodide of iron were prescribed.

February 23.—Returned, eczema almost well; eyelids sore and stuck together. For eyes, was given salve, consisting of:

R. Hydrarg. oxidi flav.	gr. iii.
Ungt. petrolii.	℥ss.

M. S. Apply.

This proves a very valuable preparation in such cases, and is followed by very good results. For internal use, maltine was administered. Large quantities of this remedy are now given at the hospital, and its use is always attended with improvement. At the present time, patient is in better condition than he has ever been during his previous life.

CASE IV. DIPHTHERIA.—John R——, eleven years of age, sick three days, high fever, voice hoarse, respiration hurried and somewhat labored; tonsils much enlarged and covered by membrane. The treatment was citrate of iron and quinine in appropriate doses, given every four hours, and midway between these doses, eight grains of salicylic acid suspended in glycerine, and as a local application, a gargle of chlorate of potash, alternating with the carbolic acid spray. This boy was the fourth member of the family who had taken this disease within two weeks and the result in his as well as the other cases was, recovery.

CASE V. EPILEPSY.—Eddie W——, ten years old, had been troubled last winter by an occasional epileptic seizure, but during February, he became much worse, having attacks every night for more than two weeks. About eight or ten o'clock at night he would jump out of bed and ask to have a big negro taken away, or entreat his father not to whip him. He then appeared to have a kind of convulsion, followed by deep sleep or by fever. Treatment:

R. Potassii bromid.	ʒiii.
Fld. ext. ergotae,	fʒii.
Aquæ cinnam.	fʒii.

M. S. Teaspoonful three times a day.

Under this treatment he rapidly improved, and after coming several times, the attacks ceased entirely, but the continued use of the medicine was enjoined upon the mother, but as it subsequently appears, the advice was unheeded, and the administration soon discontinued. Consequently, not long ago, the patient returned, complaining of a recurrence of the affection. The same prescription was given, and as far as known, the child has been greatly benefited by its employment.

CASE VI. CHOREA.—Annie B——, twelve years of age. She had an attack similar to the present one, about two years ago, at which time she was sick for more than two months. Has now been ill for about two weeks, and manifests the characteristic symptoms of the affection. The convulsive movements are limited to the right side (it will be remembered that it much more frequently is confined to the left side) and have become so severe as to compel her to leave school.

The treatment must necessarily consist in large doses of *time*, chorea being a self-limited disease, but she was given one grain of the sulphate of zinc, three times daily, in conjunction with elix. citrate of iron and columbo, and under this treatment she seemed to improve slowly until at the end of about two weeks she was almost well.

## EDITORIAL.

VOL. IV.

SEPTEMBER, 1880.

No. 3.

MEDICAL CONTRACTS AND "BENEVOLENT"  
SOCIETIES.

In a Vienna medical journal appears a letter from Budapest, the chief city of Hungary, explaining an unfortunate condition of affairs proceeding from the custom (there become common) of organizing associations (*krankenvereine*) for the purpose of obtaining medical service by wholesale contract and at the lowest terms. The writer states that the city is overrun by practitioners so disregardful of professional pride and the dignity of the honorable body of which they are supposed members, that they resort to measures scarcely to be called decent in order to secure position in the public eye.

It will be remembered that Bilroth, Professor of Surgery in Vienna, inveighed very bitterly against this class in a book published some months back. The writer states that these men press their services upon the associations, offering them gratuitously and promising to procure additional members, etc. It must be understood, that in Germany and France it is common to find associations for mutual benefit of various nature, to afford members aid in case of sickness, life insurance, ceremonious burial and the like.

This importunity for public notice in some cases results in rather comical devices; for instance, a doctor will establish an association of his own relatives as a nucleus and use this for his further advancement. Such a consummation weakens our faith in the proverb that a prophet is without reward among his own kin. These associations secure medical service for members and their dependents at a nominal rate, the attending

doctor receiving \$100 to \$150 per annum from perhaps one hundred families as a body. Such degradation of professional standing seems incredible. Of course such a custom when widely prevalent, is fatal at once to the prosperity of the profession and to the best interests of the community. The best doctors find themselves without sufficient support, and in the end the public loses through loss of them.

In England a somewhat similar organization appears not to be unknown, and one of the illustrated humorous papers depicts the parting of the contract doctor from his wife as he sets out upon his rounds; she is made to say, "Now, don't you forget and give quinine, when it is so dear, to them club patients." A prudent bit of advice and very suggestive for those who want something for next to nothing.



## PASTEUR AND THE CHOLERA OF FOWLS.



In a former number of the *COURIER* an account was given of the discovery made by Pasteur of a microbion in the excrement of fowls attacked with the destructive disease known as "chicken cholera." Pasteur described before the Paris Academy of Medicine experiments with this microbion that resulted in the establishment of the fact, in his mind at least, that this organism when given to fowls in their food or drink would produce the "cholera," while the same in a modified form, injected under the skin, causes a mild local disorder (abscess) only, but the bird after this inoculation is no longer susceptible to the "cholera." The microbion is cultivated in an infusion of chicken broth in which it multiplies with prodigious rapidity. The peculiar method of cultivation to obtain the modified microbion for inoculation, has not yet been made public. The result of these experiments at once suggests an analogy with the effects of vaccine, and also holds out a hope that the vague theories in regard to the zymotic nature of many diseases may

receive a greater degree of distinctiveness with a reasonable expectation of final demonstration of the actual infecting germ or germs.

The explanations of Pasteur, however, were not received without demur by his associates. One Academician objected that he (Pasteur) had not clearly proven that his microbion was actually the cause of death in the fowls experimented upon, that it might possibly be a product of the disease and not its exciting cause. In reference to this objection, Pasteur with much emphasis described his latest and most conclusive experiments. He exhibited a vessel containing chicken broth and turbid with multitudes of microbia that had been generated in twenty-four hours from an infinitesimal amount of an infected broth added for the purpose. The broth which the day before while non-infected could have been freely injected under the skin of fowls without inducing the cholera or death, now has become so virulent that the most minute fraction of a drop so used will cause death, and the whole body will become poisonous. If this highly virulent liquid be filtered and all the living bodies removed, thus purified, it may be injected at will without causing disease or death. If a tube containing the microbion germs by milliards be suspended for several days exposed to a constant temperature, the germs will fall to the bottom; the supernatant liquid may be injected without harm, while that part containing germs will cause the disease and death. Pasteur regards these experiments as crucial and demonstrating beyond a doubt that the cholera is produced by the microbion, which is capable of cultivation as described. Pasteur also regards his laboratory experiments, as establishing for the first time the community of origin of vaccinia and variola, vaccinia being (in analogy with his microbion, pure and modified) only an attenuated form of human variolous virus.

CESAREAN SECTION ; ITS IMPROVEMENTS OR ALTERNATIVES ; LAPARO-ELYTROTOMY AND OVARO-HYSTEROTOMY, OR PORRO'S OPERATION.

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Laparo-elytrotomy and ovaro-hysterectomy may be considered as established resources in certain conditions of obstructed parturition, and are almost certainly destined to replace the equally if not more dangerous proceeding of gastro-hysterotomy or Cesarean section, in many instances.

We are indebted to Dr. Harris, of Philadelphia, for very careful compilation of statistics relating to the first and last of these procedures ; the result of a study of which, unavoidably leads to the conclusion that where the cause of obstruction is irremediable and permanent, Porro's operation is the preferable, as it brings about a termination to further gestation and lessens a certain class of risks to life. As to laparo-elytrotomy as performed and advocated by Dr. T. G. Thomas, further observations are necessary in order to contrast it on fairer grounds. Yet there will arise conditions when it should be entitled to preference, or at least to due consideration.

Cesarean section or gastro-hysterotomy as shown by Dr. Harris, has always proven a much more successful operation in America than in Europe, where it has been chiefly performed in hospitals, the results being nearly always fatal to the mothers.

In Great Britain the latest statistics, those of Dr. Radford, 98 cases with additional 20 cases collected by Dr. Harris, total 118 cases, give 96 fatal results, while of 100 cases occurring in American practice, 44 women were saved, and this proportion could have been much increased had the surgical procedure not been delayed until the parturient was exhausted by prolonged labor and efforts at delivery *per vias naturales*.

In 1870, Dr. T. G. Thomas, of New York, performed the operation described by him in the *American Journal of Obstetrics*,

April, 1878, under the title "Laparo-elytrotomy;" intended as a substitute for Cesarean section, safer than the latter, for the reasons that neither uterus nor peritoneum are injured. The operation consists, after dilating the uterine os, in dividing the abdominal wall by an incision extending from a point one inch above the anterior superior iliac spine, with a slight downward curve, parallel with Poupart's ligament until it reaches a point one inch and three quarters above and to the outside of the spine of the pubes; after the transversalis fascia is divided, the fold of peritoneum is lifted carefully by the fingers and the upper part of the vagina thus exposed; this is lifted by means of a stout steel sound passed in from the vulva, the vagina is opened on the sound to an extent sufficient to admit a finger, which lacerates the wall until the opening is made large enough to admit the hand; the child is then delivered by turning if the head or arm present, by extraction if the breech; the placenta is delivered, and the uterus caused to contract firmly, the iliac fossa should be cleansed by a stream of warm water introduced through the incision; if hemorrhage exist, ligatures should be applied, if possible, through the abdominal wound, or, this failing, the bleeding points should be seared by the actual cautery per vaginam.

The abdominal wound is closed by interrupted silver sutures; the vagina cleansed every five hours with warm carbolized water. Milk and meat broth are freely administered; opium or other medication according to necessity. This operation may be resorted to for the sake of the child in lieu of embryotomy, which is so frequently fatal to the mother.

The right side is the one of selection, in order to avoid the rectum, but a second operation, should occasion arise, would necessarily be made on the left side, when the difficulties that are anticipated would be determined. As the chief danger proceeds from the liability to hemorrhage from the abundant supply of vessels to the vaginal walls, probably the best plan of opening this would be by means of a thermo or other cautery, until space for introducing the finger is obtained; if this be used, a wooden support instead of metallic should be introduced, per vaginam, to sustain the wall for incision.



The few operations thus far reported are so satisfactory, as to encourage its due consideration. Of five operations reported by Thomas, the operation was in none the cause of death. Two died, but they were *in articulo* at the time of delivery.

“Cesarean ovaro-hysterectomy,” or ablation of the uterus and ovaries as a termination to Cesarean section, was done in the United States by Dr. Storer, of Boston, in 1869, his patient dying. In 1876 Professor Porro, of the University of Pavia, in performing Cesarean section on a rachitic dwarf, finding that the uterus failed to contract sufficiently to prevent hemorrhage, immediately determined to remove the organ, which he did with a strong iron wire and ligature around the cervix opposite the inner os; the pedicle was fastened in the abdominal wound, and the case treated as an ovariectomy, except that a drainage tube was passed through Douglas’ cul de sac. In forty days the cure was complete, and the woman could walk, run and jump, without the production of abdominal pain. The celebrated James Blundell, of London, suggested this operation fifty years ago.

Dr. I. E. Taylor, of New York, reports (*American Journal of Medical Sciences*, July, 1880) a case in which he dropped the pedicle into the abdominal cavity, the patient dying. Dr. Harris, in his remarks upon the statistics of the operation, urges the external treatment of the pedicle, as practiced in Europe where the successes have been  $51\frac{2}{7}$  per cent.

These operations, intended to preserve the lives of mother and child, the last looking to prevention of further risk from gestation, deserve the earnest thought of the profession; compared with the European countries, we have few cases of such deformities as require severe surgical interference in midwifery, so that we are not apt to become so familiar experimentally with these expedients.

In all cases it is of importance that the necessity for their performance should be recognized at the earliest moment, in order to prevent exhausting, futile efforts on the part of the patient and attendant.

VITAL STATISTICS OF ST LOUIS, 1880.

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The excessive mortality observed in large cities as compared with that of rural communities led to a careful study of the causes that produced this result, and the studies so undertaken have brought about a wonderful amelioration of the conditions of urban health and life. Year by year subjects of domestic and public hygiene, of preventive medicine and general sanitary matters demand and receive more considerate attention from the profession and from the more intelligent classes of the laity.

A few items culled from the Third Annual Report of the Health Commissioner of St. Louis, for the year ending April 12th, 1880, which has just been laid on our table, will be of interest.

That "the health of the city during the past year has been remarkably good," no physician in the city will question; but "that in comparison with all other cities of equal size or population, St. Louis still holds the front rank in point of healthfulness," the disclosures of the census make doubtful. We certainly shall not be able to show as low a rate of mortality as we have supposed that we were entitled to.

The importance and value of the ordinance requiring physicians to report contagious and infectious diseases, is illustrated by one occurrence that is reported for this purpose by Dr. R. Luedeking, clerk of the health commissioner, etc. The mortality returns during last January, showed a remarkably high percentage of deaths from diphtheria and scarlatina, in a certain limited district of the city. An investigation by the sanitary officers showed wells containing impure water which was used by the families in the houses where repeated deaths had occurred; cisterns from which drinking water was drawn, were found to be polluted by waste from imperfectly constructed privy vaults, and defective sewer connections allowed obnoxious vapors to escape into a house occupied by a large number

of people. If the health department had been notified promptly on the first development of these diseases, these dangerous hygienic conditions would have been discovered earlier and, perhaps, a number of lives saved.

While the census returns of our population render valueless the estimate of the total mortality rate, some of the other calculations are unaffected. The percentage of deaths from zymotic diseases compared with the total mortality, is but 17.01, San Francisco, New Orleans and Philadelphia alone showing a lower ratio.

Phthisis has steadily increased in frequency as the city has increased in size. In 1867 the percentage was 7.1, but this year, 12.6.

It is noted that among the colored people the rate of mortality from constitutional causes is very high, while there are few deaths from zymotic causes.

The total number of deaths during the year was 6,167, of which 1,825 (29.5 per cent., were of infants under one year, 2,666 (43.2 per cent.) under five years.

Zymotic diseases caused 1,818 deaths; constitutional diseases, 1,346; local diseases 2,364; developmental diseases, 367; there were 275 deaths from violence, and two from unknown causes.

The highest number charged to any one cause is 781, to phthisis and tuberculosis pulmonalis; convulsions and trismus follow with 496; while the next highest is cholera infantum, numbering 477.

The report of Dr. Geo. Homan, chief sanitary officer, contains many interesting details as to the character of the work performed by the health department during the year, and further measures which it is deemed important to carry into operation. Among these last, one which seems specially interesting, is the matter of securing the establishment of an abattoir and the removal of all slaughter houses and rendering establishments from other parts of the city. The importance and extent of the financial interests involved, and the marked influence which such establishments exert upon the health and comfort of those living near them, and the necessity of having:

them under suitable and efficient sanitary control, render this subject one for careful and serious consideration.

From the report of Dr. A. C. Robinson, dispensary physician, we learn that 9,566 new cases were cared for at the dispensary; there were 1,639 cases of different kinds of fever; 536 of bronchitis; 517 of diarrhea; 2,740 persons were vaccinated by the dispensary physicians.

In the City Hospital, as stated by the superintendent, Dr. D. V. Dean, there were 224 patients, April 1, 1879; 2,243 were admitted during the year; 902 were discharged well, 732 improved, 191 not improved and 387 died.

At the Female Hospital, Dr. P. V. Schenck, Superintendent, 133 patients remained at the commencement of the year, and 1,058 were admitted, of whom 654 were discharged cured, 185 relieved, 69 not relieved, and 127 died.

Of 163 infants born during the year, 140 presented by the vertex and 23 by the breach; 93 were born between midnight and noon, 70 between noon and midnight.

Dr. N. DeV. Howard, superintendent of the Insane Asylum, reports 322 patients April 1, 1879, and 189 admitted during the year. Of these 39 have been discharged recovered, 24 improved, and 14 not improved, and 21 deaths have occurred.

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#### AN INTERNATIONAL SANITARY CONFERENCE.

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The Secretary of State has, in pursuance of a joint resolution of Congress, approved by the President on the 14th of last May, issued a circular letter for the information of all interested, copies of which have been sent to the diplomatic representatives of the United States at the capitals of the maritime powers of the World, inviting them to send delegates to an International Sanitary Conference, which is called to meet at Washington, January 1, 1881.

A memorandum in relation to points proposed to be sub-

mitted to the conference accompanies the circular, which recites in the language of the joint resolution the apparent existing necessity for such a conference, mentioning particularly yellow fever and cholera, and goes on to say that the resolution had its origin in the practical difficulties which have been encountered in the administration of the regulations and rules recommended by sanitary experience and framed by the legislation of the country, to the end of preventing the introduction and spread of contagious or infectious diseases in the territory of the United States; the extensive prevalence of yellow fever in certain parts of this country during the past two years is referred to, together with the fact of the almost continual existence of the danger of the introduction of such diseases as yellow fever and cholera by vessels coming to this country from infected ports abroad.

The efficient application of domestic, remedial legislative measures is prevented, to a great extent, by the hesitation shown by the local authorities of certain foreign ports where contagious or infectious diseases have existed, as to co-operating with the consular and medical officers of the United States in carrying out regulations deemed essential by this Government as a sanitary safeguard.

The document alludes to the embarrassments experienced in consequence of the vague and untrustworthy evidence obtainable in some cases as to the sanitary condition of suspected foreign ports, and of unnecessary quarantines to which vessels coming thence have been subjected; while on the other hand, vessels from non-infected ports of this country, have been compelled to submit to the same inconvenience through ignorance of the sanitary condition of American ports—the ultimate aim of the joint resolution being to obviate all such occurrences by securing an international system of notification as to the actual sanitary condition of ports and places. The essentially local character of quarantine requirements is recognized with their varying adaptability to the sanitary conditions and risks in the seaboard and other districts where they are applied; and the impracticability of bringing all requisite public health precautions under one Procrustean governmental code is clearly set forth.

The belief is expressed that the great inconveniences and losses which the commerce of the world has been and is now suffering from the delays and obstructions caused by unnecessary quarantines can, to a great extent, be relieved by the establishment of an international system of notification as contemplated by the joint resolution; and the memorandum closes with a presentation of the propositions to be submitted for discussion to the proposed conference.

We cannot refrain from expressing the belief that the action of the government in this instance is wise and timely, not alone in the light of our past experience of yellow fever, but in view of other possible public evils in the near future. Apparently authentic advices from the East, indicate the gradual westward progress of Asiatic cholera which is reported as prevailing in malignant form in the southeastern portion of the Russian empire. Having in mind all contingencies, the desirability of sanitary agreement or alliance with other powers for mutual protection and defense against foreign plagues, must be admitted, for in such co-operation or union, is to be found the surest guarantee of successful resistance to their introduction or spread; and if the gospel of practical sanitation in its various details shall be observed and preached by all maritime powers, the usual course and fatality of epidemics of contagious or infectious diseases, may be greatly modified and lessened, if not entirely controlled.

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#### TAPPING OF PULMONARY CAVITIES.

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The operation of tapping pulmonary cavities has lately been receiving considerable attention. In a late number of the *Med. Times and Gaz.* appears the report of a case of cavity in the base of the lung which was treated in this manner by Dr. Powell and Mr. Lyles, of London. This case appears to have been one of fibrous degeneration of the lung with dilatation of the bronchi.

The results in this case were favorable, inasmuch as the emptying of a small cavity seemed to check an immoderate expectoration, and to lessen the cough. The operation was harmless in itself, but the patient died soon afterwards of pleuro-pneumonia of the opposite lung, and there was no opportunity of observing whether the operation would have any lasting or permanent effect.

The operation was not so innocuous in a case reported by Mr. Erichsen, where general emphysema followed the tapping of a pulmonary cavity. Mr. Erichsen lays great stress on the drainage, and has little faith in antiseptic applications. He believes in making a free opening, even a double one, and letting out foul material which tends to poison the system. He thinks it would be advisable in cases of bronchiectasis.

At the late meeting of the American Medical Association, Dr. Wm. Pepper, of Philadelphia, read a paper on the local treatment of pulmonary cavities, and claimed many good results from his method of treatment. He makes direct injections into the pulmonary cavities, using an instrument similar to but larger than an ordinary hypodermic syringe. The solution he prefers is Lugol's m.x-3j to the 3j of water. He claims to have seen great benefit from this treatment in improving the general health and condition of the patient. The operation was harmless, and at most excited a cough and slight pain. He believes that it tends to promote the cicatrization and obliteration of the cavities injected, and narrates cases where the post-mortem evidences of an obliterated cavity have been found after such treatment. Dr. Pepper is, however, not sufficiently satisfied with the operation to recommend it for general use.

The evidence of these observations simply shows the comparative impunity with which the chest wall and lung can be perforated, if such evidence is needed in addition to the general experience of surgeons in dealing with wounds of the chest.

That it is not entirely devoid of danger, is fully shown by the case of Mr. Lyles where the wound, although made at the eighth intercostal space, missed perforating the diaphragm and

entering the peritoneal cavity by one-eighth of an inch. The contracted condition of a fibroid lung can account for this. Then, again, it is not so easy to locate the exact spot of a filled cavity. Even such an expert diagnostician as Dr. Douglas Powell, struck a small superficial cavity when he aimed for the larger and deeper one. To drive a trocar into an inflamed lung, can certainly not be of benefit to the patient. How many practitioners can define the limits of a filled cavity when it is surrounded by consolidated lung tissue.

Mr. Erichsen says, he uses drainage, to free the lung from a mass of foul matter which would soon poison the system. This would certainly hold true if we had to deal with a single cavity; but in the large majority of cases where we find one cavity there are many others, some of them not appreciable by the art of physical diagnosis. There is no doubt, that, if we could thoroughly cleanse and disinfect all the cavities in a case of phthisis, we could accomplish a great deal in assisting nature to accomplish a cure; but, unfortunately, phthisis is a systemic disease, not a local disease of the lung, and even if we could keep the cavities constantly clean, we should find the greater part of our work still to be done. Hence Dr. Pepper's plan of injecting cavities with disinfecting solutions without other medication would prove futile.

English authorities do not agree with Dr. Pepper in considering injections innocuous. Both Mr. Erichsen and Dr. C. T. Williams speak of them as causing additional irritation.

It has been suggested by an English surgeon, that in cases of basic cavities communicating with a bronchus, the patient should be reversed several times a day, and the secretion thus allowed to drain off.

Another important point, can we suddenly dry up a suppurating cavity in a phthisical lung without provoking a corresponding process in another part of the lung involved in the disease, or even in the opposite one? We certainly do find in cases of seemingly arrested phthisis, that when activity is again started, it is not manifested in the diseased, but in the previously sound lung. The sudden checking of any suppurating drain is always prejudicial to a phthisical subject. We consider an



encapsulated cavity as a favorable condition and sign of arrest, and even when nature does obliterate it, as it sometimes does, it is not done suddenly, but very slowly.

The treatment by inhalation, especially when pursued in the manner advocated by Drs. Gadbury and Cohen,<sup>1</sup> certainly is more in accordance with the laws of nature. By this method, antiseptic remedies can be brought in contact with all cavities, and what is much more important, with the bronchial membranes and lining membranes of the air cells.

These means, with the internal use of antiseptic remedies, as the benzoates, salicylates, etc., to the point of full saturation of the blood, will accomplish the desired results of destroying the fetor and moderating profuse discharges.

If the operation of paracentesis of the lung is at all justifiable, it must be in rare cases of bronchiectasis, where the foul odor from the discharges renders life intolerable, and in these cases the open drainage of Mr. Erichsen would seem preferable. But before any operative measure is attempted, it will certainly be prudent to try the reversal process of emptying the cavities. In the case of cavities which do not communicate with a bronchus, this would be useless.

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### CHOLERA IN RUSSIA.

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Telegraphic advices of recent date from abroad to the daily press, convey intelligence of the prevalence of Asiatic cholera of a virulent type at Saratov, a city in the Russian province of the same name, situated on the right bank of the Volga, about 460 miles southeast of Moscow. From the meagre details given, it would seem that the pestilence first appeared in, or was confined to the military barracks; but fears of its spread were expressed. Such an event is not improbable, though by the adoption of prompt and stringent sanitary measures with a

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<sup>1</sup> see COURIER, August, 1880.

military *cordon sanitaire*, doubtless the progress of the disease may be stayed at that particular point.

This outbreak, if the report be true, may be regarded as a herald of its distant approach, that the pest, issuing from the far East near the expiration of the period fixed in the popular mind and borne out to a degree by medical observation, namely, about sixteen years, has set out on its westward course and is threatening Persia and European Russia. The period referred to, may be computed from its appearance in the United States in 1866, the ravages of the disease in the Mississippi Valley in 1873 being clearly but a flaming up of pestilential embers brought hither by emigrants from Central Europe, where it lurked for some years after the first named date.

The movement of the Mohammedan populations in their annual pilgrimages will, within a year or two, coincide with the warm season ; and the unspeakable filth that marks the personnel and route of the pilgrim masses, will assuredly give to the disease its wonted epidemic energy and fatality.

As compared with other periods of devastation due to the advent of cholera, it will be of interest to medical men and sanitarians to note what effect the lately increased and increasing control acquired by Europeans, particularly the English and French, over the various routes, lines and methods of travel and communication in Eastern Asia, will have on it, and what results, if any, are shown thereby, in preventing its propagation or spread.

## CORRESPONDENCE.

## EDITORIAL LETTER.

PHILADELPHIA, August 18, 1880.

*Bros. Editors*:—The city of Philadelphia always possesses great interest for the physician, even at this time of the year when the “lights” are shining elsewhere, and the general upsetting indicates a season of interruption of regular activity. Owing to these natural causes, I cannot give a long and detailed account of the doings of famous professors, capital operations, etc.; but shall write out a rambling sketch of what met my eye and seemed likely to be of some interest to our readers.

The physicians first thought on visiting this city, is to inspect the two great medical colleges, the Jefferson and that of the University of Pennsylvania. These two are close rivals and are evidently straining every nerve to gain the lead against one another. Competition between such institutions so well supported and in a wealthy city, has resulted in a grand accumulation of material. Those who attended the Centennial will remember the new building of the medical department of the University, commodious, well designed and provided. One is ready to allow the boast that it is the finest edifice devoted to medical instruction in the world. Its noble museum is particularly rich in dry preparations of the vascular system (injected) and of the nervous system. The subject of comparative anatomy has a generous space. Apart from the aid in technical education, such a collection must have a great influence upon the mind of the student, it familiarizes him with the best work in dissecting, and tends to raise him out of the miserable narrow rut that permits one to see nothing in the sciences of Physiology and Anatomy but what may be of “practical” use in a surgical operation or in the making of a diagnosis. No man in these days has more need of *liberal* education than the doctor.

Adjoining the college is the new laboratory building, four stories in height, 151 feet long by 46 feet wide. The whole upper story is fitting for a dissecting room, an unexampled hall for that purpose. It is of good height, and is finely lighted. In the basement a cremation furnace is building, which it is expected will relieve the faculty of what is recognized as a most embarrassing consequence upon dissection. I was informed that the faculty is now salaried, which is an excellent final to the University scheme of reform in the method of medical education, and for obvious reasons. One of the faculty assured me that since the introduction of the reforms, the character of the class had vastly improved, and while the numbers had at first diminished, they felt confident of the future.

Both the Jefferson and the University have their own hospitals, and in their immediate neighborhood. The operating amphitheatre in the Jefferson hospital is grand. Visitors to the Centennial will recall that large and striking painting representing Prof. Gross in the midst of his class in this room, lecturing upon a case of necrosis of the femur. He has just cut down to the bone, and is now calmly explaining to the students, some of whom in a few tiers form the dim background. Assistants are exploring the wound, absorbed in their duty, while, to add tragic force to the flowing blood and gaping cut, the terrified wife is pictured on the other side with averted head and outstretched hands convulsed in horror. Just above her the reporter is seated, impassively taking notes. This painting is now in Prof. Gross's room at the college. In these hospitals the antiseptic treatment according to Lister, does not seem to have gained ground, the usual carbolic dressings only being apparently in use. In the University, sand bags and extension take the place of the swinging splint; a boy had, in addition, the long straight splint applied for the fracture of the femur.

The Pennsylvania hospital has lately been the scene of much excitement, owing to the presence of the victims of an accident on an excursion train of the West Jersey railroad. The hinder car, filled with people, was run into by the locomotive of a following train; besides crushing some, its cylinders giving way, threw steam and hot water into the car, doing dreadful work. There has been an immense amount of travel in the East this season. Excursions have been overcrowded,

and accidents only too numerous and shocking. A very favorite excursion with the Philadelphians is to the coast at Cape May and Atlantic City. Truly they are blessed in having such a place of refuge from the heat as Cape May at their door. Two hours' travel by express, suffices to carry one to this delightful sea-side resort. Its beach of hard sand is unsurpassed, being perfectly safe, without sudden pitches or undertow. Cape May is not quite so accessible as Atlantic City and is held to be more exclusive. Just think of being able, in the short space of two hours, to leave behind summer-heat and dust and the turmoil of the town, to breathe the free ocean air, to bathe in the surf—in fine, to enjoy elysium. The physicians of Philadelphia largely support these places of refuge, and, as a grateful recognition of their services in encouraging travel, the railroads actually give them free passes for the season. This last statement appears incredible, but it is a fact.

There are serious defects in the municipal government of Philadelphia, which must be productive of much sickness that can be cured only by fresh air and pure water. The streets in the main part of the city are in a filthy condition, the gutters are stink traps soaking in stagnant and putrefying water; at every corner the nostrils are assailed with a fresh offence. The site of this part of Philadelphia is rather flat, and not much above the high tide level in the Delaware. Cobble-stones and blocks are used for paving, filth collects between them and there remains. While the limestone dust in St. Louis is annoying in the extreme, still I cannot but believe that the limestone macadam is essentially healthful. It makes a solid bed, impervious to water, and in wearing down continually, presents a fresh, clean surface. The dust is a disinfectant, and mingled with the street offal, is swept away by the rain or street cleaners. But there need be no flying dust. St. Louis must adopt a plan for general sprinkling. No doubt that omnipresent, irritating dust has cost the city incalculable loss in property, and in deterring valuable accessions to her population.

The water of Philadelphia is simply detestable. At the present time it has a flat, brackish taste, much like swamp water. It made me violently sick the first day, vomiting and purging. After inspection of the source of supply, the visitor will not be surprised at the character of the liquid. The Schuylkill is at best a small stream, and dammed at the water works, be-

comes sluggish in current, forming a sort of long pond that is the boating place of the city. Small excursion steamers also ply up and down; water weeds grow in abundance. Six miles above the dam large iron works occupy the right shore; nearer, on the left, a village drains into this stream—and such an inky contribution, the mere sight of it is enough to excite a convulsive action of the diaphragm and abdominal muscles. Of course both banks drain into the all-receiving Schuylkill. All along its upper course manufacturing towns, villages, and farms contribute to the water supply of this huge city. It is simply dreadful to contemplate. There is a plan agitated for supplying good water, but the agitation is already ancient and the settlement may be deferred until the citizens are aroused by calamity.

The notorious Buchanan, the diploma peddler, is again the subject of newspaper discussion. Buchanan for years has defied the law by the aid of unscrupulous lawyers and other devices, but lately he seems to have been unusually hard pressed, probably through lack of money. Yesterday while on the Delaware ferry he jumped into the river, and now the question is, did he actually commit suicide, or is this another trick to escape justice. So much for an evil reputation, one cannot even die in peace.

The readers of the *COURIER* will recollect that in one of the spring numbers appeared a sketch of the Philadelphia College of Physicians, which is not a college in the sense of educating students, but a literary association. It possesses a substantial building, corner of Locust and Thirteenth streets, in which are its library, museum, and assembly room. Its library is a fine one consisting of 15,000 or 16,000 volumes of medical books. Among the periodicals, I greeted the familiar title page of the *COURIER*. The museum is very choice, including a very valuable collection of preparations of the human ear, made by Prof. Politzer, of Vienna, and numerous specimens of Prof. Hyrtl's wonderful injections and corrosion preparations, some of the latter being so extraordinarily delicate and beautiful, that they might well adorn a salon table as unique specimens of coral or vitrified mosses. The Philadelphia County Medical Society holds its meetings in the same building. The society has begun within the year to establish a library of its own. It has started on the same plan as the Medico-Chirurgical

Society of St. Louis, soliciting loans of books from its members. We, of the Medico-Chirurgical, may have reason to feel elated over the knowledge that the Philadelphia gentlemen have not gotten together more than one-half as many books as ourselves. We may rest assured that through our own efforts, seconded by the *actual* deposit of the COURIER reviews, as agreed upon, we shall soon have a library for consultation that we may find of the greatest use, besides relieving St. Louis of the stigma of not possessing such an one.

Yours respectfully,

CHARLES A. TODD.

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## BOOK REVIEWS AND NOTICES.

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THE MANAGEMENT OF CHILDREN IN SICKNESS AND IN HEALTH. A book for mothers. By AMIE M. HALE, M. D. Philadelphia: Presley Blakiston. 1880. 12mo.; pp. 110. Cloth, 50 cents. (Through H. R. Hildreth Printing Co.)

Nothing short of a reprint of the whole, or a critical review even more voluminous, would serve to give our readers such a knowledge of this little book as it deserves. All we have space to attempt is to induce them to gain this knowledge at first hand. Whether it is essential that mothers should learn *all* that its bright pages convey, may be questioned; there can be no doubt that *physicians* should know it all. And we can assure all young practitioners, that the practical experience of many years and the commission of many blunders are the usual price of what can be learned from this little book with ease.

We have selected a few extracts to illustrate the general manner of treatment and the crisp style of the judicious author. They are by no means the cream of the book—its pages are all equally pleasant reading, its matter is all instructive, and thoroughly sensible. It is addressed, it should be remembered, to mothers.

“Do not be too ready to adopt general maxims or inflexible rules for the treatment of your children, such as that ‘an in-

fant should have a cold bath every day,' or that 'food should never be given between meals.' Be satisfied with principles, and in details be governed by circumstances. Remember that conditions vary constantly. In case of illness, serious or otherwise, when you have chosen a physician, do not hastily discard his advice for that of the wellmeaning but mistaken mother, or aunt, or neighbor. It is true that the doctor may be wrong, but the chances are a thousand to one that it is the friend who is so. Consider that, though she may have raised half a score of children, his experience is wider than hers. A physician in good practice sees more disease in one epidemic than the most peripatetic neighbor, who is 'so good in sickness,' sees in a lifetime. The doctor, too, trained as he is to observe details, sees things which escape the unprofessional eye, and he knows, also, their relative importance. I speak of the well-educated physician, and have no wish to undervalue those sensible, good women, whose practical experience is worth more than the superficial knowledge of the ignorant graduate, whose study is a sham and whose diploma is a fraud. I wish chiefly to indicate the fact that amateur doctoring, though it may chance to do well, is an unsafe dependence, since it has few principles to guide it, and its practice is founded upon a limited number of facts, and those but imperfectly understood. Like everything else amateur, it is wholly unsatisfactory when tried by any high standard of professional art." . . . . .

"There is a prejudice against night air which can only be justified in malarious regions. . . . Florence Nightingale remarks that in great cities the only pure air to be had is the night air. The great factories are then still, the thousand fires are quenched, the dust settles on the pavements. Every one who goes abroad at night, or who sleeps with open windows, recognizes the purer atmosphere of night—purer, not because it is cooler, but from the absence of that which makes the day air impure. Miss Nightingale further asks very pertinently, what kind of air one expects to get in the night time. You cannot breathe the day air in the night, she says. Your choice is between foul night air and pure night air. But most people manage to breathe the day air in the night. They hoard it up during the day, and, having already breathed it over several times, continue to breathe it over in calm unconsciousness." . . . . .



"I would object to children being abroad in the evening as a general rule, both because they should go early to sleep, and because the air, unwarmed by the sun, is less beneficial to them. . . . I should add that in the city all this is, in a measure, changed. I have spoken of the purer night air in the cities. It is also much less damp than it is in the country, after nightfall. . . . In the hottest weather the only endurable part of the day is after dark, and I do not see why the children should be excluded from the refreshing coolness which rests as much as sleep, and, indeed, invites sleep." . . . .

"Vomiting in the infant is a much more easily performed and less disturbing process than in the adult. An excess of food is easily thrown off. Some hint as to the suitability of this food, and the condition of the digestive fluids, may be gotten by observing the rejected matters. The milk may be returned from the stomach because of over-feeding. The baby takes more food than the digestive fluids, which his stomach secretes, can digest. Now, when the body is over-fed, there is also another special cause of indigestion. Over-feeding means too frequent nursing. Too frequent nursing means too rich milk. The longer the milk remains in the breast, the thinner, that is, the more watery, it becomes. . . . So that by too frequent nursing, the baby's stomach is not only overloaded with superfluous food, but that quantity which he could or should digest is made difficult or impossible of digestion by being too rich. A new-born babe, nourished at a healthy breast, should be nursed only once in two hours; and five meals a day are sufficient for a child eight or ten months old." . . . .

The temptation to continue these extracts is very strong; there are some admirable descriptions and very excellent advice in the chapters on indigestion and on "taking cold." Indeed, the hygiene in this book is perfectly sound and very thoroughly applied. The formulas at the end are rather out of place, and a few pages are filled with "aphorisms" which, in so far as they are not repetitions, might more properly have been worked into the body of the book. We are not certain as to their authorship, for the last one is followed by the signature "*Selected*," and this may be intended to apply to all of them. Certain it is, that many of them are at variance with better advice in the earlier chapters; and the very last, referring, we take it, to the *prenatal* "management of children," is too ludicrous to quote.

THE VENEREAL DISEASES, INCLUDING STRICTURE OF THE MALE URETHRA. By E. L. KEYES, A. M., M. D., Professor of Dermatology and Adjunct Professor of Surgery in the Bellevue Hospital Medical College; one of the Surgeons to Bellevue Hospital; consulting Surgeon to the Charity Hospital, etc., etc. *New York: William Wood & Co. 1880.* (Through C. C. Pease).

This is one of the volumes of Wood's Library of standard medical authors, and the work of one already well known to the profession through several books, essays, etc., heretofore published.

Part First, of fifty-two pages, treats of the chancroid or non-syphilitic venereal ulcer. In the first line of the text the author writes himself down a dualist.

In Part Second, of nearly two hundred pages, syphilis is treated in a comprehensive and able manner. As a sample of the vigor and clearness of the style, we quote the following definition which, the author says, touches only upon the outskirts of the disease. "Syphilis is a specific disease, acquired only by inheritance or by direct contact of a surface capable of absorption with the poisoned secretions of a person already diseased. It is characterized by periods of eruption of varying severity, and periods of repose of varying duration. The earlier symptoms are superficial, the latest involve the viscera. No organ of the body is exempt from paying tribute to the disease; the connective tissue suffers most. Treatment may modify and shorten the disease; time alone can wear it out. A perfect recovery is possible." This is as near a definition as we remember to have seen, of a disease that nothing short of a detailed description can define; "a disease," as the author says, "of magnificent exceptions, full of absorbing interest."

Strong grounds are taken against the views of Auspitz and that school, who do not allow the distinctions between the initial lesion of true syphilis and chancroid, and who claim to prevent syphilis by excising the initial lesion. In this we agree with our author.

The treatment of syphilis, in the work before us, is not different from what the author has before advocated in his published works. The "tonic" dose of mercury is made smaller, and the time it should be taken longer than he formerly advocated.

The topography of the syphilitic skin-lesions is illustrated by means of wood-cuts from photographs. These add somewhat to the descriptions.

Gonorrhœa is placed in the rank of virulent diseases, a position not accorded it by some writers of eminence. We have never seen any good reason for the opinion held by those who do not believe in the virulent character of this most venereal of all diseases; and we think Keyes has performed a good work in taking the ground he does. That there are no clinical differences between a simple urethritis, when it runs high, and a gonorrhœal urethritis, which always runs high, is acknowledged on all sides. This, however, is not sufficient reason for saying that gonorrhœa is a non-virulent disease. Neither are the histories given by vain and selfish men, who wish to shift a responsibility, or by women who yield their bodies to strangers, safe grounds on which to base opinions concerning the virulence or non-virulence of clap; for, if their stories were true, who would be willing to brave the awful dangers of a modern water-closet, or dare to micturate in a draughty alley? The methods resorted to, to prove that a person can contract a true gonorrhœa from one who has not a true gonorrhœa, are too full of the possibilities of error to be worthy of scientific credence.

In studying the symptoms of inflammation of the urethra, in the male, the author divides them into (1) symptoms of urethritis of an unhealthy urethra, not due to the contact of a virulent pus, and (2) symptoms of inflammation in a healthy urethra, due to contact of gonorrhœal pus, or other irritating substance, under circumstances capable of generating urethritis. This division, while still somewhat ambiguous, is perhaps the best that can be made, in the present state of our knowledge, and provides against all contingencies, especially against those delicate ones where the physician is called upon to assume judicial functions and decide as to the purity of a woman.

In discussing the above question, the author has taken occasion to give some practical examples of the beneficial effects of placing a patient, suffering from urethral disease, under proper hygienic conditions, sexually, that are well worthy of the consideration of those to whose lot may fall the treatment of urethral disease. Sexual hygiene is beginning to receive the attention it justly deserves, and that, too, at the hands of men better qualified to deal with it than are those whose wont it has been—and is yet—to recommend fornication as a cure:

for sundry diseases of the sexual organs. Some considerations brought forth on pages 250 and 251, are of sufficient importance to entitle them to a separate place, under proper caption; yet we do not find any allusion to them in the index.

We find here, stricture of the male urethra treated at length, and in the ablest manner. A strict division of labor would cause this purely surgical part of the volume, to be omitted; but no one will object to finding the views of so excellent a surgeon as Keyes, in these pages. These views are of the soundest, and the descriptions of the operations of the clearest character.

"I have raised my voice," we quote from the preface, "for what it may be worth, in protest against the views of the new school in urethral pathology, which seems to claim that every natural undulation in the tissues of the pendulous urethra is a stricture fit for cutting, and that all the ills of the genito-urinary passages may be accounted for by the existence of these undulations, and, usually, made to disappear when they are cut."

He tenders his respects to "the honest labor and mechanical genius of the leader of this school," and thinks the profession is indebted to him for some capital instruments, and for a broader understanding of the tolerance and the possible capacities of the urethra. It is hardly possible to speak, at the present time, when so much and angry discussion is taking place, of the methods and theories of Otis and his followers, without appearing to be partisan; but it is not too much to say that when time shall have judged of these things, he will be found entitled to much credit. That too much cutting of the male urethra has been going on of late years, and that some strictures have been cut that did not need it, and others that could have been treated by methods that are safer and equally efficient, hardly admits of a doubt. But, for all that, internal urethrotomy, especially of the penile urethra, when done with Otis' excellent instruments, has its place in urethral surgery; and that place is not a small or unimportant one. Experience seems to have demonstrated that too much has been claimed for this operation; but it should not be forgotten that there would have been no litholapaxy, had not the capacity and tolerance of the urethra been demonstrated. And it is a question, whether the capacity of the male urethra is not even yet underestimated.

For stricture at or near the meatus, the author says cutting is necessary, but for those farther down the canal, we are pleased to note that he, along with the best surgeons of the present day, still holds that dilatation should first be attempted. Abundant evidence is now at hand to show that cutting is no more lasting in its results than thorough dilatation. For strictures of the deep urethra (*pars membranosa*), other methods than internal cutting are urged, on the ground of danger from hemorrhage, etc. The very large number and variety of means for arresting hemorrhage from the deep urethra, after internal urethrotomy, is sufficient evidence of the danger from this cause.

Under the head of the treatment of urethral fever, we find: "Quinine, formerly much used, is not to be depended upon. I cannot say that it is without value, but long experience with it has made me unwilling to trust it alone." The injection, hypodermically, of 10 minims Magendie's solution of morphine, fifteen minutes before operation, and the subsequent use of jaborandi, also hypodermically, are recommended, the main reliance being on the morphine. Chloroform in 20 minim doses is recommended after the chill comes on, to be used in conjunction with the morphine.

The work is in every sense of the word excellent, and, we predict, will find a high place in the estimation of the profession—a place it certainly deserves. J. B.

BLANK CHARTS FOR RECORDING TEMPERATURE, RESPIRATION AND PULSE CURVES IN DISEASE. *New York: G. P. Putnam's Sons, 182 Fifth Avenue; 40 cents per block.*

These blank charts furnish a ready and accurate method of keeping clinical memoranda of cases in hospital or private practice. Horizontal and vertical ruled lines divide the sheet into spaces in which it is very easy to indicate the morning and evening variations of temperature, pulse and respiration during a sickness of two weeks, while on the other side of the sheet are spaces for recording other clinical notes as the cases progresses. The spaces for temperature, respiration and pulse are numbered so that it is only necessary to make a dot or draw a line in order to continue the curves from day to day.

The blanks are furnished in blocks of a convenient size for the pocket, 7 x 4 $\frac{3}{4}$  inches, and will be very serviceable in facilitating the preservation of accurate records of cases.

LESSONS IN GYNECOLOGY, by WILLIAM GOODELL. A. M., M. D., Professor of Clinical Gynecology in the University of Pennsylvania, etc. With ninety-two illustrations; pp. 453. *Philadelphia, Pa.: D. G. Brinton, 115 South Seventh St. 1880.* (Second edition revised and enlarged).

In the natural course of literary events, the excellent work of Dr. Goodell was not one year of age when we were treated to a second edition, which exhibits the careful modelling hand of the master. The frequency of early second editions of valuable treatises in medicine is oftentimes a subject of regret on the score of expense to those who desire always to have the latest, but in this instance it was to be expected, as the first was evidently an experimental attempt which proved, as it deserved to be, one of the most popular, as it was one of the very best didactic works we have received, upon the subjects treated. We know few authors upon any subject in medicine more attractive than the learned master of "Preston Retreat."

The present edition is increased in size by seventy-three pages, which includes numerous additions to chapters. And four new lessons especially to be noted is the lesson on "Ovaritis and prolapsed ovaries." We are glad to note that the author alludes in terms of merited compliment to the valuable addition to the long list of pessaries, that devised by Dr E. C. Gehrung, for the treatment of anteflexions and versions.

The additional lessons upon "affections of the vulva and surrounding parts, metritis and endo-metritis," are full of interest and instruction; the "Lessons" have been very greatly enhanced in value, and from their very practical character deserve to be carefully studied by every practitioner of medicine.

The mechanical execution is of the best.

G. A. M.

## BOOKS AND PAMPHLETS RECEIVED.

THE PRACTITIONER'S HANDBOOK OF TREATMENT, OR THE PRINCIPLES OF THERAPEUTICS. By J. Milner Fothergill, M. D., Member of the Royal College of Physicians of London; etc., etc. Second American from the Second English edition, enlarged. *Philadelphia: Henry C. Lea's Son & Co.* 1880. 8vo, pp. 647. Cloth, \$4.00. (Through Hugh R. Hildreth Printing Co.)

CONTRIBUTIONS TO ORTHOPEDIC SURGERY; including observations on the Treatment of Chronic Inflammations of the Hip, Knee and Ankle Joints by a New and Simple Method. Lectures on Club-foot. By Jos. C. Hutchinson, M. D. *New York: G. P. Putnam's Sons,* 1880. 12mo., pp. 121; cloth, \$1.25.

THE STUDENT'S DOSE-BOOK AND ANATOMIST COMBINED. By C. Henri Leonard, A. M., M. D., etc. Part I. The Multum in Parvo Reference and Dose-Book; third revised edition. Part II. The Vest-Pocket Anatomist; second revised edition. *Detroit: Leonard's Illustrated Medical Journal,* 1880. 16mo., pp. 100—60. Cloth, \$1.00.

THE MECHANICAL TREATMENT OF CYSTOCELE AND PROCE-DENTIA UTERI. By Eugene C. Gehrung, M. D., Consulting Physician to St. Louis Female Hospital, etc., etc. (With two wood cuts) Reprint from the *American Journal of Obstetrics,* July, 1880. *New York: Wm. Wood & Co.*

THE YELLOW FEVER QUARANTINE OF THE FUTURE. Based upon the Portability of Atmospheric Germs and the Non-Contagiousness of the Disease, by Henry F. Campbell, A. M., M. D., Augusta, Ga. Reprint from Vol. V. Public Health Papers of the American Public Health Association. *Cambridge: Printed at the Riverside Press.* 1880.

SENILE OBLITERATION OF THE UTERINE CERVICAL CANAL. By Henry F. Campbell, M. D., Augusta, Ga. Reprint from Vol. IV. Gynecological Transactions. 1880.

NOTES ON NEURASTHENIA. By C. H. Hughes, M. D., St. Louis. Reprinted from the *Alienist and Neurologist,* Oct. '80.

OFFICIAL REGISTER OF PHYSICIANS AND MIDWIVES to whom certificates have been issued by the Illinois State Board of Health under the Act of May 29th, 1877, and of Physicians and Midwives who have registered in the County Clerks' offices under the Act of May 25th, 1877, and who claim to have practiced in Illinois ten years prior to July 1st, 1877, but to whom no certificates have been issued. *Springfield: Weber & Co. State Printers.* 1880.

THE PATHOLOGY, DIAGNOSIS AND TREATMENT OF DISEASES OF WOMEN, including the Diagnosis of Pregnancy. By Graily Hewitt, M. D., London; F. R. C. P., Professor of Midwifery and Diseases of Women, University College, etc., etc. Third American from the third London edition, revised and enlarged, with one hundred and thirty-two illustrations. *Philadelphia: Lindsay & Blakiston.* 1880. 8vo, pp. 751; cloth \$4.00; leather \$5.00. (Through St. Louis Book and News Company.)

THE MICROSCOPIST. A Manual of Microscopy. Fourth edition, greatly enlarged, with two hundred and fifty-two illustrations. By J. H. Wythe, A. M., M. D., Professor of Microscopy and Histology in the Medical College of the Pacific, San Francisco, Cal. *Philadelphia: Lindsay & Blakiston.* 1880. 8vo, pp. 434; cloth, \$5.00. (Through St. Louis Book and News Company.)

REPORT AND SUPPLEMENTARY REPORT to the Parliamentary Bills Committee of the British Medical Association on Vaccination Penalties. The Principle of Compulsion in Vaccination. By Ernest Hart, Chairman to the Committee. Reprinted by order of the Committee, from the *British Medical Journal*, July 3rd and 17th, 1880.

ATLAS OF SKIN DISEASES. By Louis A. Duhring, M. D., Professor of Skin Diseases in the Hospital of the University of Pennsylvania, etc., etc. Part VII. Eczema (pustulosum), Impetigo Contagiosa, Syphiloderma (papuloseum), Lupus Vulgaris. *Philadelphia: J. B. Lippincott & Co.* 1880.

LES HYSTERO-NÉVROSES et leurs Rapports avec l'Hystero-Névrose Menstruelle de l'Estomac par le docteur George J. Engelmann. Traduit de l'Anglais par le docteur Raoul Fauquez, Officier de l'Académie etc., etc. *Paris: V. A. Delahaye et Cie. Libraires Editoriales.* 1880.



OM SPETELSKA (elefantiasis Græcorum vel lepra Arabum). Af Med. D:r Fr. Eklund, Förste Bataljons-Lakäre vid Kongl-Flottans Station 1. Stockholm.

DEN MIASMATISKT-KONTAGIÖSA LUNGSOTENS och den kroniska lung inflammationens verkliga orsaker och medlen att förebygga dem, i största korthet framställda. af Med. D:r Fredrik Eklund.

NAGRA ORD om mina nyuppfunna metoder att göra fartyg helsosamma och omöjliggöra farsoters uppkomst och utbredning om skeppsbord jemte förslag till tidsenliga och högst nödvändiga hygieniska förbättringar a fartyg af Med. D:r Fredrik Eklund, etc. Stockholm, tryckt hos A. L. Normans Boktryckeri-Aktiebolag, 1880.

A NEW SCHOOL PHYSIOLOGY. By Richard J. Dunglison, A. M., M. D., Editor of Dunglison's Dictionary, etc., etc. Illustrated with one hundred and seventeen engravings. *Philadelphia: Porter and Coates.* 12mo., pp. 314; cloth, leather back.

TRANSACTIONS OF THE MEDICAL ASSOCIATION OF THE STATE OF MISSOURI at its Twenty-third Annual Session, Held at Carthage, Missouri, May 18th, 19th, 20th, 1880. *St. Louis: Davis & Freegard.*

ANÆSTHESIA BY ETHYL BROMIDE. By H. Augustus Wilson, M. D., Ophthalmic and Aural Surgeon to St. Mary's Hospital, etc., etc. Reprinted from the *Med. and Surg. Reporter*, Aug. 7th, 1880.

THE DANGERS INCIDENT TO THE SIMPLEST UTERINE MANIPULATIONS AND OPERATIONS. By George J. Engelmann, M. D., St. Louis. Reprint from Transactions of Missouri State Medical Society. 1880.

COLLEGE OF PHYSICIANS AND SURGEONS, MEDICAL DEPARTMENT OF COLUMBIA COLLEGE IN THE CITY OF NEW YORK. Seventy-third Annual Catalogue and Announcement. *New York, May, 1880.*

SCIENCE AND THE HEALING ART, or A New Book on Old Facts. By John Custis Darby, M. D., Mt. Sterling, Kentucky. *Louisville: John P. Morton & Company.* 1880. 8vo, pp. 403, cloth.

TRANSACTIONS OF THE STATE MEDICAL SOCIETY OF ARKANSAS AT ITS FIFTH ANNUAL SESSION. *Little Rock: James Mitchell,* 1880.

ANNUAL ANNOUNCEMENT OF THE DEPARTMENT OF MEDICINE AND SURGERY OF THE UNIVERSITY OF MICHIGAN FOR 1880-81. *Ann Arbor*: Published by the University, 1880.

ANNUAL REPORT OF THE HEALTH COMMISSIONER OF THE CITY OF ST. LOUIS FOR THE FISCAL YEAR 1879-80. *St. Louis*: Woodward, Tiernan & Hale, Printers and Binders. 1880.

PERSISTENCE THROUGH LIFE OF THE SOMATIC ELEMENTS. By John Stuart Woodside, M. D. Reprint from *Journal of Nervous and Mental Diseases*, July, 1880.

QUESTIONS Submitted to the Graduating Classes of the Medical College of Ohio from 1871-72 to the Present time. *Cincinnati*: C. R. Murry, 103 W. 6th St. 8vo, pp, 33; paper, 25c.

PREGNANCY VOMITING. By J. Marion Sims, M. D., LL. D. Reprint from the *Archives of Medicine*, June, 1880. *New York*: G. P. Putnam's Sons. 1880.



## TRANSLATIONS.

MICRO-PARASITIC INVASION OF THE ENTIRE BRAIN CORTEX.

Dr. Hugo Ribbert—Bonn.

In the municipal dead-house of the city of Bonn, a post-mortem made August 3, 1879, resulted in the discovery of a singular cerebral lesion.

The body was that of a man, *æt.* 64. He had been treated for sometime for emphysema, but eight days before death, had an apoplectic seizure, which resulted in right hemiplegia and marked disturbance of vision and hearing. No history of previous apoplexies. After this attack, the patient was rarely in condition to give rational answers, he was almost constantly delirious, made attempts at escape, etc. Up to the time of death, there were occasionally moments of consciousness.

Besides the emphysematous condition of the lungs and the usual senile changes in the heart and liver, the organs of the chest and abdomen presented nothing remarkable.

Removing calvarium and dura-mater, which offered nothing pathological, there could be seen through the pia, and more distinctly after its removal, a peculiar appearance over the whole surface of the cerebral hemispheres; the cerebellum did not present this appearance. White spots the size of a pin's head, and irregular lines and figures gave the brain a speckled look. The same phenomena were evident in the deeper part of the cortex.

As the brain was rather soft, further examination was deferred until it had been sufficiently hardened in alcohol, when sections demonstrated that the spots and lines were present throughout the cortex, but were not to be found in the medullary portion. On closer examination, it was found that the white markings always contained a central dark spot, which, on vertical sections, changed to a dark line that could be followed into the white substance, and then frequently joined a bloodvessel; the dark spots and lines evidently were bloodvessels.

The remarkable feature of the case is, that these vessels were crammed with microscopic bodies. Under the immersion lens they proved to be enlarged, about twice as long as wide; they were distinct, not forming chains. They were found only in the vessels.

The brain substance surrounding the vessels and giving rise through its altered nature to the *white markings*, exhibited only a slight cloudiness, commencing degeneration.

In the neighboring white substance also, some of the vessels contained the bacteria, while some of the cortical vessels were free; about these latter there was no secondary degeneration. In the finer vascular branches at the base of the brain, bacteria were found; sometimes mingled with blood, sometimes filling the vessels completely.

Numerous apoplectic cysts were scattered throughout the cerebral white substance, the left hemisphere containing the most and largest. The cysts varied in size from that of a pin's head to that of a hazel nut. The walls were smooth and firm; the contents, a yellowish fluid, clouded with delicate fibrinous flakes, and depositing in the deepest depressions a brownish red flocculent mass. Cysts of the size of a pea were numerous present in the left thalamus, less so in the right, still less numerous in the pons; none in cerebellum.

The bacteria could not have arisen through putrefaction. Against such a supposition the general condition of the body which did not exhibit marked decomposition, the presence of the bacteria only in the vessels, and the peculiar parenchymal changes—all protest.—(Virchow's Archives, Vol. 18, p. 505).

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#### SUDDEN INTERMITTENT SWELLING OF THE PAROTID GLAND.

At a meeting of the *Société de Chirurgie*, held April 28th, Mr. Terrier communicated an interesting fact which he had recently observed. A man, aged 35 years, was taken suddenly in eating with considerable augmentation of volume of the parotid region. In exploring the course of Steno's duct, he found no dilatation of this canal, but he saw at the opening of the canal, an aphthous appearance; the extremity of a stylet penetrated freely into the interior of the canal without meeting any obstacle. At the moment when the stylet was withdrawn, an abundant flow of saliva occurred and the tumefaction disappeared completely. At the evening meal a similar swelling was produced, but much less considerable. The next day the same phenomena were renewed though noticeably less, then, little by little, everything returned to a normal condition. In searching to see if analogous facts have been observed, M. Terrier has found cases of tumefaction produced by tumors compressing the duct of Steno, or by calculi obliterating the caliber of the duct, or by strictures of the same duct, or, finally by compression of the canal, made with a view to the cure of salivary fistula; but he has seen nothing like this tumor, produced by the ulceration of the opening of the duct of Steno, with consecutive spasm of the layer of muscular fibres of the canal causing arrest and accumulation of the saliva.

These facts, rare for the parotid, are more common for the submaxillary gland. Obliteration and consecutive swelling of the ducts of Wharton, have been observed quite frequently, consequent upon inflammatory exudations situated at the site of the opening of this duct.

M. Desprès said that he had seen at l'hôpital du Midi, a wine

merchant's boy whose cheek swelled at each meal. From the first mouthful that the patient ate the swelling occurred, and the parotid gland gained the size of an apple; then, after the meal, the swelling would completely disappear. In examining the buccal cavity, M. Desprès recognized that the orifice of Steno's duct was almost obliterated. He succeeded, however; by the aid of an extremely fine stylet, in penetrating into the interior of the duct; every day he practiced dilatation for about a quarter of an hour. At the end of a month, the swelling diminished considerably, and ended by complete resolution. M. Desprès thinks that this is due to the obliteration of the orifice of the canal of Steno by ulcero-membranous stomatitis at this orifice. He has observed an analogous fact after an operation of ablation of a tumor of the floor of the mouth; this is, moreover, a very frequent cause of swelling and dilatation of the submaxillary gland.

M. Dentu said that he had observed two similar cases of intermittent swelling, in which, however, he was unable to determine any cause whatever for the condition.

M. Verneuil said that, aside from such causes of obstruction as the inflammatory swelling and the foreign bodies which produce these phenomena, the obliteration of the duct of Steno may be due to a spasm, pure and simple, of this duct. By an anatomical arrangement common to all excretory ducts, the canal of Steno is provided with a constrictor apparatus which may contract even under slight irritation; the liquid excreted is then retained in its reservoir, and, if the spasm terminates suddenly, a flow of saliva occurs more or less abundant and more or less energetic; this is what occurred in the patient of M. Terrier when this surgeon terminated the spasm by the pressure of the stylet.

We know how common it is to see spasm of the sphincters of the lids, of the anus, of the vagina, succeed to the irritation, even very slight and superficial, of the mucous membrane beneath them: it is the same with the muscular tunics of the excretory ducts. M. Verneuil thinks that in M. Terrier's case there was simple spasm of the muscular tunic of Steno's duct, due to the existence of an aphthous ulceration of the orifice of this duct. He had seen analogous cases, and he considers that this cause of temporary obliteration of the canal of Steno merits special attention.—*L'Union Méd.* June 26, '80.

## REPORTS ON PROGRESS.

## SURGERY.

**Lead Wire for Sutures.**—DR. HILL, of Augusta, Me., reports his experience in the use of lead wire sutures for a period of twenty-five years; he has used only lead wire during that time in all operations where metal sutures were preferred. He gives his conclusions as follows: The wire has never failed to remain without the slightest ulceration, any length of time required to complete a cure. Any size of wire may be used. A very easy way of introducing the wire is to shave off about half the thickness at one end and bend it over a short loop of thread passed through the eye of a needle. In confining the stitch the ends may be twisted, bent, or hooked together; either is safe. Lead wire is very pliable, easily put into any shape desired, and is amply strong for any purpose. It is especially good for perineorrhaphy and operations of that kind.—*Bost. Med. and Surg. Jour.* Aug., 1880.

This mention of lead sutures lead us to refer to the fact that stout single hairs taken from the tail of a horse are used exclusively by some surgeons for uniting the skin and mucous membrane after the operation of circumcision, and are undoubtedly the best for that purpose.

**Perityphlitis.**—DR. H. B. SANDS publishes a paper upon this subject in the *Annals of the Anatomical and Surgical Society of Brooklyn*, for July, 1880.

In this paper, while the author gives his hearty support to the plan of treating perityphlitic abscess by early incision, he lays special stress upon the fact that many severe cases tend to spontaneous recovery, and he calls attention to the necessity of carefully distinguishing whether a given case demands operative interference or not. The paper deals only with those cases of inflammation of the cæcum in which the disease is circumscribed, excluding those in which general peritonitis follows rapidly upon perforation of the appendix or cæcum, as these latter are beyond the reach of art, and therefore, devoid of surgical interest. Twenty-six cases are cited, divided into four classes:

1. Cases terminating in resolution without evidence of suppuration, (10 cases.)
2. Cases of abscess terminating in spontaneous recovery, (3 cases.)
3. Cases of abscess treated by operation, (11 cases.)
4. Cases of abscess unopened and ending fatally, (2 cases.)

Inasmuch as many persons believe that perityphlitis, when once established, must necessarily go on to the formation of abscess, Dr. Sands shows his diagnosis to have been carefully made out in the first group of cases, those without suppuration. In all, the following symptoms were present,

namely: Abdominal pain and tenderness, sometimes limited to and always most marked in the region of the cœcum; fever, the temperature being from 100° to 104°; and the presence of an indurated swelling distinguished by palpation in the iliac fossa or by digital exploration of the rectum. In all instances the tumor was deep-seated, immovable, and tender on pressure. In half the cases resolution began between the fifth and eighth days, and in only one case was it delayed beyond the fourteenth day. In some cases the tumor subsided so rapidly as to suggest that an abscess had been ruptured, although a careful examination of the urine and feces failed to detect any blood or pus. In most cases, however, the subsidence of the tumor was gradual, and in one instance nearly five months elapsed before the disappearance was complete.

So far as the early symptoms are concerned, the author finds nothing to distinguish the cases of this group from those which are destined to go on to suppuration; he therefore, advises delay before giving a definite opinion. It is only when resolution is delayed to the tenth, twelfth, or fourteenth day, usually, that the question of surgical interference comes up.

Rigor, sweating, high temperature and pulse, abdominal pain and tympanitis, and an increasing extent combined with diminishing firmness of the tumor, are the chief signs of the formation of pus; whereas, if resolution is to take place, toward the close of the second week the course of the disease is mild and favorable.

In the eleven cases treated by operation, the knife never failed to penetrate an abscess except in one instance, and in one case only was there a fatal termination. The method of operation recommended, is the division cautiously of the aponeurotic and muscular layers of the abdominal wall until the abscess is reached or the transversalis fascia is exposed. If, after the transversalis fascia is exposed, fluctuation is evident, the abscess may be opened; if there is no fluctuation, the fascia should be penetrated in various directions by means of a hypodermic syringe till the seat of the abscess is discovered, when a narrow bistoury may be entered along side of the needle. An external incision of two inches will give room enough, and the wound should grow narrower as it goes down. This careful and cautious method is strongly recommended by Dr. Sands in preference to that of plunging a bistoury at once into the abscess. The usual treatment is followed after operation.

It is to be observed that the author has omitted one important means of diagnosis, which should be available at least in New York, and this omission prevents his paper from being complete. When it is a question whether *confined* pus is present in any given case, that is, whether an abscess exists with no outlet, the question can be settled by a careful reckoning of the blood corpuscles by means of a hemacytometer. If *confined* pus be present, the ratio of the white to the red disks will be greater than normal.

**Suturing Divided Nerves.**—DR. L. S. PILCHER calls attention to this subject, claiming that in all cases of division of the nerve trunks there is no reason to expect any evil result from uniting the extremities by sutures. In many cases the sutures need be inserted only in the nerve sheath, but, if necessary to obtain sufficient hold, they may be made to traverse the entire thickness of the nerve. Without the use of sutures, although there are no

record many instances of spontaneous reunion of nerves, in no case has the surgeon a right to expect such a result.

Among other cases cited in support of this view, is a remarkable case of suture of the sciatic nerve, by Von Langenbeck. Two years after the accident which divided the nerve, the patient presented himself at the clinic; the right leg was much wasted, complete insensibility occupied the outer half of the foot and leg, and there was halting lameness caused by dragging the flaccid limb. The nerve was exposed by dissection, and the cut ends were found to be two inches apart, both being in a bulbous condition. The ends were refreshed and fastened together by two catgut sutures. No unpleasant symptoms followed, and at the end of two months great and progressive improvement was apparent.

Dr. Pilcher says that the uniform benefits and freedom from dangerous or unpleasant complications attending these cases, encourage a more general practice of immediately fastening together by sutures the ends of divided nerve-trunks. Fine carbolized silk or catgut sutures may be used.—*Annals Anat. and Surg. Soc. of Brooklyn*, July, 1880.

**Burns and Frostbites.**—DR. G. H. BOYLAND in discussing this subject, classifies burns under three heads by a difference in degree: 1st. Inflammation without exudation under the epidermis. 2d. With exudation, blisters, etc. 3d. Death of the parts, gangrene. Frostbite is said to admit of an identical classification and the progress of the affection is regarded as almost precisely the same, although the processes brought about by burning are more of an acute and active character, while those caused by freezing are more torpid. Attention is also called to the fact that the most intense effect of cold upon the general system (frost asphyxia) is doubtless due to the same direct cause as sunstroke, namely, congestion of the brain.

Dr. Boyland makes his treatment consistent with his pathology, treating both affections at first by cold. He gives bicarbonate of soda its proper place, however, as practically the best dressing for all ordinary burns.—*Med. and Surg. Reporter*, July, 1880.

**Heaton's Operation for Hernia.**—DR. W. H. PHILIPS, in *The Toledo Medical and Surgical Journal*, June, 1880, contributes a paper strongly recommending Heaton's operation, and giving his own experience, which unfortunately has not been large. However, every publication should be welcomed which calls attention to this valuable and much neglected operation.

When Dr. Heaton published his book in 1877, he gave a report of 140 cases, selected, as he says, from many hundreds of successful cases that he might have reported. In all, permanent cures were obtained. The names and post-office addresses of the patients were given, that surgeons might satisfy themselves of the facts. In spite of this the book fell flat, or, as one writer says, *still born* upon the profession. Those who tried to induce surgeons having hospital appointments in Boston and New York, to test the operation, failed to arouse their interest, in spite of the somewhat startling disclosures by Dr. Heaton.

Those who have not access to Dr. Heaton's book will find all necessary information in a paper by Dr. W. B. DeGarmo, in *New York Med. Rec.*, Vol. xvii, No. 6, 1880, and in the communication cited above.

The neglect of Heaton's method in the hospitals, ought to be a stimulant



to surgeons apart from the medical centers to give it a trial, especially as they almost always have access to many cases suitable for operation; more over the instrument is cheap—it is figured in the *New York Medical Record* Vol. xvii, No. 6, 1880—and little or no assistance is required.

Dr. Heaton directs the operator to proceed as follows: “Invaginate the right forefinger in the scrotum and find the external abdominal ring, then with the left forefinger press perpendicularly upon the integument directly over this ring, and use sufficient force, if possible, to press the integument together with the finger directly into the ring. The spermatic cord and the sac, if in the way, are pushed to one side, so that nothing may remain between the external pillar of the ring and the finger, except the integument and superficial fascia. Keeping the left forefinger thus at or in the ring, take the instrument in the right hand, introduce its freshly sharpened and polished beak, quickly penetrating the integument and superficial fascia, just passing, but not grazing the external pillar, and entering the canal at once, then remove the left forefinger and gently insinuate the beak further on, well into the canal. Having satisfied himself that the beak is in the canal, the surgeon then deposits about ten minims of the liquid irritant, emitting it drop by drop, and spreading it as much as possible.” The formula for the irritant is as follows:

R. Fl. Ext. Quercus albæ,	ʒiv.
Ext. Quercus albæ (solid)	gr. xiv.
Morphiæ Sulph.	gr. jss.

**Peachstone in the Intestine for Seven Months.**—DR. R. B. MORRISON, of Baltimore, publishes full notes of the case which may be condensed as follows:

On July 23, 1879, the peachstone was swallowed. August 17—severe abdominal pain for first time, a lump found, size of a small egg at border of rectus muscle, on a level with superior spinous process of the ilium. For two weeks bowels regular, but pain in abdomen continued. Temperature 101°; pulse, 100.

In October the patient was obliged to keep his bed. The lump always present, though less in size. Marked emaciation and failure of strength, no sufficiently good signs of pus to justify operation.

January 13.—Pus to the amount of two ounces drawn off by the aspirator and a free incision made into the tumor. Nothing hard could be detected in the cavity.

February 19.—The patient died after having suffered for some time from symptoms of septicemia.

*Autopsy.*—In the alveolar tissue connecting the ascending colon with the lumbar fascia five ounces of fetid pus was found.

No sign of peritonitis.

Posterior external surface of cœcum and ascending colon for a space three inches square, was firmly bound down in the iliac fossa by thick adhesions. Vermiform appendix, ileocœcal valve and ileum normal. A blackened peachstone was found lying free in the colon just above the ileocœcal valve; the bed of the stone was an ulcer on the posterior internal surface of the colon, of irregular outline, three inches square, with thick raised edges, full of pultaceous fungosities.

C. W. COOPER.

## THERAPEUTICS.

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**Iodine in Malarial Fever.**—Fordyce Grinnell, M. D., says that while he was occupying the position of Government physician at the Wichita Indian Agency, he treated 135 cases of intermittent fever with ten drop doses of tincture of iodine in a third of a glass of sweetened water, three times a day, with the most beneficial results. He says "The remedy seemed to act almost as by magic; in many instances the paroxysms were not repeated after the medicine was given.—*Southern Practitioner*, July, '80.

**Volkman's Antiseptic.**—Many surgeons have substituted thymol for carbolic acid as an antiseptic. Volkman uses the following solution for both operations and dressings:

Thymol, 1 part,  
Alcohol, 10 parts,  
Glycerin, 20 parts,  
Water, 100 parts.

[*Jour. de Phar.*, Apr.]

**Potassium Nitrite.**—Nitrite of amyl has proved to be an agent of such great value in warding off attacks of epileptic convulsions, angina pectoris and asthma, that the discovery of any preparation, the psychological action of which would prove to be identical, but whose effects would be more lasting and therefore more suitable for continuous administration, would be hailed with delight by the profession.

Dr. S. Weir Mitchell and Dr. Reichert have been making a series of experiments for the purpose of discovering such an agent. Dr. Mitchell found in testing the alkaline nitrites on himself, in doses of four to seven grains, that they caused acceleration of the heart's action and a sense of fulness, flushing of face and sometimes of extremities. He is now trying them in epilepsy, believing from their psychological action that they will prove beneficial. He suggests their use in the chill of ague, and in asthma and eclampsia.

Dr. Reichert, demonstrator of experimental therapeutics in the University of Pennsylvania, says the local action of potassium nitrite is in all respects identical with that of the amyl nitrite, excepting that it is irritating. After having made many experiments on the lower order of animals and taken into consideration S. Weir Mitchell's experiments, he comes to the conclusion that the identity of the psychological action of the potassium and amyl nitrites has been clearly demonstrated.—*Amer. Jour. Med. Sciences*, July, '80.

**Coca in South America.**—Dr. Geo. A. Ward, in a letter to the *Record*, says that, from personal observation and experience extending over a period of eight years, in the districts where coca grows, he would say "That the great encomiums lavished upon its use are all bosh."

He says tobacco is better to prevent hunger—it prevents thirst, in a measure, and chewing a bullet will do the same—it relieves colic, promotes digestion and excites the genital functions.

He says the Indian there chews coca as the American chews tobacco; its

use being limited and confined principally to the males.—*N. Y. Med. Record*, May 1, '80.

**Quinine and Wine in Cholera Infantum.**—Dr. Böing reports having treated fifty cases of cholera infantum without a death, by the administration of fifteen grains of quinine in twenty-four hours to a child five months of age, and about twenty grains in the same length of time to a child from five to ten months of age, and from twenty to thirty grains to a child from one to four years of age. Tokay wine was used in one-half to two teaspoonful doses every fifteen minutes, diluted with as much water for the younger children. He persisted in the treatment, notwithstanding the vomiting, until the stomach retained what was administered. Boiled milk was given diluted with an equal amount of boiled water. He considers calomel opium and cold applications dangerous remedies.—*Allg. Med. Cent. Zeit.*

**Potassium Iodide in Scarlet Fever.**—Dr. W. S. Watson of New Holland, Ills., says he has found potassium iodide a very efficient remedy in the treatment of scarlet fever. He says: "Since using the potassium iodide as advised by Dr. J. P. Walker of Mason City, some four years ago, I have not seen the disease spread as before its use. I have often had a typical case in a family of five other children of various ages, not one of which was confined a day to the bed. I have all faith in iodide of potassium as having a controlling power over the infection, and also in preventing the usual sequelæ of this affection." He gives about one grain every three hours to a child five years of age.—*Mich. Med. News*, July 10, '80.

**Bromide of Ethyl as a Local Anesthetic.**—M. Périer of Paris has used bromide of ethyl successfully as a local anesthetic in a number of instances. In consequence of its non-inflammability it can be employed when the actual cautery is to be used.—*La France Médicale*.

**Iodide of Ethyl for Dyspnea.**—According to Dr. Robt. M. Lawrence, of Boston, iodide of ethyl exerts a special influence on the respiratory function, and, when inhaled, has the power of relieving certain forms of dyspnea. It seems to act as an anti-spasmodic, by relaxing the muscular contraction of the bronchial tubes. In dyspnea of bronchitis and of chronic affections of the air passages, it promotes a free mucous secretion. The drug is administered by inhalation; a small vial containing half a drachm being applied to the nostrils. The inhalations are continued for ten minutes at a time, thrice daily or oftener.—*N. Y. Med. Rec.*, June 19, '80.

**Potassium Iodide in Hepatic Affections.**—Dr. Jno. Guitéras has used the iodide with good effect in chronic interstitial hepatitis, with enlargement followed by jaundice; also in inflammation of the larger biliary tubes, produced by the passage of stones through the common duct; in sub-acute catarrhal jaundice. In all of these cases the drug was administered in large quantities of water during fasting.—*Phila. Med. Times*, June 5, '80.

**Hydro-Therapeutics in Neuralgia.**—Beni Barde recommends an alternate stream of hot and cold water thrown forcibly against the affected part. He begins with warm water and gradually increases the temperature to the highest point at which it can be borne, and then suddenly withdraws the hot and substitutes the cold stream. He concludes the treatment with a general cold douche, if it can be borne.—*La Revue Méd.*, Vol. I, No. 1.

Dr. Norwood on the Action of *Veratrum Viride*.—W. C. Norwood, M. D., says *veratrum viride* meets many, if not all, the prominent indications in disease. It produces the very opposite effects, and therefore becomes the counter-agent of all diseases. He says in all cases it renders a frequent and weak pulse slow, full and distinct; a flushed, hot and dry surface, more or less pale, cool and moist. This it does without exciting the least nausea or vomiting, by giving to an adult male five drops and increasing the dose one drop every third hour, till the pulse is reduced to sixty-five beats per minute. When the pulse is decreased to sixty-five, do not increase the drops. It may be kept at sixty-five indefinitely, without vomiting or nausea.

He says it is the only agent that will render the rate of the pulse slower, in health, than natural and not diminish its fulness and strength. It never renders a pulse weak in health or disease, except when given in doses sufficiently large to nauseate and vomit. It is destitute of all poisonous effects in any dose, large or small. No ill effects have followed a two ounce dose.—*Southern Clinic*, July, '80.

J. P. KINGSLEY.

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## OBSTETRICS.

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Obstetric Forceps and Ruptured Perineum.—DR. C. E. STEDMAN said at a recent meeting of the Obstetrical Society of Boston, that he had made some inquiries concerning the frequency of perineal laceration as related to the more general use of the forceps during the last ten years, and had received the following memoranda: "My experience is that nine-tenths of complete ruptures of the perineum are caused by the use of the forceps.

WM. GOODELL."

"I should not make the proportion quite so large, for many ruptures occur in delivery of head and arms in head-last labors; but I should say that lacerations in the second and third degrees have been greatly increased in frequency by the more frequent use of the forceps, which has characterized obstetric practice during the last decade.

T. G. THOMAS."

DR. LYMAN said that he was astonished at the statements of Goodell and Thomas. Of the many cases seen at the City Hospital, almost all had been delivered without forceps. An occasional bad rupture has no doubt been so caused, but not the vast majority. It should be noted that until recent years the laboring class had not been examined for this lesion so frequently as now.

DR. FORSTER had seen several cases of rupture where forceps had not been used, very few where they had.

DR. ABBOT had employed the forceps in ten and a half per cent. of his cases for the last twenty years, and only regretted that he had not used them as freely before. The worst laceration that he ever saw, occurred in a case where the child was born before the physician arrived.—*Bost. Med. and Surg. Jour.*, May 27, '80.

**A Monstrosity.**—DR. W. W. HENDERSON presented to the Obstetrical Society of Cincinnati a remarkable monstrosity of which he had delivered a patient shortly before. From his account, and the report of Dr. T. A. Reamy, who was appointed a committee to examine the specimen, the following account is taken:

The mother supposed herself to be eight and one-half months pregnant, but had felt no movement of the child for six weeks. Besides the monstrosity there was also another child, well formed in every respect, and attached to a placenta in the natural method by an umbilical cord.

The monstrosity consisted of a child, naturally formed from a point about midway between the crest of the ilium and the acetabulum downwards, showing the legs and other parts well developed, but in a state of partial decomposition. From this point upwards is a mass of flesh, natural in appearance so far as the skin is concerned. This mass of flesh completely enveloped the upper part of the body of the child, hiding from view the arms head and other parts so completely that we could not determine whether there was anything other than what we could see. Opening this mass, however, revealed the rudimentary parts of a child in about the same decomposed state that we found the lower extremities. Upon the upper part of this mass of flesh we found on each side, corresponding to points opposite to the ears, two abraded surfaces which had the appearance of having had some connection with the uterus previous to delivery.

This mass already described had the appearance of living tissue. It was about six inches in diameter, including the skeleton of the child, and about fifteen inches in length. There was no umbilical cord or other appearance of maternal connection other than the abraded surfaces above described.

The tissue of the unnatural parts seems to have been in a living state up to the time of accouchment; whilst the lower limbs and the body of the child contained within the living mass, were in a state of disintegration.

There was an enormous redundance of skin, and great extent of surface. If all the folds and duplicatures had been smoothed out, the supply would have been sufficient to coat a child twelve years old. But such was the irregularity of development that the garment could by no means have been made to fit the form of anything, living or dead, that I ever saw.

Section of the skin at a point near what would have been ordinarily the axillary fold, showed it to be from 3-4 to 1 inch thick. Subsequent examination of a small section of the skin showed it to contain fibrous bundles of areolar tissue, some perfect, some in process of formation, with fat globules in the inter-space.

These conditions, I think, warrant me in pronouncing this a case of "elephantiasis lymphangitidis."

The inferior maxilla was perfect; the superior entirely wanting; the cranial bones all present, but very imperfectly ossified, even for the fetus at term. They were also deficient in extent of development, especially those of the vault. The posterior orifices of communication between the orbital and cranial cavities were unusually large; the eyes entirely wanting. The anterior orifices of the orbits were covered by a thin layer of skin, which was continuous with that covering the entire surface. On opening the cranial cavity the dura-mater was found unusually thick and not firm. The brain

substance was more pulpy by far than usually found at term. The lobes could not be made out; nor could any distinction be drawn between cerebrum and cerebellum, there being no falx nor tentorium. The quantity of brain substance was not sufficient to fill the cranial cavity, especially deficient in the frontal region.

Attempting now to open what I supposed to be the thoracic cavity, I found only thickened integument with adipose tissue surrounding the vertebral column, there being no sternum, no ribs, clavicle or scapula in this region. Extending my incision downward to the lower part of the trunk, I encountered at the level of the sixth vertebra, the upper border of a sternum, to which was attached on the right side a clavicle; none on the left. But further examination disclosed, at a level corresponding with these structures, two normal scapulæ, the right one in articulation with the clavicle, the left having no bony attachments. The sternum was found to extend down to the pubis. On either side were found twelve ribs, which articulated posteriorly with the five lumbar and lower seven dorsal vertebræ, the three lower ribs extending only about half way to the sternum, corresponding to the floating ribs.

These ribs were exceedingly small and soft. They were so short, and so sharply bent as to allow but little space between the attached sternum and the spinal column. This cavity above the pelvis, which would correspond with the abdominal, was quite small, and contained nothing, save at its upper portion, in which was found a liver, small in size, void of any gall-bladder or duct. From the liver, which lay on the right side of the spinal column, was found passing upward and obliquely forward to the left, an artery and vein. These vessels, however, could be traced to no special point, being apparently lost in the tissues composing the anterior wall. There were no intestines found, no pelvic organs, and no stomach, heart or lungs, and no apology for either; no kidneys; in short, all organs, thoracic, abdominal or pelvic, save the liver were wanting. The pelvic bones were perfect in form, but unusually small and quite soft. The lower extremities were nearly normal; external organs of generation not sufficiently developed to determine sex.

Cutting into the masses which appear on either side, there was found on each side a humerus articulating with the corresponding scapula at the glenoid cavity; on the left side the radius and ulna of proper size and articulation, with an attempt at a hand; on the right side bones of forearm and hand absent.

The total absence of an alimentary canal and of mucous membrane, together with the almost total deficiency of circulatory apparatus, would seem to imply that whatever causes may have acted thus early in fetal life, completely arrested all physiological development from the middle and internal layers of the blastodermic membrane. The external seems to have been influenced to a less degree, since there was abundance of skin and a fair supply of bone, although the formation and arrangement were quite symmetrical. The disturbing influences must have commenced at a very early period of gestation.—*Obstet. Gazette.*

## SOCIETY PROCEEDINGS.

## AMERICAN GYNECOLOGICAL SOCIETY.

The fifth annual meeting of the American Gynecological Society has just been held at Cincinnati, the sessions occurring on the 1st, 2d, and 3d insts.

It was not a large meeting, less than half the members of the society being present. About the same number of gentlemen from Cincinnati and Covington, with a few from other cities were invited to sit with the society and take part in the discussions, and a general invitation was extended to the profession to attend the meetings.

On Wednesday morning at 10 A. M., the society was called to order, and after roll-call, an address of welcome was made by Dr. T. A. Reamy, of Cincinnati.

The first topic of discussion as announced by the programme, was, "What is the Proper Field for Battey's Operation?" by Dr. Robert Battey, of Georgia, who first advocated and performed the operation which has excited so much interest in this country and abroad during the past few years. He had not written out a paper, but spoke from brief memoranda, taking the same ground that he has hitherto maintained in regard to the indications for the operation, which he specifies as follows: 1. Absence of uterus with unrelieved menstrual molimina. 2. Occlusion of metro-vaginal canal. 3. Ovarian or menstrual mania. 4. Ovarian epilepsy. 5. Amenorrhœa with menstrual molimina, destroying the health and happiness of the patient. 6. Submucous and interstitial fibroids with severe hemorrhage in cases where the tumor cannot be removed. 7. Incurable flexions which are not amenable to other treatment. 8. In case of Cesarean section being performed, he advises the removal of the ovaries.

Discussion on this subject was taken part in by Drs. Wilson, Byford, Wood, Sims, Dunlap and Barker. Dr. Byford does not think that the relief afforded by the operation is always permanent. He has under his care a lady who was operated upon in

Canada, and reported as cured, but her condition now is as bad as ever. The operation was performed for the relief of hemorrhages dependent upon uterine fibroids, but they were not permanently arrested by the removal of the ovaries.

Dr. Sims says, that the operation has been performed by few in England, the first time in 1878, twenty-eight times by one operator in the last eleven months with two deaths. He has himself recently operated four times. Two cases of menstrual epileptoid convulsions were cured. One died from influence of bromide of ethyl. The fourth has been little benefited.

Dr. Drysdale asked how far removal of both ovaries is efficient in procuring the menopause, to which Dr. Battey, in concluding the discussion said that he thinks this result always follows as an immediate result.

Dr. Geo. J. Engelmann's paper on "Two Cases of Anterior Displacement of the Ovary, Simulating Internal Inguinal Hernia, Battey's operation," was the next upon the programme. The first of these cases is that of a young woman upon whom Dr. Engelmann has operated, removing the prolapsed ovary, with a result, so far, quite satisfactory. The other case is that of a woman forty-six years old, who has suffered all through her menstrual life from nervous symptoms which have brought her at times to the verge of insanity. It is a question whether the removal of the ovary now would be of any material advantage, inasmuch as the nervous system has already been so profoundly affected. Furthermore, there are such evidences of the advent of the physiological menopause, that there is probably no ground for incurring the danger involved in the operation for promoting it artificially.

In the discussion, Dr. Barker gave some interesting particulars of three cases of anterior prolapse which he has seen. Dr. Wilson knows of one case on which he intends to operate soon.

The morning hours having already elapsed, the society adjourned and partook of an elegant lunch provided for them at the residence of Dr. T. A. Reamy.

They assembled again at College Hall in the afternoon, and first heard a paper by Dr. H. P. C. Wilson, of Baltimore, on a "Case of Ovariectomy Complicated with Pregnancy." The result of the case was a complete success, both mother and



child being saved. He has collected reports of twenty-nine cases, in twenty-four of which the mother recovered, and in twenty the child was saved.

This paper elicited much and animated discussion by members and invited guests. Dr. Chadwick has seen several cases of small ovarian tumor and one large one, where the patient was safely delivered without interference with the tumor. Dr. Dunlap favors the induction of abortion where pregnancy is complicated with ovarian tumor. Dr. Byford thinks the best course is to tap the tumor now and then, and not to perform the major operation until after delivery.

Dr. A. R. Jackson read a paper on "Uterine Massage as a means of treating certain forms of Enlargement." He finds it valuable in cases where the uterus lies low in the pelvis and is spongy and distended, not where the organ is firm and hard. The massage may be applied in three ways: First, externally upon the abdomen alone; second, by combined manipulation by the vagina and abdomen; and lastly, by the rectum and abdomen, with slowly increasing force, always commencing with manipulation of the abdominal walls. He does not often find occasion to use the third method.

In the evening the profession of Cincinnati gave a banquet to the society at the Grand Hotel. Nearly one hundred and fifty physicians sat down to the table, where attention was given exclusively to the refreshments for the inner man, as there were neither toasts nor speeches.

Thursday morning the session commenced at 10 o'clock, taking up the unfinished programme of the preceding day. The first paper was by Dr. Sutton, of Pittsburg, "A case of Cataleptic Convulsions Cured by Trachelorrhaphy." This was followed by a paper from Dr. Byford, of Chicago, "Extirpation of an Encephaloid Kidney."

"The Value of Quinine in Gynecic and Obstetric Practice," by Dr. Campbell, of Augusta, Ga., led to considerable interesting discussion. He denies *in toto* the ground taken by many, that quinine is an abortifacient, and claims that in malarial regions a judicious but liberal use of quinine is absolutely essential to prevent abortion. Most of those who spoke upon the subject supported him in the main.

The next item upon the programme was the "Fifth Annual Address," by the President, Dr. J. Marion Sims. He alluded

to the brilliant career of this young society, and to the value set upon its transactions at home and abroad. He made some suggestions as to changes to be made in the constitution of the society, which, however, did not seem to meet the approval of the Fellows.

At the adjournment at one o'clock, the society were hospitably entertained at the residence of Dr. Henderson, of Covington, Ky., which gave the visitors an opportunity of seeing the suspension bridge and something of the beauty of Covington. About thirty-five physicians enjoyed the occasion.

In the afternoon session the whole time was taken up by the presentation and discussion of a paper by Dr. Geo. J. Engelmann, of St. Louis, "The Instinctive (or natural) and Physiological Position of Woman in Labor." The paper was very long and Dr. Engelmann "talked" most of it without the manuscript. The allotted half hour having expired, another half hour was granted by vote of the society. He presented numerous skilfully prepared drawings<sup>1</sup> illustrating the various positions taken by the women of different ancient, modern, civilized and uncivilized nations during the act of parturition, which he classified as perpendicular, inclined, and horizontal. He concludes that the natural, and therefore, best position, is the semi-recumbent or one of its varieties, kneeling or squatting.

The discussion that followed was quite lively, and Dr. Campbell's remarks were exceedingly humorous.

Dr. W. W. Dawson gave a brilliant reception in the evening to which were invited the members of the society and of the general profession of Cincinnati, Covington and Newport and other guests, together with their wives.

Friday morning after the business meeting held at 9 o'clock, the open session commenced with a paper by Dr. Parvin, of Indianapolis, on "Secondary Puerperal Hemorrhage," showing thorough research, careful thought and happy expression.

In the discussion of the paper, Dr. Barker called attention to the fact that malarial poison is a not infrequent source of secondary hemorrhage. It is a matter of considerable interest that malarial affections are increasing in frequency and severity in New York City and other points along the eastern sections of New York State and southern New England.

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1. These drawings were prepared for Dr. Engelmann by the well-known artist, Carl Gutherz.

Dr. Howard's paper, "Three fatal cases of Rupture of the Uterus with Laparotomy," was the next upon the programme. He says, that of fifty cases of laparotomy only twenty have succeeded, which, however, is a better record than the old operation, where there was only one success in twenty-one cases. Drs. Wilson, Parvin, and Campbell took part in the discussion.

Another meeting with closed doors was held at two o'clock. At half past three the doors were opened and Dr. Chadwick, the secretary of the society, read a paper on "The Hot Rectal Douche." He claims great superiority of injections of hot water into the rectum over similar injections into the vagina as a means of treatment of inflammatory affections of the rectum, uterus and peri-uterine tissues. He says that the intestine filled with hot water acts like a large poultice, relieving pain, backache, difficulty in defecation, etc., etc. The water should be used at as high a temperature and in as large quantities as can be borne.

The discussion which followed was taken part in by Drs. Howard, Campbell and Reamy.

Dr. Reamy was next on the programme with a paper on "Ulceration of the Cervix Uteri," but as it was growing late, he gave way to allow the reading of a paper by Dr. Eve, of Augusta, Ga., which had been sent to the secretary. Afterwards Dr. Reamy stated the leading points of his own paper which he said was too long to read then. Some other papers were announced upon the programme but were not read before the society.

The meeting was brought to a close with a brief address by Dr. Sims, in which he thanked the Fellows for the courtesy shown to him, and with well deserved compliments to Dr. Byford, of Chicago, introduced him as the president elect for the coming year.

The next meeting of the society is to be in New York City on the third Wednesday of September, 1881. The officers for the year are: Dr. W. H. Byford, of Chicago, President; Drs. T. A. Reamy, of Cincinnati, and H. F. Campbell, of Augusta, Ga., Vice-Presidents; Dr. Jas. R. Chadwick, of Boston, Secretary; Paul F. Mundè, of New York, Treasurer; Drs. A. H. Smith, of Philadelphia, J. C. Reeve, of Dayton, O., G. H. Lyman, of Boston, and J. T. Johnson, of Washington, D. C., Council.

ST. LOUIS OBSTETRICAL AND GYNECOLOGICAL  
SOCIETY.

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Stated Meeting, June 17th, 1880. Dr. Boisliniere, President, in the Chair.

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Discussion of Dr. Prewitt's paper on Post-partum Intra-uterine Injections. See page 217.

*Dr. Engelmann.*—I must confess, for my own part, that I am not positive as to the cause of death or even of those alarming symptoms which are occasionally seen to follow intra-uterine injections. There are two causes which are plain, I think—one is shock, the other is the possible escape of a portion of the injected fluid through the Fallopian tubes into the peritoneal cavity. As to all the other reasons assigned, I take them to be purely theoretical, and I do not think that any one of them can be positively proved. There are some who say that in case of alarming symptoms following the injection of the non-gravid uterus or the non-puerperal uterus, the mischief is caused by the forcing of air into the cavity. I will confess that I do not see how air could enter in sufficient quantity to do any harm with the unabraded mucous membrane lining the entire cavity. Let us suppose that a little air did get into the cavity of the uterus; where does it go? It cannot escape into the vessels as the mucous membrane completely covers the entire surface. In the case of the puerperal uterus, the os is large enough to admit the passage of two or three fingers. If the nozzle of the syringe is now introduced into the cavity, how can we suppose that air can be forced into the occluded or contracted sinuses? Will it seek to enter imaginary spaces into which it would have to be driven with force and the use of great precaution, or will it escape through the great, large os? It will most assuredly seek the easiest way out, and that is through the uterine cavity, the cervical canal and the greatly enlarged os. It cannot, whilst this path is open, by any possibility force its way into the uterine sinuses. If you were to make an effort to inject the uterine sinuses, you would be obliged to constrict the os with the greatest care, and then you

would probably be unsuccessful. I do not admit that with a dilated cervical canal and a dilated os, it is possible to inject air into the uterine vessels; it is bound to escape through that great patulous os. I agree with Dr. Prewitt that, under certain conditions, injections into the puerperal uterus are permissible, and must even be made. I think that it is hardly possible that death should occur from any other cause than shock or the injection of fluid through the distended Fallopian tubes. Whilst you cannot prove that injury has been caused by air entering the peritoneal cavity, it has been done by perchloride of iron. When the discussion upon this subject took place in England, in the London and Edinburgh Obstetrical Societies more especially, case after case of death from injury by injection of perchloride of iron into the peritoneal cavity was related. These cases result from the two causes I have stated; upon the others I cannot touch, because I am not willing to theorize.

*Dr. Boisliniere.*—How long after the last injection did your patient die, Dr. Prewitt?

*Dr. Prewitt.*—About the second day after the third injection. The nurse told me that she injected the uterus, and it was followed by rigor and great depression, from which the patient never rallied. She died the next day.

*Dr. S. G. Moses.*—During the extrusion of the child was there any of this headache?

*Dr. Prewitt.*—No sir. Nothing of the kind; but, as I stated, during the labor there was a giving away of something which the woman noticed and called my attention to.

*Dr. S. G. Moses.*—It may be that a rupture of some portion of the neck of the uterus occurred. As she died, not immediately after the operation, and as the symptoms were repeated a second or third time, it seems to me that it is unlikely that this is a case of death from shock. I think it probable that some rupture of the uterus had occurred, so that some portion of the injection passed into the peritoneal cavity. This strikes me as most likely in the case.

I must acknowledge that for a great many years I was entirely opposed to the use of the intra-uterine injection. I had seen one or two fatal cases of injection of the non-pregnant uterus in which the post-mortem disclosed the fact that death had resulted from peritonitis. Of course I cannot say there was no

shock ; but I am inclined to think the fluid passed through the Fallopian tubes.

I recollect a case that made a great impression on my mind, in my early life here : A certain physician, who was in the habit of injecting the uterus with nitrate of silver, had injected the uterus of a patient and she died from peritonitis. I was called in after the operation and assisted at the post-mortem. I think in this case the fluid had escaped through the Fallopian tubes into the cavity of the peritoneum, and I am inclined to think that in Dr. Prewitt's case some such accident occurred, not through the Fallopian tubes, but through some slight rupture of the uterine wall. Again we know that there is a peculiar susceptibility in some uteri.

*Dr. Maughs.*—Mr. President, I recollect some two or three years ago, when this society was first organized, we had a talk about this subject. I took occasion to point out the dangers of these injections. A thorough dilatation of the os is a comparative security against danger in uterine injections. There should always be a free return of the liquid, for while this does not necessarily prevent shock, it will greatly lessen the probability in the non-parturient condition.

Dr. Prewitt has assumed, and very incorrectly, that there is no danger of injecting the sinuses. He thinks it is a very difficult matter to get the air into them, while in fact, they are in the very condition to be readily injected. Dr. Simpson injected air into the uterus to produce premature labor. The patient died, and the post-mortem indicated that air had been injected into the gaping sinuses, and the heart filled with air causing the livid appearance of the face, shock, and the death of the patient. In the post-partum condition, the woman is kept from bleeding to death by the presence of thrombi in the uterine sinuses. Just after parturition the thrombi soften and pass out, and the patulous sinuses rid of the thrombi, might be readily injected with air.

The syringe should be filled before the nozzle is introduced into the uterus, else the included air is forced into the uterus and probably into the patulous sinuses. This condition was exactly simulated in a case of large fibroid tumor in the hands of an eminent surgeon. The injection of air into the patulous uterine vessels produced death. It was not the result of fluid passing into the abdominal cavity. These cases show the

great precaution necessary in excluding air from the syringe, and they also show us the great necessity of beginning the injection with the very slightest force. While there is very little danger if care and precaution is used, there is great danger if it is done carelessly or with too much force.

*Dr. Engelmann.*—I agree fully with Dr. Maughs, that these cases show the necessity for caution in the use of intra-uterine injections; I do not, however, for my part, regard Dr. Maugh's argument as conclusive by any means; there are several points upon which I would take issue with him. I do not see that any comparison can be made between this case and the well known experiment of Simpson where the catheter, or soft nozzle, which is ordinarily used, is introduced well up toward the fundus, between the bag of water and the uterine walls, between chorion and decidua or between the decidua and muscular wall. The bag of water, which is elastic, and adaptable, fits closely about the catheter so that there is no possibility of a retrograde escape of air, and quantities of air are forced with an effort through the tube, and as it cannot escape backwards, it will make its way in the direction of least resistance. If the catheter is introduced between the decidua and the muscularis, as there are at that time no thrombi in the sinuses, the quantity of air which is forced through the tube can find no other outlet than the one through the still open sinuses. Now, how is it possible with the existing conditions so totally different, to make a comparison between the forcible injection of air into the gravid uterus and the case given, where, if careless, we inject gently with a syringe, a little air, which cannot at most, be more than one syringeful, into the uterus which is like a bag with an opening into which you can run three or four fingers. Dr. Maughs has very clearly pictured the condition of the sinuses filled with thrombi, and he says very truly that were these thrombi not there, the woman would bleed to death. He admits that the vessels are closed by thrombi, at all events they are closed, whether by thrombi or by the contraction of the uterine wall. How can a few bubbles of air enter these well guarded openings with a square inch of space below inviting them out? In the course of a day or two, the thrombi begin to disintegrate. If the vessels were open and the thrombi not there, or partially gone so that air could be forced into the vessels, the woman would bleed to death; it is not even easily

possible to force air into the vessels if they are bleeding and not occupied by thrombi. At most, one syringe-ful of air, not more than an ounce bottle-ful, could be forced into the uterus if a bulb syringe is used. In the fountain syringe, such as used by Dr. Prewitt, we have the clamp below, and the hose and reservoir above is filled with water. Then only the nozzle and a few inches of hose contain air; this, even if not voided, cannot possibly do any damage.

Again, Dr. Maughs says, that we should observe the greatest caution, that we should make the injection gently at first. That is just the very thing which Dr. Prewitt did. He used the fountain syringe elevated not more than two feet above the patient—thus obtaining a very gentle current. Now, it appears to me, that the force of this current would hardly force a nozzle-ful of air—a half-ounce bottle-ful of air—into the veins of a post-partum uterus with patulous os.

*Dr. G. A. Moses.*—I cannot understand the harmfulness of forcing air into the dilated uterine cavity. I cannot see how it can possibly do any harm. I doubt if there is ever a case of labor where a considerable quantity of air does not enter into the cavity of the uterus. If there is an outflow of blood from the sinuses sufficient to call for an intra-uterine injection, however strong the force of the outflow of blood, there is a route for influx of air; and unless you use such an instrument as would adapt itself perfectly to the sinuses, I do not think we would have any dangerous result. As to cases in which the uterus is occupied by a tumor, the bleeding surface of the tumor and the pressure against the capsule co-operate against the introduction of air into the vessels, which are not large, open sinuses, such as we see in labor. The bleeding is from very small vessels in large numbers, and even if be from large vessels which lie on the surface of the tumor, they are not in a condition during the outflow of blood to permit any accidental intrusion of air into the veins. The injection of simple water causes pain and colic, not infrequently. This is commonly known. Physicians rarely use simple water. Simple water has an irritating effect on mucous membranes. A little table salt or any alkali renders it more bearable. In the case Dr. Prewitt reports, I think death was the result of shock, or, as my father has suggested, there was possibly some rupture of the uterine wall or peritonitis to a greater or less extent. As to thrombi



normally closing the uterine vessels, I think further pathological investigation necessary. I see no room or necessity for them in a well contracted womb.

*Dr. Prewitt.*—Mr. President, I want to say a few words in conclusion. I was anxious to learn all that there was to be learned about this subject of intra-uterine injections post-partum. I wanted to know what arguments could be brought in favor of them, or whether it was preferable to discontinue their use. I wished to call attention to the fact that there are dangers that we cannot anticipate. Dr. Maughs very forcibly depicted some of the dangers which may and do occur under some circumstances; but, as Dr. Engelmann and Dr. Moses said, I am not satisfied that they apply to this case. In the first place, he was not aware that I had used the fountain syringe. I used the fountain elevated two feet and half above the level of the patient. The little clamp was down near the extremity of the tube. The point of the syringe, an ordinary vaginal nozzle—was not larger than one-eighth of an inch in diameter, the force of the current not greater than a fall of two feet would give through a very small opening. If it be true that the mouths of the sinuses are closed by thrombi, it would certainly follow that no air could enter these vessels, and especially is this true when the uterus is contracted as it is after parturition. It is true that Hervieux takes the ground that there are no thrombi—that the vessels are not closed with thrombi; but they certainly are closed either by the contraction of the uterine walls or by thrombi; and we cannot force air into them, I think by forcing any amount of it into the uterus; the air would simply impinge on the surface without any danger of passing into the sinuses. If you block up the outlet by passing the point of the instrument into the mouth of the sinuses, then you might force air in. Where this accident has occurred most frequently as you know, is in the removal of tumors, the orifices of the vessels being rendered patulous by the traction upon them, or when there is a vacuum formed in the chest in respiration, air is carried into the veins. But the symptoms are not such as occurred in this case. There is great disturbance of respiration, disturbance of the heart's action, tumultuous action of the heart which under these circumstance produces profound and protracted syncope, if not instant death. In this case these symptoms

were not present, but the patient was conscious and repeatedly referred to the pain in her head. In Sir Jas. Y. Simpson's case, the uterus was enlarged, and the veins in it were probably punctured. These vessels were full of a flowing current of blood, while the membranes below closing over the catheter, prevented the escape of the air outwards, and it would readily pass on with the general current. You can, of course, force air into the veins by passing an instrument into them—you could do that with a hypodermic syringe; but it would not go in against the blood current while it had ready means of exit in another direction. In this case the uterus was contracted. A period of time had elapsed, so that there must have been a decided change looking to occlusion of all the sinuses. As to the theory of embolism and the presence of thrombi, it is not certain that thrombi do close up the uterine sinuses. It may be simply the contraction of the uterine walls. Dr. Playfair cited a number of cases, in the *London Lancet* in 1867, I think, in which he shows that where pulmonary embolism has occurred, it has always been preceded by other trouble, such as phlegmasia dolens, or some other trouble in the veins of the leg. The thrombi never come from the uterine sinuses. Necr has embolism ever occurred earlier than the nineteenth day. The thrombi don't break down at an earlier period than that.

Now, it is possible, that some rupture occurred, as suggested by Dr. Moses, and that the peculiar noise, the sound I heard, may have been caused in this way. I felt alarmed and apprehensive the moment I heard the sound. Labor went on uninterruptedly, but I feared that a rupture had taken place to the extent of an opening into the peritoneal cavity. I hoped that if it was a rupture it would rapidly close. There is no tissue in the body that unites more rapidly when brought in contact than the peritoneum. We get union in a case of ovariectomy in from two to four days. Then with the contraction that had occurred, even a large rent would be rendered but a trifling point. So it is not probable that a current of water as gentle as that flowing from a fountain syringe, with a fall of two feet, through the point of a nozzle that did not exceed one-eighth of an inch in diameter, would have disturbed the adhesions that must have occurred after a lapse of nearly six days. Whatever occurred in the first instance, certainly occurred in the second,

as the symptoms were precisely the same, only they were intensified.

*Dr. Engelmann.*—Mr. President, I wish to say a few words upon the subject discussed at the last meeting, more especially because it appears to me that the use of chloroform in labor is, as a rule, sadly abused, not among us in this city any more than in the entire land, the obstetrician like the average American citizen being to some extent ruled by woman's wish; it is for this reason that it would be well to have a free expression of opinion from all the gentlemen with regard to the use of anesthetics in labor. We all yield more or less to the demand of our patients. I think that in these cases it is often done in an undue measure. There are two questions to be answered with reference to the use of chloroform in labor; first, when *should* chloroform be used? and second, when *may* chloroform be used? In hospital and poor practice we use chloroform when we *should* use it, when it *ought* to be used, and in private practice we, to a great extent, use chloroform when *asked* to use it, or to satisfy the whim of the patient or her surroundings. I was brought up in a very rigid school; I was taught to use chloroform when it was necessary, without any reference whatever to the patient's wishes, when it would facilitate labor; that the accoucheur should use chloroform rarely, only when the pains were intensely severe, and in all obstetrical operations.

I must confess, that I consider that its use has contributed greatly toward my success in many cases of version and forceps delivery. I always use it in performing these operations, and I think that we should always do so, after satisfying ourselves, of course, that no conditions exist which would contraindicate its use. We should use chloroform in the last stage of labor when the pains are very severe and labor is very rapid, or if operative interference becomes necessary. In many cases of intensely distressing and not very effective pains, where we are accustomed to give chloroform, we could obtain the result desired, relieve the suffering and make the pains more regular and efficient by the use of ipecac and a small dose of opium. In case of operation we are obliged to resort to chloroform, and we have nothing to replace it. It is here that we experience its happiest effects, as it facilitates the operation in a wondrous degree. The patient suffers no pain,

she offers no resistance, her muscles are relaxed and do not spasmodically contract, nor is the accoucheur annoyed by her cries and struggles; if there is a slight danger in the use of chloroform, it may be ignored, as it is without doubt vastly more than counterbalanced by the rapidity and ease of delivery as well as the comfort of the patient.

Now, the second point to be considered is, when may we use chloroform. Some gentleman said in the last discussion, that we should give a little chloroform in the first stage of labor because it satisfies the patient and dulls the pain. We play with the patient, so to say. This I take to be admissible, and I do not think that we thereby retard labor, or that we in any way injure the patient by this use of chloroform. I know well that there are some patients who do not wish to feel anything of the labor; not a single pain. They want to go through the entire labor in a state of unconsciousness. Perhaps there is no harm in this course, but I will never be a party to such a proceeding. It may not injure the patient, but to my mind it is not correct practice. I do not think that the labor will go on as naturally, the contraction of the uterus afterwards will not be so thorough, nor will the patient have so good a getting up in ninety-nine cases out of a hundred. It should not be given so as to produce anesthesia in the early stages.

I was very much astonished after my return to this country when I was for the first time asked: "Doctor, do you give chloroform?" I was nonplussed, I did not understand the meaning of this question. I was in the habit of giving chloroform when I thought proper, but I was asked whether I gave chloroform so as to keep the patient under its influence completely after the expulsive pains began. It is a question proposed to many a physician, and, as a rule, he does as requested. for my part, I claim the right of using it when I see fit to do so; a very little chloroform will usually suffice; it should be given in sufficient quantity to dull the pains and allay the patient's anxiety and may be crowded as the head begins to distend the perineum, but at once stopped when it has passed the outlet. I will again say, that during obstetric operations, I deem it eminently proper to use chloroform. Reference was made to this point in the previous discussion, and it was stated that it would be injudicious to give chloroform under the circumstances, as it was necessary to have the co-operation of the

patient, to have the guidance of her sensations in order to know whether we are doing injury or not.

The sensations of the patient, I think, are liable to be fallacious. I have been astonished at the lack of sensibility in some persons, and the hyperesthesia in others. The obstetrician should guide the forceps with his hand, and his common sense must tell him what he is doing. He must not rely on the feelings of the patient in that matter. Again, anesthesia relaxes the parts and entirely removes the sensibility, so that he can operate rapidly and safely; he is not hindered by the patient's struggles or the contraction of her muscles, voluntary and involuntary. The operation is performed much more neatly, it is not necessary to keep the patient under the influence of chloroform but for a few moments. It has been said that the patient is more liable to post-partum hemorrhage, after the use of anesthetics. I believe that I have seen one case where the hemorrhage followed the use of chloroform; where the patient was kept under its influence during the entire labor. I suppose that we might expect, from the relaxed condition of the tissues, that, possibly, hemorrhage would follow; but I do not think that this can be looked upon as the rule. The dread of hemorrhage would not prevent me from using chloroform for obstetrical operations.

*Dr. Papin.*—I have used anesthetics in labor very extensively. With Dr. Engelman, I play with chloroform in the first stage of labor; I become a little more earnest in the second stage; and when the child's head begins to come out, I give a full dose and produce anesthesia. I think sir, I was probably the first student in Paris who witnessed the use of ether. I was a student when Charles Smith, of London, came over o'erflowing with enthusiasm in the use of ether. This was in 1847, I think. He went to Cazeaux and began relating a number of cases and explaining the peculiar properties of ether. His French was miserable, and, as Cazeaux did not understand English, I was called in to act as interpreter. It was decided to try ether in the case of a woman already past thirty years of age. It was a case of premature labor, and the pelvis was somewhat less than normal size. The child, when born, weighed eight pounds and a half. The labor was very slow. Ether or chloroform, administered profoundly from the first, does retard labor; play with it, merely deaden the sensibility of the patient

and it helps instead of retarding. In the case I spoke of, however, the ether was administered profoundly from the first, they didn't do things by halves, and the labor was very slow. The woman was in labor 18 hours, the expulsive pains lasting nearly three hours of that time. The ether was administered, as I said, thoroughly, with intervals of ten, fifteen or twenty minutes, so as to give the woman a chance to rally, but when she became semi-conscious, she was made to breathe it profoundly again. So it went on from the first labor pain to the last, until she gave birth, naturally, without the interference of instruments, after eighteen hours of labor. The post-partum hemorrhage was fearful. The child was almost asphyxiated. It was with difficulty that we revived it. The blood that passed from the vagina (I took some of it in my hand) was so thoroughly impregnated with ether that I really believe that I could have etherized the woman with some of the blood. It was nearly three hours before we could rally the woman, and I do not wish a repetition of it I assure you. I think chloroform is the greatest boon that the women have in labor, when judiciously used, according to the rules laid down by Dr. Engelmann. It is the king of remedies.



## ST. LOUIS MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, July 26, 1880. Dr. Pollak in the Chair.

### TINNITUS AURIUM.

*Dr. Todd.*—Mr. President, some time ago I stated a case to the Society and asked for advice—not being entirely satisfied as to the exact nature of the trouble. Since then I have had the advantage of the opinions of Drs. Hodgen and Bauduy on the case, so that, I think, we have got to the bottom of it. The case, you will remember, was that of a young man about thirty years old, who came to the city from the rural districts to be relieved of a disturbance, a crackling sound in the ear, which could be produced at will. I thought it was due to some fault of the sterno-cleido-mastoid muscle. The noise could be heard distinctly, and the patient said it could sometimes be heard

twenty feet away. I heard it a distance of a foot, distinctly. It was a subjective sound. The case was a very puzzling one. At first it seemed to be produced by the bubbling of air. The patient was very anxious to have the case examined by a surgeon. He was very nervous, hypochondriac. I took the patient to Dr. Hodgen, who at once decided that there was no likelihood of any trouble of the brain, which some of the country doctors had thought probable. He also noticed that the noise could be heard distinctly at the anterior nares, and that it was not produced by muscular contraction, exactly.

*Dr. Hodgen.*—The sound could be heard in the mouth as well.

*Dr. Todd.*—Dr. Bauduy subsequently examined the patient, and concluded that the trouble was not probably a syphilitic one, and also fairly concluded that he would never get over it. Following Dr. Hodgen's suggestion, or rather his observation, I examined him closely, and found that sometimes the movement of the soft palate was spasmodic, also that the sound could be heard distinctly at the anterior nares as well as the ear. I had already performed paracentesis of the membrane, and he was relieved somewhat by the discharge from the ear, but not thinking it necessary to keep the opening, it finally closed up. I thought the noise might be produced by the Eustachian tube, which being open and then closing, might cause some such noise. Thus yawning would put to the stretch these muscles and the tendons attached. It was a very curious case, a very puzzling one, unless one was pretty well versed in the anatomy of the parts. The diagnosis was, that this sound was unquestionably produced by the spasmodic action of the tensor-palati muscle acting upon the Eustachian tube, bringing the moist surfaces of the tube together and then suddenly drawing them apart. The Eustachian tube consists partly of a cartilaginous portion, one wall. The other wall is entirely membranaceous. The fibres of the tensor-palati muscle are attached the whole length of the cartilaginous portion. Ordinarily, the tube is closed, possibly there may be a little opening. During the action of the soft palate, this muscle contracts and bears down the cartilage, and the cavity is dilated. Of course this takes place in swallowing. This is why we make a patient take some water in his mouth and swallow just at the time we blow into the ear, and we

all know we can blow in with considerable violence at that time.

The sound was made in the act of deglutition, the soft palate being then put on the stretch.

I heard it very distinctly without instruments. I can make such a noise myself. But in this case it was very spasmodic, violent. I could hardly make it more than once, while in this case it was repeated. I put the patient on a tonic treatment as he was very much run down. I also told him to take a sponge bath every morning, and to exercise considerably. He had not been taking much exercise on account of an old abdominal trouble, disturbance of the bowels, I think. He went home feeling much encouraged. There are several cases on record similar to this one. They are very interesting. It is one of the curiosities of medicine. I think it is simply a general muscular contraction of one side of the neck, involving, to some degree, the soft palate.

*Dr. Pollak.*—What was your object in the performance of paracentesis?

*Dr. Todd.*—I thought there might be an accumulation of blood in the middle ear. These cases of sounds in the ear are very serious. There is a case on record of a man who was disabled from active pursuits by a roaring sound in the ear. There is nothing to relieve them.

*Dr. Pollak.*—Father De Smet was afflicted with a similar sound. He had a tooth pulled, and from that moment he had a sound in his ear. He said the loudest trumpet could not make a greater noise. That was a coincidence. It came on during the extraction of the tooth. His ear was normal, not a trace of disease to be seen. The membrane was natural.

He went to Europe; went to every medical college of note here or on the other side, and after being abroad three years, came back without benefit. When he came back there was already paralysis of one side of his face. Strabismus and double vision, and at last hematuria set in, and he died after three years, suffering intense agony. He said if he hadn't been a priest, he would have been tempted to commit suicide.

*Dr. Glasgow.*—I would like to ask what proportion of these cases are relieved?

*Dr. Todd.*—If a patient comes to me with a noise in his ear, I tell him it is likely to die with him.

A certain surgeon recommends a very minute mirror to be



introduced into the tympanic cavity, so as to examine it, and then with forceps or other properly constructed instruments, to cut away whatever may be abnormal. I recollect, some years ago, I had some mirrors made, simply to examine the wall of the external meatus, and I found I could not see anything at all. The surface was so small I couldn't make out anything. I used them a few times and then put them away, and I haven't taken them out of the case since. Fancy how much could be seen in the tympanic cavity—adhesions, thickening of ligaments, etc., with such a mirror.

#### FOREIGN BODY IN THE PHARYNX.

*Dr. Hodgen.*—Not long ago I was called to see a child who had great difficulty in breathing—noisy respiration. I looked into the mouth and could see nothing. The child was three or four months old. I called to see it again in the evening. It was breathing about the same as before. There was not so much cough as there had been in the beginning. I inquired if it had met with any accident, and was told that it had not. The trouble came on suddenly without provocation. I called again the next day and found the child better, but it still had difficulty in breathing and difficulty in swallowing.

After an interval of three days I called and found it much better. When I saw it last, the difficulty had pretty well passed off.

Some time afterwards the father came to my office and said that after I had ceased visiting the child, he sent for another physician who attended it for some time, and advised that the child be taken to the country.

The morning before the father called to see me, the mother was putting on a diaper, with the head of the child well down, when a ferrule from the end of a little child's wagon fell out of its throat.

The ferrule was perhaps three-quarters of an inch long, or probably a little longer than that.

It had been in the pharynx, no doubt, during the whole of the time I visited the child. There is no question but what the nurse girl knew of it, as she confessed that she saw the child have the ferrule playing with it, and she, doubtless, knew that it swallowed it and didn't mention it. In this case a thorough examination would have revealed the nature of the difficulty.

*Dr. Baumgarten.*—I extracted a foreign body last winter by a way which I am sorry I cannot elevate into a method. A girl was brought to me with a pain in the throat in talking. She said she had been playing with pop-corn; throwing it into her mouth and inspiring at the same time. She said that a piece of pop-corn lodged in the throat and she could not get it out although she swallowed water, etc.

I inspected the throat with the laryngeal mirror and I could see nothing. I then felt with my fingers as far as I could. The girl stood it admirably well. I felt nothing. I withdrew my finger then suddenly. I had a very violent pain in the tip of my finger, and on examining it I found a pin sticking there.

#### FOREIGN BODY IN THE UTERUS.

*Dr. Pollak.*—Speaking of foreign bodies, a few years ago I was called to see a woman who had a foreign body—a large knitting needle in the uterus. She sat down suddenly in a chair on which there was a ball of yarn, and the knitting needle, which was sticking in it, was driven into the vagina and uterus. She sent for a midwife very quickly, and the midwife felt the needle in the vagina and pulling it out quickly, broke it off so that she couldn't reach any more. I went down to see her. I could feel it very easily but it was impossible to grasp it and bring it down. I called in Dr. Gregory and we tried for hours to get that knitting needle out and didn't succeed. We could feel the end of the needle, but it was impossible to grasp it. We even got an instrument made to fasten to it, but we couldn't possibly draw it. We had to leave it.

*Dr. Hodgen.*—Was the needle protruding in the os uteri?

*Dr. Pollak.*—Yes. It could be felt with the finger in the neck of the uterus. It did not protrude far. The midwife broke off half of it. She thought at first she had drawn it all out, but on comparing the piece with another needle, she found it was broken off.

*Dr. Hodgen.*—Last summer a man called on me and told me his friend had broken off something in the womb. He brought her around, and upon examination, I found a knitting needle in the os uteri. I took hold of it and pulled it out. It was four inches long and of a dark color, except a part about one-third of an inch long—which was near the end. I thought that it had punctured the fundus of the uterus and gone into the peri-

toneal cavity, and that the portion which was in the uterine wall was clear and that in the uterine cavity and intestines discolored. She was using the knitting needle and it broke off.

It was removed with little difficulty. In Dr. Pollak's case, the needle must have been driven into the bone. If it had been merely driven into the soft parts it could have been removed without difficulty.

I can understand how it may have entered obliquely and become fastened in some bone or cartilage. It was probably broken and the midwife merely drew out the broken piece.

I remember some years ago a boy was sent to the city hospital—a bell-boy of Barnum's hotel—who, while running up a stairway, fell and a cedar pencil was driven into the tibia. The point of the pencil struck the head of the tibia near the side of the tubercle. He was sent to the hospital and in a few days, the knee was very much swollen. I learned from the boy that the pencil was broken off, so I enlarged the opening into the bone and found that a portion of the pencil—cedar wood and lead three-quarters of an inch long, was driven into the bone. We would scarcely suppose that wood could penetrate a bone.

*Dr. Tuholske.*—A cigar maker, who lives in my neighborhood, came to my office and spoke of a difficulty he had experienced in walking, and of a peculiar noise he heard. This noise was noticeable along the thigh—femur. He told me it had existed about five days. He limped a little. Otherwise he was well. I sent him home and called to see him. He said that while occupied in raising a bundle of cigar boxes, he heard a crackling sound, but didn't mind it at the time. That day and the next day he walked around as usual; still he noticed the noise. So he kept about for five days until I examined him. I found a dislocation of the head of the bone, and the muscles about the upper end of the femur were decidedly contracted. There was no crepitation; nor could I produce any while he was lying down. Motion of the limb produced that same noise. There was about half an inch shortening of the limb. I could not move the neck of the bone upon the tibia. He had walked five days with his leg in this condition, so that I was very doubtful about the matter. I made him go to bed and he stayed there two weeks, although he didn't see any reason why he should be in bed, as he didn't feel badly, and one day

when I called I found him out of bed. A swelling made its appearance soon after somewhere in the neighborhood of Poupard's ligament. I put the man in bed again, and he stayed there three weeks. I examined him again and concluded it was a fracture of the neck of the bone. The fact that he could walk about was unusual. I cannot explain the cause of the noise that was produced. I would state also, that the last time I saw him, about a week ago, he told me he had gone to some other doctors and they had made a diagnosis of fracture of the neck of the femur.

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SELECTIONS.

THE DRY TREATMENT IN SUPPURATION OF THE  
MIDDLE EAR.

A change of views from those I formerly entertained, and which seem to be at variance, judging from recent literature, with views held by aural surgeons generally, leads me to offer this contribution to the subject of the treatment of suppurative inflammation of the middle ear.

The common practice in acute troubles of this character, after an opening has been established in the drum-membrane (whether it has occurred spontaneously or has been effected by the needle), has been, in epitome, the warm-water douche and the air-bag operation. The bath is designed to keep the parts free from the constantly-renewed secretions, and in its temperature to afford a grateful application to the inflamed surfaces. It is also supposed that the heat influences favorably the course of the disease.

The air-bag acts by re-establishing communication between the naso-pharynx and the middle ear, and tends to free the cavity of the tympanum; and probably the mechanical effect of the air-bath may have some tendency toward renewing a healthy action in the tissues involved. This is considered sufficient, in

the majority of cases which have been seen early, to effect relief. If the suppuration continues, other means are resorted to—usually the instillation of one of the many astringent solutions. In chronic suppuration, the repeated use of the bath is directed, and in the hands of the surgeon, after drying, the parts are medicated as they seem to him to require.

The treatment which I am about to describe, and which I have practised for two years or more, is radically different from this; and, while it may have been followed by others besides myself, I am not aware if this be true, and the note has not been made of it which I am persuaded it deserves. Becker has written an article (*Monatschrift für Ohrenheilkunde*, Vol. XIII, No. V.) on dry cleansing in otorrhea, in which he claims an advantage for cleansing by means of cotton, over the use of water by the syringe or douche. I think that he takes radical ground, but it is the opposite swing of the pendulum, and points to a recognition of the dangers which lie in the old method.

Prefatory to the consideration of a different mode of treatment, I desire to point out what may be regarded as objections in the treatment by the bath. The middle ear, it must be borne in mind, is not reached by a stream of water which is directed against a drum-head that has not yet, or has but recently ruptured, and only infrequently and imperfectly in the case of older openings, unless there has occurred destruction of tissue in this outer wall of the tympanum. This at once limits the usefulness of the syringe as a means of cleanliness, to the effect it has upon the meatus.

In acute inflammation of the middle ear, again, if pain continues after rupture of the drum-head, the warm water, which affords relief during the moment of its contact, causes the pain to recur with increased energy on its suspension. This leads to a prolongation of the bath—in which procedure there is danger of involving other structures in the inflammatory process, and of the further softening and consequent breaking down of the tissues of the membrana tympani.

Allowing these premises at all, the unavoidable conclusion is that there are cases of acute otitis media, where the bath had better be dispensed with; and in these cases to use the bath is not only to incur danger, but, from the treatment being ineffectual, there is to be taken into account the loss of valuable time which has been sustained.

I know the high esteem in which warm water is held, and confess that I have experienced misgivings in the past where I have omitted its use, and I now question, in some cases, the clearness of my judgment; but I submit if the following cases do not make it worth while to institute the question at least in our minds as to whether or not water is *always* a valuable adjuvant to those other means—of leeching, tympanal inflation, dry heat, and the internal exhibition of opium—which we practise.

CASE I.—Daisy H., æt. 10 years, had an attack of scarlet fever five weeks previous to her call at my office, May 18, 1880. There arose as a complication of her sickness, a double suppurative inflammation of the middle ear. The middle ear trouble on the right side led to the involvement of the external ear and to subperiosteal post-auricular abscess. Her father, who is a prominent physician, incised the tissues over the mastoid to the bone, and was under the impression that there was communication with the mastoid cells. This afterward was excluded. The discharge, at the time of her first visit to me, was quite profuse and very offensive. The ears had been treated by the syringe and with various astringent solutions—apparently to no purpose whatever, so far as controlling the discharge went. I found that the inflammation of the right external ear had subsided, except some slight redness and swelling in the meatus—which was not more, however, than might be caused by the discharge which constantly bathed its walls. There was a circular opening in the right drum-head, about two millimetres in diameter, nearly central of the membrane, just below and in front of the manubrium mallei. The lining membrane of the tympanum, showing through the opening, appeared very red and swollen. The left side presented very nearly the same peculiarities in appearance, except the position of the opening which was higher up, still anterior to the manubrium. Rejecting the bath, I cleansed the ears with very great care—using absorbent cotton on the cotton-holder both before and after Politerization. I then applied powdered iodoform through the openings and closed the meatus with a loosely-fitting plug of absorbent cotton, which was inserted *to the bottom of the canal to rest upon the drum-head*. The wounds were dressed twice daily without any change from this treatment until the fourth day, when the iodoform was omitted. On the fifth day the discharge had entirely ceased, and on the 1st of June the openings in the drum-heads had closed. I should not omit to state that a catarrhal condition of the naso-pharyngeal mucous membrane was treated by the insufflation of powders, and the pharynx, from time to time, received applications of liq. ferri sub sulph. (1-4 parts of glycerin.)  
[Lack of space necessitates the omission of four other cases.—ED.]

I might multiply the number of cases very many times from my records. Those presented serve to illustrate the point which I desire to make. The dry cleansing which Becker recommends has been followed—but it is the dry dressing to which I am inclined to attach more importance. It protects the

wound from the air at the same time that it attracts the discharge from the middle ear, and causes a gentle stimulation, entirely unirritating, which conduces to healing. I have made it a practice, after placing the dressing, to use the air-bag with the view of attaching the membrane to the cotton by the moisture which would be forced through the opening.

I have designed in this way to exercise through the cotton a gentle traction on the membrane which would overcome the tendency to falling in, that obtains to a greater or lesser extent whenever its continuity is broken. If this can be obtained, the favorable influence which it would exert is obvious.

I do not claim for this method of treatment that it is applicable in every case, but it is largely appropriate, and where it can be used, according to my experience, it insures a speedier good result, and does away with the injurious effects which in these cases would be occasioned by water applications.

I am disposed to lay down a law that the condition of complicity or not of the external auditory canal in the middle ear inflammation, should decide the indication for the use of the bath in acute processes—and in chronic suppuration of the middle ear, I would restrict its use to cases of very profuse discharge, and to those cases presenting peculiarities in location of the ulcerative process, where to effect cleanliness by the cotton, is either impossible or would be attended with a likelihood of injury from the irritation induced by prolonged manipulation. Or, to express it in other words, water has no remedial virtue so far as the mucous membrane of the middle ear is concerned.

That it has been assigned this place relative to other mucous tracts, I think there is no doubt. And my position in regard to its value in aural practice can be readily appreciated by those of large experience in naso-pharyngeal and gynecological practice.

A negative argument in favor of a nicer discrimination in the use of the syringe in aural practice, is found in the indiscriminate use which is made of it by the laity, and, I am sorry to add, by many general practitioners. Every one affected with deafness, it is considered, should have the benefit of the doubt, and inspissated cerumen is syringed for with a zeal which would be highly commendable if better directed.—*H. N. Spencer, A. M., M. D., in the American Journal of Otology.*

## NOTES AND ITEMS.

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REYNOLDS' SYSTEM OF MEDICINE.—The following work from Dr. J. Adams Allen, President of Rush Medical College, of Chicago, shows his estimate of this valuable work :

CHICAGO, August 29, 1880.

J. W. CHAMBERS, ESQ., 305 Locust St., St. Louis, Mo.:

DEAR SIR.—I beg leave to acknowledge receipt, per United States Express, in good order, of the three Vols. of Reynolds's System of medicine, edited by Dr. Hartshorne.

It is a magnificent work, and deserves a royal reception at the hands of the profession.

If comparisons may not seem invidious, I would say these three volumes are worth more than the entire set, so far as received, of Ziemsen's Cyclopaedia. Dr. Hartshorne's part in the work alone ought to make the American edition a success.

Very respectfully yours,

(Signed)

J. ADAMS ALLEN.

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## OBITUARIES.

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PROF. FERDINAND HEBRA died in Vienna on the 4th of August. He was born in Brunn, Moravia, in 1816, and completed his medical studies in Vienna. As assistant to Skoda, he began to take rank with the galaxy of men who gave a new direction to medical science. In 1842, he entered upon the practice of Dermatology as a specialty, and in 1848, he took charge of the recently established wards for skin diseases in the general hospital. In 1849 he was made professor, and soon his fame spread over the world. He continued to lecture until a few days before his death. Amongst the thousands of scholars that attended his lectures, was Dr. Kaposi, who afterwards became his assistant and married his daughter. He has also acquired a world-wide fame and will no doubt succeed to the professorial chair. Amongst the published works of Hebra, his atlas, with magnificent illustrations by Elfinger, is the finest.



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ORIGINAL ARTICLES.

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THE USE OF CHRYSOPHANIC ACID IN THE  
TREATMENT OF DISEASES OF THE SKIN.

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BY R. W. TAYLOR, A. M., M. D., *Professor of Diseases of the Skin in the University of Vermont, Surgeon to Charity Hospital, New York.*

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IT may be truly said of chrysophanic acid, that unlike the majority of new remedies, it has a greater range of usefulness than has yet been claimed for it. Indeed it is, in the treatment of certain skin diseases, what quinine is to malarial fever, almost a specific. This acid, as is well known, is in the form of a yellowish-brown powder, and is derived from an Eastern remedy called goa powder, in which it exists to the extent of 85 per cent. It is also said to be derived from rhubarb. Originally this goa powder was used for ring-worm in Eastern countries, and it is only within a few years that its use has been extended to the treatment of other cutaneous affections.

To Dr. Balmanno Squire, of London, certainly belongs the credit of our more extended knowledge of the usefulness of this valuable agent and its derivative acid. Having myself used it in a number of skin affections, including

many cases, I desire now to present my views as to its general sphere of usefulness, and to consider certain drawbacks which we must admit there are in its application. I hope thus to draw out the experience of other physicians who have used the agent. First, let us consider the form and strength of the ointment to be used, since this is the most convenient mode of application. Some of the physicians who first used it, recommended a strength of two drachms of the acid to the ounce of lard or cerate. But I am convinced by experience, that in this country this strength is far too great. Such an ointment is rarely necessary, and should always be used with the greatest caution, as I will point out later. I may here remark that I have found no necessity for the use of hot lard in the formation of the chrysophanic acid ointment, nor for its solution in benzol before mixing it with the cerate or lard. My preference is that the acid should be thoroughly triturated with a few drops of alcohol before mixing it with equal parts of vaseline and simple cerate or cold cream. This makes a smooth ointment, which readily penetrates the skin. As to the strength of the ointment preferred by me, I would say that I constantly use it in the proportion of ten grains to the ounce of cerate, and rarely higher than one drachm to the same quantity. In speaking of the various diseases, I will state the proportion usually found beneficial by me for each. In general, brisk inunction, once or twice a day, leaving a coating of the ointment on the parts, is all that is necessary, but in some instances it is essential to apply the salve spread on lint as a plaster. Care should always be taken that only the morbid tissue is thus covered. To state briefly its general applicability, I may say that chrysophanic acid ointment is useful for chronic subacute skin affections attended with superficial infiltration or with much epidermal proliferation. In cases of very deep infiltration, it is not, I find, as beneficial as other agents are, for the reason that the strength of the ointment is necessarily so great that it of itself causes inflammation around the part, and even then it does not afford especially good

results. Then again, it is not to be used upon excoriated surfaces, yet in cases such as psoriasis, lichen planus, in some of the early papular and some superficial tubercular syphilitic eruptions, its action is marvellous. My general rule is to employ it only in cases in which the epidermis is intact or not shed, or again when this layer is much thickened. The disadvantages of the ointment are its staining qualities, its tendency to produce erythema, severe edema, and sometimes furuncles. While we cannot prevent the pigmentation of the skin, we can use measures for its removal, such as brisk friction with powdered pumice-stone on a pad of flannel. As regards the inflammatory sequelæ I think that, as the observer becomes more familiar and skilled in the use of the agent, he will be less liable to see them. When I first used the ointment in the proportion of two drachms of the acid to the ounce of fat, I several times in cases of psoriasis saw much edema around the patches, following the application, but still the disease yielded so quickly and the inflammatory symptoms were so speedily relieved by cold water dressing, that in some urgent cases I did not regret its occurrence. However, I could from further experience, counsel caution, and advise a moderately strong ointment, although the cure will not be quite so rapid. In some rare instances little boils and large ones, even, will appear after the application of a mild ointment; and sometimes it will be necessary to stop the remedy in consequence, but such instances are quite rare. One point has struck me very forcibly in using this agent, namely, that it has not very pronounced anti-pruritic properties, so that in some affections attended with severe itching, we are compelled to combine with it one of the tarry oils or camphor or carbolic acid.

Let us consider briefly the value of chrysophanic acid in various skin diseases, for, as I have said, its range of application is very wide, greater than is generally conceded, and is not by any means limited to the treatment of psoriasis and ringworms. In acne much good can be obtained from the use of a mild ointment, ten to twenty grains to the

ounce. But here its staining properties are almost insuperable objections to its use. Yet my experience in dispensary practice has convinced me, that many cases of simple and of the indurated form of acne will be benefitted by this, more than by any other single remedy. I have directed patients to first bathe the face with hot water, and then to rub over each papule or tubercle a little of the ointment, leaving a film of it to be absorbed. The result is that the next day the whole face is stained to the copper color of an Indian, to remove which it is necessary to scour the parts well with powdered pumice stone, which operation however is not always followed by complete success. Great as is the drawback, there are persons who will undergo the annoyance in hope of ridding themselves of their chronic disfigurement. In cases of acne complicated with rosacea and in rosacea I have seen excellent effects from a tolerably strong ointment, twenty, thirty or forty grains to the ounce. I have seen the dilated superficial capillaries wither under its use several times in very severe cases. Let me here say that great caution must be exercised in using a tolerably strong ointment on the face, since in this situation it is liable to cause severe inflammation, sometimes resembling erysipelas. The best mode of procedure is to use at first a mild ointment and simply rub a little in, carefully watching the result. Then we may go a step further and apply it spread on linen lint constantly. Should at any time inflammatory symptoms show themselves, the application must be suspended and water dressing applied. But care and observation will make the prescriber skillful in avoiding such accidents. In eczema the use of chrysophanic acid is limited, I think, to chronic localized spots not attended with great infiltration. To these it can be applied in moderate strength continuously, but in general it will be necessary to combine with the ointment a sufficient quantity of the oil of cade, birch oil, and tar oil to relieve pruritus. In chronic eczema of the palms of the hands I have used with great benefit an ointment made of fifteen grains of the acid to diachylon ointment one ounce. The

same ointment I have used with equally good results in chronic cases of \*scaling eczema of the scrotum, in which there was considerable thickening. When used upon the hands or scrotum the ointment should be spread on lint and kept continuously applied. It may be necessary, of course, to envelop the former in india-rubber gloves, and perhaps to envelop the scrotum over the dressing with gutta-percha tissue. In any case in which the itching is severe, I think a sufficient quantity of a tarry oil should be added. In two instances of sycosiform eczema of the beard in the chronic and somewhat infiltrated stage, I produced a cure by ten grains of the acid to the ounce of diachylon ointment, the dressing being kept on continuously. This, indeed, was after the usual remedies had failed.

In ringworm of the scalp, chrysophanic acid is often very useful, but it is necessary to use it with considerable care, as it has and may produce severe inflammation. Ten grains to the ounce of cerate and vaseline is generally sufficiently strong. Of course it is necessary to use epilation in bad cases. One drawback to its use on the scalp is the staining of the hairs to a purplish brown color. I think it well to mention this fact to patients when stating to them the advantage of rapid cure which we are warranted in promising from the use of this acid. Ringworm of the body is readily cured by an ointment of moderate strength rubbed in several times daily. When used upon the trunk or extremities, chrysophanic acid will inevitably stain the underclothes. To get over this trouble as well as we can, I state the fact to patients, and advise them to wear such clothes as are well-worn, and to continue their use while under treatment, as the time is usually not very long. In lichen planus, I have seen some of the most rapid cures produced by this agent, but the itching which usually accompanies this affection, often necessitates the addition of some anti-pruritic agent. In other chronic forms of lichen this acid may often be used with great benefit. I have now under treatment a case of lupus erythe-

matosus, which I am sanguine of curing by an ointment of the strength of twenty grains of the acid, to the ounce of ointment.

In a number of cases of papular and scaling syphilides, I have seen excellent results from the use of a mild ointment. Particularly valuable is this agent combined with diachylon ointment in the scaling syphilides of the palms and the soles. Its application here must be continuous, and a previous removal of the scales may be necessary, while in severe cases the hands should be enveloped in india-rubber gloves. It is, however, in the cure, perhaps I may more properly say the removal of psoriasis, that the acid owes its great and well-deserved reputation; and here I may add that my experience in its use convinces me that the high praise which has been accorded to it by others, is well deserved. Indeed it is rare to see any agent act as promptly and uniformly as this one does. One feels assured in prescribing it that a good result will surely follow its use. In psoriasis it is generally necessary to use mild ointments from ten to sixty grains, rarely any stronger. Care and caution should be exercised in treating children, particularly if very young, since severe inflammatory reaction may follow the use of a strong ointment. For such patients I have rarely had to exceed fifteen grains; I usually employ only ten to the ounce. Of course, the scales must be carefully removed by scraping or by baths, and the ointment should be well rubbed into the patches. If inflammation follows, the parts must be treated by the water dressing. In some very chronic cases I have used the two-drachm ointment, and in order to avoid inflammatory reaction I have ordered the parts to be enveloped in linen and kept continually wet with cold water. In this way I hurried the cure and avoided bad results. In general, however, a mild ointment is sufficient, and the strong one should never be used unless the patient is fully under control. Though chrysophanic acid has been recommended in the treatment of tinea versicolor, I am able to say from considerable experience that it is less efficacious than the remedies usually employed.

*42 West Twenty-first street, June 1st, 1880.*

## THE PATHOLOGY OF SO-CALLED "DESQUAMATIVE PNEUMONIA."

BY J. HILGARD TYNDALE, M. D., MANITOU, COLORADO.

THE existence of an acute form of inflammation of the lungs, quite separate and distinct from croupous and catarrhal pneumonia, was first announced by Prof. Buhl, of Munich, in a communication to *Henle & Pfeiffer's Journal*, Series viii, 1856. His views have since undergone some modifications, while other authors have denied desquamative pneumonia a separate existence and distinctive characteristics.

Buhl had for a number of years noted the fact that the inflammatory products of some lungs removed from persons who had died of pulmonary phthisis or of acute lung inflammation, contained a proportionally larger quantity of *cast-off epithelium* than could be accounted for by rating the cases as catarrhal pneumonia. The same appearances were noted in cases where the patient was said to have succumbed to hyperemia, or edema of the lungs in connection with some infectious disease.

In connection with clinical facts of which we will speak hereafter, Buhl announced the following conclusion: Catarrhal and croupous pneumonia are characterized by changes in secretions, while in desquamative pneumonia *serous infiltration of the parenchyma of the lung is the cause of the profuse desquamation of epithelium.*

According to Buhl, desquamative pneumonia presents itself in two different forms and modifications. His views will here be presented in abstract, followed by the opinions now held by most authorities in reference to excessive desquamation.

The first variety and lowest grade is that which occurs as an *accompaniment to severe general diseases*, and is

therefore denominated by Buhl "*consecutive desquamative pneumonia*." It is to the lungs what albuminuria is to the kidneys, namely, a serous infiltration, followed by shedding of epithelium in the course of acute infectious diseases, such as typhoid fever. In croupous as well as catarrhal processes, the chief factor is to be found in quantitative and qualitative changes of the secretions, while in the desquamative process no secretion occurs, but a serous infiltration of the stroma carrying the blood-vessels leads to shedding of epithelium.

It would lead too far to dwell upon all of the histological appearances of the lung during this process. I will mention that in contradistinction to croupous and catarrhal pneumonia, pus-corpuses are wanting and pleurisy absent.

The second form—called by Buhl *genuine desquamative pneumonia*—is claimed to be an inflammation of the lung *sui generis*. Clinical observation, attested by post-mortem examination, shows it to have its beginning in the upper lobe, its downward course being readily noted. It holds the same relation to the consecutive form as does genuine Bright's disease to albuminuria accompanying general diseases.

The microscope reveals detached epithelium in profusion, filling the alveoli and bronchioli, undergoing fatty degeneration, while at the same time there is rapid formation of new connective tissue binding down this plastic exudation. Hand in hand with fatty degeneration goes epithelial regeneration, which together with proliferation of connective tissue, are the chief points to a claim of an independent parenchymatous inflammation.

As sequelæ to desquamative processes in general, we have: Chronic fatty degeneration, cirrhosis of the lung and cheesy pneumonia or caseous degeneration.

*Chronic fatty degeneration* is a continuation of genuine desquamative pneumonia, and to be considered as a mere prolongation of the same process, during which massed-up epithelium undergoes fatty degeneration, without any con-



siderable reabsorption following it. It may happen that a part of the inflammation resolves completely, while another, usually at the apex, resists restitution and falls a prey to fatty degeneration.

A second termination is that of *cirrhosis of the lung*, the chronic proliferation and subsequent contraction of interalveolar connective tissue. I will speak of this pathological condition farther on, when comparing present views with those of Buhl.

Termination in *cheesy degeneration* takes place where the products of inflammation, in this case the desquamated epithelium, undergo water abstraction and shrinkage, forming what is known as a caseous mass. Of this condition also, I will have a few words to say hereafter.

Buhl also claimed that there existed a close relation between desquamative pneumonia and tubercle, the formation of giant cells in the latter amidst the proliferating epithelium of the alveolar walls constituting the chief distinction. As above stated, it is useless to go any deeper into Buhl's reasoning, since his standpoint as originally taken, has been practically abandoned.

Now let us turn our attention to the present views regarding these desquamative processes. Why is it that these conditions and their sequelæ had not been previously noticed, and a proper interpretation placed upon them?

To Buhl is due the credit of having observed and drawn attention to processes in which profuse shedding of epithelium is the prime factor, far in excess of desquamation as it is known to occur in croupous or catarrhal inflammations. His mistake lies in his having forced these conditions into the frame of a separate and distinct disease.

The present accepted theory is that profuse desquamation of epithelium, with its consequences, is a *stereotyped accident of all forms of inflammation*. It may occur in the course, or follow in the train of serous, croupous or catarrhal inflammations, and is the *localized expression of a so-called scrofulous diathesis*. This opinion was first expressed by Rindfleisch, and since has been ratified by many others.

Microscopical researches have finally satisfied me that all inflammations, whether of the lung or other organs, can be explained upon the basis of Prof. Heitzmann's theory of granular living matter.

The *quantity* of living matter which each individual brings to his case is the governing factor. Serous infiltrations, catarrhal and croupous inflammations, all accompanied by more or less shedding of epithelium, are only *degrees of inflammation (not convertible into each other, of course,) their occurrence depending upon the amount of living matter and of fibrin* which each individual may be endowed with.

This would teach us that, as far as pulmonary troubles are concerned, strict individualization should be practiced, and the family history closely inquired into, in order to arrive at a correct conclusion regarding the present condition of the patient.

With the above facts in mind, we are prepared to judge of the various forms of inflammatory infiltrations of the lung. We know that when there is any *sudden* stoppage to the circulation in the lungs, either from active determination of the blood, or the sudden formation of an embolus in the large pulmonary vessels, we have rapid serous transudation more or less mixed with blood, and we speak of "edema." The process is too rapid and decisive to be accompanied by shedding of epithelium, though this condition may subsequently supervene.

Another form of serous transudation, partaking more of the nature of a slow, venous stagnation, accompanies acute infectious diseases, and results in more or less rapid desquamation of epithelium, together with a constant attempt at regeneration. By slow and steady infiltration of serum the epithelial cells become swelled, are raised from their stratum and separated from each other, in other words—desquamated.

What becomes of this product? This will depend upon the strength remaining to the patient suffering from the infectious disease. If he regain his full strength, the lung will, in all probability, be cleared up. Detached epithelium

in the lumen of the alveoli and bronchioli will be largely expelled with the sputa. The deeper and more recent productions readily undergo fatty degeneration, and are then in the same good condition for absorption, as is fat in the alimentary canal.

In case of slow and imperfect convalescence of the patient, these products are not removed by expectoration and absorption within a reasonable time, and it is then that three roads to consumption are open.

The patient failing to regain his assimilative and nervous powers, the same process of desquamation, fatty degeneration and abortive regeneration will continue *ad infinitum* and lead to:

1. Chronic fatty degeneration, as described by Buhl.
2. The active desquamative process having in a measure ceased, the exudation may gradually be deprived of its watery constituent, and shrink. In other words, it will undergo cheesy degeneration.
3. In the deeper tissues we find the following process: Whether or not the desquamation ceases, or whether the exudation is removed by expectoration and absorption, or in part remains in situ, if the trouble lasts for more than a limited period, hyperplasia of connective tissue with subsequent contraction will take place. This condition then represents nothing more nor less than the beginning of a so-called fibrous phthisis.

In the condition which Buhl christened *genuine desquamative pneumonia*, we have seen that the serous infiltration is accompanied by very rapid formation of new interalveolar connective tissue, leading to decided desquamation of alveolar epithelium.

This "very rapid formation," together with shedding of epithelium, forms the basis of Buhl's new disease.

In the human body we have connective tissue from the firmness of a dura mater down to the delicate accompaniment of blood-vessels, and the connective tissue between the alveolar pouches. This stroma is traversed by the numerous capillaries formed by the pulmonary artery as

one great network. Where there are plenty of blood-vessels, we may reasonably expect plenty of inflammatory product, and a correspondingly rapid development of new connective tissue. The same great vascularity in a delicate network which opposes so little tension against transudation from the vessels, begets a rapid development of epithelium with no firm cement substance, shedding almost as rapidly as it forms.

I have stated above that, at present, desquamative pneumonia is no longer looked upon as an independent disease. It is a *stereotyped occurrence in all active disturbances which befall the lungs of scrofulous and syphilitic persons*. Copious proliferation and shedding of imperfect epithelium, accompanied by and sometimes as a sequel to the more important development of imperfect connective tissue, are simply the chief anatomical elements in lung inflammations of the scrofulous and syphilitic.

Close observation has long since convinced me that lung trouble accompanying infectious diseases, as well as independently inflammatory, may be croupous, catarrhal, interstitial or desquamative, according to the amount and quality of living matter (protoplasm) which the afflicted individual is possessed of.

It is the individual himself, with his inherited and acquired tendencies and composition of blood and tissues, who determines which particular form will supervene, and this again is modified by the degree of the disease.

A plethoric individual would be most likely to have a croupous pneumonia accompanying typhoid fever; patients of average health, the catarrhal form; while inflammation of the lung in the scrofulous and syphilitic will be characterized by rapid and consequently imperfect formation of indifferent elements and epithelium, which is rapidly shed—in short, a desquamative process.

Scrofulous, I said. We know that scrofulous individuals are such as are incapable of producing respectable plastic products, but small, indifferent elements, in profusion. The scrofulous suffer from a deficient nutrition of the body.

Rindfleisch very correctly says: "A certain quantitative insufficiency and incompleteness of the nutritive and assimilative apparatus is not only a chief ingredient of what is known as a scrofulous constitution, but is likewise an essential cause of all singularities which distinguish scrofulous inflammation from an ordinary inflammatory process." In conclusion, let me recapitulate the present pathological standpoint of so-called "desquamative pneumonia."

A limited shedding of epithelium occurs in connection with catarrhal, as well as croupous pneumonia. Infiltration, with decided desquamation of epithelium, in which the shedding and constant regeneration are the leading factors, occurs in three different conditions:

1. As an accompaniment to infectious diseases in persons of doubtful constitution, whose general condition was below par previous to the invasion.

2. As a chronic sequel to or following closely in the track of catarrhal or croupous pneumonia, whether these inflammatory processes are of independent origin, or were precipitated as an accompaniment to an acute infectious disease, such as typhoid fever.

3. As an acquired sub-acute inflammation (Buhl's genuine desquamative pneumonia), manifesting itself by decided desquamation of epithelium, and rapid formation of connective tissue. It is to be looked upon as that form of an inflammatory process of the lung, which scrofulous and syphilitic individuals alone are prone to; an inflammation which in more robust persons would be a catarrhal or croupous one with their respective products.

## RHEUMATISM.

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 BY J. H. EGAN, M, D., PULASKI, TENN.
 

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IT is unnecessary to consider the pathology of rheumatism, as it is known to every tyro ; and as I have nothing new to offer in relation thereto, I will consider its treatment in the acute and chronic forms. I do not propose to notice rheumatic gout or syphilitic rheumatism.

The great danger in acute attacks is the cardiac complications. On this ground we endeavor to cut short an attack as soon as possible, because the sooner a cure is effected, the less likely are these to occur.

My clinical experience has been very extensive ; having served many years at sea, and also in army, dispensary and hospital practice and in the public institutions of South Carolina and Louisiana.

In all cases both acute and chronic the bowels must be kept open, and the liver must not become congested. So soon as it becomes torpid, there is an aggravation of the symptoms. My usual prescriptions are :

℞. Podophyllin, gr. i.  
 Alcohol, ℥viiss.  
 Fl. ext. arom. powder, ℥ss.

M. S. A teaspoonful to be taken every night or every other night as required.

Or :

℞. Elixir Wahoo and Blue Flag (Wyeth) ℥ii.  
 S. Two teaspoonfuls at night.

It is essential that the liver be kept in a normal condition and such doses are to be administered as will limit the action to the liver. It is impracticable to conjoin stimulation of the liver and irritation of the intestinal glands.

When the fever is high, veratrum or aconite is to be exhibited. If the fever be accompanied by a weak pulse,

aconite is the remedy; a strong pulse demands veratrum. The recipe I exhibit is ten drops to four ounces of water, a teaspoonful of which is given every hour. In all cases I employ the fluid extract or specific tincture of equal strength.

From 1863 to 1873, my remedy was "Brahee Sugar Powders," a medicament which raised a furor in the medical world. The reason why I do not now employ it, is the difficulty of procuring it. It is not kept in stock in the United States, and I have been compelled to import it, which is inconvenient. Under its exhibition the most violent attacks were dissipated in three days. Such was the experience of Dr. Henderson, of Leith, who introduced it to the notice of the profession through the medium of the *London Lancet*, and I fully corroborate him.

In 1873, I commenced the use of salicylic acid, manufactured both by the German process and from wintergreen, but was necessitated to discontinue the remedy owing to the stomach derangement it produced. Patients could not be induced to continue the remedy. I then exhibited the salicylate of soda and potassa, and find them all I desire. My formula is:

R.	Salicylic acid,	ʒii.
	Bicarb. potass.	ʒiv.
	Aquæ,	ʒii

M. S. A teaspoonful every three hours in water.

So soon as I discover that I have destroyed the acidity of the blood and rendered it alkaline, which I generally accomplish within twenty-four hours, I discontinue this remedy, and order a preparation of iron. This presupposes an abatement of the fever, as iron is always contra-indicated when the temperature is abnormal.

As an adjuvant, I employ the topical application of a strong anodyne and stimulating liniment, which can be made to suit the views of the prescriber and the feelings of the patient. This is to be rubbed on the inflamed parts for not less than half an hour at a time, and repeated three times daily. The swollen joints are frequently so sensi-

tive that great gentleness is requisite in the use of the liniment. Gradually the pressure can be increased, until any weight can be borne without inconvenience, and the pain is dissipated.

After applying the liniment, I envelop the joints with a poultice of mullen leaves steeped in warm vinegar, or strap the whole limb with a Martin's rubber bandage.

On rare occasions I find persons with delicate stomachs who cannot tolerate the salicylate. To them I administer nitrate of potash in its stead.

Latterly I have used a new remedy which has given me satisfaction. I refer to fluid extract manaca which is a Brazilian medicine, officinal in the pharmacopœia of that country and justly celebrated for its remedial powers in rheumatism. My general formula is :

℞. Fl. ext. manaca,	ʒii.
Elixir simplicis,	ad. ʒii.

M. S. A teaspoonful every hour.

The great benefit derived from manaca is the profuse perspiration which it produces and alleviation of pain. Sometimes headache is occasioned, but it is transitory and can be at once cut short by partaking of a cup of coffee. The above prescription is alternated with the salicylate of potash or iron.

In chronic rheumatism I use the manaca conjoined with a liniment applied three or four times daily.

When heart complications exist, remedies must be used to meet the indications of each case.



## TIME OF CONCEPTION AND DURATION OF PREGNANCY.—SUPPLEMENTARY.

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BY GEORGE J. ENGELMANN, M. D., ST. LOUIS.

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SINCE the appearance of my short paper upon Time of Conception and Duration of Pregnancy in the *COURIER* for May, 1880, three additional cases have been reported to me by gentlemen well-known to the profession; these cases are well-authenticated and established beyond the possibility of a doubt, by the character of the patients, and the careful cross-questioning by the judicious attendant. On account of the extreme rarity of reliable cases of this kind, in which we can positively trace conception to a first and single intercourse, and in order to complete the table, I wish to record these additional cases as supplementary to the above-mentioned paper.

I will briefly recall the cases already published, which have occurred in my own practice, and, to facilitate comparison, I will number them as in the previous article:

Case I.—Patient is an educated lady, 22 years of age, physically well developed, but nervous and troubled with menstrual irregularities; the intermenstrual period varying from four to six weeks.

The last menstrual flow appeared on the 28th of April; while on a visit five weeks later, on the 4th of June, as she was expecting the next period, she yielded to the seducer, with whom she had connection but once, as she returned to her home soon after. The expected flow did not appear; a normal pregnancy followed; on the 2nd of March, 272 days after impregnation, she was confined, and early on the 3d delivered of small, but healthy female twins.

Case II.—A well developed and unusually healthy young lady of 24 years, yielded, for the first time, on the 4th of July; as she has never been regular, she is unfortunately

not able to recall the date of the last sickness previous to this, her first coitus; however that may be, she never menstruated after it; and had connection but once more toward the end of July, at least three weeks after the first.

This patient was also confined on the 2nd of March, 242 days after the first intercourse, and was delivered of a fine healthy child, which, with but a few trifling differences, bore all the characteristics of a child at term.

Case III.—On the 3d of March I was consulted by a girl of 24 years, daughter of a farmer, who, to all appearances seemed to be in the eighth month of pregnancy; the fundus uteri a hand's breadth above the navel, the navel pouting, ballotement distinct. Patient had menstruated last about the middle of July, and had yielded for the first time during the last days of the period, before complete cessation of the flow; connection was had but once at this time, and, although indulged in very frequently afterward, opportunity did not again offer for almost a month, which would have allowed time for the recurrence of the menses had not conception taken place, and, judging from the development of the uterus and the position of the fetal head in the pelvis, gestation must have continued well over seven months, and impregnation must have taken place during the last days of the menstrual flow.

Case IV.—The young lady, whose case is reported by Dr. W. Sinkler, of Philadelphia, was a healthy, well-developed girl of 20, always regular in menstruation; she was engaged to be married, and at the close of a menstrual period, on the 9th of August, yielded to the heedless passion of her affianced. The mortification consequent upon the act caused a temporary separation, but, when a month later the non-appearance of the menstrual flow told that pregnancy had resulted from the single imprudence, marriage followed, and upon May 15th, after the lapse of 280 days, the lady was delivered of a well-developed female child.

The labor had perhaps been hastened by an accident which happened May 11th, causing the escape of the waters.

Case V.—This case occurred in the practice of Dr. T. L. Papin of St. Louis. The patient was a refined, delicate lady of 19, who might almost be called an invalid, as she never had been strong, and was recovering from an attack of pneumonia when she was married. For eighteen months the menstrual flow had been absent, but, as she was improving, and her health seemingly to a great degree restored, a return of the catamenia was looked for. On the 22d of January she was married, but, as coitus caused her great suffering, the thoughtful husband refrained from further intercourse out of regard for the delicate health of his young wife. The menstrual flow did not return, and on the 15th of October she was delivered of a well-developed female child.

Case VI.—This case also occurred in the practice of Dr. Papin. The patient was a young married woman, 21 years of age, of delicate constitution, although in good health and free from any uterine ailment. She conceived soon after marriage, but miscarried in the third month; this was in April, and, on the 22nd of the following August a second conception took place in consequence of a single intercourse, the first which occurred after the cessation of the menstrual flow; upon the following day the husband left his wife, and returning after a two weeks absence, found her suffering from nausea and complaining of sick stomach. The flow did not return, and on May 12th a well-developed male child was born, 263 days after intercourse.

Cases IV. and V. like the cases primarily related by me, are examples of fruitful first intercourse.

In Case IV. conception occurred during the last days of a period, and in Cases III. and VI. immediately after the cessation of the flow.

These patients are all primiparæ, and in only one of the six cases (Case IV.) was the ovum carried to the full term of 280 days, which seems to be in harmony with the ordinarily accepted belief that a first child never receives the full development accorded by the ordinary duration of pregnancy—a very wise provision for the young mother.

The term varied in these cases from 242 to 280 days, and the average duration of pregnancy for the cases recorded is 264.6 days.

In all the above cases conception followed a single coitus of known date, and, in all but case VI. it was a first coitus.

Though it seems but an accidental coincidence, it may be noted that when conception occurs immediately before the appearance of the menses, the offspring is likely to be of the female sex, whilst when conception results from an intercourse directly after the cessation of the flow, the child is likely to be of the male sex (Case VI).

Case IV. unfortunately will not harmonize with this theory.

I shall not analyse these cases, as no new features have been developed, and I could add nothing to the observations made in my previous paper; the additional cases merely seem to corroborate the conclusions reached by a consideration of the first.

Much has been written of late upon the circumstances which determine the sex of the child; some will have it dependent upon the time of conception in relation to the menstrual flow—others upon the age of the mother, whilst still others assert that it is governed by the relative age or vigor of the parents.

J. B. Swift (*Boston Medical and Surgical Journal*, Sept. 26, 1878) claims that the sex of the offspring is determined by the number of spermatozoa which penetrate the ovule; if few in number, as in intercourse just before the period, when they must travel far into the female passages, the female element predominates and stamps the sex of the child; after cessation of the flow, when the ovule has come lower down the tubo-uterine canal, it is subject to impregnation by greater numbers of spermatozoa, and a male child results.

Stock-breeders have successfully availed themselves of this theory, and Swift verifies it by twenty recorded cases; in eleven of these, fruitful intercourse took place within eight days after the cessation of the catamenia, and a male

child was born in every instance; in the remaining nine cases, in which conception took place shortly before the appearance of the flow, the gentler sex was produced.

Nestel (*Medical Record*, Nov. 9, 1878,) denies this theory on the ground that one spermatozoon suffices to impregnate the ovule and that only one can enter, although physiology and comparative anatomy teach that among lower animals several spermatozoa are necessary for impregnation.

Dr. Joseph A. Mudd (*Medical Record*, Nov. 23, 1878) without theorizing, claims as a fact proved by his 110 cases, the very opposite of the law so carefully elaborated by Swift. In harmony with the facts proven experimentally by Thury of Geneva, upon animals, Dr. Mudd claims that a female child will result from a conception which occurs soon *after* menstruation and a male child from fruitful coitus just *before*, because he has found that in cases where the duration of pregnancy was longer than normal the offspring was male, and if labor came sooner than expected, female.

All seek reasons peculiar to themselves. Thus Dr. H. U. Upjohn (*Medical Record*, Dec. 7, 1878) sees the same law verified by his own experience, and explains it by the existence of male and female spermatozoa, the female being the more numerous and the male the more vigorous. Before the menstrual flow, when the ovule is still high up in the tube or uterus, it can only be reached by the vigorous male spermatozoa; whilst after the period, it comes down in the uterus and is impregnated (overpowered seems more correct) by the greater number of female spermatozoa. (*Centralblatt. fuer. Gynæcologie*, No. 9, 1879, II.)

Others again have sought to connect the age of the mother with the sex of the child. Bidder (*Zeitschrift f. geburtsh. u. gynaekologie II*.) has collected 11,871 cases, 4,441 primiparæ and 7,430 multiparæ; he finds that the proportion of males exceeds that of females in mothers aged from seventeen to twenty-one; the number sank in the twenty-second and twenty-third years, reached its minimum at the ages of twenty-four and twenty-five, and then

again increased in proportion to the age of the mother.

I merely state these various views, but whatever my belief may be, I dare not express it until corroborated by a sufficient number of authenticated cases.

Number of Cases.	Physician Attending.	Age of Patient.		Number of Pregnancy.	Time of Fruitful Coitus Relative to Menstruation.	Date of		Duration of Pregnancy.	Sex of Child.
		Married or Single.				Concep.	Deliv'y.		
1	Dr. Engelmann	22	S	I. para	Immediately Before Expected Period.	June 4.	March 2	272	F tw's
2	Dr. Engelmann.	24	S	I. para	.....	July 4.	March 2	242	M
3	Dr. Engelmann.	24	S	I. para	During the Last Days of Flow.	July.	.....	.....	.....
4	Dr. Sinkler.	20	S	I. para	At the Termination of Period.	Aug. 9.	May 15	280	F
5	Dr. Papin.	19	M	I. para	Before Expected Period.	Jan. 22.	Oct. 15	266	F
6	Dr. Papin.	21	M	II para	After Cessation of Flow.	Aug. 22.	May 12	263	M

## CASES FROM PRACTICE.

## TWO SPINAL CASES.

BY FRANK R. FRY, M. D., ST. LOUIS.

The differential diagnosis between a hyperemic and an anemic condition of the spinal cord, is often hard to make. About the latter condition, particularly, there has been much discussion. The majority of medical men is not disposed to regard it as occurring so often or as presenting so definite a line of symptoms as several prominent writers on nervous diseases have represented. Yet there is no doubt that it does occur, and that it is accompanied with symptoms by which it may be recognized

I believe that the following cases, taken from hospital practice, present respectively some of the symptoms of most service in discriminating between these two conditions, and for that reason, I have thought it might be well to report them, and to do so, I have copied portions of the clinical history of each case.

CASE No. 1.—Wm. L—, age twenty-nine years, laborer, native of Tennessee, U. S., married, admitted to the St. Louis City Hospital, February 26, 1880. Diagnosis—Spinal Hyperemia.

Patient complains of a stiffness in his lower extremities and a numb, dead feeling of all that portion of the body below the waist. He is able to walk slowly with the use of a cane. Says walking does not cause him pain but that his legs feel powerless. Says the left leg feels cold, that the right one feels hot. When he first gets up after lying down he feels very stiff and almost helpless in his legs. The sensibility in the left lower extremity is considerably impaired, that of the right seems natural. When lying on his back in bed, he is unable to raise the heel of the left lower extremity from the bed, but he can flex the leg. He was unable to pass his urine last night and this morning (second night after his admission), and was relieved at

ward-hour with a catheter. Says he had not needed such assistance before. His bowels are constipated. He complains of much pain over the spine between the scapulæ and in the lumbar region. This is intensified by both pressure and percussion. The patient gives this previous history of his illness: Three weeks ago he first began to have a peculiar sensation in his right lower extremity. When he went outdoors, his leg felt exactly as one's leg feels when he presses the leg of his pants against it after standing before a hot fire. (This was his own description of the sensation, and is, so far as I know, original). This sensation of heat has continued to the present time, but is not so marked as at first. Soon after the commencement of this feeling in his right lower extremity, a weakness and stiffness began in the left one. This has continued, and has gradually got so bad, that he has to use a cane to walk. During the last three weeks it has been difficult for him to urinate, having to strain a good deal. During the same time his bowels have been constipated, and he has had constant pain in his back, especially at the above named points. Nine years ago he had rheumatism (?) in his left leg; since then he has had no trouble with it up to the present time.

There is no history or other evidence of venereal disease. There are physical signs of incipient phthisis pulmonalis and a family history of that kind. The case was examined carefully with a view to finding the cause of his trouble, but no apparent one was discovered. The patient improved rapidly on drachm doses of the fluid extract of ergot, cathartics and laxatives.

CASE No. 2. Wm. E——, aged 35 years, bookseller, native of England, married; admitted to the St. Louis City Hospital, November 6, 1879. Diagnosis: Spinal Anemia.

Patient is very feeble, hardly able to stand. He complains of general weakness and a feeling of numbness in his lower extremities, and peculiar sensations that he can only partially describe. Tickling the palms of the hands and soles of the feet seems to cause him great distress, and in the lower extremities some reflex jerking. A soft cotton cord drawn over the palms seems to amount almost to torture. He can stand alone and take a step or two with his eyes shut as well as with them open, but he is too weak to stand long. There is no impairment of the co-ordinating power of any of his extremities. An examination with the esthesiometer was rather negative.



The use of the instrument caused him much distress, and, he said, actual pain. The spine was carefully examined and no tender or painful spots found. He has had no pain in his back or head at any time. His right testicle is gone. He says it disappeared during the time a sore on his scrotum was being washed out with a solution of carbolic acid. Patient seems to be very comfortable when allowed to lie undisturbed on his back. He states that his health had always been pretty good up to eight weeks before his admission. At that time he felt himself gradually getting weak and feeble, particularly in his lower extremities. His legs gave way under him several times, and he fell to the ground. He felt uncertain in his movements, and at times had to be very careful to keep from falling. He has had pain in the joints all over his body, particularly in the knees. For several days his eyesight was very poor, says he could hardly see at all, at times. There has been no trouble of this kind lately. His bowels have been regular, and he has had no trouble in passing his urine.

This patient was at first put on iron and quinine and there were soon added to this treatment extract of nux vomica and phosphide of zinc. Under this treatment he gradually improved, and by the 24th of the month was much better. By the advice of one of the consulting physicians of the hospital, the treatment was changed for awhile to that of the fluid extract of ergot in drachm doses two or three times a day. This drug produced no apparent effect except nausea at the commencement of its exhibition. For three weeks previous to his dismissal from the hospital, the only remedy he received was iron. When he left, he was apparently in a fair way to recover and had improved very much. This case was in some respects peculiar, and was examined with care by several of the consulting physicians. One of two of these gentlemen particularly interested in diseases of the nervous system, pronounced it a case of locomotor ataxia. The other said it was spinal hyperemia. The paresis of the lower extremities and other symptoms were such as to lead them to believe that there was a spinal trouble, but no two of them had the same idea regarding the case. I think that the symptoms together with the manner of his recovery and the treatment under which it took place, point to the diagnosis given above. The following points of difference between these two cases are perhaps particularly worth no-

ticing: In No. 1 there was pain in the back and two well defined spots where the pain was increased by percussion; in No. 2 there was no pain and no such points. I failed to find even the *tender spots* so much spoken of in the books in connection with spinal anemia. In No. 2 a relief and comfort were obtained by lying on the back, which was not the case with No. 1. The distinct bowel and urinary troubles in No. 1 were altogether absent in No. 2. In No. 1 there was anesthesia, in No. 2 there was hyperesthesia. These, I believe, most authors regard as important points to be taken into account in differentiating between these two opposite pathological conditions of the cord.



## A CASE OF DIABETES INSIPIDUS (POLYDIPSIA.) CURED BY ERGOT.

BY E. W. SAUNDERS, M. D., ST. LOUIS.

Mrs. P.—æ. 53, consulted me first December, 1879. Her history was as follows: Two years previously her health had failed. She became too much enfeebled to attend to her household duties. She drank excessively of water, rising many times during the night to quench her thirst. At the same time the catamenial flow, which had continued irregularly up to that period, ceased entirely. Anorexia was complete, and meat she rarely tasted. She could not take salt in her food, not even the usual amount that is put in bread. Of coffee she drank to great excess. She had lived most unhappily with her second husband, whom she had married eleven years previously. Her father had suffered from religious mania several years previous to her birth, but he recovered completely from the attack, which lasted eighteen months, and he had no return of it; living many years subsequently. She suffered greatly from pains in back and side (pleurodynia). She had borne

ten healthy children, the youngest ten years old. Syphilis was excluded.

*Status præsens.* Excessive emaciation, skin dry and harsh, bowels excessively constipated. From eight to ten quarts of urine were passed in twenty-four hours. Sp. gr. 1004; chlorides greatly diminished; no trace of sugar or albumen and no casts. An eczema of many years standing, in right groin and in hollow of right knee.

*Treatment.* Ex. ergot. fl. one drachm three times a day, bitterwater, arsenic. In addition directed patient to abstain from coffee almost entirely, to salt her food well and to eat meat, at the same time drinking as little water as possible. On the first day of treatment the quantity of urine was reduced nearly to the normal, causing the patient much alarm by its deep color. The arsenic was soon discontinued as useless. The appetite became good, the emaciation disappeared, and with a few relapses caused by the unauthorized discontinuance of the ergot, the patient in two or three months made a perfect recovery, and now August, 1880, has been in perfect health for months.

The use of the ergot was suggested by reading a case published by Dr. Da Costa in the *American Journal of Medical Sciences*. The dose was reduced to a drachm and a half a day, after some time, though this amount was entirely inadequate to control the diuresis in the beginning of the treatment.

## EDITORIAL.

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## HEBRA AND HIS INFLUENCE ON DERMATOLOGY.

In our issue of last month we gave a short account of the death of Hebra, but the eminent services which this illustrious dermatologist has rendered to medical science, deserve at our hands, a more extended notice.

Hofrath Prof. Ferdinand R von Hebra, was born at Brünn, in the year 1816. He made his medical studies in Vienna, at which university he took his degree in 1841. It is said that his first inclinations were for surgery, but becoming attached to the service of Skoda, as assistant, he became interested in medicine, and, at the instance of his great master, devoted himself especially to dermatology. His first course of private lectures was delivered in 1842, and such success attended his efforts that he soon became a candidate as *privat-docent*, and through the intervention of Skoda, a section of the general hospital was set apart for skin diseases. In 1848, he was made Extraordinary Professor, and in 1870, Ordinary Professor. For ten years he edited the *Zeitschrift der Gesellschaft der Aerzte, in Wien*, and at the death of Rokitansky, the Vienna Gesellschaft der Aertze made him their President. Besides numerous important contributions to dermatological science; he left behind him as lasting monuments to his fame, his magnificent "Atlas der Hautkrankheiten," and his "Handbuch der specielle Pathologie und Therapie der Hautkrankheiten," which has been so acceptably translated by the New Sydenham Society.

In the space at our command it is only possible to indicate in the broadest way some of the fruits of Hebra's life-work. Although it may be truly said that Robert Willan laid the foun-

dation of scientific cutaneous medicine, to Hebra belongs the credit of rearing the superstructure. He found a cumbrous classification and nomenclature, loose observation, and a traditional therapeutics. He left in their places a scientific classification (anatomico-pathological) an acute and logical method of investigation, and a rational treatment. He abolished a host of useless and pernicious drugs, born of the humoralistic notions of other days; and demonstrated that in many instances the local was of greater value than the constitutional treatment of skin diseases. In addition to the masterly descriptions of a number of hitherto undescribed affections, his vast erudition and clinical acumen enabled him to recall the attention of dermatologists to the neglected or forgotten observations of others; indeed, there was no subject connected with cutaneous medicine on which he did not bestow an additional light. Besides possessing a powerful and original mind, capable of grasping the broadest generalities, while not forgetting the essential details of a subject, the pupil of Skoda and colleague of Oppolzer was not devoid of that healthful medical scepticism so vital to the scientific man.

To this habit of his mind we must ascribe much that he accomplished; for he pronounced neither in favor of nor against a thing until it had passed the ordeal of a severe practical application. As Neumann has well said he proceeded from the maxim, *Nihil est in intellectu quod non fuerit in sensibus*.

When Hebra first entered upon the arena, the great dermatological school of Paris, was in the zenith of its glory, and the wards of the Hospital St. Louis, attracted students from all quarters of the world; but the fame of the new teacher and the new teachings soon spread abroad, and Vienna became henceforth the Mecca of the dermatologist, a pre-eminence which it has been since successful in retaining.

That the genius of Hebra has been paramount in its influence on modern dermatology, the number of his disciples and the character of their published works fully attests. In Germany he has left a galaxy of brilliant followers, in whose hands the reputation of the Vienna school is assured. In England, where Erasmus Wilson has ruled autocratically for so many

years, the ideas and methods of Vienna have visibly affected the thought of the younger generation, although, perhaps, somewhat modified by that wise and cautious conservatism which lends such value to English medicine. In this country the influence of Hebra in fostering the study and practice of dermatology has been truly remarkable. The *London Lancet*, in a recent complimentary editorial entitled "Dermatology in America," after referring to the great number of Americans who had studied skin diseases in Vienna, says: "On their return to the New World, stimulated by Hebra's example, imbued with his spirit, and fortified by his teaching and their devotion to the subject, these physicians found lectureships and special clinics gradually constituted for them at almost all the first-rate universities, hospitals and dispensaries, where they could pursue their work, so that at the present time America can look with pride at the numerous bands of workers who are contributing year by year papers of first-rate importance on dermatology, and advancing its studies in a thoroughly scientific spirit."

In conclusion we must admit that others have done special work equally as well as Hebra, and in some departments he has been excelled by several of his immediate followers; but in the broad comprehensiveness of his labors, and in his impression upon the world of contemporaneous thought, the creator of the new dermatology must stand alone in his day and generation.



#### THE INFECTION DOCTRINE OF TUBERCLE.

In his brochure, "Tuberculosis considered as an Infectious Disease," M. Cohnheim has thrown a fire-brand which has opened up anew the vexed question of the nature of tubercle. He argues that the essential element in the production of tubercle lies in a specific virus and its capacity of infection or transmissibility from person to person, and thus finds the

closest analogy to syphilis. The various forms of miliary tubercle, cheesy pneumonia, phthisis and scrofula, are made identical, dependent on a common virus, and the old doctrines of Laennec are fully adopted. The virulence of the disease depends upon the amount of poison absorbed. It may remain latent for a length of time, retained in cheesy nodules or glands, and although producing the condition known as phthisical habitus, it may remain innocuous until developed by favorable conditions. The proposition is advanced that tubercle is developed only by tubercle, a specific disease with a specific poison solely capable of producing it. He considers that the virus is taken into the body mainly through being inhaled into the air-passages or taken with the food, as, for example, the milk of tuberculous cows—in the one case finding lodgment in the lungs, and in the other in the alimentary canal. The infection of the ovum by the semen is made a possibility. From the local lesion, the point of absorption, the virus invades the lymph glands in the next vicinity, the bronchial and pulmonary glands or the mesenteric glands; passing through these, it is absorbed into the blood and the disease becomes general. For the production of tubercle of the meninges the track is found through the ethmoid foramina. The existence of tubercle in the different organs, as the pleura, pericardium and in the bones, is explained by its absorption into the blood.

M. Cohnheim bases his theory on observations and experiments made on rabbits and guinea-pigs. He inserted into the sub-cutaneous tissue, into the peritoneum, into the pleura, and into the anterior chambers of the eye, indifferently, particles of miliary tubercle, cheesy lungs, strumous cheesy glands, and produced as a result cheesy nodules. Further experiments with a similar result have been made by feeding rabbits on tubercular matter and by confining them in an atmosphere impregnated with tubercular sputa by means of a spray.

These experiments of Cohnheim are neither original nor new. The same experiments and results are announced by Villemain in 1865, and the deduction of the possibility of inoculating tubercle considered by him as established. His experiments were also made on rabbits and guinea-pigs.

Sanderson, Fox and others discovered, however, that the cheesy nodule was produced in these animals by inoculation with any foul substance, as putrid liver or muscle and even by the insertion of a simple cotton thread. Although true of guinea pigs and rabbits, this did not follow in the case of other animals. Guinea pigs and rabbits may be considered as strumous animals, and any injury or wound may be followed by the production of a cheesy nodule, exactly in the same manner as suppurative arthritis is seen in the strumous human being to follow a slight injury to a joint.

Schotteleus, also, experimenting in the same direction, impregnated the air with different products, tubercle, brain, the secretion of simple bronchitis, cheese, cinnabar, and produced with each the cheesy nodule.

Bühl, of Munich, has long foreshadowed the same doctrine of infection, when he asserted the auto-inoculability of the disease, the possibility of a person with strumous, cheesy glands becoming tuberculous by absorbing into the system the infected material of the cheesy gland, and thus developing lung tubercle.

The English writers, Drs. Maddox and Budd, many years ago advanced the theory of the dependence of tubercle on a specific poison similar in many respects to that of the zymotic diseases.

The profession is not quite ready to accept the infection doctrine of tubercle or phthisis. The experience of practical medicine is at variance with the deductions of the pathologists. The reports of large consumptive hospitals gives the most positive denial to the conclusions claimed. The fact in isolated cases of the partners in married life both dying with consumption must be critically examined, and every other circumstance eliminated which could tend to develop the disease, before the infectious nature of the disease can be considered.



MUNICIPAL HEALTH BOARDS.

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The local bodies to which affairs of the public health are committed in different American cities, are variously constituted, but quite fairly reflect in their acts and proceedings, the character and spirit of the communities which they serve. There is, however, a greater activity in this regard in the East and North than in the West and South, and the fruits of this diligence is shown by the official reports of these organizations. It is not the purpose of this article to particularize, but to call attention to the underlying idea of their existence; not especially to note shortcomings and undeveloped or disused functions, but to urge the lagging to greater and worthier efforts in the line of their high calling.

The primary motive of creation of such bodies, implies earnest and resolute *work*, that they shall point the way to the attainment of higher municipal health, take the lead in all public health questions, and be fully abreast of the most enlightened views on such topics; not that every vagary or theory broached by ill-balanced enthusiasts should be endorsed, but that the body as such, shall be the exponent of the best practical results of the progressive spirit, enlarging knowledge and calm intelligence of the day on all that relates to the protection of population health. To fall short of this, is virtual forfeiture of official birth-right, a cancellation of their reason of being, a confession of inutility of their existence as a body.

This holds good particularly with regard to professional men having seats in such bodies, as something more is expected now-a-days of such medical membership than perfunctoriness, a mere discharge of routine board duties; although to attain that something may require a great effort to break the bonds of cumbrous precedent and ultra-conservative habit. As in all other affairs of the world, such bodies must stand

to be judged by their fruits, and this test strictly applied, would find far too many lacking in that which would plead their justification, and warrant their further tenure of life. A few years in these times show many changes in the conditions of intellectual life, and moving apace as the word does, unceasing effort is the price exacted of those who would not be left in the rear. If the end of a decade shows no substantial advance or improvement in methods of state or municipal health work over its beginning, the fact is weighty as going to prove the inadequacy or delinquency of the means relied on for the accomplishment of such purposes.

The field of public health is now so wide and widening, the outlook and overlook so far and large, that to fully and worthily occupy even a small portion of it falls singly to the lot of comparatively few men. Even before this subject secured governmental recognition, there was ample room for many workers, and now that its study has received fresh impetus, surely no lessened obligation to labor is laid on those charged with circumscribed and more strictly local concerns. The protection from cheats and adulterations, harmful or less hurtful as they may be, that should reasonably be thrown around the sources and articles of common food, securing the purity of vended milk, guarding the integrity of water supply, insuring proper household and tenement hygiene, and that of schools, the prevention of epidemic diseases, either indigenous or foreign, caring for drainage, all these are but a tithe of the subjects legitimately within the purview of health authorities. In fine, to properly scan all avenues by which the well-being of a community may be assailed or jeopardized, requires a wakeful vigilance and zealous care that can never be out of place or observed too much. Preventive, instead of curative medicine, has come to be the accepted doctrine of the time, and the measure of success attained in this direction will gauge the degree of merit to which health bodies may be entitled. Not the least of their functions is the duty of creating and fostering by frank appeals to the sober sense and good judgment of the people, a public sentiment that shall sustain them in their efforts to introduce newer ways and better methods of public health administration.

It is to be sincerely hoped that the example and vigorous agitation of the few in these important matters will rouse to activity and fruitful life the dry bones which now supinely slumber in the valleys of municipal apathy in different parts of the country.

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### ASPHYXIA IN STRYCHNINE POISONING.

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Richet explained (*Gaz. Heb.*) before the Paris Academy of Medicine, August 30th, the modes of asphyxiation in dogs poisoned with strychnine, pointing out one mode that is of special physiological interest. Dogs poisoned with strychnine suffer asphyxia through two events: first, the contraction of the tetanized respiratory muscles; secondly, through the enfeeblement of respiratory nervous centers. But there is still a third and hitherto undescribed mode of asphyxiation, which is one of the principal causes of death in strychnine poisoning: it is the asphyxia which results from the great interstitial combustion that occurs in the violently tetanized muscles. If, after giving a dog a mortal dose of strychnine, 0.007 ( $\frac{1}{3}$  grain) subcutaneously, artificial respiration is maintained at the rate of 20 to 30 movements a minute, the animal will die at the end of ten minutes, or, at all events, at the end of an hour or two. If the artificial blood be examined, while the dog is still living, it will be found to be dark, just like venous blood. Making 50 respiratory movements, the blood is less dark, but still does not recover the brightness of the arterial. But dogs that have received 0.007 ( $\frac{1}{3}$  grain) of strychnine chlorohydrate will live, if the muscular system be paralyzed with a sufficient dose of curare. If then an animal poisoned with strychnine dies, notwithstanding careful artificial respiration, it is because the general muscular contraction has deprived the blood of oxygen, and has charged it with carbonic acid and possibly with other products of disassimilation.

## BOOK REVIEWS, AND NOTICES.

THE MICROSCOPIST, a Manual of Microscopy, etc., etc., fourth edition, greatly enlarged, with 250 illustrations. BY J. H. WYTHE A. M., M. D., Prof. of Microscopy, etc. *San Francisco, Cal.: Lindsay & Blakiston.* 8vo.; pp. 434, price \$5.00.

In 1877, the third edition of this work was issued with 259 pages and 205 illustrations, and met with such favor, that the author and publishers are encouraged to send out the new edition of almost double the size, with a large addition of fine and valuable illustrations, while the price is only advanced 50 cents.

The microscope has become a necessity to the study of so many different topics, has rendered possible so many discoveries and such phenomenal advances, that a bare enumeration of its useful applications in the various departments of science would fill many volumes. But while such an extended field could not be cultivated by any individual, and while most of the workers confine themselves to a single or at most to a few of these departments, it is a matter of interest to every one, to have easily accessible to him, an abstract of the knowledge acquired in all the departments of science by the aid of the microscope. This place, the "Microscopist" is intended to fill, and fills well. It is no easy task to select judiciously from the overwhelming mass of precious knowledge, such salient points as will be of interest and importance to every one, yet our author has accomplished it successfully. The most prominent authors in the various scientific disciplines have been carefully examined, and the status of knowledge fairly stated in compendious form, while in the present edition especial attention has been given to the branches necessary to the practitioner of medicine, by the addition of full chapters on the use of the microscope in pathology, diagnosis and etiology.

Many things are here judiciously compiled which cannot be found conveniently without a search through a voluminous literature of the subject. The first six chapters are

devoted to a description of the various modifications of the instrument and the best methods of preparation and examination. Next comes the application to mineralogy and geology. The discoveries of Forbes and Sorby, Heer and others, are well represented and beautiful illustrations given. We miss the mention of the names of Zirkel and Rosenbusch, and others of the pioneers of microscopic petrography. Chapter eight treats of micro-chemistry and does full justice to Wormley's meritorious researches, and introduces much interesting matter and many illustrations from Thudichum's *Chemical Physiology*. Chapter nine gives a well-selected critical abstract of the present status of biology, the facts being stated without much theoretical speculation. Instead of dividing living beings into two groups, plants and animals, or assuming between these as a third the protista, he prefers to make three divisions, fungi, plants and animals. In chapter ten, vegetable histology and botany are briefly considered and abundantly illustrated. A valuable table of classification of diatoms inserted from the *Micrographical Dictionary*, will prove of especial interest to many. To general zoölogy, chapter eleven is assigned, and as fair an outline is given as twenty-four pages can afford. The second half of the book, of the most special interest to the physician, treats in four chapters, 166 pages, of animal histology, pathology, diagnosis and etiology. Ten large plates, some exquisitely colored, and a large number of woodcuts, most of them from Rindfleisch, do full justice to the illustration of this important portion of the work.

The appendix contains recent additions to the microscope and microscopic technology and a classification of the cryptogamia, followed by an index and glossary of terms, which adds much to the usefulness of the work.

We hope the book will meet with the well-deserved encouragement of large and rapid sales. C.

TRANSACTIONS OF THE MEDICAL ASSOCIATION OF THE STATE OF MISSOURI AT its Twenty-third Annual Session, held at Carthage, Mo. 1880. *St. Louis: Davis & Freegard Printers.*

A volume of 164 pages, nicely printed on tinted paper, of good quality, contains the transactions of our own State Society.

In the annual address, which is entitled "Medical Ultraisms," Dr. J. M. B. Maughs contrasts the practice of medicine now with that of thirty years ago, with particular reference to the growth of specialties.

Dr. A. J. Steele read a paper describing the course of treatment adopted for the relief of a deformity at the wrist joint. Two cuts illustrate the paper, one showing the deformity, the other the apparatus which was applied. Dr. F. M. Johnson described a "Complete outward Dislocation of Radius and Ulna."

The next paper is that of Dr. Geo. J. Engelmann, on "The Simplest Uterine Manipulations and Operations and the Accompanying Dangers." It is a carefully prepared paper, and details, under appropriate heads, such as Dangers from use of the Uterine Sound, from Sponge Tents, from Incision of the external Os, twenty-three cases from the practice of himself and others, in which serious or fatal results have followed upon the simplest manipulations and most trivial operations.

Dr. George Halley reported two successful operations for the relief of facial neuralgia. He made a resection of the infra-orbital nerve and sphenopalatine ganglion. In both cases the patient had been entirely relieved, in the first, over two years having elapsed, in the other, six months.

Dr. J. M. Allen's paper was entitled "The Relation of Mind to Matter."

Dr. F. J. Lutz discussed the subject of Abdominal Surgery and reported an interesting case of "Cyst of the Broad Ligament," for which he operated successfully.

Then follows Dr. C. A. Todd's paper on the "Dry Treatment of Discharges from the ear;" an abstract of Dr. J. E. Tefft's paper "On Miasmata;" a paper by Dr. H. H. Mudd, discussing the relative merits and scope of "Lithotomy and Lithotrity;" and also a case illustrating the subject of Cerebral Localization as a guide to surgical treatment.

Dr. S. S. Laws presented the "Report on Medical Education" Dr. J. S. B. Alleyne, that on the "Progress of Medicine," both carefully prepared and able papers.

The last thirty pages of the volume are filled with the lists of members for 1880, and officers from the organization to the present time, and the constitution, by-laws and code of ethics of the Society.

TRANSACTIONS OF THE MEDICAL AND SURGICAL FACULTY OF THE STATE OF MARYLAND, Eighty-Second Annual Session, held at Baltimore, Md., April, 1880.

This is a volume of 216 octavo pages, well printed on tinted paper.

The subject of the inaugural address of President S. C. Chew, M. D., is "Medicine in Past and in Future." The annual address by Jno. W. Mallett, M. D., was on "The Claims of Science for its Own Sake upon the Medical Profession," an able plea for thorough scientific culture in the physician, both on account of advantage to himself in his work, and on account of the opportunity which his position gives him to stimulate similar scientific research and culture in others.

The report of the "Section on Practice of Medicine," consists of a paper by Prof. A. B. Arnold, M. D., on the use of the Sphymograph, accompanied by sixty-seven cuts of tracings.

The reports on Surgery, and Obstetrics and Gynecology, contain brief summaries of work in those departments during the year. That on Sanitary Science, by J. A. Steuart, M. D., contains interesting details of the work of the Health Department of Baltimore, especially with reference to the substitution of hydrant water for public pumps, which were found to be supplying water contaminated by waste from privies and sewage.

"What Can be Done for our Imbeciles?" is the title of a paper that relates briefly the history of the work that has been done in this country in behalf of this unfortunate class, and a more detailed statement of the state of things in Maryland, where there is, as yet, no institution for the education of imbeciles or feeble-minded. The paper is carefully prepared and interesting.

The Section on Ophthalmology and Otology, present a paper by J. J. Chisholm, M. D., on "Optico-Ciliary Neurotomy," and one by Geo. Reuling, M. D., on the "Extraction of Cataract within the Capsule."

There are also papers by R. Winslow, A. M., M. D., on "Clonic Spasms of the Muscles of the Arm and Trunk;" by J. E. Atkinson, M. D., on "Caustics in Dermatological Practice," by L. McL. Tiffany, M. D., on "Diagnosis of Malignant Tumors of the Upper Jaw in Youth."

TRANSACTIONS OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, AT THE THIRTEENTH ANNUAL SESSION, held at Vicksburg, April, 1880. *Jackson, Miss.: The Comet Book-Printing Establishment.*

We must confess to having experienced a new sensation. We have looked carefully through this volume of transactions of a state medical society, and have laid it down, not with a

feeling of weariness and satisfaction at having completed an ungrateful task, but rather with the consciousness of a pleasant experience and real enjoyment.

From the Address of the President, Dr. E. P. Sale, on "The Duties we owe our Women," and the Annual Address, "Medicine in the Cotton States," by B. F. Ward, M. D., to the briefest reports of cases from practice, every writer seems to have kept clearly in mind the standing resolution of the Society which requires that papers on special subjects "shall consist as nearly as possible of additions to the literature of the profession," and to have brought to the meeting the result of careful observation, close study or pains-taking research.

The report of Dr. Hill on "Recent Advances in Surgery," is a thorough and exhaustive review of the subject, showing a thorough acquaintance with the current literature of the day, and admirable tact in condensing valuable facts into brief space.

Dr. Guice's report on "Recent Advances in Obstetrics" is also a well considered résumé of the literature of that branch during the last year.

Dr. Phares calls attention to a new remedy for whooping-cough, *Ascyrum Crux-Andreas*; Dr. Greene considered "Malarial Hematuria;" Dr. Kittrell presented a full report of a case of "Hemorrhagic Malarial Fever." Dr. Rice read a paper upon the "Treatment of Wounds" in which he dissents from the method of Lister. Dr. Brownrigg reported an "Operation for Strangulated Inguinal Hernia." Dr. Johnston reported two cases of "Amputation of the Leg" with one of "Traumatic Tetanus which recovered." Dr. Taylor presented "Notes on some Cases of Interest," six cases of serious post-partum hemorrhage. Dr. Halbert related the "Removal of Urethral Calculi by Perineal Section;" Dr. Bennett gives an account of an operation of "Lithotomy" performed with the instruments of an ordinary amputating case and pocket cases and a pair of dentist's universal forceps. The result was an entire success, although the condition of the patient was not such as to render the prognosis favorable. He thinks this the first operation of Lithotomy performed in Southern Mississippi. Dr. Hall reported an "Unusual Congenital Malformation of the Anus." Dr. Sale a successful operation for "Atresia Vaginae, Complicated with Pregnancy." The last paper is an account of the "Yellow



Fever at Concordia, 1879." At the close of the volume are obituary notices of members of the Association who have died during the year.

Having found so much that is satisfactory and commendable, we regret to say that we observed a considerable number of typographical errors, and incorrect use of Latin words in several instances, which mar a really valuable series of papers. We shall hope that the next volume will be more carefully corrected in these particulars, and will retain the same excellent quality of material as we have found in this volume.

TRANSACTIONS OF THE STATE MEDICAL SOCIETY OF ARKANSAS, at its Fifth Annual Session. Little Rock: Printed by James Mitchell, State Printer.

The Arkansas State Society is of recent organization, and the transactions form a volume of but 120 pages. The Annual Address by the President, E. T. Dale, M. D., sketches briefly the history of medicine from its earliest rudiments to the present day. He calls attention to the subject of reform in medical education, and to the importance of organizing a State Board of Health. He suggests, as a practical way of increasing the interest and profit of the meetings of the State Society, that the routine business should all be transacted in the mornings, and afternoon and evenings sessions be devoted strictly to the reading and discussion of papers, and, further, that topics for discussion be selected and published with the transactions. In this way members would be more likely to come prepared to read papers or take part in the discussions.

Dr. D. A. Linthicum presented the report on State Medicine. "An Account of the Yellow Fever, as it appeared in Forrest City, Arkansas, during the summer of 1879," was read by Dr. J. B. Cummings.

Dr. J. H. Southall reports in a paper entitled, "Expert Testimony without Compensation," the result of a contest in which he and Dr. A. L. Breysacher were summoned to a distant county as medical experts, while the defendant in the case, at whose instance they were summoned, refused to pay them their fees as experts. The decision of the court was that they could not be compelled to give expert testimony without due compensation.

E. T. Murrell, M. D., reports a case of "Unusual Sequels of Scarlatina;" E. R. Du Val, M. D., a case of "External Perineal Urethrotomy;" J. E. Bennett, M. D., a case of "Fracture of the

Coronoid Process;" A. Dunlap, one of "Diabetes Mellitus," treated first with sulphide of calcium and later with salicylic acid. G. B. Malone, M. D., discusses "Malarial Hematuria;" J. C. Shibley, M. D., "Some Points in the Treatment of Pneumonia;" C. E. Nash, M. D., "Scarlatina and its analogues, Diphtheria and Membranous Croup;" Thomas W. Hurley, M. D., "Septemic Poisoning and Mercurial Eczema, caused by wearing Vulcanite Plates."

The use of a better quality of paper and a little greater care in proof-reading, would have made a great improvement in the appearance of the volume.

CONTRIBUTIONS TO ORTHOPEDIC SURGERY: Including Observations on the Treatment of Chronic Inflammation of the Hip, Knee, and Ankle Joint, by a New and Simple Method of Extension, the Physiological Method; and Lectures on Club-Foot, delivered at the College of Physicians and Surgeons, New York, (Special Course) by JOSEPH C. HUTCHINSON, M. D., Visiting Surgeon to the Brooklyn (N. Y.) City Hospital; Surgeon-in-Chief to the Brooklyn Orthopedic Infirmary; Consulting Surgeon to the Kings County, St. Peter's and St. John's Hospitals; formerly Professor of Operative Surgery and Surgical Anatomy, Long Island College Hospital; Ex-President of the Medical Society of the State of New York, of the New York Pathological Society, of the Kings County Medical Society, and Ex-Vice President of the New York Academy of Medicine; Member of the New York Surgical Society, of the American Medical Association, and Honorary Member of the Connecticut and the New Jersey Medical Societies, etc. *New York: G. P. Putnam's Sons.* 1880. 12mo., Cloth, pp. 121, price \$1.25.

This is a beautiful little book, the binding in cloth is quite artistic, the paper is very heavy, No. 1, and tinted; the letter-press is most excellent, and the typographical errors few. All this redounds to the credit of the publishers, the Putnams. But there are some things for which the author is responsible that are not in such good taste: The unconscionably long title of the book is possibly pardonable, though it seems like much ado about a little thing; but the great number of titles affixed to the author's name was certainly avoidable and unnecessary. We have purposely given all these titles in order that their number and rank might be the best condemnation to such a practice as has been indulged in by Dr. Hutchinson, following the lead of some others. He has drummed up a long list of titles, a veritable monument, arranged on the title page in the shape of a reversed truncated cone, in which we are told of fourteen different positions held (past and present) by the

author, and are given to understand by the added "etc.," that much more of the same could be furnished. If it had been, Heaven save the mark! To be told that he is "Surgeon-in-Chief to the Brooklyn Orthopedic Infirmary," were quite sufficient. What care the reading public that he is an "Honorary Member of the New Jersey Medical Society"? The fact, though a sweet *morceau* to the recipient, does not increase the value of his book to us. If what he says on joint troubles is new and good, it will be commended, but none the more so, because he happens to be a member of this, that or the other society. We characterize this excessive titling as fulsomeness.

On the third page comes a long "dedication," which we must believe, Dr. Squibb can scarcely consider complimentary; not but what the terms of endearment and commendation are deserved, but a physician of such note, were worthy of a higher honor than to receive the dedication of a mere reprint, for such is all that the book is; the first part having been given to the profession through the pages of the *American Journal of Medical Sciences*, in 1879, and the Proceedings of the Kings County Medical Society, same year; the second part through lectures delivered at the New York College of Physicians and Surgeons. These multitudinous titles and the page of dedication would not be quite so *mal à propos* (though the former would be in bad taste anywhere,) if the book was an octavo of a thousand pages, filled with original matter, the result of great erudition and research, instead of being a small 12mo. reprint of 120 pages.

Part first is devoted to the consideration of chronic joint-troubles of the inferior extremity, not of the cause, symptoms, or pathology, but only of the treatment, which, designated as the "physiological method," consists simply of putting the patient on crutches, an elevated shoe on the sound side, and allowing the limb of the affected side to hang pendent, claiming that the weight of the limb, "one-fifth of the whole body," in case of the hip will afford all the requisite extension, and immobilization of the joint is sufficiently secured by the peri-articular muscles<sup>1</sup> which are excited by the local inflammation to reflex contraction.

In hip-joint disease, Dr. Hutchinson condemns all apparatus

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1. This he says is true in the hip; in the knee and ankle he uses splints to fix the joints.

applied to the limb, and protests against the hip splints of Davis, Taylor, Sayre, and all others which are claimed to afford motion to the joint while the reparative or healing process is going on. In this latter particular he is right, for while inflammation exists, quiet is the sheet-anchor of treatment. It has been a matter of observation with us that the portative splints referred to, with a joint to afford motion at the hip, did not accomplish the end designed; while they permitted motion, they did not compel it, and thus but little motion was had, and that little injurious. Surgeons given to the notion that motion is necessary to the repair of a diseased hip-joint, and constructing their splints with that intent, have been courting and following an *ignis fatuus*, and we suspect they are beginning to realize it, for both Taylor and Sayre now connect the thigh piece with the hip-band by a strap, thus preventing motion, so that the joint in the apparatus becomes merely a convenience for adaptation. The apparent joint motion is in the lumbar vertebræ. Diseased hip-joints, treated with apparatus, have recovered, not because of the joint in the splint, but in spite of it.

Dr. Hutchinson's condemnation of the long hip splint, *e. g.*, Taylor's, goes too far. The splint does not prevent Dr. H.'s physiological extension, the weight of the limb, from acting, and it additionally increases that extension; and, secondly, while there are no crutches for the axillæ, yet there are crutches for the perineum, which support the weight of the body; thirdly, Hutchinson claims that the unaided action of the muscles immobilizes the joint. Well, they do so none the less that a splint is on the limb; fourthly, by the "physiological method," extension of the limb is made only while the patient is on his crutches, which would not average one-fourth of the time. If extension is necessary to the cure, it were advisable that it be continuous twenty-four hours in the day, as contemplated by Taylor, and not six only, as by our author. The objection urged by Dr. Hutchinson to the long splint, that it does not keep up its extension, but that with every step of the patient the extension strap relaxes or loosens, contains a grain of truth, but this is partially due to neglect; the splint requires attention, to be kept well up to its work. However, this weak point in the splint has been recognized, and remedied by an appliance of Dr. Shaffer, whereby one portion of the side-bar telescoping into

another, through the action of a spiral spring the extension is rendered equable and constant; or, as the reviewer has suggested, the two lower straps are made to pass over rollers and come together on the outside of the bar and find attachment to an elastic rubber or spiral spring, whereby the slight relaxing, when a step is taken, is prevented.

We do not object to the adoption of crutches, but we certainly deprecate the discarding of all means of extension except the simple weight of the limb. And a child could not be trusted to never lay aside its crutches; at times weight would be borne upon the limb to its detriment. In a case lately treated by Dr. Wyeth, the use of the long splint was happily combined with the crutches.

While the author's plan of treatment is not new, (Taylor employed it as early as 1867,) yet it is new to rely upon it alone in any and all stages of hip-joint disease; and we must believe that Dr. Hutchinson with this simplified treatment, orthopedics made easy, or every patient his own doctor, will have done much harm if he succeeds in inducing medical men to adopt the "physiological method," and to rely upon it alone to the exclusion of all other means.

To evidence the truth of the theory, seven cases are given, only three of which came under his own observation, and two cases were evidently synovitis, a brief affair. They are, of course, selected and show charming results. We trust our author may, in the near future, present statistics of, say fifty or a hundred cases, reported in the order of their occurrence without selection, and had under personal observation from their commencement to final issue.

Affections of the knee and ankle are treated by accurately fitting splints, to the former of felt, to the latter of plaster, the elevated sole on opposite shoe, and the sustaining crutches. Assertion is made that the weight of the pendent leg in one case, and of the foot in the other, affords all the extension requisite without other aid, and that in the case of the knee the weight of the leg, equaling one-twelfth to one-tenth of the whole body, excites an extending force even though an accurately fitting, completely encircling splint be applied. This cannot be true, as the close adaptation of the splint would cause it to receive much or most of the weight of the leg. And the same would be true of the ankle with its splint ap-

plied. The plan is commendable, not because of the extension secured, but on account of the fixing of the joints, and the removing of the weight of the body from the diseased part.

The latter half of the book is devoted to the consideration of club-foot, its causes, pathology and treatment. The descriptions are quite lucid and accurate; the treatment advised is manipulation and the plaster bandage, tenotomy when necessary, followed by the plaster; the foot being brought into good position, a mechanical shoe is worn until the cure is perfected. After division of the tendon, Dr. Hutchinson, differing from many surgeons, defers stretching until the fourth day.

In conclusion, we would inquire of the author why he spells the word with a diphthong on the covers, orthopædic, while within the covers it is simply "e", orthopedic? Consistency is a jewel.

A. J. S.

THE SURGERY, SURGICAL PATHOLOGY AND SURGICAL ANATOMY OF THE FEMALE PELVIC ORGANS. In a series of Plates, taken from Nature, with Commentaries, Notes, and Cases by HENRY SAVAGE. M. D., London. Fellow of the Royal College of Surgeons of England, one of the Consulting Medical Officers of the Samaritan Hospital for Women. Third edition, revised and greatly extended. Thirty-two Plates and twenty-two Wood Engravings with Special Illustrations of the Operations on Vesico-vaginal Fistula. *New York: William Wood & Company, 27 Great Jones Street. 1880. (Wood's Library of Standard Medical Authors.)*

In the reproduction of this most valuable work, Messrs. Wood & Co. have given more evidence of their intention to thoroughly carry out their design of presenting to the profession the works of standard authority, in convenient form and at such prices that there can be no reason why every studious medical man should not possess them. The plates only lack the coloring of the originals to make them as handsome, the details are absolutely correct. The different shape of the pages has imposed the necessity of rearranging the numerical order of the illustrations, so that in referring to these, authors of papers should be careful to state whether the plate is from the "Wood's Library" or from the edition published by Lindsay & Blakiston.

We have had occasion so frequently to commend this series to our readers, that we can only advise those who have not yet subscribed, to do so at once and secure the entire set for 1880 complete.

G. A. M.

THE STUDENT'S DOSE BOOK AND ANATOMIST, COMBINED. By C. HENRI LEONARD, A. M., M. D., Professor of Diseases of Women, Michigan College of Medicine, etc., etc. Part I. *Multum in Parvo* Reference and Dose Book. Part II. *Vest Pocket Anatomist*, *Detroit*: 1880. 16mo, pp. 100-60, cloth, \$1.00.

Each of the little volumes which are here combined, has had an extensive sale, and has met a want that is often felt by a medical student, and not infrequently by the practitioner, a means of readily refreshing the memory with reference to the dose of a remedy or the exact anatomical relations of different parts.

Besides the list of doses and the condensed anatomy, this volume contains other valuable matter for reference, such as, "Poisons and their antidotes, Tests for Urinary Deposits, Obstetric Memoranda, Tables of Weights and Measures, etc., etc.

THE PATHOLOGY, DIAGNOSIS AND TREATMENT OF DISEASES OF WOMEN, INCLUDING THE DIAGNOSIS OF PREGNANCY. By GRAILY HEWITT, M. D., London, F. R. C. P., etc., etc. Third American from the third London edition revised and enlarged, with one hundred and thirty-two illustrations. *Philadelphia*: *Lindsay & Blakiston*. 1880. 8vo., pp. 751; cloth, \$4.00, sheep, \$5.00. (Through St. Louis Book and News Co.)

The learned treatise of Dr. Hewitt has already become familiar to American practitioners, and the third edition is now placed before them. In this, we find a general alteration of the method of arrangement of the previous editions, rendering it more convenient for reference, without losing any of its value. We know of no author who more carefully and satisfactorily elucidates the art of diagnosis. The great difficulty in making correct and fine distinctions in intra-pelvic or abdominal diseases is so often exhibited that every aid to a more thorough knowledge of the elements of differentiation is of great value, and no labor given to the elucidation of these, and comprehension of the comparative value of different symptoms and signs is wasted. Daily practice in gynecology presents problems which will often tax every source of knowledge to the utmost. Therefore, the work before us, commends itself most highly to the general as well as the special practitioner, as a most thorough treatise in this branch of gynecological medicine.

Dr. Hewitt is the champion of the mechanical etiology of uterine disorders, and makes the strongest possible arguments for this side of the question, consequently he has paid most attention to mechanical methods of treatment, so that, as a

guide in such cases as require instrumental aid for support or correction of position, our author is a most reliable and suggestive guide.

The mechanical execution of the work deserves commendation by reason of the excellent type and paper, notwithstanding some typographical errors.

G. A. M.

INDEX-CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY. Authors and Subjects. Vol. I. A.—Berlinski. *Washington: Government Printing Office. 1880.*

It is impossible to form an adequate idea of the immense amount of labor involved in the execution of such a work as this Index-Catalogue of which the first volume lies before us. It is a work by the conception and achievement of which Dr. Billings has placed under obligations to himself the whole medical profession; for while a comparatively small number will themselves have or ever see the volumes, they will reap the benefit of them from the writings of those whose researches will be facilitated by their use.

It consists of a catalogue both of authors and subjects of original articles in the various medical journals and volumes of transactions contained in the Library of the Surgeon-General, the most complete collection of medical literature in the world, and will be invaluable as a means of reference upon all topics in medical literature. It will be the most complete index ever published.



## BOOKS AND PAMPHLETS RECEIVED.

PROSPECTUS OF THE ST. LOUIS COLLEGE OF PHARMACY, Fifteenth Annual Session, October 1880, to March 1881. *St. Louis, Mo., Bag and Printing Co.*

SEVENTEENTH ANNUAL REPORT of the New York Society for the Relief of the Ruptured and Crippled. May, 1880.

A PRACTICAL TREATISE ON TUMORS OF THE MAMMARY GLAND: Embracing their Histology, Pathology, Diagnosis and Treatment. By Samuel W. Gross, M. D., Surgeon to Jefferson Medical College Hospital, etc., etc. Illustrated by twenty-



nine engravings. *New York: D. Appleton & Co., 1880.* 8vo, pp. 246. Cloth.

THE BRAIN AS AN ORGAN OF MIND. By H. Charlton Bastian, M. A., M. D., F. R. S., Professor of Pathological Anatomy and of Clinical Medicine in University College, London, etc., etc. With one hundred and eighty-four illustrations. *D. Appleton & Co.* 1880. 12mo, pp. 708. Cloth. (Through H. R. Hildreth Printing Co.)

THE ART OF PROLONGING LIFE. By Christopher William Hufeland. Edited by Erasmus Wilson, M. D., author of "A System of Human Anatomy" etc., etc. From the last London edition. *Philadelphia: Lindsay and Blakiston, 1880,* 12mo.; pp. 280. Cloth, \$1.00. (Through the H. R. Hildreth Printing Co.)

A TREATISE ON COMMON FORMS OF FUNCTIONAL NERVOUS DISEASES. By L. PUTZEL, M. D., Visiting Physician for Nervous Diseases, Randall's Island Hospital, etc. *New York: Wm. Wood & Co., 1880.* Wood's Library of Standard Medical Authors. (Through C. C. Pease, General Agent, St. Louis.)

HYGIENIC AND SANATIVE MEASURES FOR CHRONIC CATARRHAL INFLAMMATION OF THE NOSE, THROAT AND EARS. Part I. By Thos. F. Rumbold, M. D. *St. Louis: Geo. O. Rumbold & Co.* 1880. 12mo, pp. 174; cloth \$1. (Through H. R. Hildreth Printing Co.)

ON THE BILE, JAUNDICE AND BILIOUS DISEASES. By J. Wickham Legg, Fellow of the Royal College of Physicians of London. *New York: D. Appleton & Co.*

CONTRIBUTION A LA MÉCANIQUE GYNÉCOLOGIQUE. *Par le Dr. E. C. Gehrung, de Saint Louis (Etats Unis) Annales de Gynécologie* Août, 1880.

DETROIT MEDICAL COLLEGE. Order of Exercises for the Freshman, Junior and Senior Classes. Regular Term, 1880-81.

NATIONAL ASSOCIATION FOR THE PROTECTION OF THE INSANE AND THE PREVENTION OF INSANITY.

TRANSLATIONS.

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TOTAL OBLITERATION OF THE LEFT COMMON CAROTID IN TWO  
CASES OF ANEURISM OF THE ARCH OF THE AORTA.

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*Dr. Eug. Fraenkel.*

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CASE I.—A man *æt.* 50, without history of previous sickness had an apoplectic seizure May 25th, 1879. This was followed by complete right hemiplegia and facial paralysis of the same side and aphasia May 27th, paralysis of the left motor oculi communis. Death, October 27th. The motor oculi paralysis had slightly diminished, the hemiplegia had persisted unchanged.

*Post-mortem.*—The left internal carotid in the carotid canal was solidly filled with a grayish adherent, and resistant clot. There persisted at this level a capillary opening. Two centimetres below the origin of the ophthalmic artery there was no free passage at all; the clot was hard and adhered very closely to the arterial walls. The carotid originated from the anterior part of an aneurismal sack developed at the expense of the arch of the aorta. It was flattened and completely obliterated for the distance of several centimetres. Higher, its calibre was almost of normal size but filled with a soft, reddish clot which was removed without difficulty.

The left ophthalmic artery and the Sylvian artery of the same side were closed by a clot which was continuous with that filling the petrous portion of the internal carotid. The island of Reil, the point of the parietal lobe, the frontal convolutions at the base of the left cerebral lobe were sunken and presented very distinctly yellow softening upon their surface, a softening which extended inwardly towards the central ganglia.

An aneurism the size of the fist, occupied the arch of the aorta back of the sternum, and included the origin of the three great arterial trunks.

CASE II.—A man *æt.* 54, was taken into the hospital of Hamburg, April 5th, 1876. There was found a dulness at the supe-

rior part of the sternum over a space as large as the hand, and independent of the cardiac dulness. At the same level a sharp murmur could be heard.

According to the history received, the patient about two years previously had had the first loss of consciousness, in consequence of which he remained aphasic and paralyzed three days. Speech and motion returned, but he never recovered his intelligence. In 1875, second loss of consciousness. Finally, April 2d, he fell again insensible at his work.

The left carotid felt decidedly smaller than the right; no pulsations detected in the superficial temporal.

August 2d, pulsations in the left carotid wholly stopped. Fresh loss of consciousness August 28th. Pneumonia of the left inferior lobe. Death, December 24th, with phenomena of great collapse.

The condition of dementia had increased during his stay in the hospital. Pulsation did not re-appear in the left carotid. The dulness over the sternum persisted.

At the autopsy, points of disseminated softening were found on the surface of the left cerebral hemisphere—one of the centers occupied the third frontal convolution. Rusty colored cicatrices were present in the opto-striated ganglia. The ventricles were distended with a great quantity of serous liquid.

An aneurism of the size of the fist, included the arch of the aorta from its origin to the point of emergence of the left carotid. Its anterior wall was ulcerated away and replaced by the surface of the sternum. Its cavity was lined with a stratified clot. The opening of the brachio-cephalic trunk was free. The trunk of the left common carotid was obstructed by a very resisting clot of yellowish color and continuous with that filling the aneurism. The carotidclot extended to the bifurcation.—

*Virchow's Arch.*, 1880.

## FRACTURE OF THE FEMUR THROUGH MUSCULAR CONTRACTION.

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Dr. E. Vallin, Professor of Hygiene, at the Val de Grace.

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In 1873, at Batna, Algiers, there being no civilian physician in the neighborhood, I was charged with the weekly visit at the hygienic dispensary for prostitutes. The women were all examined per speculum, and mounted by aid of a stool, the table which was about 80 centimetres (31 inches) high.

A young Arab, of 16 or 18 years, lively, robust, and of healthy appearance, prepared to take her place, and was raising herself upon the stool when she suddenly gave a cry and fell into the arms of the assistant who was by. She declared that she could not raise her leg, that she had felt something crack, that the leg was broken. I found that the right thigh was fractured below the middle, but too high to indicate separation of the epiphysis; crepitation, and mobility were not very distinct, but sufficiently so for diagnosis. Almost without leaving my chair and upon the instant I could determine the exact manner of the occurrence. The woman had walked without any difficulty for more than a quarter of an hour to reach the dispensary from her residence; she had walked about the court chatting with her companions a few minutes before the accident. She had made no misstep when climbing upon the examination table, before which I was seated watching her movements. The rounds of the stool were a little higher than an ordinary step, perhaps thirty centimetres, (eleven inches) and it was at the moment when the right thigh was supporting the whole weight of the body that the fracture took place. It is impossible to conceive an *ensemble* of circumstances more completely under the eye of the physician; it is evident that in this case muscular action together with the weight of the body alone caused the injury. An apparatus was applied and she remained in hospital under my charge. Recovery was rapid; at the end of six weeks the patient laid aside the splints and at the end of two months left the hospital. Some months later I saw her dancing in a public café.

While she was in the hospital I examined her with great care

as to morbid antecedents. She was not cancerous nor of that diathesis; her mother was in habitual good health. There were no traces of syphilis. Under the circumstances I felt obliged to attribute the abnormal fragility of the bone to an inherited syphilitic diathesis. I arrived at this opinion solely through the process of exclusion and it scarcely has scientific value. The woman was not scorbutic, anemic, nor cachectic; was well developed, vigorous, well modeled, had superb regular teeth. The urine was examined several times but exhibited neither albumen nor sugar.

The published case of Dr. Clarence Foster in the *London Medical Times and Gazette*, July 17, 1880, prompted me to make this case also public. Dr. Foster states that he was called to see a man aged 50, who had a simple transverse fracture of the left femur at the middle third. The patient had suffered no fall nor received any blow, but while walking had made a slight misstep, when, during the effort at maintaining his balance, the fracture occurred. Dr. Foster also states that he had no reason for supposing the existence of any previous disease of the bone. (*Gaz. Heb.* Sept. 10, 1880.)

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## REPORTS ON PROGRESS.

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### DISEASES OF THE GENITO-URINARY ORGANS.

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Influence of Varicocele on the Nutrition of the Testicle.—DR. WILL, in a recent clinical lecture, discusses this subject at length, contrasting the opinions of such surgeons of eminence as have recorded their beliefs. Sir James Paget is of the opinion that the fears so frequently expressed by patients, that varicocele is a forerunner of wasted testicle, debility of sexual organs, impotence, etc., are groundless. Sir Astley Cooper writes that "varicocele should scarcely receive the title of a disease, for it produces in the greater number of cases no pain, no inconvenience, and no diminution of virile powers;" while Professor Humphrey thinks it is rarely productive of any decidedly injurious effect upon the testicle or the character of its secretion. Evidence of the opposite character comes from Barwell, Curling, Henry Lee, Gosselin and Percival Pott. Mr. Barwell thinks that the testicle from which the varicocele springs, is not of much use. Mr. Jonathan Hutchinson's views are peculiar. He thinks the cause of the varicocele, as well as

the wasting of the testicle, is due to central nerve disease. Will thinks it impossible to reconcile the diverse views of authorities, but brings forth some strong clinical evidence to substantiate the view that the nutrition of the gland is endangered by a varicose condition of its veins, especially when the varicocele is large. The fact that the condition of the gland improves after successful operation, is very strong evidence in favor of the latter view. He lays down the following conditions as being those indicating operation: 1. If the varicocele is very large or increasing. 2. If the testicle is atrophied. 3. If acute pain be complained of. 4. If the patient be disqualified from entering the public service. 5. If the stability of his mental faculties be endangered.—*Lancet, American Edition, Aug., 1880.*

**Points in the Surgery of the Urinary Organs which Every Practitioner Ought to Know.**—TEEVAN, in a paper recently read before the Harveian Society of London, called attention to the following points:

1. Retention of urine in children, is always caused by stone, unless there is some mechanical obstruction to the escape of urine, such as a contracted meatus or foreskin.

2. Incontinence of urine, when diurnal as well as nocturnal, may be caused by a calculus impacted in the deep urethra. A stone would thus, in the one case, give rise to retention, and in the other to incontinence, for the reason that when in the bladder and at the *meatus internus*, it caused contraction of the sphincter which closely embraced it; advancing farther for half an inch down the canal, it acted as a gag preventing the contraction, and allowing the urine to dribble away by its side.

3. Incontinence of urine in boys may be caused by a congenitally contracted meatus, preventing the free escape of urine and setting up reflex action, resulting in the dribbling.

4. Dribbling of urine in men signifies retention, not incontinence. There is at first retention, until the bladder is overfilled, when gradually the obstruction is overcome by contraction of the bladder-walls, and then there is dribbling, the bladder still remaining distended.

5. When a catheter is introduced, if the urine is expelled with violence and pain, not only through the instrument but along its sides, between it and the urethral walls, there must be a calculus impacted in the deep urethra.

6. It is not possible to empty the bladder completely in every case, for the reason that it may be sacculated.

7. A gleet of more than six months standing implies an incipient stricture.

8. In cases of enlarged prostate, suspect a stone, for the reason that all the conditions necessary for its formation are present.

9. When a man, complaining of frequent and painful micturition, is worse during the day than at night, he most likely has stone. In prostatic cases of frequent and painful micturition, the patient is much worse during the night. Calculus cases are most comfortable in bed; when they move about during the day they have pain from the movements being impressed on the stone.

10. When a man complaining of frequent and painful micturition, is worse when riding on horseback, or in a vehicle, suspect stone, the reason being the same as just above.

11. See that the bladder of the woman in labor is empty before delivering the child.

12. The bladder of a woman who has retention after childbirth, should be emptied with an elastic, olivary catheter, the interior of which should be filled with a bougie; for want of this precaution the catheter will often become plugged with mucus, and thus foil the nurse in efforts at evacuating.—*Lancet, American Edition.*

Transplantation of a Testicle from the Groin to the Scrotum.—WOOD, of London, reports the following case: The patient was aged thirteen. A tumor, which disappeared when lying down, was noticed in the right groin, when he was quite young. For this he had worn a truss all his life. This prevented the descent of the tumor until ten days before he was seen by Mr. Wood, when it slipped past the instrument and could not be returned. This was followed in four days by pain, rapid increase in size, sickness and constipation. When examined by Mr. Wood, there was found at the right external ring, a solid, irreducible, excessively painful tumor, that gave no impulse on coughing. The right testicle was absent from the scrotum. Diagnosis: inflamed, undescended testicle. An ice-bag was applied, and in a week the tumor had been reduced to its normal size. It could not, however, be returned to the abdominal cavity. Mr. Wood now exposed the testicle by an incision over the abdominal ring, and found it smaller than its fellow. The cavity of the *tunica vaginalis* could not be found, and appeared to be obliterated. The testicle was attached to the pillars of the ring by very firm adhesions, which were with difficulty broken down. By freeing the cord for about an inch and a half, he was able to bring the testicle down about an inch, though he found the cord considerably shortened. He then everted the scrotum, stitched the testicle to the everted part with catgut and sewed up the opening, putting in a drainage tube, with a pad above the testicle, all being done under antiseptic precautions. The patient did well, the testicle remaining outside of the ring, and the temperature never going above 99°. A water-pad truss was worn to keep the gland away from the ring, when the patient was discharged.—*Lancet, May 1, 1880.*

Irrigation of the Urethra for the Cure of Gleet and Prevention of Stricture.—REGINALD HARRISON, of Liverpool, concludes that (1) the large majority of strictures, excepting those caused by injuries to the urethra, are preceded by more or less chronic gonorrhœa or gleet, and (2) that the most frequent seat of stricture corresponds with that of gleet—namely, the subpubic or deeper portion of the urethra. It looks, he thinks, as if the persistence of gleet and formation of stricture were due to the imperfect means hitherto adopted for dealing with the membranous portion of the urethra when chronically inflamed; in fact, that the disease escaped treatment altogether, when the ordinary means of injection were relied on. He has used, for some time past, with highly satisfactory results, an apparatus for thoroughly irrigating the deep urethra. An ordinary Higginson's syringe is adapted to a soft catheter, of sufficient length to reach the deep urethra, and by this means the parts are thoroughly drenched with a medicated solution at least twice a day. The sulpho-carbolate of zinc, in the strength of about half a teaspoonful to a pint of water, is generally made use of, though sulphate of zinc, borax, lead acetate, quinine and carbolic acid have their uses, according to circumstances.—*Lancet, Aug. 2, 1880.*

**Antiseptic Nephrectomy for Hydronephrosis of Kidney.**—MR. THOMPSON, of the Samaritan Hospital, London, recently removed a large hydronephrotic kidney, from a girl æt 7.. The bichloride of methylene was the anesthetic used, and caused some retching and vomiting. The operation was done under strict antiseptic precautions. An incision commencing an inch above the umbilicus was carried down its left side to three inches and a half. The peritoneum was caught up by artery forceps and divided, exposing the cyst whose slight adhesions were easily separated by the fingers. The cyst was emptied with the small ovarian tapping trocar. It was found to be enclosed between the layers of the descending meso-colon, the descending colon having been pushed forward and to the right. The sigmoid flexure was also much displaced, and laid across the lower part of the cyst, between it and the bladder, which was distended with urine and rose above the pubes. For enucleation, an opening was made in the capsule to the inner side of the descending colon. No distinct ureter could be made out, only a cord-like structure passing down from the lower part of the cyst to the fundus of the bladder. The renal vein and artery were tied separately with silk, about an inch from the aorta; another silk ligature was tied around the whole pedicle on the distal side of the first two and the pedicle cut away; very little sponging was necessary. The temperature never rose above 101.6°.

The first urine passed after the operation was bloody, and the interesting question, whether the hematuria was due to the carbolic acid used in the antiseptic method or to the sympathetic irritation of the right kidney, is discussed, the reporter inclining to the former opinion. During the convalescence the urine was quite normal.—*Lancet. Am. Ed.*, Sept., 1880.

**Lactic Acid, in Chronic Catarrh of the Bladder.**—DEECKE, of Utica, N. Y., speaks highly of the antiseptic action of lactic acid in those cases of cystorrhœa, where it is desirable to prevent the ammoniacal decomposition of the urine. He experimented with normal urine, and with urine from a patient with mild chronic catarrh of the bladder. The substances tried were, silicate and sulphite of soda, permanganate of potassa sulphuric, nitric and muriatic acids, carbolic acid, salicylic acid and lactic acid. He found the lactic acid far beyond comparison with the other substances. An addition of one per cent. of lactic acid prevents a decomposition and alkaline fermentation of normal urine and the development of micrococci and gliococci for a long period; in pathological urine it arrests their growth and multiplication almost instantly. It seems to be a specific poison for these microscopic forms of life. He calls attention to the fact that the antiseptic action of lactic acid is not the only effective property of the drug. Its dissolving power for catarrhal and diphtheritic exudations is known, being superior to that of any other acid. It, furthermore, easily dissolves ammonium compounds, the ammonio-triple phosphates and the calcium phosphates. When the conditions are unfavorable to local application, it can be easily made to appear in the urine by the administration of three or four grammes of the drug, by the mouth; and its effect is enhanced when given with buttermilk. It also, makes a pleasant lemonade with sugar and water.

[This being the case, the remedy will prove a valuable one in certain



forms of pyelitis, the suppurating surfaces in this disorder being inaccessible to topical applications.]

For injections, a 0.5 to 1.0 per cent. solution is commended.—*Buffalo Med. and Surg. Jour.*, Feb. 18, 1879.

**Importance of the Early Detection of Stone.**—BUCHANAN, in a recent paper read before the Medico-Chirurgical Society of Glasgow, urged the advantage of the early detection of stone, and the necessity of the surgeon being on his guard, lest the first symptoms escape him. He calls the attention of practitioners to the following points: 1. A stone may remain in the bladder for years without causing symptoms demanding an examination of the bladder, if that has not been done on the occurrence of the first symptom. 2. A stone may be in the bladder for a long time, single symptoms recurring at long intervals, while during the intervening periods it may cause no annoyance at all. 3. Symptoms of chronic cystitis may predominate to such an extent as to withdraw the attention from the necessity of examining the bladder for calculus. 4. An examination of the bladder on the first occurrence of the symptoms, detects the stone when it can be removed with the greatest facility and safety. 5. Postponement of sounding allows the stone to grow to a size difficult and troublesome for lithotripsy. 6. When the bladder is fairly healthy and the urethra capacious, lithotripsy is available for even large stones. 7. When a very small stone is detected in the bladder of a child, it can be removed with ease and safety by a thin-bladed lithotrite.—*Lancet, Am. Ed.*, July 1880.

**Is Excision of Obstruction at the Neck of the Bladder Justifiable?** TEEVAN, in his Lettsomian lectures, recently published, recommended for advanced cases of prostatic trouble, where catheterism is difficult, "excision of the obstruction as invented and practiced by Mercier," and exhibited drawings of instruments "for incising the muscular valve and excising the prostatic one." This endorsement of Mercier's method of dealing with the form of obstruction that sometimes occurs in enlarged prostate, doubtless caused surprise in the minds of many American surgeons; for in this country, we believe, the operation has never been performed, and is not even so much as mentioned in the text books devoted to genito-urinary surgery. Indeed, Mr. Teevan conceded that the operation had never been done by himself or any one else in England.

Mr. G. Buckston Browne, in a communication, calls attention to the above points, and claims to have information from the leading surgeons of Paris to the effect that none of them approve of Mercier's procedure in these cases, much less employ it. He is able to state, from correspondence with these surgeons, that there is no evidence that these excisions or incisions about the neck of the bladder have ever been found serviceable, while it is certain that they have been, not only useless, but injurious,

Mr. Teevan, in his reply to Browne, quotes from the report of a commission of the Académie de Médecine, sanctioning the importance and utility of Mercier's operative procedure, and also from a more flattering report made to the Académie des Sciences. He says, furthermore, that Mercier's operation has recently been described by Mr. Reliquet, and its indications set forth. It will be observed that Mr. Teevan fails to show that the operation has been performed by any one of late years, a fact that Mr. Browne calls atten-

tion to in his rejoinder. There is quite a difference between describing an operation and setting forth its indications, and showing that that operation answers the purpose for which it is intended without too much risk to the patient's life. The correspondence may be found in the *Lancet Am. Ed.*, for Sept. 1880.

Speaking of this operation, Sir Henry Thompson says, (Diseases of the Prostate, 1872, p. 207): "I have never performed any such operation myself, nor do I feel justified in recommending its adoption in any circumstances."  
JOHN BRYSON.

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## DERMATOLOGY.

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Sulphur and its Compounds in Diseases of the Skin.—L. D. BULKLEY, in a paper before the American Medical Association at New York, said of sulphur:

First, as to its internal use. Pure sulphur is seldom given alone for skin disease. In eczema about the anus and genitals, however, it is very useful, especially if there is any constipation or piles. It may be given with equal parts of cream of tartar, in teaspoonful doses. Sulphurous acid (SO<sub>2</sub>), is rarely used internally.

Sulphide of calcium is very valuable in skin lesions attended with suppuration. In *acne* it is often useful, but chiefly in those cases which have a considerable pustular element. It is not of much use in *acne rosacea*. In *hordeolum* it is very valuable; also in *furunculosis*, relieving not only the symptoms, but preventing further crops of boils. Like testimony may be given regarding its effects in carbuncle and suppurating buboes. True, non-parasitic *syccosis* is sometimes benefited by sulphide of calcium. The drug is liable to be poor, and should have its characteristic smell of sulphuretted hydrogen. Dr. Bulkley usually gave gr. 1-4 q. i. d.

Sulphuret of potassium probably has the same effect as the sulphide of calcium.

It is undoubtedly the sulphur that does the good in these cases, for other combinations of sulphur, such as the hyposulphite and sulphuric acid, have been found similarly beneficial. A wonderfully valuable combination of sulphur is that known as "Startin's Mixture."

R. Magnes. sulph	ʒi.
Ferri sulph.	ʒi.
Acid sulphur. dil.	ʒij.
Tr. gentian.	ʒi.
Aquæ	ʒiij.
M. Sig.—ʒi. dose after meals.	

This is very potent in reducing cutaneous congestion in such conditions as erythema multiforme, erythematous eczema, and urticaria.

In regard to the use of natural sulphur waters, some benefit is obtained from them, but it is impossible to speak definitely of them, until more data are collected. The speaker would be pleased to receive help from any in collecting such facts.

Externally, sulphur has gained its widest reputation in the treatment of scabies, for which it is almost a specific. It should be remembered that sulphur is an irritant to the skin.

Besides scabies, sulphur is beneficial in acne, either in the form of the pure sulphur or the hypochloride, the latter being used as an ointment, about  $\mathfrak{z}$ i. to  $\mathfrak{z}$ i. Sulphur will also destroy the parasite of favus, ringworm, and tinea versicolor, pure sulphurous acid being the best form for these.

Sulphur vapor baths are of value in very few diseases of the skin. They stimulate the skin and liver, and they destroy skin parasites. But not much more can be said for them.—[*Med. Rec.*, June, 1880.

**Oil of Turpentine as a Parasiticide.**—FOULIS treats tinea tonsurans by placing the patient's head over a basin of hot water and soap, and then pouring a little of the turpentine over all the affected spots. Directly the oil begins to smart, the head is well washed with hot soap and water, rubbing in the soap, which seems to have the power of neutralizing the turpentine. One application made in this way is generally sufficient to kill the disease. [The writer is either mistaken in his diagnosis, or he has given to the profession a remedy of superlative value: for it is well known that of all diseases which the dermatologist is called upon to treat, ringworm of the scalp is the most rebellious and difficult of cure. REP.] *Edin. Med. Jour.*, Aug. 1880.

**Sulphide of Calcium in Acne.**—SQUIRE has given this drug in doses as high as six grains three times a day without causing any inconvenience to the patient, but at the same time without improvement to the acne. [We, in common with others, have seen material benefit in certain of these cases under the administration of the sulphides. REP.] *Lancet*, Sept. 4, 1880.

**Ecchymosis of the Eyelids.**—GRAINGER STEWART related the case of a patient before the Medico-Chirurgical Society of Edinburgh, who had occasionally during the last four years ecchymosis of the eyelids, which occurred suddenly and spontaneously, at first only after exertion and latterly without apparent cause. There was very little tendency to hemorrhage elsewhere; no scorbutus, or hæmophilia. The hair of his head, face and body had become scanty and attenuated. Upwards of two years he had had chronic laryngitis, with occasional ulceration. The muscular fibres of the heart and other muscular structures were enfeebled and relaxed. The patient did not have syphilis, and had experienced no loss of weight. Treatment unsuccessful. *Edin. Med. Jour.*, Sept. 1880.

**Ethylate of Sodium.**—H. S. PURDON has given this caustic an extensive trial in the Hospital for Skin Diseases in Belfast. He says that in lupus vulgaris and erythematosis, scrofuloderma, small patches of cutaneous cancer, warts, mucous tubercles, nævus, and all non-malignant new formations of the skin, the ethylate of sodium is not only useful but curative, and, as a rule without destroying the skin or producing deformity. He suggests this agent for the bites of dogs and snakes. (?) *Archives of Dermatology*, July 1880.

**Ichthyosis Hystrix Congenita.**—F. C. CURTIS reports under this title another case of papillomatous growth, limited to the left lateral half of the body, and following the distribution of the cutaneous nerves (See COURIER, p. 64, July, 1880.) *Archives Dermatology*, July 1880.

**Changes of Color in Skin and Hair.**—SMYTHE has observed some curious instances of marked change of color of hair and skin in healthy persons. A man, aged 47 years, had up to the age of 35 a fair skin, with light hair and dark eyes. About this time his hair begun to turn gray, but the hair which did not become gray turned to nearly a jet black; his skin at the same time assumed a dark and bronzed hue. Health has remained perfect. Several other cases of the same sort are given. *Archives of Dermatology*, July, 1880.

**Treatment of Acne of the Face.**—M. GENTILHOMME finds, that in certain cases, acne of the face is due to the presence of a parasite in the sebaceous glands, the destruction of which immediately terminates the trouble. He applies every evening to the affected part a sulphuro-alkaline pomade which removes all the fatty matter at the surface of the skin and softens the plug at the mouth of the excretory duct: The next morning the affected parts are washed first with soapsuds to remove the pomade and softened sebaceous matter, then with plenty of water. The surface of the skin being thus perfectly clean, and the excretory ducts of the gland become permeable, a parasiticide lotion, a one per cent. solution of the bichloride of mercury, is applied. There is no general treatment except in cases where a diathésis is evident. Destruction of the parasite may be secured in this way, but the total destruction is very difficult and can only be obtained by a very long and very careful treatment. *L'Union Méd.* Aug. 28, 1880.

**Leprosy.**—ELKLUND in a brochure on this disease seems to disregard the etiological influence of heredity. Out of thirty-four cases one only was considered hereditary as well as congenital; while the others are credited to contagion. In sixteen cases the fact of contagion was satisfactorily established in the writer's mind. He found constantly in the blood of lepers, in the nodules, conjunctival fluid, sweat, in the discharges from the ulcers, and in the morphea spots, numerous bacteria. They were round unicellular hyaline elements, which he does not call micrococci, because they possessed a decided independent movement. They multiply by division. Their relatively slow rate of multiplication accounts for the long incubation term of leprosy. (Neisser and Hansen corroborate these statements, and the latter claims priority for his researches. He found no bacteria in the blood. REP.) *Om Spetelska*, pp. 91, *Stockholm*, 1879.\*

**Rhus Poisoning.**—BLACKWOOD makes the interesting statement that in poisoning from rhus, reflex irritation, by inciting friction at parts as yet apparently unaffected, transfers the disorder to that locality; in other words, that the transfer is not merely inoculation by the finger-nails. He says that in cases which have been carefully observed, the scratching has been done by well persons on parts as yet unaffected (on the sick person) with the result of bringing out the characteristic eruption. The experiment must be made in the height of the disease. *Phila. Med. Times*, Sept. 11, 1880.

**Chlorate of Potassium in Epithelioma.** DUSCHESNE treats those forms of epithelioma which are chronic, without ganglionic engorgement, superficial and ulcerated, by a ten per cent. solution of chlorate of potassium topically

\* For abstracts from this brochure, which the author kindly presented to the COURIER, the reporter is indebted to Dr. Nilroy's article in the *Medical Times and Gazette* and to Dr. Thier's abstract in the *London Medical Record*.

applied; the results are said to be excellent. *La France Méd., Phil. Med. Times*, Sept. 11, 1880.

**Quinine Exanthem.**—DENK gives the details of an interesting case of quinine eruption, in which an erythematous and vesicular eruption followed upon the administration of 0.1 gram of that drug. Considerable edema of the lids was also present. For several days there was slight constitutional disturbance, with feeling of tension of the skin, but no burning or pruritus. The eruption disappeared by drying up of the vesicles, and desquamation of the cuticle. The desquamation occurred in small scales and in large lamellæ. After an intermission of eight days the quinine was again administered, which resulted also in the production of a uniform scarlet rash, but this time no vesicles were observed. [Morrow has collected sixty cases of quinine exanthem, thirty-eight of them were erythematous, twelve urticarial, two vesicular, and five purpuric in character. REP.] *Wiener Med. Woch. No. 34, 1880. N. Y. Med. Jour.*, March, 1880. W. A. HARDAWAY.

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## DISEASES OF THE THROAT AND LUNGS.

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**Complete Extirpation of the Larynx, Pharynx, Base of the Tongue, Velum Pendulum and Tonsils.**—PROF. CASELLI reports the following case and operation to the Medical Society of Bologna: The patient, a girl of nineteen years, was admitted to the hospital on August 29, 1879. Thirteen months previously she experienced a slight but continuous pain in the throat, a sensation as if a grain of corn was sticking in it. This caused some dysphagia, so that even swallowing saliva caused pain. The pain gradually increased, and at last every attempt at deglutition caused vomiting and severe cough, accompanied generally by dyspneal attacks. The disease continuing to increase, she sought relief at the hospital, where the disease was diagnosed as epithelioma of the larynx, pharynx, base of the tongue and velum palati. At the back of the tongue the ulcers were excavated with raised indurated edges. On the soft palate the loss of substance was extensive. The epiglottis was involved to two-thirds of its extent by a large mass of granulations, whilst the whole circumference of the glottis was infiltrated and covered with vegetations so as to scarcely admit a No. 10 bougie. There was no infiltration of the glands of the neck.

On the 24th of September, chloroform having been given, a preliminary tracheotomy was performed with the galvano-cautery knife and Trendelenburg's tampon-cannula introduced. The patient was then placed with her head hanging over the end of the operating table and Prof. Caselli, sitting at the head of the table, the patient's head was placed on a cushion on his knees. With the galvano-cautery knife, the operator made an incision in the median line from the upper end of the tracheotomy wound to the lower border of the inferior maxilla. As the wound was deepened, the sterno-hyoid muscles were divaricated so as to save their attachments

to the hyoid bones which he hoped to preserve. Preserving as much as possible of the perichondrium, the attachments of the thyroid cartilage to the hyoid bone and cricoid cartilage were carefully divided with the cautery. The cricoid now proved to be involved, and was removed in a similar manner, and the upper extremity of the trachea secured from retraction by means of Lister's silk sutures. To obtain sufficient room, it now became necessary to divide the hyoid bone, which was done with the bone forceps in its centre, and the genio-hyoids were partially detached. Through all this part of the operation, two branches of the superior thyroid arteries alone required ligature. The pharynx was now separated at its sides and behind and a platinum wire having been passed round the esophagus to prevent retraction, this latter was divided at a point corresponding to the fifth cervical vertebra. The patient was now noticed to have ceased breathing, and artificial respiration was at once resorted to. Vomiting came on, due apparently to the peristaltic action incited by the division of the esophagus. The operator then removed the base of the tongue and the epiglottis with the galvano-cautery knife.

The next stage of the operation was performed through the mouth. The jaws being kept open by the American gag, the whole of the soft palate was separated from its bony attachments. The upper part of the pharynx was now divided opposite the posterior nares, the faucial pillars cut through and the tonsils removed. The remaining pharyngeal attachments having been divided, the whole neoplastic mass was removed through the wound in the neck. One of the pharyngeal vessels alone required the ligature. Fifty grammes (about thirteen drachms) of blood were lost during the operation, which occupied three hours and ten minutes. The wound was washed out with carbolyzed water, (18 per cent.) the two pieces of the hyoid bone brought together with strong catgut, and the whole cavity disinfected with carbolic spray. Eight sutures brought the skin accurately together.

The case progressed subsequently in a favorable manner. Not satisfied with Gussenboner's artificial larynx, Caselli devised one for himself. On the 7th of December he exhibited the girl to the Medico-chirurgical Society of Bologna, and showed that she was able to swallow liquids and solids, and was able to speak for a length of time in a perfectly intelligible manner.—*Dublin Medical Journal (Del Bullitino delle Scienze Mediche di Bologna)*.

**Hemorrhage Requiring Ligature of the Carotid Following Spontaneous Opening of an Abscess of the Tonsil.**—DR. EHRMANN, of Mulhouse, reports the case of a young Italian admitted to the hospital for angina tonsillarum of a few days duration. Three days after admission, the abscess opened spontaneously and immediately a gush of bright red blood took place into the mouth. It soon ceased, but in three hours began again but not so violently as at first.

The patient was pale, bathed in cold perspiration, and with a small, quick pulse. Complete rest, the use of ice was tried, but in a few minutes a third gush took place fully as copious as the two former. The patient was now in a state of syncope, very pale and almost exsanguine, the extremities cold, and pulse thready. Immediately Dr. Ehrmann tied the common carotid below the omohyoid, tying the vessel in two places and dividing it between the ligatures. All progressed favorably, and the patient left the hospital in a month and a half.—*Dublin Medical Journal*.

**Eross on Syphilitic Laryngitis in Children.**—The essential difference between the syphilitic laryngitis of children and adults is noted, as well as the unfavorable duration and more rapid course.

Eross reports the following case: A child three and one-half years old, had suffered from whooping cough for six months, and during that time had developed a scaly eruption of a transitory nature. In November, on admission to the hospital for suffocative dyspnea, a condyloma was found near the anus, and mucous patches in the mouth, inner surface of the lips and tonsils. The mucous membrane of the nose was inflamed and injected; the glands in the neck and in the inguinal and submaxillary regions were enlarged. The hoarseness which had begun with the whooping cough increased to complete aphonia; there were now frequent suffocative attacks and spells of convulsive coughing. Laryngoscopic examination showed the epiglottis thickened and several times its natural size; the ary-epiglottidian folds were thickened and pale red; the left vocal cord was more than twice as thick as the right, and at its free edge bulged out towards the opposite cord; both were of a yellowish-red color. There can be no doubt but that the laryngeal affection was only a part of the general constitutional syphilis, which was abundantly evidenced by the other symptoms, and by the result of treatment (mercurial inunction.) In two months and a half the child was almost well, although when admitted, tracheotomy seemed urgently called for.—*London Med. Record.*

**Luxation of the Left Cornu of the Hyoid Bone.**—DR. DAILY, of Pittsburg, relates a rare case of luxation of the hyoid bone, which gave the following symptoms:

Head bent a little forward and to the left side; straightening it up caused a dull, pricking pain in a spot over the left cornu; speech clearly articulated, but indulged in with caution. He had suffered in a similar way on many previous occasions when yawning or laughing. The present attack having been brought on by laughing.

The throat was grasped firmly below the hyoid bone with the thumb and forefinger of the right hand whilst the head was steadied with the left, and the patient directed to swallow vigorously; at the same moment the parts were compressed between the fingers and quickly released. After the third effort he declared he was all right, and as a proof, moved his head rapidly in all directions with ease and comfort. Difficulty in swallowing both liquids and solids is said to be characteristic of this luxation, and in this case it was present in a marked degree until the luxation was reduced.—*Archives of Laryngology.*

**Case of Anemia with Mitral Post-diastolic and Presystolic Murmurs.**—In the differential diagnosis of organic and hemic murmurs, the following case is of interest as proving the existence of a blood murmur at the mitral orifice with an absence of any organic lesion. The patient was a tall overgrown girl with marked anemia and of a strumous aspect. An examination of the blood showed the normal number of blood corpuscles but a deficiency in hemo-globin. Muscæ, photopsia and tinnitus were present, with dyspnea and palpitation on exertion. The cardiac apex was felt in the fourth space, an inch and one-half inside the nipple. There was no thrill and the impulse was not purring. Cardiac dulness, normal. A systolic hemic murmur was heard near the pulmonary artery, and the second sound was distinctly accentuated; both sounds were weak over aortic valve and free

from murmur. When the patient was sitting, a typical pre-systolic murmur was heard over the apex with a normal second sound. On the patient's lying down, the pre-systolic murmur became weaker, a reduplication of the second sound was heard, with a short murmur immediately following. The second reduplication and the pre-systolic murmur soon entirely disappeared. When the patient sat up again, the pre-systolic murmur reappeared with a total absence of the reduplication and the post-diastolic murmur. Hemic murmurs were heard in the carotids and jugulars. In the course of a month the patient was discharged much improved, the physical signs having disappeared, with the exception of a faint mitral systolic murmur.—*Med. Times and Gaz.*

**Large Hydatid Cyst of Lung.**—DR. EDWARD KRAUS narrates the case of a hydatid tumor of the lung, the size of a child's head, which existed for a long time without causing any inconvenience or distress. The patient, a sixty-eight year old man, stated that he had always enjoyed the best of health and had never had a cough. The attack commenced with high fever and a violent paroxysm of coughing. During such a paroxysm, accompanied by vomiting, he ejected half a basinful of foul, offensive fluid. Since then he has suffered continual and great dyspnea, a constant cough with a profuse offensive, muco-purulent expectoration, he is markedly cyanosed, and is only able to retain the sitting posture in bed. The attempt to lie down always producing the most intense dyspnea.

An examination of patient showed the percussion sound anteriorly to be normal to about the fifth rib. Over the sternum at the third ribs, the percussion note was clear, tympanitic, and this extended a short distance over the right intercostal space. Over this portion metallic tinkling râles were heard, whilst over the remaining portion of the chest the respiratory sounds were normal and accompanied by numerous dry mucous râles.

Behind, over the lower part of the right lung, the percussion sound was dull, but free and clear in all other parts. Auscultation showed loud sonorous and sibilant râles present everywhere; over the lower right lobe metallic tinkling and amphoric breathing was heard.

A curious change took place on changing the position of the patient; the tympanitic percussion sound disappeared entirely.

The liver could be felt one and one-half finger's breadth below the ribs. The diagnosis was made, a large cavern filled with fluid connecting with the bronchi and surrounded entirely by normal lung tissue. The patient died within thirty-six hours, completely cyanosed and with great dyspnea.

The post-mortem made by Dr. Hans Chiari, showed the left lung partially bound by pleuritic adhesions, the lung itself slightly edematous, but normal, and the bronchi filled with muco-purulent matter. In the lower lobe of the right lung was found a cavern the size of a child's head, communicating with several large bronchi. The lung tissue was somewhat thickened and in a condition of purulent infiltration. In the cavern was found, besides purulent matter, a large collapsed echinococcus cyst.—*Wiener Med. Wochenschrift.*

**Spontaneous Rupture of the Aorta into the Pericardium.**—**Pulmonary Apoplexy.**—**Death.**—DR. DESPLAYS, of Lille, mentions an interesting case in which the post-mortem examination showed an opening between the



aorta and the pericardium; the pericardium was filled with blood clots and the ventricles were perfectly empty. The aorta as far as the arch was dilated, but from this point it was greatly contracted as far as the junction of the iliac arteries; the internal coat of the aorta was congested. The tear in the aorta measured six centimeters—there was also a smaller rupture. Lungs, slightly emphysematous, were highly congested and presented numerous apoplectic points, some of great extent. The bronchi were filled with blood.

The patient had been suffering for some time with alternate attacks of suffocation and diarrhea, and for a long time he had been in bad health. He was brought to the hospital for an attack of suffocation accompanied by an agonizing pain referred to the sternum. About the second rib over the sternum could be heard an intermittent bruit, synchronous with the diastole. The heart sounds were normal, his lips were highly cyanosed, and the pulse very small. He died suddenly during a profuse hemorrhage.—*Union Médicale*.

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## DISEASES OF CHILDREN.

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**Hernia in children.**—SWASEY considers this a very important matter, especially for the reason that during the early years of life, particularly the first decade, more conditions simulating hernia are found, than in later years; for instance, encysted hydrocele of the spermatic cord, congenital hydrocele, and a testicle lodged in the inguinal canal or just below the external rings, not yet having completed the descent into the scrotum.

Of 6,469 cases of hernia taken from English reports, about one-half occurred during the first five years of life, and about two-fifths of the whole number during the first year. Of Dr. Swasey's 500 cases (under twenty years of age), which include 411 of inguinal and femoral hernias, four-fifths occurred in the first five years, and two-fifths in the first year.

Femoral hernia during childhood is very rare; in the 500 cases before us only four are noted—the reason for this infrequency being that the pelvis has not reached full expansion, and the points of attachment for Potpart's ligament are comparatively near together, so that the depth of the arch formed by this ligament and the border of the bony pelvis opposite, is too shallow at the situation of the femoral opening to give lodgement for a protrusion.

In women, especially if multiparous, the iliac wings are more expanded, the crural arch deepened and muscles are less developed than in men, while in old age, muscles and tissues have become atrophied and the passage is less strongly guarded.

The connection between phimosis and inguinal hernia as before brought to notice by Kempe (*London Lancet* 1878) was observed to occur to greater or less extent in a great majority of instances, the obstruction to urination occasioning pain and straining during the act; but the author is not disposed to consider this a well-defined cause, as hernia is very frequent and often very unmanageable among Jews who have been circumcised.

The observations of the author fail to discover any marked heredity as a

predisposing cause, which has been claimed by Sir Astley Cooper and by Kingdom, of the London Truss Society.

Dr. Swasey urges the importance of treatment at the earliest stages of discovery, during infantile life by constant wearing of a properly adapted steel spring truss, which should only be removed for cleansing, and with the child in the dorsal position. We may expect to produce radical cure.

The truss should pass over the opposite hip to that side on which the hernia exists, the pad should usually be egg-shaped, adapted and fitted to each individual case. The parts should be kept scrupulously clean and dry, and it is well to bathe the parts with some astringent solution such as tannic acid and alum in alcohol and water. The surface on which pressure is made should be protected by soft muslin filled with powdered starch which has a gloss which will admit of motion over the surface without chafing.—*Am. Jour. of Obst.*

**Peptonized Milk as Food for Infants and Invalids.**—Nunn recommends the following modes of preparing this valuable food: Take one pint of milk at 80° F.; add a teaspoonful of rennet solution or ten grains of pepsin, and keep the mixture at 80°. When coagulation is complete, but before the whey has begun to separate, beat the whole up smooth with a whisk or beater, and pass through a fine milk-strainer to insure the minute division of the curd. This preparation appears to keep equally as well or better than raw milk, remaining apparently unchanged for twenty-four hours if kept cool. Dilute and sweeten for feeding as usual.

By this method coagulation is complete, and no further change of that nature is requisite, the weakened stomach of the invalid receives the necessary nutriment carrying with it its own digestive principle.

In conditions of exhaustion consequent upon diseases requiring more oleaginous food, cream peptone may be prepared, by treating sweet cream after the manner described for milk.

The salts and sugar of peptonized milk may be increased by adding whey or abstracting curd, the solids increased by adding curd or abstracting whey, while the amount of fat may be varied by adding or taking away cream; sugar may be added as desired.

When milk can be obtained directly from the cow, the pepsin may be placed in the vessel into which the cow is milked, and the food administered fresh, which Dr. Nunn considers the most healthful method.

If desirable these preparations may be frozen and given as ice-cream.  
*bid.*

G. A. MOSES.

SOCIETY PROCEEDINGS.

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ST. LOUIS MEDICO-CHIRURGICAL SOCIETY.

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CORRECTION. In the synopsis of the session, July 26, 1880 of the Medico-Chirurgical Society, given in the September COURIER, Dr. Todd is represented as stating that "Noises in the ear" are *incurable*. This of course is a misrepresentation of the Doctor's remarks, since it is hardly necessary to state that temporary tinnitus is a common symptom.

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Stated Meeting, July 12, 1880. Dr. Pollak in the Chair.

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## INDUCTION OF MISCARRIAGE IN CASE OF PLACENTA PRÆVIA.

*Dr. Engelmann.*—Mr. President, some weeks ago Dr. Boisliniere presented to the Society a placenta which I was requested to examine and report upon. I have several other placentas to show in comparison, which will serve better to explain the one in question. This normal placenta is of the same age as that presented by Dr. Boisliniere, and is an excellent contrast to it. I merely relate the history of the case as interesting in itself and somewhat unusual; on June, 28th, I was called by Dr. Greiner to see Mrs. B., who deemed herself four months pregnant, and had been flooding almost constantly for two months; Dr. Greiner had given acids, had ordered absolute rest, etc; in fact, he had exhausted the entire course of treatment which is usually resorted to in such cases, without success; and as the patient was failing, he deemed it necessary, as a dernier resort, to produce miscarriage. The lady had last menstruated four months before I saw her, so that she very naturally concluded that she was four months pregnant. Examination revealed the fundus within two inches of the navel; the fetal heart was not to be heard; the placental bruit, however, was distinct; the appearance was that of a pregnancy of from five, to five and

one-half months, with which coincided the fact that the patient had felt motion, I think on the 26th, two days before. Again, the internal examination revealed the cervix soft and the os patulous. I suspected placenta prævia, and told her that it would be almost impossible to save the child, that her own life would be endangered, if she attempted to go to term; that this could only be accomplished by observing absolute rest in bed and the most perfect quiet. As all other means had been exhausted, I advised, as Dr. Greiner had already done, that a miscarriage be produced. She readily consented, and I introduced the uterine sound, which entered easily, of course, as far as the internal os, where it impinged against a soft yielding mass; this mass was no doubt the placenta; the sound was, finally, with some difficulty, passed on one side of the placenta and quite up to the fundus of the uterus. Hot water injections were ordered, and, on the following day, the 29th, a sponge tent was easily introduced a short distance, but impinging against the placenta, it did not pass beyond the internal os. This, of course, had very little effect, and on the following day, the 30th, the external os being enlarged by the first tent, I succeeded in introducing a slippery-elm tent to the fundus, and by its side a sponge tent. Labor pains came on, and twenty-four hours later Dr. Greiner removed the tents; early the next morning the fetus was expelled from the womb; the placenta, however, remained, and this I was called to remove the following morning. The patient made a good recovery. The length of the fetus, which showed signs of life for a few minutes after its delivery, was ten inches or a little over, thus verifying my previous diagnosis that the woman was in the sixth month of pregnancy.

Dr. Thomas has recommended the producing of premature labor in cases of placenta prævia, and speaks of it as resulting very successfully, although he refers more especially to the eighth or ninth month of pregnancy. I think it was in 1877, that he stated he had had eleven such cases, in which he had induced premature labor, and had lost only two of the mothers, one from post-partum hemorrhage that set in several hours after delivery, and the other from puerperal fever. Now, I am very sure there was no possibility of preserving the fetus in this case, as the patient had some three and a half or four months to go yet, and she was, moreover, very feeble at this

time. The placenta is about three-quarters of an inch in thickness throughout its greatest extent, and where the navel string is inserted, it is over an inch in thickness. Its shape is unusual, being oblong,  $4\frac{1}{2}$  inches long,  $3\frac{1}{2}$  inches wide at the broadest part, which is at the upper part, and is smooth and regular. The lower part is  $2\frac{1}{2}$  inches wide, and very much lacerated. This part lay directly over the internal os, and was undoubtedly lacerated by the action of the sponge tent. The tissue is perfectly healthy and also presents a healthy appearance under the microscope.

#### THE PLACENTA IN HABITUAL MISCARRIAGE.

This specimen which Dr. Boisliniere presented, is from a case of habitual miscarriage, and is itself the result of the fifth premature delivery of the same woman.

He thought after the third accident that an existing inflammatory condition of the uterus might be the cause of the miscarriages, and so he treated the patient for this chronic inflammation and succeeded in curing it.

The doctor also thought that there might be another reason for the tendency to miscarriage, namely, syphilitic taint; and although neither the wife nor the husband presented any symptoms of syphilis, he put them both on antisiphilitic treatment. The woman became pregnant for the fourth time, and, under the antisiphilitic treatment, carried the child to near the sixth month, but then an accident occurred; a carriage in which one of her friends was riding overturned. She felt the shock very much; from that time the doctor found the strength of the child's heart-beats decreasing, and saw that the child was dying by degrees. After her next conception, the fifth, she concealed the fact of her pregnancy from him, and was not treated in any way. The result of this last pregnancy is the ovum which is before you.

Attention was called to the interesting fact that these habitual miscarriages, at the same period, are rather rare, and I will hence relate a similar case, with regard to which I was consulted a few days ago. This patient is a lady 29 years of age, who was married in 1875, and since that time has had five children, one every year; the first one she carried to within two weeks of full term; the next to six and one-half months, delivery taking place in April, 1877; the third to eight months,

delivery August, 1878; the fourth to seven and one-half months, delivery July 17th, 1879. Now she is again at about the same period, and, as my informant tells me, she is hourly expecting a miscarriage, because she is now suffering from the same series of symptoms which she has experienced in the previous labors. This patient, in each pregnancy, has been in good health to within two weeks of her confinement, when she is siezed with a fever, which continues from ten to thirteen days, and then culminates in the birth of a macerated fetus, which in every case has presented with the feet.<sup>1</sup>

Now let us compare the placenta from Dr. Boisliniere's case with the healthy placenta from my case of placenta prævia; they are of nearly the same age, hence we may compare them to advantage. This placenta, the product of Dr. Boisliniere's case of habitual miscarriage, has not the appearance of a healthy one with well developed cotyledons. It has been in alcohol for some two months and must be somewhat changed; it is of rather a membranaceous appearance with comparatively undeveloped villi; it is very thin; only three or four cotyledons are still distinct and those are hard, as if infiltrated; the other portions are dotted with small undeveloped villi. In the center this placenta is  $\frac{1}{3}$  inch in thickness, and gradually decreases towards the margin, so that in two or three places it is not more than  $\frac{1}{8}$  inch in thickness; towards the centre is an indurated parchment-like surface, with a small, red nucleus towards one extremity. There is no appearance of gummata

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1. Since making the above remarks the patient has miscarried, as expected.

The fetus had been dead for some weeks. The placenta was much more fully developed than the one presented by Dr. B.; the results of lobular inflammation were very distinct, but not yet so wide spread; the central portion thin, yellowish, and solid, a fibrous mass, not as yet contracted, hard, and membranaceous as in Dr. B.'s case.

The appearance of the ovum suggests syphilis, so also the return of the miscarriage, although both parents have so far denied the existence of the poison.

Extremely remarkable is to me the annual recurrence of miscarriages in this case, and with almost the same regularity in Dr. B.'s case; again the unusually large, healthy, well developed placenta, with inflammation in a single cotyledon, which I have shown, is from a patient in whom I suspect syphilis, and she has also had three children, following each other at intervals of twelve months; she does not miscarry, but bears a healthy child to term and loses it at the age of six or eight months.

in the placenta; on the contrary, a more careful examination confirms the statement made by me upon the first hasty examination upon the evening of its presentation, that it was the result of an inflammatory process.<sup>1</sup>

This placenta bears distinctive marks of placentitis, of simple inflammation with its consequent induration, the pathological condition to which this organ is most frequently subject and most frequently the cause of miscarriage. The different stages of degeneration are distinctly marked in this one specimen, and will show the lobular character of the inflammation by which, one after another, the lobuli disappear until the nutrition of the fetus is completely destroyed.

In the healthy placenta which I have presented, which is of about the same age, we see the full, healthy tufts of the

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1. At the close of this discussion it was ascertained that the husband of the patient whose history is given by Dr. Boisliniere, had been afflicted with venereal diseases at various times before marriage, and had also had a syphilitic ulcer and had been treated for syphilis: at least so he stated to the gentleman who gives the information, whom he consulted, after his engagement, in regard to the propriety of marriage. At that time there was no evidence of syphilis, nor have any signs since appeared, and to Dr. Boisliniere he has denied any infection. I am now convinced of the existence, at some time of syphilitic infection, on the part of the husband, in both cases of habitual miscarriage, perhaps long before marriage, and to all appearances, completely overcome by treatment. I now also believe that syphilis, latent syphilis of the husband, existed both in Dr. Boisliniere's case and the one related by me notwithstanding denial by the husbands.

Or could it be latent gonorrhoea producing a chronic uterine inflammation and this causing a morbid state of the ovum, especially the placenta? I have distinctly stated, in a previous discussion upon the same subject, that my experience has been a large one, both in hospital and out-door practice in Vienna and Berlin, and it has taught me that in case of syphilis of the father, miscarriage would occur, but at a later stage of pregnancy in each following conception, until finally a living child would be born, which would soon die, the next child would live longer, and so on.

I still adhere to these views as they have been forced upon me by oft-repeated observations, but, how to reconcile them to the occurrence of these habitual miscarriages at about the same stage of pregnancy when no direct evidence of syphilis of the father can be obtained, I do not know; unless, indeed, these be the result of latent gonorrhoea.

In the cases (of which I have seen so many) cited by me in the previous discussion, distinct evidence of syphilis of the father was at hand, and in those cases the consecutive miscarriages were each at a later stage. At some future time I will elaborate the important and interesting subject upon which I can here give only these crude and hasty thoughts.

chorion and the cotyledons, though not yet distinctly formed, in the normal condition for that period. In the diseased placenta by its side, there are three or four not entirely shrivelled portions, in which the inflammation has been more recent; they are dense, red and hard, hardened by the fibrinous deposits and reddened by the coloring matter of the blood. Later, this deposit grows paler, and, finally, becomes yellowish red, grayish or whitish; this change in color is consequent upon the change in tissue—which is the same in every one of those inflammatory foci. The young connective tissue, as well as the plastic deposit, gradually contract, and with them is drawn in the destroyed placental tissue; and as a result of the inflammatory change, we have in the last stages, the thin, tough, grayish, callous sheet with no trace of placental tissue left. This is sclerosis of the placenta. As the cotyledons are separately attacked, the nutrition of the fetus is only gradually impaired, and thus the fetus is enabled to survive until the greater part of them are destroyed. We have here [showing a third placenta] a large healthy placenta in which a single cotyledon only has undergone this inflammation; you see upon its upper portion this same yellowish, fibrous, almost membranaceous condition. The patient from whom this was taken was delivered of a very large child with a large hard head; it was a very difficult delivery by forceps. Except for the inflammatory degeneration of that one cotyledon, this is an excellent specimen of a healthy placenta at term, and it shows well the lobular nature of placentitis. It is recognized at a glance; the healthy tissue has that peculiar purplish color of the placenta, while the diseased cotyledon presents a yellowish white color. It was evident that there had been a fibrinous deposit, or that an inflammatory process had taken place, and connective tissue had formed.

[Dr. Engelmann here presented under microscopes sections of healthy placenta injected and showing the villi very perfectly, also sections showing the infiltrated condition of the few cotyledons which are still, in part, preserved in the diseased placenta, and sections from the membranaceous part showing no villi but numerous small cells forming new connective tissue. Of these last he said:]

If the process had gone on still longer, it would have led to the formation of perfect connective tissue; as it is, it is already



hard, and leather-like. That is the most ordinary pathological condition of the placenta, and there are various ideas with regard to its origin; some think that it is the result of placentitis, which, of course, may itself result from syphilis; others, that it arises from fibrinous deposits in the cotyledons, destroying and compressing the villi, and impairing the nutrition of the fetus. Others still, say that it is due to a hemorrhage in the separate cotyledons, and that we have the same process which we find in hemorrhage occurring in other places; nutrition is impaired, and finally absorption takes place until nothing but connective tissue is left.

*Dr. Boisliniere.*—The literature on this subject is rather unsatisfactory. The causes are not plain in my mind. One authority says it has an inflammatory origin, a previous placentitis, and that it is followed by the formation of connective tissue. These changes are somewhat analogous to those in the corpus luteum.

*Dr. Engelmann.*—In the corpus luteum we have a fatty degeneration; here, it is fibrinous.

*Dr. Boisliniere.*—It is something of the stearoid character, a waxy appearance. Perhaps, the fatty element is followed by the fibrous element. Rokitansky thinks the yellow color is due to a change of the blood. I have no doubt there was placentitis in this case. Simpson recommends in these cases of recurrent miscarriage a repetition of small bleedings from the arm—take three or four ounces of blood from the arm three or four times a month. He quotes a case which he saved by giving alkaline salts during half the pregnancy, until the formation of the placenta was so complete as to no longer necessitate this treatment. But it must be begun in time and kept up until the placenta is completely formed. The placenta is the fetal organ of respiration, and as a man may live with one lung while the other breathes for two, so as long as there are any cotyledons of the placenta left, there are hopes that the child may be carried to a time when it will be possible to induce premature labor and save it. If the child can be carried to seven and a half or eight months, we may accomplish this. It is not an unusual thing in uterine pathology to have a recurrence of this trouble in the same woman. The woman's life is always safe in these cases, but we wish to save the life of the child.

*Dr. Prewitt.*—I must confess, I do not see how repeated bleedings, if it be placentitis, would reach the trouble. The question is, where does the fault lie? Does it necessarily come from the mother? Might it not come from the father? The placenta is a fetal organ, and the mother is a rather feeble woman; you would not want to bleed her. I have such a case now, a lady who has miscarried several times. There is some fault with the placenta; there are those hard, white tufts in it, but she is not a subject for depletion. She is rather fleshy, it is true, but rather feeble, and I would not be willing to bleed her; and then, if the fault be in the constitution of the fetus, how would the bleeding of the mother affect the fetus? How would that treatment check the inflammatory action going on in the placenta? Now, if it originates in the condition of the mother, how is the bleeding going to alter that condition?

Very often the fetus itself is diseased. I have noticed, that in three or four cases, the fetus was hydrocephalic, and the death of the fetus affected the placenta and destroyed its life, and produced a serous condition of the placenta. The death of the fetus was antecedent to the death of the placenta, so that the disease of the fetus was the cause of the change in the placenta.

There are cases where this process is going on in the placenta before the child is affected. The child dies by inches. In those cases, if you are fortunate enough to see the woman when she is six months gone, the child has been very lively, and the motion is observed to grow feebler and feebler, the child becomes weaker and weaker, and finally dies in one, two or three weeks. Now did he die from disease of two or three month's duration, or did he gradually, by not calling into use the placenta, cause death of the placenta, cause the placenta to become vitiated and thus destroy nutrition and respiration? That is the question you see. In this case the doctor speaks of, the child was lively enough up to the seventh month, when a runaway accident occurred, and the patient received a shock; from that time the movement of the child diminished, and within two weeks after ceased. The child in that case was hydrocephalic, and how did it come so? Did the shock give the hydrocephalus to the child?

*Dr. Engelmann.*—There was no appearance of hydrocephalus in my case. The child was well preserved. If the child had

been dead for a month, it would certainly have been somewhat macerated. It died because the placenta ceased to furnish the necessary nutrition.

*Dr. Boisliniere.*—It is just the same as a man with consumption. He will live with one lung, in fact, he may live until the last particle of lung dies. This is consumption, phthisis, of the placenta.

The placenta and child die together, and then labor sets in after a greater or less period of time. Simpson, Barnes, and and some other writers recommend spoliative bleedings. You ask how the bleeding acts. Congestion precedes the placentitis, and we bleed to take away some of the blood from them.

*Dr. Engelmann.*—Why do you not scarify the uterus?

*Dr. Boisliniere.*—I would scarify the placenta if I could.

*Dr. Prewitt.*—There is a difficulty in my mind, to decide whether the placentitis is the result of the faulty inherited constitution of the fetus and its appendage, the placenta, because the placenta is a fetal organ, or originates from the condition of the mother during pregnancy. If there be extravasation of blood in the placenta, this must come from the fetal circulation, and the bleeding of the mother would not affect that, it strikes me. If the trouble be the faulty constitution of the fetus, it seems to me that bleeding the mother would not reach the difficulty. It might be that the trouble arises from the faulty condition of the mother's system during pregnancy, which would affect the nutrition of the fetus. Then, again, the child might receive the faulty constitution from the father, so that this thing might not occur with another husband.

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Stated Meeting, August 23, 1880.—Dr. Bryson in the chair.

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CHRYSOPHANIC ACID AND PILOCARPINE IN SKIN DISEASES.

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*Dr. Hardaway.*—The members present will probably recall to mind a case of psoriasis occurring in a boy of 13, whom I exhibited to the Society some months ago. At that time the eruption had disappeared after a few weeks of treatment by an ointment of chrysophanic acid. He took no constitutional treatment. When seen a few months ago there had been no

return of the eruption. This case is not brought forward to prove that relapses do not occur after the use of chrysophanic acid, for a considerable experience with this drug in this disease demonstrates the contrary; but I mention it merely as exhibiting the now acknowledged remarkable influence of the remedy, and principally to show that local treatment is all sufficient for the relief of psoriasis, and that the recurrence of the eruption is not any more to be expected, than after the most carefully conducted general medication. In a case recently treated, occurring in a gentleman of about 40 years, who had been affected from youth, the eruption was unusually inveterate, and required, for some patches, an unusual strength of ointment—ninety grains to the ounce—for its removal. Usually a ten or twenty per cent. ointment is sufficient. While on this subject I may mention some recent experiences with the muriate of pilocarpine in skin diseases. I have given the drug in a number of cases of alopecia but as yet with no definite results. In an exceedingly obstinate case of general pruritus, after I had run through the usual list of local and internal remedies without avail, I placed my patient on  $\frac{1}{8}$  grain doses of pilocarpine, as advised by Pick. This quantity proving of no service, I increased it to  $\frac{1}{4}$  grain twice a day. The former dose had not produced the physiological effects of the drug; but  $\frac{1}{4}$  grain caused profuse perspiration, with but little salivation, and very soon after this effect was noted, the pruritus disappeared.

*Dr. Bryson.*—I would like to know if there was an increase in the urinary secretion.

*Dr. Hardaway.*—I made no observations in that regard. The patients seem to differ in regard to the idiosyncrasy of the drug. Given in  $\frac{1}{8}$  of a grain doses, recently, it produced intense perspiration, while with others  $\frac{1}{8}$  of a grain had no effect at all.

*Dr. Leete.*—When do you give the medicine?

*Dr. Hardaway.*—Morning and evening.

#### PILOCARPINE IN MALARIAL FEVER.

*Dr. Pollak.*—Last summer, I see, they used pilocarpine in Bellevue Hospital for the epidemic typhoid fever, and in seventeen cases it succeeded remarkably well, one or two injections were sufficient. In no case was there increased secretion of urine. I have used it in adults and small children in malaria.

*Dr. Hardaway.*—Didn't you find that you had to increase the dose? that the patient became accustomed to it?

*Dr. Pollak.*—Very likely they would. In no instance have I given it more than twice, in most of them only once.

*Dr. Hardaway.*—I omitted to say that after several weeks I found I had to increase the dose.

*Dr. Briggs.*—How did you administer it?

*Dr. Hardaway.*—In water twice a day. In some cases I used as high as a quarter of a grain.

*Dr. Gehring.*—Dr. Pollak in what relation to the malarial attacks did you administer the pilocarpine?

*Dr. Pollak.*—I give it just when I have the opportunity. The most fortunate case I have seen, was that of a poor carpenter who had suffered from malarial fever all summer. When the next rigor commenced, a little chill, I injected at once one-fifth of a grain of pilocarpine and in less than five minutes it began to influence the attack; he sat down to dinner with his family and has never had an attack since.

*Dr. Gehring.*—Perhaps you gave it accidentally at the right time, that is, shortly before the advent of the chill, in your successful cases, while in the others you may have failed to do so. Or, the successful cases may have been those in which the malarial poison has been previously neutralized by the use of quinine, i. e. chronic cases, in which not the malaria, but its consequences, as the congestion of certain organs, the habit of recurrence etc., had to be broken. The unsuccessful cases may have been those in which the malarial poison was not previously neutralized. There is an important question: Is quinine an antidote to the malarial poison, or does it merely promote its elimination? That it is not probably the former is shown by the cures obtained by diverse other substances, substances that have apparently no analogy to quinine. Does pilocarpine, besides its other qualities, contain an antidotal principle against malaria? The success following the administration of this substance is probably dependent on its eliminative qualities. Dry heat applied along the spinal column acts very similarly to pilocarpine, and has perhaps some advantages over it. Years ago, when I was yet practicing in Denver, Colorado, where malaria is scarcely ever seen, unless imported, I have treated many of these imported cases by means

of dry heat to the spine, with good success; commencing the application about an hour before the expected chill, at times assisted by such small doses of quinine as would otherwise be considered inadequate (two or three one-grain doses) and almost always succeeded in preventing the next attack, though these cases were of every type and degree of severity. Whether the success depended on the peculiar climate of Colorado, or on the treatment used, I have not been able to verify by crucial test in *this* country, as such cases do not come under my observation, since I quit general practice. The heat was applied by means of heated sand bags, eight to ten inches broad and reaching from occiput to coccyx. These bags are placed on a bed made nearly level, and covered with blankets and quilts until the heat transmitted through these feels comfortable to the touch. The patient is made to lie down upon this and covered lightly. Perspiration will soon commence and probably sleep ensue, the chill and the consequent reaction, the fever, does not appear.

*Dr. Briggs.*—I had long been of the opinion that the Turkish bath was one of the most effectual remedies in malarial disease. I had supposed that the sweating is probably a true eliminative process, by which the system is freed from a certain poison.

*Dr. Gehrung.*—The poison of malaria, undoubtedly, has the quality of causing contraction of the peripheral capillaries, thus throwing the bulk of the blood into the internal organs, thereby leaving the skin bloodless and causing the chilliness of the surface; then the subsequent reaction dilates the capillaries, and the blood rushes to the surface and perspiration takes place. Now if the heat acts as mentioned before, it will naturally interrupt or prevent the central accumulation of the blood. This being driven at once to the surface, the chill is prevented and reaction not necessary.

*Dr. Pollak.*—I have frequently applied heat in malaria but not in that form. I used heated bottles, but I never succeeded in preventing the recurrence of the fever.

*Dr. Gehrung.*—I would especially call attention to the fact that when heat is applied to the spine, care should be taken not to apply heat simultaneously elsewhere. For, if thus applied, it would partly or wholly destroy the beneficial effect, unless it were applied over the whole surface, when it would be peripheral, and not central application of heat.

*Dr. Briggs.*—I am very glad to hear this method spoken of by some one who has successfully experimented with it. It seems to supply us with a means of readily and economically procuring diaphoresis without the administration of medicine or the risk of exposure of the patient.

#### SAND BURR IN LARYNX.

*Dr. Mudd.*—I have a little specimen, Mr. President, which may be of interest, it is called a sand burr. A little child about 10 or 12 years of age playing around the station of Centreville, Ills., rolled from the platform and fell among the bushes, and in falling drew this burr into the larynx. It remained there three or four hours after the accident. Upon looking into the larynx I found the burr suspended in the opening of the larynx. It didn't move with respiration. He was hoarse, but could talk a little and had expectorated some blood. There was some blood about the larynx. I took the curved forceps and made several efforts to catch the burr. I then laid him on his back and made an effort to grasp it, using my finger as a guide, and failed. Dr. Hodgen also tried that expedient. We then put him into the chair again. He seemed by this time more tractable and by using the laryngeal mirror and curved forceps which opened antero-posteriorly, I grasped it and lifted it out without difficulty. The boy has had no trouble since. It caused no inflammation of the larynx. It filled pretty well the lumen of the larynx and was held in position by the aryteno-epiglottidean folds.

#### CALCULUS REMOVED BY LITHOLAPAXY.

I have also another specimen here; it is a calculus removed by crushing and rapid evacuation. It was removed from a young man 26 years of age who had suffered for six months with symptoms of stone. Sunday, August 8th, we operated upon him. Having anesthetised him and injected five ounces of warm water, we used the ordinary lithonriptor, crushed the stone and evacuated it very readily and quickly by use of Bigelow's evacuator. The patient upon the next day, that is, in the succeeding twenty-four hours, made water twice only, and upon the second day was allowed to go about his business and has been working ever since.

*Dr. Pollak.*—How much does this weigh?

*Dr. Mudd.*—About a gramme. The only feature of interest in connection with the operation was the position of the patient, which I think is of some importance and one which I arrived at last winter, in the course of some experiments made upon the subject. I believe it is now used by some operator in New York. This position consisted in elevating the pelvis during the crushing, and depressing it during the evacuation. It is certainly a great help in catching the stone. We had no trouble at all in catching it.

*Dr. Pollak.*—How long did the operation last?

*Dr. Mudd.*—I should think not more than fifteen minutes.

#### PARALYSIS FROM INJURY OF THE CAROTID.

*Dr. Hodgen.*—Mr. Chairman, I had recently two cases presenting some very interesting, and to me, unusual conditions. One was a gunshot wound involving the internal carotid as it passes out of the inner end of the petrous portion of the temporal bone opposite the body of the sphenoid. The boy became paralyzed on the opposite side of the body and remained so during the time he lived, two months. In the other case, the right common carotid was wounded about the middle, and this patient had paralysis of the opposite side occurring within the first twenty-four hours, perfect paralysis of motion; and he is still paralyzed, but improving. That accident occurred three weeks ago. In neither case was sensation seriously disturbed. In the last case the patient was able, after the first three days, to move the middle finger, also, within a day or two, to flex the ring and little fingers and move the foot and leg of the paralyzed side. The reflex response was very marked in the last case, probably also in the other. I think it is rare for injury of the carotid artery to produce paralysis, yet I see no reason why it should not occur so frequently as to attract attention. There is another interesting feature to which Dr. Mudd called my attention in connection with these cases, that the motor paralysis was complete, sensory paralysis not of so marked a character, if it existed at all, the carotids supplying the anterior and middle portions of the cerebral hemispheres, while the posterior lobes are supplied principally by branches of the vertebrales.



## SELECTIONS.

## RELATIONS OF PHYSIOLOGY AND PATHOLOGY.

Looking around for a firm basis to start from, we find it admitted on all hands that physiology is a branch of the science of living beings. Looking more closely into the matter, we find that all living beings are capable of being studied under two aspects. In the first place, they possess characteristics of form—external and internal, superficial and deep—which distinguish them from things which are not living. In the second place, they act upon, and are acted upon by, the world around them in ways which are not possible to lifeless things. The former considerations supply the basis of the science of morphology; the latter, that of physiology proper. All living things may be studied independently from either of these points of view. Were it possible to arrest for a while, without collapse, the multitudinous movements of the universe, were the whole sum of things to fall into a sleep deeper than that fancied by the laureate in his poem of the *Day Dream*, a sleep which also stayed all growth and stilled the molecular whirlpools of the tissues, there would still be ample material for collecting data and elaborating laws of form, distinguishing the things which we now call living; there would still be scope for the morphologist, though, in absence of all action, the physiologist would be without employ. Conversely, we can readily imagine a state of things in which the pulse of the movements of a living being might be investigated, the product of chemical activity determined and measured, its actions and reactions studied, though it itself was never seen, and its outline and structure remained unknown. Such a condition would exemplify a physiology existing without any corresponding morphology. \* \* \* \*

The two branches—morphology and physiology—run their several courses along lines which at present seem parallel; I say, at present, because we can already see that in the future they will converge and meet. The science of morphology will

receive the crowning of its edifice when the forms of living beings can be fully explained by the action of the environment on the living substance; and the science of physiology will similarly be perfected when the actions and reactions of a living organism can be predicted from the molecular structure of its constituent tissues, just as now the superficial character of some of its motions can be explained by the mere mechanical relations of its constituent parts. But that time is still far distant, and we may at present rest content with the view that physiology is the study of the actions and reactions of living beings; and the instance I gave just now of the movement of a limb may be taken as a type of all physiological problems. Whatever action of living organism we examine, whether of a vegetable or of an animal, be it a matter of the circulation, or of digestion, or of that as yet almost unknown territory, the central nervous system, we find that the problem suggested by that action is incrustated, it may be, with a shell (sometimes thick and hard to crack, sometimes thin and easily brushed away) of questions of a purely mechanical or physical or chemical nature—questions which might present themselves in reference to any action of either living or not living matter; but that within the shell there is the kernel question; and that, whether it be the contraction of a muscle, or the changes of a secreting cell, or the molecular agitations of an excited nerve, is the true physiological question—the question which cannot be studied elsewhere than in a living frame, the question towards the solution of which knowledge of form and shape (short of molecular construction) gives little or no help. \* \* \*

The physiologist who is pressing forward to the solution of the wider problems opening up at the present time before him no longer enters on his work in the spirit of one who, placed in the midst of a collection of ingenious inventions, sets himself to discover the purpose and working of each; on the contrary, he becomes day by day more convinced that the key which will unlock the mysteries of life is an understanding of the broader laws of that conflict of atoms which is going on in every tissue, that perpetual building up and breaking down, that molecular strife which appears now as the piling up of material in growth, now as the rush of a secretion, or the shock of a muscular spasm, or the thrill of a nervous impulse. Whatever part of physiology he may take up, sooner or later he

finds himself face to face with problems of this kind, compelled to desert the question of special function, driven to search into the more general characters of living matter. The physiology of function and organ forms but the outer court of the science itself. \* \* \* \*

I might multiply to weariness illustrations of the tendencies of modern physiology. I will, however, content myself with pointing out that these extensions beyond the simple inquiry into organ and function are not mere idle speculations. It little boots either the sick man or the sound man to know that the function of the stomach is to secrete pepsin, or of gastric juice to digest proteids, unless he be master of the conditions affecting the character of the secretion or the potency of the juice. And the extensions of which I am speaking are simply efforts to understand these very conditions, to explore the laws by virtue of which the amount, and the character, of each drop of juice which falls into the cardiac pouch is determined by the tremors of a cerebral cell, or the labors of the hepatic tissue, or the heating and cooling of the cutaneous nerves.

But if this conception of physiology be admitted, a most important deduction follows—no less a one than this, that all distinctions between pathology and physiology are fictitious and unreal; for what are the things which we call pathological, if they be not the deeper strata of phenomena of which I have been speaking thrust up to the surface by some catastrophe great or small? Indeed, if we even simply look at the matter from an *a priori* point of view; we must arrive at the same conclusion. For what should we say of the kindred science of meteorology, if it were divided into a normal science of bad weather, and an abnormal separate science of fine weather? Undoubtedly, there are bad days and good days; there are unhappy conditions which we may call maladies; and the one may present superficial problems which are absent from the other; but directly we leave the outside of each, directly we attempt to grapple with the fundamental questions lying at the bottom of each set of conditions, we find we are in each case struggling with the same things. \* \* \* \*

It was as a physiologist, working by methods purely physiological, that more than a quarter of a century ago, one who has since achieved the highest renown as a practical surgeon, but whose career physiologists selfishly deplore as having with-

drawn from their midst a puissant captain—I mean Joseph Lister—carried out those remarkable researches which opened up an epoch, on the one hand, as regards inflammation, on the other, as regards the circulation. It has been through methods purely physiological at the hands of Cohnheim and others, that our knowledge of inflammation has since been advanced. On the other hand, the physiologist who is inquiring into the abstruse problems of the capillary circulation, finds that the only path to progress lies through the study of changes of a more or less inflammatory nature, naturally occurring or purposely induced. And what I have said of inflammation may also be said of other so-called morbid processes; indeed, of all the phenomena, both structural and dynamical, of disease. The famous cellular pathology is in reality a physiological essay; and for these many years past the progress of pathology has been marked by investigations, pathological it may be in name but physiological in scope and in method.

The view, then, which I would venture to urge respectfully on your serious attention to-day is, that physiology is not a collection of curious problems concerning the living organism in an abstract ideal condition, called health; it is not simply the answer to a series of questions, what is the normal function of this and that organ? Fundamental as distinguished from superficial physiology has before it the task of investigating the elementary properties, we might say the molecular movements of living matter (including matter which is becoming alive, and that which is ceasing to live), those movements, the combinations of which come to light in the effects which we may, if we like, call functions.—M. Foster, M. D., in *Brit Med. Jour.*, Aug. 21, 1880.

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#### THE MEDICAL COLLEGE OF JAPAN.

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In 1878 the medical college at Tokio was transferred from the home department to the educational department, and thus became a part of the national organization for culture and training. It is now located in the new buildings in Kaga Yashiki, having well-arranged lecture-rooms, laboratories, an operating amphitheatre, a commodious and modern-modelled hospital, and rooms and space for an extensive out-patient department for

clinical purposes. In a very large building, formerly occupied by the daimio's retainers, are rooms for lectures and recitations of the large preparatory and Japanese medical classes.

The "I-Gaku-Bu," or medical school, is divided into two departments: (1) preparatory; (2) special or advanced course. To complete the full course five years are required in each department. The language of the school and hospital is German.

Each year written examinations are held. Each student is required to attain a certain standard in all branches before he can be advanced.

To enter upon the special course each candidate must have passed in the preparatory school or must take the written entrance examination.

The course is gradual, methodical, and not unlike that pursued at Harvard. A certain standard must be attained in order to enter the next class.

At the final and state examination in order to take the degree of I-Gaku-shi (conferred first in 1879), the candidate must satisfy the faculty and the government commission of proficiency in *all* branches studied during his course. Instruction is imparted by lectures, text-book recitations, clinical lectures, and clinical work in the hospital and out-patient department. Owing to the difficulty of obtaining material and the infrequency of autopsies, only the advanced students pursue practical anatomy; the majority are instructed from diagrams, charts, and models of *papier-maché* and plaster.

At present, on account of the large number of students and the limited facilities, but little practical work is done in chemistry, physics, physiology, or pharmacy. According to the last annual report, there were in the college hospital three hundred and eighty-eight male and ninety-two female patients, and upwards of four thousand five hundred came to the out-door patient department. To all advanced students cases were assigned in the wards to be followed through their entire treatment. Each student is required to present a complete history of the progress, treatment, and result of his case, which is submitted to and criticised by the clinical professor.

The medical library has upwards of nine thousand volumes in the German language.

Translations of hand-books on practice, on therapeutics, on the eye and ear, on the throat, on venereal diseases, and on

surgery, have been made into the Japanese-Chinese characters used by the educated classes by the native instructors, and are being widely disseminated. Upwards of fourteen thousand copies of the Japanese edition of the lecture notes of the professor of therapeutics have already been sold. Hartshorne's "Essentials" and Wyeth's "Medical Reference-Book," in the character-writing, are having an extensive circulation.

There has been added to the medical school a department in which all instruction is in Japanese and all the instructors gentlemen who have studied Western medicine. The course of study is four years, of which two years are devoted exclusively to therapeutics and clinical work. Persons upwards of twenty years of age and possessing a sound Japanese and Chinese education can enter the school. The examinations are annual, and two consecutive failures are followed by expulsion. Graduates are given a government permit to practise medicine in any part of the empire and relieving them from future ken (provincial) examinations.

According to the last report of the I-Gaku-Bu, there were 11 German instructors and 33 natives. Of students in the special or advanced course there are 39 public cadets (all expenses being paid by the government, as in the naval and military school), 59 *shikuse* (students who are in the future to refund the government the funds advanced for their education), and 36 private students; in preparatory department, 161; in the Japanese, 656; and in the therapeutic class (made up of practitioners of the "Chinese school" who desire to learn of Western methods and drugs), 82,—a total of 1033. The tuition is free, except in two latter-mentioned departments, of which the fee is one dollar per month. Board, rooms, charcoal, and necessary expenses in the student-quarter amount to less than seven dollars per month. The school is in session about nine months. Regular attendance and continued advancement are demanded of all in the school.—*Phil. Medical Times.*

## ANALYSIS OF A SECRET CANCER PLASTER.

A person living not a thousand miles southwest of Chicago, treats such patients as he can convince that they have cancers, as follows: He applies a caustic plaster for six hours, producing a white eschar. Removing the plaster he poultices the spot for twelve hours, and then applies the plaster for six hours more. In this way the cautery is gradually deepened, and the eschar turns black and begins to separate from the living flesh. When he judges the action to be sufficient, he ceases the use of caustic until the slough drops out, when, if any suspicious points remain, he reapplies the remedy. The incompleteness of the work, however, is manifest by the large proportion of cases where the disease reappears in the same spot.

Some of his caustic having fallen into my hands, I gave it to Prof. M. P. Hatfield for analysis. The material was in the form of a brown paste, which, on close inspection, consisted of a fine brown powder imperfectly mixed with a transparent or translucent paste containing the caustic. Applied to the raw surface of a cancer, I found it to turn it white and to produce an eschar. Prof. Hatfield found the active principle to consist simply of chloride of zinc. A faint trace of iron was present as an impurity, and the coloring matter was a vegetable powder.

The quack claims almost miraculous powders for his secret plaster of chloride of zinc, and finds a considerable number of dupes to employ him.

The moral of this tale should be pondered by surgeons. The general horror of the knife is natural, and it is so decided that many minds cannot calmly face it, even with the promise of ether. Such patients will gladly endure great pain from a caustic, if they can be spared the thought of the cruel steel. A mental pain is as real as a physical one, and harder to bear. Would it not be really humane in properly selected cases to use caustics more than we do, making up for their clumsiness by attention and determined persistence, so as to be thorough in the extirpation?

Esmarch's painless caustic powder might serve in some cases,

and chromic acid, used while the patient is under the influence of morphine, would serve a quick turn in others.

Esmarch's painless powder is prepared after the following formula :

R Arsenious acid,	one part.
Sulph. morph.,	one part.
Calomel,	eight parts.
Puly. gum Arabic,	forty-eight parts.
Mix.	

Sprinkle thickly every day on a surface either raw or denuded of cuticle by a blister.—*Edmund Andrews, M. D., in Chicago Med. Rev., August, 1880.*

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#### THE LATE MISS NEILSON.

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DR. W. E. JOHNSTON, of the Boulevard Malesherbes, Paris, writes to *The Times* as follows :—“For the last five years I have had charge of Miss Neilson's health during her visits to Paris, one of the treatments running through a period of four months. The disease from which she suffered principally was gastralgia—one of the forms of dyspepsia attended with neuralgia of the stomach, a form extremely fantastic in its coming and going, and in her case quite as dependent on moral causes as on errors of diet. The last fatal attack in the Bois de Boulogne was evidently one of her usual attacks of gastralgia, which might have been relieved then, as it often had been before, by a free use of morphine. The unfortunate lady sent her maid for me at seven o'clock, but to my great regret I was absent that evening on a visit to my family in the country, and did not hear of her illness till I heard of her death. At three o'clock in the morning, twelve hours from the commencement of the attack, during a most violent recurrence of the pain, she suddenly ceased to complain, went into a state of syncope, and died in the syncope. The post-mortem examination made the next day by Dr. Brouardel, Professor of Legal Medicine at the Medical School of Paris, and now one of the first in Europe in legal medicine, disclosed the extraordinary fact, one of the rarest in



the history of medicine, that in her writhing she had ruptured a varicose vein in the left Fallopian tube, and had died from internal hemorrhage. Two quarts and a half of blood were found in the peritoneal cavity, and the ruptured vein presented an orifice of from four to five millimetres in diameter."—*The Lancet*, Aug. 28, 1880.

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## NOTES AND ITEMS.

SIMILARITY OF RED BLOOD-CORPUSCLES OF MAN AND CERTAIN OTHER MAMMALS. I suppose no experienced microscopist, who has thoroughly investigated this subject, will be misled by Dr. Richardson's paper, but there are many physicians who possess microscopes, and work with them, more or less, to whom a partial statement of facts, on such a subject as this, is peculiarly dangerous; and the object of the present paper is to point out to this class of readers that Dr. Richardson's statement of the case, even if all he claims, be granted as true, is after all, not the whole truth, that there are certain mammals—among them the dog, the constant companion of man—whose red blood corpuscles are so nearly identical in size with those of human blood, that they cannot be distinguished with any power of the microscope, even in fresh blood, much less in dried stains; and that, consequently, it is never in the power of the microscopist to affirm truthfully on the strength of microscopical investigation, that a given stain is positively composed of human blood and could not have been derived from the blood of any animal but man. *Dr. J. J. Woodward in Monthly Microscopical Journal*, Feb. 1875.

AFFINITY OF GLYCERINE FOR WATER.—G. W. Kennedy states as the result of experiments which he has made, that glycerine of specific gravity 1.26, exposed to a damp atmosphere for nearly two years, increased in weight by absorption of water from the air, from 21.292 per cent. to 59.417 per cent. accordingly as it was contained in narrow-mouth vials or in wide-mouth flat jars.—*Druggist's Circular*, September, 1880.

ERADICATION OF SYPHILIS.—G. F. French, in a paper read before the Maine Medical Association in 1878, advocates the most stringent measures for the eradication of syphilis. He takes the ground that it should be considered criminal for a syphilitic to have children. "To have syphilis or leprosy is no crime in itself, for the disease may be hereditary or acquired without blame; but it is criminal to be willing to perpetuate these maladies.

Supplementary to existing laws, a woman infected with syphilis, convicted of prostitution should be spayed, . . . ; and, not to make any invidious distinction on account of sex, every syphilitic or leper, married or single, should be interdicted from sexual co-habitation, under no less penalty than the deprivation of the procreative power. Under existing law, it is optional for married syphilitics to live together or separate, but the continuance of the marriage relation under such disabilities, should be regarded as a crime; and I believe the time will come, when it will be considered an outrage against society, and a heinous sin, for a person tainted with any grave transmissible disease to enter upon the marriage relation.—*Chicago Med. Rev.*, August 20, 1880.

THE MIRACLE OF THE IODIDES.—Who shall say that therapeutics is without its romance? It was before the laryngologists, in the days of the Second Empire, eight and twenty years ago. R—was the first tenor of Paris. Scarcely any one could sing even second to him, and he held the French capital enslaved within the compass of his gamut. But suddenly his song ceased. Days past and he came not on the boards. Was he tired? Perhaps. Weeks went by and he warbled not. Was he not well? He was not well. Then weeks ripened into months and months into years, and R—had been consigned to the brilliant past of the opera. But one day, after a silence of two years, it was announced that he would sing again, and in his old rôle, in *Favorita*. What a rush there was to see the resurrection, and to judge if the tradition of his song were true! The emperor was there with Eugenie; Maguan, commander of the garrison, a hundred thousand strong; the admiral of the fleets; De Morgny, in all his supposed brilliancy; and what concerns us most, the *Ecole de Médecine* was out in full force; and Ricord was there in the zenith of his fame. R— never sang better. His melody came by the gushful. The storm of ap-

plause shook the roof. Rising even above the rest of the din, were the plaudits of Ricord—Ricord who notoriously knew not one note from another, save those upon the bank of France. Marshal Magnan sat beside him. “How comes it, Ricord,” he said, “how comes it thou cheerest the music so vociferously—thou who diagnosest not between A minor and B flat?” Then answered him the great Ricord, “Hang the music, Magnan (*sacré musique!*); it is for the Iodide of Potash I hurrah!”—*Louisville Medical News.*

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## OBITUARIES.

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DR. RUDOLPH GEBSER died in this city, September 12th, 1880, in the 42nd year of his age. He was born in Germany, and after receiving a thorough general training at Erfurt and Weimar, he commenced his medical studies at Leipsig, at which famous university he took his degree. He afterwards pursued his studies in Berlin, where he was the pupil of Graefe, in Vienna and in Paris. He came to America in 1868, and was settled for about nine years in New York, a greater part of that time acting as assistant to Dr. H. Knapp. Sometime during the course of these years, he went to Japan, where he engaged in practice for a while; he did not remain there, however, many months, but returned to New York. It was on his way to Japan that he passed through St. Louis, and gained his first favorable impression of this city; indeed, he was so gratified with the result of his observations here, that he determined to make St. Louis his home.

Accordingly, the year 1876 found him established in St. Louis, in the exclusive practice of ophthalmology and otology. He came to our city a total stranger, with the exception, we believe, of a single acquaintance, and it is significant of the man, that he died possessed of a host of really warm friends, both in and out of the profession. His rapid and brilliant success was due to the happy combination of social, moral and technical qualifications for his chosen calling. There never existed a more kindly, genial and generous gentleman; and to

the innate qualities of the heart, were added those accomplishments which were the result of a liberal education, extended travel, and a large experience of the world. But there was one preëminent quality of his character, which was left to his professional brethren alone to appreciate—a pure professional morality. Rudolph Gebser was to his heart's core an honest physician. His true and open nature was inconsistent with dubious methods, he had no small jealousies for his professional brethren. He had enjoyed quite exceptional opportunities for the study of diseases of the eye, and his acquirements as an ophthalmologist, showed that he had taken advantage of them. He was an exceedingly ready diagnostician, a sound therapist, and a good operator. As is usually the case, his experience as a general practitioner was of great value to him as a specialist. He had written but little, although his neglect in this respect was not due so much to a lack of well-digested observations, as to his constitutional habit of modesty, and to an aversion to premature publications. In the year 1876, Dr. Gebser founded the Missouri Eye and Ear Infirmary, which, under his management, and with the able assistance of Dr. Frazier, soon became one of the best attended and most useful eleemosynary institutions in the city. With his customary generosity, more than half the expenses of this charity were defrayed by him. He was also ophthalmic surgeon to the St. Mary's Infirmary.

Dr. Gebser was a stockholder in the Medical Journal Association, an earnest supporter of the "COURIER," in which he always manifested the liveliest interest.

The Medico-Chirurgical Society passed the following resolutions of respect to his memory:

WHEREAS we have learned with deep regret of the death of our esteemed friend and colleague, Dr. Rudolph Gebser, who has been taken from among us in the prime of his social and professional usefulness; therefore, be it

*Resolved* that in our fellow member's early death we have to deplore the loss of an honorable and cultured gentleman, a generous and kindly friend and a true physician.

*Resolved* that in Dr. Gebser's career in our city, and as a member of this organization, we had learned to look upon him as embodying those qualities of mind and heart—thorough but unpretentious learning, unaffected modesty and unostentatious

charity—which will be his best epitaph in our affectionate remembrance.

*Resolved* that the science of ophthalmology has lost a zealous and successful cultivator, and his patients, especially the poor to whom he had devoted so many hours of his life, a skillful physician.

*Resolved* that we respectfully extend the sincere sympathy of this society to his bereaved mother, and that a copy of these resolutions be sent to her; and, also that other copies be presented for publication to the "*Archives of Ophthalmology*," the "*ST. LOUIS COURIER OF MEDICINE*" and to the daily press of this city.

W. A. HARDAWAY,  
W. C. GLASGOW,  
G. J. ENGELMANN.

Committee.

At the meeting of the St. Louis Medical Society, Sept. 18th., Drs. Jno. Green, G. Baumgarten and A. C. Bernays, were appointed a committee and drafted the following resolution which was adopted and ordered to be engrossed upon the records of the Society.

*Resolved* that in the death of Dr. Rudolf Gebser the St. Louis Medical Society and the medical profession of the West lament the loss of a colleague whose sterling qualities of mind and heart have won for him a place among the foremost; but, recognizing the fact that the example and memory of an earnest and noble life endure beyond the grave, we find consolation in the thought that it has been good for us that he has lived among us and that he is still a living power for good to us who knew and loved him.

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DR. F. H. DAVIS, of Chicago, died at his home in Chicago, August 17th, aged 32 years. In the early part of the summer he suffered an injury which caused a prostatic abscess followed by nephritic and perinephritic abscesses and thus led to death after a protracted and painful illness.

He matriculated in the Chicago Medical College in the autumn of 1867 and graduated in 1871, his course having been interrupted on account of impaired health, in consequence of which he spent sixteen months abroad. After graduating he paid a second visit to Europe, spending several months in the study of diseases of the throat and lungs.

On his return to Chicago he entered upon the active practice of the profession and in the course of nine years he had laid well the foundation of a large and lucrative practice.

He was for some years associated with his father as editor of the *Chicago Medical Journal*, and was an active member of the Association of American Medical Editors, the Illinois State Medical Society, and the American Laryngological Association. He left a wife and two children, and a large circle of devoted friends.

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M. BROCA, the vice-president of the French Academy, a distinguished surgeon, member of most of the societies of savants, and especially one of the founders and the leading spirit of the Society of Anthropology, died last July, aged fifty-six years.

His knowledge was not superficial, but thorough and critical in almost every field of science and art; but it was to the study and development of anthropology that he devoted his best endeavors, and that it was which aroused his highest enthusiasm.

His friend and colleague, M. J. Lucas-Championnière, says of him, that he is one of those savants, such that it is necessary often to wait several generations in order to see their equals.

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DR. L. V. NEWTON, editor and proprietor of the *Druggist's Circular*, died July 10th after a long illness, at 71 years of age. He was a graduate of the Jefferson Medical College, of Philadelphia, in the class of '37.

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## SOCIETY MEETINGS.

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THE S. E. MO. MEDICAL ASSOCIATION will hold the eighth semi-annual meeting at Perryville, Mo., commencing Thursday, Nov. 8, 1880.

THE NEXT MEETING of the St. Louis Obstetrical Society will be held at the house of Dr. P. G. Robinson, 3411 Washington Ave., Thursday, Oct. 21.

ST. LOUIS  
COURIER OF MEDICINE  
—AND—  
COLLATERAL SCIENCES.

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ORIGINAL ARTICLES.

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FISTULA OF THE URETHRA OF THE MALE.

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BY AMBROSE L. RANNEY, M. D., *Adjunct Prof. of Anatomy in Med. Dept. of the University of the City of New York. Author of "A Treatise on Surgical Diagnosis", "The Essentials of Anatomy" etc.*

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THE presence of an accidental tract, lined by an adventitious membrane, and communicating, on the one hand with the urethra, and, on the other hand, with the cutaneous surface, is not to the specialist, an uncommon occurrence.

The most common sites of such fistulous openings upon the cutaneous surface are usually in the region of the perineum, thigh, or gluteal region; while the internal opening is most often found in the perineal portion of the urethra, especially in the membranous part of the canal. It is easy to understand why the membranous portion of the urethra, being unsupported by erectile tissue to any great extent, and being, as it were, suspended by its two extremities between the two layers of the triangular ligament of the perineum, and thus lacking the normal support afforded by the surrounding parts, should be the first to feel the abnormal

pressure produced by the obstruction afforded by any type of urethral trouble, to the free escape of urine from the cavity of the bladder; and, if too greatly distended, should be ruptured and thus allow of the escape of urine from its proper channels.

The length of these abnormal tracts is modified by the seat of the internal orifice. When the spongy portion of the canal is opened, the tract is usually short; but when the membranous portion is ruptured, the fistulous canals are often very long and tortuous, and have been known to extend as far as the groin, the hypogastric region, and down the thigh for a considerable distance. Every urinary fistula has only one internal opening, but the number of external openings may vary from one to a very large number. Thus Ledran<sup>1</sup> reports the existence of thirty, and Civiale<sup>2</sup> refers to a case where fifty-two such openings existed. The situation of such openings, like those of fistulous openings in general, is indicated by a red, fleshy papilla, which projects slightly beyond the level of the surrounding surface. The abnormal tract may be straight or tortuous, single or multiple. In cases of long standing, the sinus becomes of a dense and firm character, due to a deposit of inflammatory lymph, and the surrounding tissues are oftentimes similarly affected.

The causes of the fistulous tracts include urethral stricture as the most frequent cause, although they may also originate from ill-managed attempts to pass instruments, from external violence, from the protracted sojourn of catheters and bougies within the urethra, from the impaction of calculi in the urethra, from chancre within the canal, and from operations of lithotomy. The immediate cause of this affection is a solution of continuity of the mucous membrane lining the canal, followed by an escape of urine into the connective tissue. The imprisoned urine, being confined until the putrefactive changes have commenced, now suffers a *chemical change in its urea*, which, by absorbing two equal equivalents of water, changes its chemi-

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1 *Traité des Operations de Chirurgie.*

2 *Traité sur les Maladies des Organes Genito-Urinaires.*



cal character and becomes transformed into two corresponding parts of the carbonate of ammonia; the irritating properties of this salt soon destroy the life of the surrounding tissues, and rapid sloughing commences.<sup>1</sup>

The following case is cited, as illustrative of the type of cases of this affection, which will present themselves for surgical relief. I give it in full, as it appears in my case book, in order that the steps of treatment may be fully shown before the reasons for the various steps be discussed.

R. C., 35 years of age—Patient has had several attacks of gonorrhœa during his life, the last occurring about ten years before consulting me, which lasted some months. He has also had venereal sores, but gives no evidence of secondary symptoms.

For some fifteen years he has noticed a diminution in the size of the urinal stream, which has, however, never produced symptoms of pain in micturition or occasioned marked difficulty in emptying the bladder. Soon after his first attack of gonorrhœa (some twenty years ago) he had an attack of retention of urine, which was easily relieved by a catheter introduced by a physician, but has never had another similar attack.

About one year ago, the patient developed a perineal abscess which was opened by his medical attendant, and the opening has never closed. The patient states that he has never perceived any escape, from the opening, of fecal matter or of fluid during attempts at defecation, but does perceive a well marked escape of fluid whenever he attempts to empty his bladder, and it is for this reason that he seeks my medical advice.

An examination reveals the existence of a fistulous opening upon the left thigh, one and a quarter inches downward and forward from the anus. The presence of an old cicatrix brings out the fact that about one year before consulting me he had been operated upon for the relief of the

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<sup>1</sup> For a full account of the diagnostic symptoms of this affection in its early stages and the means of relief, see my article in *N. Y. Med. Journal* March and April, 1879.

trouble by an incision extending into the rectum, but that no relief followed. On instructing the patient to attempt to pass urine, the whole of the quantity passed, which was small, escaped by the abnormal opening. An examination of the urethra revealed a contracted meatus, a marked constriction in the fossa navicularis, which admitted a bulbous sound No. 6;<sup>1</sup> another of the same calibre at a distance of two inches; a third one at three and one-half inches which admitted only a No. 3 sound; and, at six inches, the urethra became so nearly closed that no exploring instrument could be passed. A whalebone guide could be introduced into the last stricture for a distance of some half inch and yielded to the touch a peculiar hard and gritty sensation. After some difficulty, a smaller whalebone guide, properly bent at the tip, was passed through the constriction apparently, but it soon emerged from the fistulous orifice. Another was subsequently introduced into the mouth of the stricture, which was found to be upon the upper wall of the canal and slightly upon the left side, and passed to the bladder, the first guide meanwhile being left in the fistulous canal to partially occlude it. Considerable difficulty was afforded by the ejaculatory ducts to the passage of the last guide, which was overcome by repeated withdrawals for a short distance and renewed attempts at progress.

A No. 2 tunnelled sound (Gouley's pattern) was passed over this guide to the bladder, and subsequently Nos. 3, 4, 5, 6, and 7, tunnelled sounds; each of which encountered a hardened mass which seemed like an urethral concretion. The whalebone guide was then withdrawn, and Nos. 7 and 8 solid sounds were passed to the bladder without a guide. The patient was then given quin. sulph. gr. x and tincture aconite  $\text{m}\text{j}$ . and the latter was repeated after an interval of an hour.<sup>2</sup>

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1 The case-book records measurements according to the English scale, which can readily be altered, if desired, to millimeters.

2 The immediate dilatation of so tight a stricture is contrary to my usual method, as I usually prefer a preparatory treatment and rest in bed for at least two days previous to such an operation, but this seemed indicated, as the

Three days later, I was obliged to enlarge the meatus with a meatotome, in order to pass larger solid sounds; when without special difficulty Nos. 9, 10, 11, 12, and 13 sounds were passed. The same doses of aconite and quinia were then given.

May 4th. For the last five days, the cut meatus has been kept open by the occasional passage of a large sized solid sound for a distance of about two inches into the urethra, and the patient has noticed a marked improvement in his condition. The size of the urinal stream has enlarged, and the amount of urine passed through the fistulous tract has diminished to such an extent as to almost entirely dispense with the use of protective dressings.

May 6th. Solid sounds Nos. 14, 15, and 16, were to-day passed, as the strictures seemed to yield readily to dilatation, and no sign of blood could be detected as an evidence that any injury had been done to the mucous membrane of the urethra.

May 21st. Since the last note, solid sounds of gradually increasing sizes have been passed at intervals of two days, the dilatation being pushed as fast as the stricture would yield without the use of force or unpleasant symptoms being produced. The fistulous tract has now closed and no evidence of the escape of urine can be detected. The urethra now readily admits a No. 18 solid sound, and no evidence of injury to the mucous membrane or unpleasant symptom has been produced by the treatment. The patient is directed to continue the occasional passage of instruments, after his return to his home, and is taught how to personally introduce a sound No. 16.

This case is one of a number from my case books, which could be adduced to illustrate the following points.

1st. That many cases of stricture of the deep urethra or even of the penile portion may not only create but indefinitely prolong urethral fistulæ.

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swelling, which would follow the passage of an instrument through so tight a stricture, might cause an attack of retention, which might be difficult to relieve without aspiration of the bladder.

2nd. That the *removal of existing urethral constrictions* will in the majority of cases cure the fistulæ, without recourse to any other method of treatment.

3rd. That *gentleness* and the *skillful use of instruments* will enable the surgeon to enter any stricture which will allow of the escape of urine, no matter how long or tortuous, or how deeply situated.

4th. That most strictures, unless they be of traumatic origin, *can be dilated* after a whalebone guide has been successfully passed to the bladder, by the use of tunnelled steel sounds of the proper curve, so as not to impinge upon the guide, in which case the guide may be broken or cut through. The proper curve of these tunnelled instruments should be much shorter in point of length, and more nearly straight than that of the ordinary sound, and the edges of the tunnelled portion should be smooth and bevelled to prevent the possibility of injury to the guide.

5th. That strictures of extremely small calibre, if situated in the deep urethra, are frequently *impermeable to solid sounds*, unless tunnelled, or to catheters, and that attempts to use solid instruments of small size without a guide are dangerous; as a liability to produce a false passage or to lacerate the mucous membrane is thus endangered, which may be followed by all the disastrous results of internal urethrotomy.<sup>1</sup>

Among my other cases of urethral fistulæ, I find one where five abnormal openings were discovered, through which urine passed; which were situated respectively in the regions of the perineum, and thighs, and which were entirely healed by the dilatation of the urethral constrictions, which had originally been the creating cause of an extravasation of urine, and which had left fistulous openings, on account of an incomplete attempt of an inexperienced operator to relieve the strictures.

By reference to the case first quoted, where the details of

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<sup>1</sup> For details of the dangers of this operation in the deep urethra, see my article in the *N. Y. Med. Journal*, August and September, 1880.

treatment are given quite fully, it will be perceived that the suggestion of Long,<sup>1</sup> as to the administration of tincture of aconite, is usually employed by myself, in addition to the use of sulphate of quinine, as a preventive of urethral fever, whenever the necessity of the passage of instruments through tight strictures arises. Those twelve fatal cases reported by Banks,<sup>2</sup> where death ensued from the simple passage of instruments, should cause every careful surgeon to hesitate before commencing the treatment of stricture even by dilatation, not to speak of the more severe cutting operations, unless the patient had been given every known advantage which preparatory treatment affords. It is, to my mind, clearly settled, that the use of *hot hip-baths* and *rest in bed*, previous to attempts to pass instruments through tight strictures, does enable the patient to bear the shock of such a procedure better than without them; and I believe that the use of some form of diuretic, even if the kidney affords no evidence of disease, previous to treatment of stricture, helps to prevent the possibility of renal complication.<sup>3</sup>

I quote from a late address delivered by Sir Henry Thompson,<sup>4</sup> what seems to me the true ground, from which all such disputed points should be argued.

“The foregoing may, I believe, be held to embody those general principles, concerning which most experienced surgeons at the present day agree—with few dissensions I am aware—and which ought to guide us in practice. That there are different modes of carrying them out, is, as I have before intimated, a matter of no less notoriety than of necessity, as inherent in the necessity of things. Such a circumstance may be regarded as one fraught with some advantages for us here, in providing scope for discussion, and so eliciting a comparison of ideas and methods among the many experienced observers, who honor the Section with their presence to-day.”

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1 *Liverpool Med-Chir. Journal*, January 1858.

2 *Edin. Med. Journal*, June, 1871.

3 See my cases reported in the *N. Y. Med. Journal*, in May, 1880.

4 *Brit. Med. Journal*, August, 1880.

There are certain fistulous tracts, which, in spite of the removal of urethral constrictions, still remain open, probably on account of the amount of induration of the walls of the canal and the adjacent structures. In these cases, it is my custom to resort first to the use of a flexible catheter, whenever the necessity for emptying the bladder of its contents becomes apparent to the patient, thus preventing the flow of urine through the fistula, and thus relieving the irritation and the constant separation of the walls of the tract. If, after a trial of this method for a month or two, the canal still remains unclosed, in case the stricture shows no tendency to recontract, I frequently introduce a wire into the canal, and raise it to a white heat by the galvano-cautery, and suddenly withdraw it; thus destroying the pyogenic membrane which lines the canal and producing a tendency toward granulation. A less severe measure, which often proves efficacious, is to inject into the external orifice of the fistula a solution of the nitrate of silver; but all of these resources will seldom prove of any avail until the urethral constriction has been completely removed.

A type of urethral fistula, which follows sloughing of the walls of the canal, or where the walls have been in part destroyed by abscess, phagedenic ulceration, local pressure upon the penis (as occurs in phimosis, the tying in of instruments, etc.), and wounds of the urethra, often demands a plastic operation to restore the tissue destroyed. Such openings, if larger than a pea, are seldom healed by ordinary means; since the edges are thin and granulate poorly, while the dribbling of the urine creates an inflamed and unhealthy condition of the margins which further tends to prevent repair. It was for such fistulæ as these that Dieffenbach<sup>1</sup> first proposed the application of a concentrated tincture of cantharides to the edges of the opening several times a day, the urethra being first stretched over a full-sized sound and the tissues

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<sup>1</sup> Die Operative Chirurgie Leipsic. 1845.

being scraped to the raw surface before each application, in order to better promote the growth of healthy granulations. Sir Astley Cooper<sup>1</sup> also suggested the use of a hare-lip pin with sutures and the external application of strong nitric acid. The union of the freshened edges of the opening after the stimulation of cantharides, by means of the interrupted<sup>2</sup> or lace suture,<sup>3</sup> is oftentimes of material benefit.

It would exceed the limits of this paper to enter into detail as to the different suggestions which have from time to time been made to simplify the efforts of the surgeon in his attempts to close large openings in the urethral walls by plastic operation. Dieffenbach has devised a method, known as the "sliding flap method," and Nelaton has made some modifications in it which are considered by some as of material aid; while Segalas, and Ricord,<sup>4</sup> have written at length upon the subject, advising the opening of the urethra behind the seat of the fistula as a preparatory step to the operation, in order to prevent the non-union of the flaps from the dribbling of the urine.

*156 Madison Avenue, New York City.*

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1 Treatise on Surgery.

2 Sir A. Cooper.

3 Dieffenbach op. cit.

4 Monthyon Prize Essay, 1841.

## ETIOLOGY.

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BY N. W. HARRIS, M. D., HARRISTON, MO. (*Address read before the Cooper County (Mo.) Medical Society.*)

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AT our meeting two months ago, I heard a very learned and interesting paper on Etiology. The writer took strong grounds, and quoted many authors to prove that contagious diseases are never produced by any cause save contagion or infection, that one case of typhoid fever is always the product of another case of typhoid fever. This theory was endorsed by two of the gentlemen present.

I make this short reply because I believe their opinion erroneous and dangerous; erroneous, in as much as I am convinced that typhoid fever in many cases does originate spontaneously; dangerous, because disseminating such belief in a community, is calculated to cause a disregard of sanitary precautions.

I will quote but few authors in support of my views; it is useless to do so because of the difference of opinion among them. A large majority of those of the British Isles take the opposite side, whilst in France and Germany the majority deny contagion.

But there is one feature in the argument of my young friend which is not sustained by a single author, as far as I know; that is the statement that "as showers of dust have been known to fall on ships a thousand, and sixteen hundred miles from land, therefore, the spora of typhoid fever may be carried great distances by currents of air, thus accounting for contagion in cases of fever appearing in isolated localities where none had been known for miles around."

This argument seems highly poetic in view of the fact that the most staunch contagionists admit that the contagion of fever is feeble, and becomes harmless even a few feet away.

Watson, whom I deem the best guide on practice, is of



the opinion that continued fever is always the product of contagion, yet he says, "There is reason to believe that the poison, unless pent up, does not remain active at any great distance from the person from whom it proceeds, not even many yards or feet."

This quotation will express the views of all the contagionists whom I have read or seen quoted, and, if true, completely explodes the above fanciful dust theory.

If I were compelled to define the cause of typhoid fever in one word, it would be—*filth*.

I do not assert that filth alone will produce fever, but that if combined with certain electrical and other causes, not well understood, it may, and often does produce fevers that once produced become infectious; for I readily admit that typhoid fever is infectious, and is often produced by infection.

That it is never engendered, is to suppose that the Creator created Adam and Eve with the seeds of all the infectious diseases in them, and thus transmitted them to us, their descendants: an idea utterly preposterous.

Then, if those diseases had in the first instance a spontaneous origin, under some peculiar circumstances, why may not those circumstances occur again and again?

Tweedie says, "The primary seat of typhoid fever, properly so called, is proved to be in the blood, caused by the introduction of animal or *vegetable* effluvia into that fluid." And further he says, "There can be no doubt that the most potent febrile poisons are the exhalations from the bodies of persons laboring under some form of fever. The proofs on this point are so clear and satisfactory, that few persons deny that fever originates in contagion. To assert that contagion is the only principle capable of producing the disease, evinces a very limited notion of the circumstances under which fever is generated."

And further he says, "The human body, not only when affected by disease, but, under certain circumstances, in a state of health, generates a poison which gives rise to fevers. This principle, notwithstanding the reasoning of

ingenious disputants, has been incontrovertibly established by a multitude of facts."

I could go on with quotations similar to the above, from a host of authors, many of them contagionists, as Tweedie was, but I deem it unnecessary. In fact, I do not think that the great authors are good judges of the question under discussion, for their experience has been confined to large cities, where it is impossible to prove non-contagion.

Country practitioners have a better chance to draw correct conclusions; therefore, let us resort to our own good common sense and observations.

Mayslick, Mt. Sterling and Paris, Kentucky, which form a triangle some thirty miles apart, have long been known as places terribly scourged with typhoid fever, breaking out every few years and proving terribly destructive to the inhabitants of those places, at times when the surrounding counties were free from fever. So marked was this, for a long series of years in Paris, that the citizens of Bourbon County, of which Paris is the county seat, called it "Paris fever." Sometimes these three places would have the scourge for several years in succession, then would be exempt for four, five, or six years. Surely there must have been some *local* cause for this.

One February, in the early fifties, it appeared in four families in Fleming County, Kentucky. I could trace no contagion, but found plenty of evidence in surrounding filth to satisfy me of its spontaneous origin in each family. These families lived several miles apart in sequestered localities. There were six cases in the four families, and although they were freely visited by neighbors, no other cases occurred for miles around.

January, 1859, four cases appeared within a few days of each other, in a family four miles from Linneus, Missouri. It was a family who lived in great isolation, in an old log house, weather-boarded and plastered, with floors well to the ground. Let me here remark that I have never seen a family occupying an old decaying building of this kind who enjoyed good health. The family were slovenly in

their habits. These four cases were very severe, but all recovered. I attended them, and living in the county seat, had every facility to know that there were no other cases in the county at the time.

During the illness of these four cases, a young married lady of Linneus, with her two daughters and a negro boy, driver, went to the place and spent three days and nights, came home, and in about two weeks, all four sickened of the disease within a few days of each other; all four died. They were visited by four physicians regularly, and were constantly nursed by neighbors, but no other case of typhoid fever appeared in Linneus that winter or spring.

A contagionist could sieze upon those four latter cases as proof positive of contagion; but could not the non-contagionist, by combining the facts of the eight cases, have the better argument, when he asserts that the disease is not contagious, and that the latter four only imbibed the local poison that produced the disease in the first four.

I have seen again and again, in country localities, where the disease had not been seen for years, scarlet fever, mumps, measles and hooping cough, suddenly appear in great numbers of cases in a few days, so suddenly and in so great numbers as to utterly preclude the idea of contagion. Yet few will deny that these diseases are contagious.

In support of this view, many authors could be quoted. Ferguson, Inspector General of British Army Hospitals, says: "All that has been urged against the contagiousness of plague applies with equal force in the case of diseases notoriously contagious, as small pox, typhoid fever, scarlatina and measles. These diseases arise or become epidemic from some atmospheric or terrestrial cause, rage for a certain time, and finally, when the epidemic cause ceases, decline. During their prevalence they spread both from an epidemical cause as well as by contagion."

It is my firm belief that most, if not all contagious diseases, do sometimes, under peculiar circumstances with which we are not well acquainted, arise spontaneously.

You have here in this town, with its boasted wealth of

intellect and ducats, and I presume in all towns, not provided with sewers, a want of sanitary precaution sufficient to disgust and shock the intelligence of a savage. If the world advances in improvements in the next hundred years as it has in the last, it will be hard for the then generation to believe the historians of this day, when they read of your privy vaults. I presume there are five hundred in this little city, pits ten to fifteen feet deep, in which are the accumulated secretions from the human body for decades, continually sending fourth their noxious vapors, debilitating and poisoning the inhabitants. No wonder you have, and have had scarlatina for eighteen months. No wonder you have typhoid fever. The wonder is that you are not decimated; and were it not that nature humanely permits the human body to become inured to poison, and gives those habitually exposed to it greater immunity than those accustomed to breathe pure air, you would be.

No need to look for the cause of disease to be wafted to you by aerial waves, when you have such sinks of pollution and death in your midst.

This question was cursorily discussed at our last meeting. I spoke of sixteen Irishmen in Kentucky, who in 1851-2, wintered in a log hut, twelve by fourteen feet, who had daubed it as tight as mud could make it. When warm weather commenced in the spring, they began to come to me, feeble, pale, torpid, with flabby, trembling tongues. At last I was sent for to visit the hut, and found the condition above described. Then the cause of the illness of my visitors was plain. I thought the horrid stench of the shanty enough to breed any disease, and told the boss that his men were poisoning themselves with their own filth and foul air. We punched numerous holes in the hut, and ordered a thorough washing, scrubbing and airing of the place and its contents. In a few days the Irishmen were themselves again.

I expressed the belief that those men would have had ship-fever, typhus, if their condition had not been speedily changed; that they were generating the disease by their

own foul secretions and the want of oxygen in the air they were breathing. It was especially this opinion which my learned friend ridiculed, and which called forth his argument, so much more eloquent than scientific, that I did not know what I was talking about; that if the men were really in the incipient stage of fever no sanitary precautions could have averted it, etc.

As it would be equally unpleasant to your readers and to myself were I to reply in a similar strain, I have endeavored to state my own views concisely, and I will close with the statement of a fact that few will dispute, that persons may be, and often are exposed to the exciting cause of diseases, whether they be emanations from the sick or atmospheric poisons, to an extent that disturbs the healthy functions of the body, so much so that they are quite unwell, and yet, by timely removal from the exciting cause, the powers of nature, the *vis medicatrix naturæ*, throws off the incipient disease that would have been fully developed had the persons remained exposed.

But when continued fever has once fully formed, I admit there is no known process that can prevent its running its regular course.



## SURGICAL NOTES ON THE MARSHFIELD CYCLONE.

BY S. H. HEADLEE, M. D., ST. JAMES, MO.

THE cyclone that swept through the town of Marshfield, in Webster County, Mo., on Sunday evening, April 18th, 1880, left in its desolated track seventy-five dead, and at least one hundred and fifty stricken and wounded people.

Included in this latter number were every age and condition, from the helpless infant at its mother's breast to the centenarian tottering under the weight of years.

The injuries and wounds comprised every variety from the simple contusion to the compound comminuted fracture of the long bones, cuts of the scalp with fracture and depression of the tables of the skull.

There was a large pre-dominance of scalp wounds and notably on the back part of the head.

Seventy-five of these poor unfortunates were, on the night following and the next day after the storm, gathered into the public school building which was hastily improvised into a hospital.

The building was a large, commodious and airy structure, well suited to the purpose to which it had so suddenly been changed, and was not at all overcrowded with numbers, as it could have been made to contain in comfortable condition, over one hundred patients.

For the first few days the arrangements were not as satisfactory as could have been desired, but in as speedy a manner as possible, considering the difficulties to overcome, everything was put in order, and before the close of the third day the sufferers were placed in as comfortable and favorable sanitary condition as circumstances and the general surroundings would permit. It is not the design in this paper to detail the course and symptoms of individual cases, although there were many that would be of special interest, but to give a synopsis of the peculiarities and anomalies that were common alike to all from the simplest to the most serious.

There were conditions and symptoms developed during the five weeks this hospital was operated, and not only among those in the hospital, but in the out-patients as well, that certainly indicated, if they did not demonstrate, the fact of some special influence operating in these cases and governing their course, that is usually absent in injuries from ordinary causes.

First, there was not a wound healed by first intention, neither in those made by the flying missiles or falling walls, nor in the clean cuts from the surgeon's knife. In the first of these, this is easily accounted for in the great

number and quantity of foreign substances driven into the wounds ; many of them it was almost impossible to cleanse, days, in numbers of them, being required to accomplish this in anything like a satisfactory manner ; and frequently after every effort had failed, the fine particles of gravel, sand and dirt were only removed by slough, so firmly were they driven into the tissues surrounding the cuts ; even the hair and skin where there was no solution of continuity were literally filled with these fine particles. But the presence of these foreign substances will not serve to explain the entire failure to secure adhesion from apposition in cuts made by the surgeon's knife.

In each case alike, from the second to the fourth day, the whole surface of the wound was covered with a peculiar grayish, dirty looking slough that very soon separated, leaving a healthy appearing, granulating surface beneath.

The larger number healed every slowly. Whilst retaining the appearance and healthy look of separation, the wounds instead of closing up were gradually enlarging, and although improvement would seem to be marked and rapid for a few days, there would generally follow a corresponding period of unfavorable symptoms, and it was near the close of the third week before there was any well-defined and decided improvement.

Another peculiarity was that a large per centage of those hurt did not know for several days that they were seriously injured. A little cut or contusion which for the first two or three days caused no discomfort or uneasiness, would suddenly begin to develop into a painful suppurating or sloughing sore, and show a depth and dimensions and constitutional symptoms that no ordinary rules of diagnosis would warrant.

There was also exalted sensation in the parts injured, whilst the patients themselves showed the profoundest apathy regarding their condition, manifesting no interest in what was transpiring around them, and at every attempt to cleanse or dress their wounds, earnestly pleading to be let alone.

This hyperesthesia was manifested in young and strong men as well as women and children, the slightest touch giving intense pain even in scalp wounds; and often this painful condition would seem to be excited by the mere presence of the nurse or surgeon where no disturbance was attempted.

This exalted sensation was universally present, in every case, and in many it continued after their wounds were rapidly closing up, but in the greater number it gradually disappeared after the second or third week.

Before the close of the first week erysipelas made its appearance among the patients both in hospital and those at private houses in the town.

At first those attacked were isolated and watched with much interest and considerable anxiety, but its general prevalence including the isolated as well as those in hospital, and its mildness and easy control rendered those precautions unnecessary. The attack was preceded by increased pain and soreness in the wound, swelling and tenderness of the cervical glands and fever. In the first twenty-four hours the temperature would rapidly rise to 105° Fah. On the second day it would fall to 102° or 103°, and generally on the third or fourth return to the normal standard. The eruption usually made its appearance at the close of the first day of the febrile excitement, and disappeared from the fourth to the sixth. It was almost entirely confined to the surface, the cellular tissue being involved in very few cases, and in only one was it followed by abscess and suppuration.

The treatment adopted was to give tinctures veratrum and aconite until reduction of temperature, and then quinine and iron. The local applications, with apparently equal benefit, were the muriatic tincture and sulphate of iron, and mercurial ointment; but it is my opinion that it would have run its course in the same time without any treatment. In fact this was demonstrated in two or three cases in which there was no special treatment given and with the same satisfactory results as had been obtained in other cases.



For many days after the injured were brought into the hospital, there was apparent a careless listlessness and want of attention that was entirely unaccountable, and that could not be explained on any theory of nervous shock caused by the injury. This apathy seemed in greater or less degree to possess every individual who had been caught in the track of the storm, whether injured or not.

It was remarkably notable that the individual members of the same family, lying in different wards, rarely if ever inquired after the condition of the others or even expressed any concern as to their own welfare. And friends and relatives followed their dead to the grave with the same stoicism that seemed so universal among the wounded.

There was no disposition to talk upon any subject, but all lay quiet and still whether sleeping or awake, and no complaints or groans were uttered or heard except when it was necessary to disturb or dress their wounds.

As a general rule they slept well at night, and ate their meals with apparent relish when taken to them, but very seldom did they ask for anything or express a desire to see or hear from any one. In all, with the exception of two or three, the intellectual faculties were perfectly clear, no confusion of ideas, no noise in the head, and no intolerance of light; in fact it was noticeable that among so many with the number of peculiar and serious conditions existing, there were so very few whose intellectual faculties were disturbed.

That there was some mysterious and powerful influence operating upon the nervous system of each and all of these cases beyond the mere shock of injury received and producing these peculiar conditions, seems after the most careful observation very clear to my mind.

What this subtle and powerful agent was, is another question. How it operated and what changes were produced in the great nerve centres, are questions that may or may not admit of solution.

Erichsen in his lectures on "Railway and Other Injuries of the Nervous System," tells us that: "We do not know

how it is that when a magnet is struck a heavy blow with a hammer, the magnetic force is jarred, shaken or concussed out of the horse-shoe. But we know that it is so, and that the iron has lost its magnetic power. So if the spine is badly jarred, shaken or concussed by a blow or shock of any kind communicated to the body, we find that the nervous force is to a certain extent shaken out of the man, and that he has in some way lost nervous power. What immediate change, if any, has taken place in the nervous structure to occasion that effect, we no more know than what happens to a magnet when struck. But we know that a change has taken place in the action of the nervous system, just as we do in the action of the iron by the change that is induced by the loss of its magnetic force."

The powerful but transitory influences that produced these well-marked and continued changes in the nervous system of the cases under consideration, we may never be able to comprehend or trace to our entire satisfaction, but that they did exist and in many individuals at the same time and under like circumstances we do know.

The number of cases and the different grades and great diversity of the injuries, all without exception showing in less or greater degree the same phenomena, preclude all idea of an explanation being based upon the theory of nervous shocks from injury or that it was spinal concussion in any of its ordinary phases.

It is probably entirely too early, May 26th, to give an opinion as to the final termination of these cases, but it is clearly evident from what has already transpired that their condition in the earlier periods of their history was dependant upon some powerful change wrought in the nervous system of each during the passage of that terrible cyclone that destroyed their homes and struck them down. But it was not the design or intention at this time to advance any theory in reference to the cause of these peculiar and anomalous conditions, the only purpose in view being to place the facts before the profession, and invite

attention and opinions as to the probable influences operating. It is to be hoped that the description has been clear enough to convey a correct idea of the real condition.

That there were peculiarities and anomalies, marked and notable, seemed very clear at the bedside of these poor sufferers. And the most remarkable of all was that, notwithstanding the great number of individuals, their wide diversity of condition in life, and the vast differences in age, sex and color, and the varying degrees and shades of injury, there should have been such a uniformity in the phenomena exhibited.

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## CASES FROM PRACTICE.

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### A CASE OF PUERPERAL CONVULSIONS—ABSCESS OF LIVER—GANGRENE OF LUNG.

BY P. C. YATES M. D., JACKSONVILLE, MO.

*Read before the Moberly District Medical Association.*

At midnight, of the 24th of March, 1879, I was called out a distance of three miles, to the bed-side of Mrs. L—; aged 29, in robust health, of fine physique, medium height, inclined to be fleshy, and in confinement with her fourth child; in her first accouchement, eleven years ago, she was the victim of puerperal convulsions, coming on during labor and leaving her in an unconscious state for forty-eight hours. I found her well advanced in labor, presentation natural, pains had come on about three hours previous to my arrival; she was complaining very much of headache; pulse was full, but soft and regular; she had taken during the night several doses of bromide of potassium, prescribed by Dr. Petty a few days previous. I administered the fourth of a grain of sulphate of morphia, which soon gave much relief from the headache. The labor pains were regular, bearing down well, with a fair prospect of a speedy termination, and I awaited the consequences. About 2:30 A. M., she was delivered of a male child, large and well developed; and immediately the headache returned. The hemorrhage being considerable, I refrained from blood-letting

and repeated the morphia which was soon followed by an intermission of the pain. About 3 A. M., the placenta with membranes and considerable clotted blood was removed by slight tension on the cord. She was soon quite comfortable, hemorrhage sufficient, pains well established, uterus firmly contracted, patient cheerful, and all felt gratified at the successful termination of the labor. I went to bed and rested until 6 A. M. During this time the patient rested well, was now quite cheerful and expressed thanks for the easy time she had had, and I left her, thinking she would have no farther trouble, as our books generally teach that the greatest danger of convulsions after labor is during two to four hours after; but near eight o'clock the headache returned. She told her nurse that she saw that little old woman with a striped shawl on, a hallucination that she had seen in her first confinement; just prior to the convulsions. A messenger was dispatched for me; at eight o'clock, five hours after the completion of labor, she was seized with a convulsion. I arrived at half-past eight, just as the second convulsion was going off. Her pulse was now full and hard, respiration stertorous, face flushed, and she was unconscious. I at once performed venesection, taking three half pints of blood before I could note any effect upon the pulse. I then administered chloroform; but another convulsion came on, lasting near five minutes, after which I gave sixty grains of bromide of potassium which was swallowed with much difficulty. Dr. Petty was sent for. We gave morphia hypodermically, and again administered chloroform; but the eclampsia came on at intervals. We prescribed fluid extract valerian, tinct. asafœtidæ, equal parts, a teaspoonful repeated at short intervals; we also gave ten-grain doses of chloral hydrate in combination with bromide of potassium. I remained with the patient. After twelve o'clock the time between convulsions grew longer, and at 3 P. M., 25th, ceased; the patient remaining comatose, breathing stertorously until about 12 P. M., when the breathing became quiet and she seemed to sleep quietly. She awoke about 4 A. M. 26th, rational, was quiet and cheerful, with no recollection of what had happened after seeing the hallucination above referred to. From this time she seemed to do well, made a rapid recovery from her accouchement, and was discharged on the third day. On the seventh day the husband informed me that she had a pain in the region of the liver, and some cough, and that her bowels were costive. I

directed ten grains of pill. hydrarg. to be given at night for three nights, also syrup of squills and paregoric to allay the cough. On the third day I called. She had taken oil; her bowels had been freely moved; she said the pills had given her much relief, that she was now free from pain, with a good appetite, had still some cough, but no expectoration. Neither auscultation nor percussion revealed anything abnormal in the lungs. She sat up at table and ate dinner in my presence with a good relish, but not to excess. On the following day, which was the eleventh from her confinement, I was sent for and found her spitting up large quantities of a greenish liquid, which appeared to be a mixture of bile, mucus and pus, and was very offensive; in fact, the stench was almost intolerable, and she said something had burst in her right side in the night; auscultation revealed nothing wrong but the passage of the liquid through the posterior part of right lung. No pain nor inconvenience were complained of except a choking and nausea from the liquid being thrown off. Diagnosis—abscess of liver discharging through right lung. I again called in Dr. Petty, who concurred in the diagnosis. Temperature was  $102\frac{1}{2}^{\circ}$ , the right shoulder-joint was much swollen and of a greenish black discoloration, as if it had been badly bruised; also a place below right shoulder-blade about two by three inches presented the same appearance. As the patient was on a thick feather bed, and had constant attention during the convulsions, these places were hard to account for. She was put on quinine, iodide of potassium and iron, and a good wholesome diet. The discharge continued abundant for five or six days, when it gradually began to diminish and change to a more laudable pus; the appetite gained, the patient became more cheerful and hopeful, but showed signs of approaching exhaustion by the appearance of night sweats, feeble pulse, etc. We prescribed aromatic sulphuric acid, and tincture of iron every four hours, fluid extract ergot, three times a day, and quinine and ammonia as directed. The patient seemed to improve for a few days, and the prognosis seemed more favorable, but soon there was severe pain in the posterior and lower part of the right lung, with dulness on percussion, difficulty of breathing, temperature up to  $105\frac{1}{2}^{\circ}$ , and in an incredibly short time, the patient was spitting a large amount of fetid pus with clotted blood, and at times large particles of gangrenous lung. This process gradually advanced until it reached the apex of the

lung, destroying the entire posterior part of that organ, notwithstanding whiskey, codliver oil and iron, and disinfectants were freely taken and very well borne by the patient. About the 20th of May, an abscess formed in the middle and inner third of the left lung, which was as rapid in its course as its predecessors of the right side; the patient now rapidly sinking, despite every effort to stay the fearful malady and to build up the system against its ravages. She died of exhaustion on the first day of June, thirty-six days from date of confinement. The causes of these fearful and fatal consequences are veiled in much obscurity. My opinion is that an embolus was dislodged during the convulsions, carried in the circulation and lodged in the upper and posterior part of the liver, cutting off the circulation of a part of that organ and causing gangrene where it came in contact with the diaphragm, and involving that muscle in the surrounding inflammation. The extreme lower part of the lung was also inflamed and adherent to the diaphragm which rapidly suppurated, and the whole was discharged through the bronchial tubes. The mother of this lady died at about forty-seven or forty-eight years, from a malignant ulcer of the stomach, having at the same time a progressive ulceration of the os uteri. The maternal grandmother died at the age of sixty from a malignant tumor of the diaphragm, which caused almost constant cough and great dyspnea, and was thought to be bronchitis till within a short time before her death, when it broke into the stomach, the patient discharging and throwing up at the same time quantities of fetid pus, having a cancerous smell and look. This discharge entirely relieved the cough and dyspnea, but the patient suffered excessively with sick stomach, with occasional vomiting of a thick black tenacious fluid, until death ended the scene. One part in particular that I wish to call attention to in this case, is the hereditary taint. I believe there was nothing inherited in this case, as the symptoms clearly showed it to be a case of gangrene, and the previous good health immediately prior to the acute attack, would prove it to be traumatic, but it should prove to every practitioner the necessity of obtaining the family history of his patients, and when we find in that history any of the numerous diseases that pass from generation to generation like an heir-loom, we should adopt the most efficient means to avert the calamity that hangs like a cloud over our patients.

## EDITORIAL.

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No. 5.

EXPERIMENTAL RESEARCHES ON THE NATURE OF  
DIPHThERIA.

A contribution of considerable importance toward a correct understanding of the nature of diphtheritic affections, has been made by Drs. H. C. Wood and Henry F. Formad, entitled, "Research on the Effects of Inoculating the Lower Animals with Diphtheritic Exudation."<sup>1</sup>

Five series of experiments were made by these investigators under authority of the National Board of Health, with a view of determining whether it was possible to produce diphtheria in the lower animals by the inoculation of the exudations from diseased human subjects.

The first series comprise experiments, thirty-two in number, performed on rabbits, cats, dogs and a goat, by the inoculation of diphtheritic matter subcutaneously, and in the mucous membrane of the mouth. Five rabbits and one cat died in an average of about eight and a quarter days following experiment, several inoculations being secondary. The result of post-mortem and microscopic examinations in these cases, showed swollen and tuberculous lymphatic glands, hyperemic viscera, with hemorrhagic infarctions of lungs, cheesy lumps at site of subcutaneous deposit, and generally, an inundation of tubercle in all organs, with occasional bacteria in the lungs.

In one instance only was there any indication of tracheal exudation; and as the formation of false membrane is the only sign which can be considered pathognomonic of the diphtheritic process, the question arose as to what caused the death of

<sup>1</sup> Supplement No. 7, *National Board of Health Bulletin*, October, 2, 1880.

these animals. This question was answered by the post-mortem revelation, not only of those animals which died, but also of those that were killed, when tuberculosis was found to be general, and in many cases intense.

“In order to discover whether the diphtheritic exudation acted specifically in the production of tubercle, or whether it merely set up a local inflammation which formed a focus,” the experimenters inserted foreign bodies, as pieces of clean wood, glass, cork, hair, and wire, under the skin, in nine rabbits, with a result of five deaths with profuse tuberculosis in each case; and the inference is drawn that a simple local inflammation, may, in the rabbit, act as a source of tuberculous infection.

The third series of experiments were undertaken to determine whether the introduction of pseudo-membrane into the trachea produces diphtheria, but owing to the advent of warm weather, a sufficient supply of exudation to test the subject fully could not be obtained; however, experiments were made in four rabbits with the result of two deaths. On post-mortem examination the trachea of one rabbit was found covered with true pseudo-membrane, the organs tuberculous, especially the liver. No lesion was found in the other rabbits.

The fourth series were performed to determine whether certain corrosives will produce pseudo-membranous trachitis in rabbits and other animals, and whether the membrane thus obtained resembles that occurring spontaneously or produced by the introduction of diphtheritic matter into the trachea. Five rabbits, one dog and one cat were subjected to the test of injecting ammonia into the windpipe. Four rabbits died within about fifty-nine hours following the operation; the fifth rabbit being killed by excess of ammonia used. The cat died fifty hours after operation, while the dog lived twelve days, and was killed while apparently recovering. In every case (save the accidental death) well developed false membrane, perfectly identical with natural diphtheritic membrane was found in larynx or trachea; in all but one, more or less tuberculous deposit, and sometimes hemorrhagic infarctions of lungs and bacteria were present.



The fifth and last set of experiments were ten in number, made on rabbits by inoculation with foreign bodies, pus, etc., in the trachea. The agents used were slough from bed sore, exudation from throat of scarlet fever patients, ammonia pseudo-membrane, purulent mucus and ichorous pus. As a result of the experiments in two cases pseudo-membranous trachitis and crupous exudation in lungs was caused by the introduction of pus. Six of the animals died, and the autopsies usually showed cheesy lumps or abscesses in different parts of the body.

These experiments go to show that in the trachea the formation of a pseudo-membrane is not the result of any peculiar or specific process, but simply of an intense inflammation which may be produced by any irritant of sufficient power.

After stating that there is no anatomical difference which can be detected by the microscope between the lesion of true croup and diphtheritic angina, the experimenters observe that a "difference has been believed by some pathologists to exist between the two diseases, in that in croup the membrane separates easily; in diphtheria, with great difficulty from mucous membrane. This seems to arise from a misunderstanding. The mucous membrane of the fauces and mouth has a squamous, not easily detached, epithelium, and consequently membrane connected with or springing from such surface is firmly adherent. The epithelium of the trachea is columnar, ciliated and detaches with the utmost facility, even in normal condition of the organ; hence membrane attached to it separates readily. The membrane of diphtheritic trachitis is always readily detached in the line of the epithelium."

After a general view of the facts elicited, the deduction is made, without committal to any theory that the "contagious material of diphtheria is really of the nature of a septic poison which is also locally very irritant to the mucous membrane; so that when brought in contact with the mucous membrane of the mouth and nose, it produces an intense inflammation without absorption by a local action. Whilst absorption is not necessary for the production of the angina, it is very possible that the poison may act locally after absorption, by being carried in

the blood to the mucous membrane. Further, under this theory it is possible that the poison of diphtheria may cause an angina which shall remain a purely local disorder, no absorption occurring, or a simply local trachitis produced by exposure to cold or some other non-specific cause may produce the septic material when absorption shall cause blood-poisoning; the case ending as one of adynamic diphtheria."

This view is advanced to reconcile antagonistic opinions concerning the value of local treatment in diphtheria, the value of such treatment depending largely upon whether absorption has or has not preceded the angina. The fact that one attack of diphtheria in no way protects against a second, would entirely remove it from any relation with exanthemata; placing it rather with septic diseases, which, as is well known, recur indefinitely.

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#### REST AFTER DELIVERY.

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A question of the utmost importance both to the practitioner and patient, is that as to the length of time during which the puerpera should be confined to the recumbent position. Nine days in bed had come to be so generally accepted as the proper time, that many practitioners adopted it as routine practice to allow a patient to rise on the ninth day without any special consideration of the extent to which the process of involution had advanced, and many patients felt aggrieved, or that a wrong had been done them, if the expected permission to leave the bed on that day were deferred.

Recently, however, some obstetricians of extensive observation and unquestioned ability, have taken a decided position in opposition to the long established practice, and have claimed that prolonged recumbency after parturition is not only unnecessary, but positively injurious; and it has come to pass that the judgment and practice of different obstetricians vary greatly.

Dr. H. J. Garrigues has contributed a most excellent and valuable paper to the October number of the *American Obstetrical Journal*, in which he has studied the subject very thoroughly.

He takes Dr. Wm. Goodell of Philadelphia, as the chief representative of those who recommend to shorten the lying-in period as much as possible. He allows his patients to "slip into a chair while her bed is making on the next morning after delivery," and on the fourth or fifth day she is allowed to get up and be dressed, if so desired.

In answer to the position of Dr. Goodell, that parturition is a physiological process and should not be made to wear the livery of disease; that the upright position excites the uterus to contract and lessens the amount and duration of the lochia; that uterine diseases are hardly known among the nations whose women early leave their beds, that experience has shown him that convalescence is thus rendered far more prompt and sure; Dr. Garrigues replies, that although a physiological process, parturition is "one in which a transition from the normal condition to the pathological is extremely common, and that the women of our time are no more in the same physiological condition as in the infancy of mankind. He suggests that the fetal head, by hereditary development of the brain in consequence of civilization, may have become larger than it was in the early history of the race, and states that the head of the new-born Indian is said to measure from one-eighth to three-eighths of an inch less in its various diameters, while the measurements of the pelvis of the Indian woman is about the same. On the other hand, the tissues of the civilized woman have no doubt become weaker and are more easily torn. He claims that it is not proven that the upright position favors uterine contraction, and even if granted, it remains true that displacements of the uterus are likely to be produced by the weight of the organ while it is enlarged and flaccid, and many careful observers have denied the statement that the lochial flow is diminished by the upright position. He attributes Dr. Goodell's admirable results, as reported, to the other measures which he adopts, to the good food, relief from pain, prevention of infection, etc., and questions whether the length of

time which the patients remain in the Retreat after delivery, averaging sixteen days, is sufficient to determine the *final* result of this mode of treatment.

He quotes Dr. J. T. Johnson of Washington, as authority for denying, that the experience of the colored women of the South, shows the advantage of a speedy getting up after delivery. Dr. Johnson says that at the Freedmen's Hospital Dispensary, patients suffering from the effects of subinvolution, uterine displacements, and hemorrhage, presented themselves for treatment more frequently than from any other ailments.

Most of the leading European authorities advise a lengthening rather than a shortening of the period of rest.

Dr. Garrigues then considers the result of the most careful and accurate investigations, as to the size of the uterus immediately after parturition, and at successive periods of the process of involution. According to the measurements of Boerner, the length immediately after delivery, varied between twelve and nineteen centimetres, (four and three-quarter and seven and one-half inches), and at the end of three weeks it still rises above the brim of the pelvis, when it is raised up from its anteflexed position behind the symphysis. According to Heschl, the weight of the uterus immediately after delivery, is from twenty-two to twenty-four ounces; at the end of the first week, from nineteen to twenty-one; at the end of the second week, from ten to eleven ounces; at the end of the third week, from five to seven ounces; and it does not reach its normal weight, which is about an ounce and a half, before the end of the second month. "It appears from these figures that the womb has only lost little in weight at the end of the first week, that the greatest diminution takes place during the second week, and that at the end of the third, it is still three or four times heavier than the non-puerperal uterus."

By means of the recent investigations of Küstner upon the *shape and place* of the puerperal uterus in the recumbent and the erect postures, he shows that the puerperal womb is anteflected, and that when the woman assumes the upright or sitting posture, the womb is displaced somewhat backward and

the anteflexion is notably increased, so that the conditions are most favorable for the production of a hanging belly; while in the recumbent position the relations are such as to afford every advantage for the return as speedily as may be, to the normal shape and place in the pelvis.

“To sum up, then,” he says, “anatomy and physiology teach us that the puerperal uterus is large, heavy, flabby, anteverted and anteflected; that all the surrounding parts destined to support it are distended, soft and yielding; that its interior presents one large wound bathed in a fluid rich in disintegrated tissue element; that the placental site is pervaded by large venous sinuses filled with recently formed blood-clots, that at least the vaginal orifice, and often other parts of the obstetric canal present open wounds; that the processes of transformation, absorption and regeneration, require at least two months, and that the retrogression is most active during the second week.”

The conclusion which he reaches is that “*the upright and sitting postures ought to be carefully avoided until involution has proceeded so far, that the uterus has receded from the anterior wall of the abdomen and returned to the pelvic cavity.*” This may sometimes occur within five days, but in a great majority of cases two weeks are necessary. In order to ascertain this, he feels every day how high the fundus uteri extends above the symphysis. When the uterus has sunk behind the symphysis, it finds sufficient support from the true pelvis. Theoretically the dorsal decubitus is the best, but as it is exceedingly tiresome to maintain this position for a great length of time, the puerpera may be allowed to vary it to the lateral decubitus, which, however, should not be confined to one side alone, lest lateral displacement be produced.

Our own experience fully sanctions the result to which Dr. Garrigues leads his readers, and we believe it is one which is approved by a vast majority of those who carefully observe and study the results obtained by both methods of treating obstetric cases.

## COMMUNICATIONS.

## ACONITE IN TONSILLITIS.

*Messrs. Editors:*—I notice in the report of proceedings of the Medico-Chirurgical Society, June 28th last, in the remarks on the treatment of acute tonsillitis, that one of the gentlemen present, an able, experienced specialist, spoke in very favorable terms of the effect of sulphide of calcium in preventing suppuration and decidedly shortening the course of this disease. One case which he quoted as undoubtedly showing its value was dismissed cured after four or five visits, in as many days. In my neighborhood, where the majority of the population is of the laboring class and of small means, the physician is generally expected to cure and dismiss a case of acute tonsillitis with one visit, which certainly is hardly just to either party, but which nevertheless often proves sufficient to ensure a fairly speedy, favorable result. I obtained my treatment from Ringer, who uses aconite as his chief remedial agent. He says in the *Lancet*, April, 1869, "The power of aconite over inflammation is little less than marvelous." "It can sometimes at once cut short the inflammation, and thereby prevent formation of inflammatory products, as lymph, new tissue, pus, etc. It is useful whenever there is acute inflammation of any tissues of the body." "The good it accomplishes can be shown both by the amelioration of the symptoms, and still better by the changes it effects in the inflamed tissues when these are visible, as in pharyngitis, tonsillitis, etc." "It is rare that a quinsy or acute sore throat, if treated at the commencement cannot be disposed of in twenty-four to forty-eight hours by its use." "The appearance of the inflamed parts also exhibits in a striking degree the beneficial effects of the drug. Thus large, livid, red, glazed and dry tonsils, may often, in twenty-four hours, have their appearance completely altered. If the medicine has been given before much lymph has been formed in these organs, in the time named the swelling and most of the redness will have disappeared, and the mucous membrane will have that look which proves the inflammation

to have subsided, namely, it has become moist and is bathed with mucus or pus." I have repeatedly verified what Prof. Ringer says respecting the effects of aconite in acute tonsillitis, so that I consider it almost a specific. I give to an adult five drops of the tincture of aconite root at once in a little water, and one-fourth as much every twenty minutes afterwards, until the pulse is reduced to ninety, and profuse diaphoresis is produced. Then a similar dose is continued hourly. I give a purgative dose of calomel unless the bowels are loose, in which case, if the tongue is foul, I give a few half-grain doses instead. Hot poultices are applied to both sides of the throat immediately; and, if the patient is willing to pay me for another visit on the next day, if I find pain and swelling still present, which is usually due to neglect of directions, I paint the tonsils and parts surrounding with a solution of nitrate of silver, thirty grains to the ounce, and give him crystals of chlorate of potassa to dissolve in the mouth, to be afterwards swallowed; also five drops of the tincture of belladonna and two drops of tincture of aconite root every two hours, a combination strongly recommended by both Bartholow and Ringer. In the case of a young man eighteen years of age, whose throat was almost completely closed from the enormous swelling of both tonsils in an acute attack, causing an extreme degree of dyspnea, and death by suffocation to appear imminent, by means of ten drops of the tincture of aconite root placed on his tongue, and a hot poultice to each side of his throat externally, I have completely relieved the urgent symptoms in thirty minutes, causing very profuse perspiration with a grateful sense of comfortable relaxation. I order patients always to remain in bed until several hours of free action of the skin have passed. I have given aconite to pale, thin children, with moderately weak pulses, and have always found one-half to two-drop doses in the beginning of the attack, repeated every fifteen or twenty minutes, to bring about copious sweating and speedy diminution of the swelling, and have never seen any unpleasant symptom from its use in this manner. If the patient has been, on account of painful, or perhaps impossible deglutition, ten or twelve hours without proper nourishment, I order an enema of beef essence.

Neither Niemeyer, nor Seiler, nor Squarey, in *Reynold's System*

of *Medicine*, nor Hartshorne say a word of this treatment, which is very probably the most efficient known in typical acute tonsillitis.

I have seen cases occurring in extremely anemic, badly-nourished children in which I would not give aconite. Children whose pulses were very feeble and irregular, and numbered near 140 beats per minute, while their temperature would only be about 105° or 101° F. In these cases there is not much dyspnea, and the type of the inflammation is decidedly asthenic. Of course they require different treatment from that above described. I use the nitrate of silver solution topically, and as poultices are more troublesome, and as there is no urgency, I order sliced salt pork with powdered camphor sprinkled on it, (after J. Lewis Smith) or a similar stimulating application externally, with fair doses of tincture chloride of iron, chlorate of potassa and quinine, and a few drops of whisky four or five times a day. Beef tea, boiled milk, pure cream, egg-nog, etc., are emphatically demanded also. These cases are not cured in one, or even two visits.

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## BOOK REVIEWS AND NOTICES.

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A PRACTICAL TREATISE ON TUMORS OF THE MAMMARY GLANDS, Embracing their Histology, Pathology, Diagnosis and Treatment. By SAMUEL W. GROSS, A. M., M. D.

The author of the above styled treatise, will pardon us for omitting the remainder of the title page of his very valuable book; for after giving to the profession such a book as that now under notice, it matters little whether the author is "Surgeon to, and Lecturer on Clinical Surgery in the Jefferson Medical College Hospital," etc., or not. The reputation secured to our author by this work will be lasting, and the knowledge conveyed to the profession of this country will add centuries of life to American women.



Many of the author's conclusions are worth repetition. One will be given. Speaking of the causes that influence the development of carcinoma, he says: "I must state explicitly that I am no believer in the constitutional derivation of carcinoma, but regard the inheritance as merely the expression of the transmission of a predisposition to a local disease, just as is seen in the hereditariness of lipoma, chondroma or sebaceous cysts in other organs or tissues which no one regards as being the local manifestation of a constitutional or blood vice. Recurrence after removal, the contamination of the associated lymphatic glands, and the development of precisely similar growths in the viscera, are surely explicable on the ground that the primary tumor acts as a focus of infection of neighboring and distant parts without invoking the theory of constitutional taint." In the treatment of malignant diseases of the breast, the author is faithful to his conviction of its local origin, and says: "Of the cases in which the affection pursued a natural course only one and five-tenths per cent. survived six years, while of those subjected to the knife, thirty per cent. were living free from disease after the expiration of six years." Then follow directions for the removal. "Thus in the most favorable of all cases, namely, one in which the tumor is of moderate size, and devoid of superficial and deep attachments and enlargement of the axillary glands, the proper procedure is to remove the entire breast and its coverings by a circular incision. Search for any out-lying lobules that may be disseminated throughout the mammary region, dissect off the fascia of the pectoral muscle and prolong the outer portion of the incision into the axilla with a view to its thorough exploration.

Although the glands may have eluded detection previous to surgical interference, careful examination will usually disclose that several are already converted into secondary tumors, and in this event the axillary space must be thoroughly cleansed out with the object of getting rid of so many independent sources of infection of the adjacent tissues and associated glands."

We have made the above extracts because of the practical value attaching to them, to those who may not have an opportunity of reading the book. We cannot conclude this brief notice, without urging every practitioner to read this book. It will enable him to make a clearer diagnosis, and, I believe,

lead him to conclusions that will add to the comfort, and lives of a class of sufferers who are too early neglected and too often abandoned by the regular practitioner to become the victims of ignorant and designing quacks.

J. T. H.

THE PRACTITIONER'S HAND-BOOK OF TREATMENT, OR THE PRINCIPLES OF THERAPEUTICS. Second American from Second English Edition. By J. MILNER FOTHERGILL, M. D., Member of the Royal College of Physicians, London, etc., etc. *Philadelphia; Henry C. Lea's Son & Co.* 1880. 8vo., pp. 647, cloth.

The fact that a second edition of Dr. Fothergill's Hand-Book of Treatment, is required at so early a day after the issue of the first, is sufficient evidence that it meets a want in the profession. The junior members of the profession will find in it a work that should not only be read, but carefully studied. It will assist them in the proper selection and combination of therapeutical agents best adapted to each case and condition, and enable them to prescribe intelligently and successfully. To do full justice to a work of this scope and character will be impossible in a review of this kind. The book itself must be read to be fully appreciated. In the introduction, attention is called to the well-known fact, that in the present style of teaching medicine, too much attention is given to the refinements of diagnosis, to the great detriment of rational therapeutics.

Iron is classified as being a food rather than a medicine; and attention is called to the fact that not only iron, but almost all other hematics are greatly increased in efficacy by being largely diluted with water. The facts that hydrobromic acid relieves cinchonism, and that, in the old, quinine may produce irritability of the bladder are mentioned. Under the heading of "When not to give Iron," the author makes a good point when he teaches that iron is forbidden in what is usually known as biliousness. He also calls attention to two classes of cases among women when iron is rarely indicated, viz., amenorrhea in florid, plethoric women, and, in the same class of women, menorrhagia. This is frequently lost sight of, in practice. He notes that opium and astringents are deadly poisons in diseases where elimination is greatly impaired, and particularly in the old. His definition of biliousness is excellent. The same may be said of his definition of typhoid fever and typhoid condition. Attention is strongly called to an old remedy in the

treatment of fever, aconite. Hydrate of chloral, according to the author, is of great value as an antipyretic, a property of this drug not so generally understood as of the former. For beef-tea, Liebig's extract, etc., the author has but little use as food; he classes them among the stimulants. He thinks they may do much harm as in the case of other stimulants if given too freely or early in acute disease.

The treatment of inflammation by calomel and opium is very earnestly condemned. Paultices over the liver to relieve congestion, obtain a favorable mention. The fact that aversion to fatty food is often an acquired habit, and the necessity of teaching children, and particularly those in whom we have to fear a consumptive tendency, to eat fats, is insisted upon. Alcohol is classed as a food, as well as stimulant, a view which will be dissented from, by many. On tubercle, the author coincides in his views with Niemeyer. The actions of, and dangers arising from, the use, singly or combined of opium, hydrate of chloral and bromide of potassium, are very ably presented. The action of digitalis is presented in an exceedingly clear manner. The value of belladonna and strychnine as stimulating expectorants, is not generally understood. In a few well chosen words he calls attention to the dangers of opium in diseases of the respiratory organs. In reference to diarrhea of trichinosis, some experience in that disease leads me to believe that the diarrhea resulting from it, ought to be checked rather than encouraged. His remarks on selection of diuretics should be carefully read by every practitioner. The same may be said of his ideas on selection of food in degenerative renal disease.

The publishers have done their part of the work quite well, but it is somewhat disfigured by a number of typographical errors. I noticed the following: pages 106, potach for potash; 158, albulan for albumen; 172, diabetic for diahetic; 179, heat for heart; 195, intestitial for interstitial; 302, combination for combination; 314, vey for very; 392, difficulty instead of difficult, and nerve for never, page 451; also, frest for fresh, page 600.

J. H. V.

ATLAS OF SKIN DISEASES. By LOUIS A. DUHRING, M. D., Professor of Skin Diseases in the Hospital of the University of Pennsylvania, etc. Part VII. Philadelphia: J. B. Lippincott & Co. 1880.

Part VII. of this superb series of illustrations contains the pictures of Eczema (Pustulosum), Impetigo Contagiosa, Syphoderma (Papulosum), and Lupus Vulgaris. We have time and

again expressed our high appreciation of the beauty and truthfulness of these delineations, and as there was every reason to expect, the present plates are fully equal to those already published.

The descriptive text accompanying the plates, is a model of clear, crisp composition. With the aid of this atlas, and the author's excellent treatise soon to be out in a new and revised edition, there is no reason why every physician in America should not acquire a reasonable practical knowledge of skin diseases.

W. A. H.

THE ART OF PROLONGING LIFE. BY CHRISTOPHER WILLIAM HUFELAND. Edited by ERASMUS WILSON, M. D., Author of "A System of Human Anatomy," etc, etc. From the last London edition. Philadelphia: Lindsay & Blakiston, 1880. 12mo; pp. 298. Cloth, \$1.00. (Through Hugh R. Hildreth Printing Company.)

This little volume has been before the profession for a number of years, but has lost none of its value and interest, nor has its place been taken by any of the more recent works upon hygiene. The work was written by Prof. Hufeland, in Germany, nearly one hundred years ago, and was translated into English before the commencement of this century. It was, however, little known until it was again brought to the attention of English readers, in a popular edition with copious notes by Dr. Erasmus Wilson. The first half of the volume is occupied with a recital of the various theories advanced from time to time, concerning the Art of Prolonging Life, Nature of the Vital Power, Instances of Longevity, etc. The last half of the volume considers the "Means which Shorten Life," and the "Means which Prolong Life." It is a work which may be read with profit and interest by physicians or laymen.

THE SKIN IN HEALTH AND DISEASE. By L. DUNCAN BULKLEY, M. D., Attending Physician for Skin and Venereal Diseases at the N. Y. Hospital, etc. Philadelphia: Presley Blakiston. 1880.

This little book is No. IX of the really invaluable series of Health Primers, edited by Dr. Keen, of Philadelphia. Dr. Bulkley has said what there was a necessity for saying in regard to the skin in health and disease with excellent good taste and judgment. There are some few things, such, for instance, as the elaborate classification of skin diseases, to which the hypercritical might raise an objection as being somewhat out of place; but the book, as a whole, is so cleverly exe-

cuted that we have nothing for it but hearty commendation. Although this little treatise is written in a popular way for popular readers, there is much in it which it would be greatly to the physician's advantage to know; indeed, since each book of the series is written by a *specialist* in the subject of which it treats, we think they are all as well worth reading by the profession as by the laity. The medical man who has the welfare of humanity at heart, and who wishes to elevate his own calling in the eye of the world, should strongly recommend these Health Primers to his patients.

W. A. H.

HYGIENE OF THE TREATMENT OF CATARRH. Hygienic and Sanative Measures for Chronic Catarrhal Inflammation of the Nose, Throat and Ears. Part I. By THOS. F. RUMBOLD, M. D. *St. Louis: Geo. O. Rumbold & Co.* 1880. 12mo, pp, 174. Illustrated. \$1.00. Cloth, (Through Hugh R. Hildreth Printing Company.)

This volume is diffuse in style, profuse in verbiage, prominent in ungrammaticisms, and copious in typographical errors. These faults are inexcusable in a book written by the editor of an important Medical Journal, who is supposed to be a judge of good composition and a competent proof-reader. That our criticism is not too harsh, will be evident on perusal of the volume itself.

Intended evidently for popular, rather than for professional reference, but slight notice of the contents of this volume is called for in a medical periodical. It consists, after preface and introduction, of a series of eleven chapters on Hygienic Measures, and eight on Sanative Measures; several of these chapters being sub-divided into sub-sections.

In the preface, the author tells us that it took him a few years in practice to find that the successful management of nasal catarrh depended largely upon the faithful observance of the laws of health by the patient, a fact which is generally supposed to be well understood by a first-course student.

The most imposing chapter is a quasi-philosophical tirade on Tobacco, its Mental and Physical Effects. In the course of which we are gravely told, that "If the female of ordinary good health, who has had one continuous cold from her girlhood to her fortieth year, \* \* \* has black hair, and the tobacco victim has light hair, then his nasal cavities will be in a much greater diseased condition than hers, and vice versa." Dr. Rumbold refers to some twenty post-mortem examinations made by him, between the years 1862 and 1865, in which he

invariably detected habitual smokers by the great darkness of the mucous membrane of their nasal passages; and in the lines following the one quoted in our last sentence, says, "If a light haired boy commences at his fifteenth year to use tobacco inordinately, and continues to use it excessively, the resulting congestion will be so severe that it will ultimately involve other important organs; the brain, the stomach, the heart, the lungs are almost certain to be implicated to such an extent that life will be shortened, by many years, and when he dies, mortification of his body will commence first in the nasal cavities."

Some of Dr. Rumbold's hygienic views and opinions are peculiar enough to quote. For example, under the head of Night-Caps, we read, "A covering or cap for the head, during the hours of sleep, is as essential for comfort and protection as is bed-clothes for the body." "Every infant, up to its eighteenth month, should in all seasons of the year, have its head protected by a light cap during the day, and a heavier one during the night, and every child, up to its tenth year, should wear a night-cap during the fall, winter and spring months. Nine-tenths of the earaches and of the attacks of croup and sore throat, grow out of the neglect of this very simple precaution." Under the head, Clothing, "Deficient clothing, colds, and chronic catarrh of the superior portion of the respiratory tract, bear the relation to each other of cause and effect." "Every time that a lady, whose garments below her waist, consist chiefly of loose skirts, passes the corner of a street on a blustery day in winter, she is chilled up to her knees in a few seconds, the warmth of her body being almost instantly blown away from her skirts."

Under the head of "Frequent Changes of Under-Clothing," the author says, "Weak patients should change their under-clothing as seldom as possible," "not until it has become soiled, which may be in about one, two, three or more weeks." Why under-garments should be worn so long, passes our comprehension, as they must of necessity become soiled in a much shorter time. It may be but a question of taste.

The chapter on Diet and Stimulants, is so much abbreviated as to be of no use whatever, although from the title of the volume, we would have expected it to be long and detailed.

The ideas of the doctor as to Anatomy and Pathology, seem

to be somewhat confused, for he speaks of the "mental portion of the brain," as well as of the vessels in the mucous membrane of the nose becoming thirty or forty times their original diameter.

The best chapters in the book, and the only ones interesting to practitioners, are on Cleansing the Nasal and Pharyngo-Nasal Passages by Patients, and on Removal of Hardened Secretions from the Nasal Passages. Dr. Rumbold has been of considerable service in promulgating his commendable series of diagrammatic demonstrations of the shortcomings of the nasal douche of Thudichum; and likewise in adopting certain changes in the position of the head to facilitate flushing the passages by insufflation from the hand. Both these subjects are reproduced in the volume before us, and are adequately illustrated. Our approval of Dr. Rumbold's labors upon these two points, however, is by no means to be construed into approval of his denunciation against the douche itself. We have been quite pleased, too, with the pictures illustrating the chapter on Cleansing the Ear, but lack of experience in the method described, disables us from an expression as to its real value. Had the entire volume been as practical as the chapters just alluded to, it would have been welcome to the profession and a credit to its author.

C. S.

WHAT TO DO FIRST IN ACCIDENTS OR POISONING. By CHARLES W. DULLES, M. D., Surgical Registrar to the Hospital of the University of Pennsylvania, etc. *Philadelphia: Presley Blakeston.* 1880. (Through the Hugh R. Hildreth Printing Co. 18mo.; pp. 70; cloth, 50 cents.

This little book contains, in brief space, information that every one should possess. Accidents occur frequently when no physician is at hand; and in some cases great suffering may be prevented or even death averted by the prompt adoption of simple means that are suggested by this writer. He considers only such accidents as are of tolerably frequent occurrence under the following heads: Obstructions to Respiration, as drowning, hanging, etc.; Foreign Bodies in the Nose or Ear; Fits, or Seizures, of various kinds; Effects of Extreme Cold or Heat; Injuries of Bones or Joints; Wounds; Railroad and Machinery Accidents; and finally, Poisons. The little volume merits an extensive sale.

## BOOKS AND PAMPHLETS RECEIVED.

MINOR SURGERY AND BANDAGING. By Christopher Heath, F. R. C. S., etc, Sixth edition revised, and enlarged, with one hundred and fifteen illustrations. *Philadelphia: Lindsay & Blakiston.* 1880. 12mo., pp. 340; cloth, \$2.00. (Through the Hugh R. Hildreth Printing Co.)

A TREATISE ON THE PRACTICE OF MEDICINE FOR THE USE OF STUDENTS AND PRACTITIONERS. By Roberts Bartholow, M. A., M. D., LL. D., etc. *New York: D. Appleton & Co.* 1880. 8vo., pp. 852; cloth, \$5.00 (Through the Hugh R. Hildreth Printing Co.)

DISEASES OF THE THROAT AND NOSE: Including the Larynx, Trachea, Œsophagus, Nasal Cavities and Neck. By Morell Mackenzie, M. D., London, etc. Vol. I. Diseases of the Pharynx, Larynx and Trachea. *Philadelphia: Presley Blakiston.* 1880. 8vo., pp. 570; cloth, \$4.00. (Through the Hugh R. Hildreth Printing Co.)

A TREATISE ON THE DISEASES OF THE EYE. By J. Soelberg Wells, F. R. C. S., etc. Third American from the Third English edition, with copious additions, by C. Stedman Bull, A. M., M. D., etc. Illustrated with two hundred and fifty fine engravings on wood, and six colored plates, together with selections from the test types of Prof. E. Jæger and H. Snellen. *Philadelphia: Henry C. Lea's Son & Co.* 1880. 8vo., pp. 895; cloth, \$—.

PUERPERAL EPILEPSY AND PROTRACTED GESTATION. By L. S. Oppenheimer, M. D., etc. *Seymour, Ind:* Reprint from the *American Practitioner.*

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DISEASES OF THE PHARYNX, LARYNX AND TRACHEA. By Morell Mackenzie, M. D., London. *New York: Wm. Woods & Co.* 1880. 8vo., pp. 440; Cloth. [Woods' Library of Standard Medical Authors.]

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(All Wood's publications through C. C. Pease, Gen'l Agt., 514 Olive street.)

A CONTRIBUTION TO THE RELATIVE VALUE OF THE DIFFERENT OPERATIONS FOR DELIVERY IN NARROW PELVIS, with the history of eighteen cases. By Aug. F. Erich, M. D., etc., *Baltimore, Md.* [Reprint from the *Maryland Medical Journal*, October 1st and 15th, 1880.]

ON THE MANAGEMENT OF INFANTILE ECZEMA. By L. Duncan Bulkley, A. M., M. D. [Reprint from the Transactions of the Medical Society of the State of New York for 1880.]

ON THE USE OF SULPHUR AND ITS COMPOUNDS IN DISEASES OF THE SKIN. By L. Duncan Bulkley, A. M., M. D. [Reprint from *Archives of Dermatology*, July, 1880.]

A PRACTICAL TREATISE ON FRACTURES AND DISLOCATIONS. By Frank Hastings Hamilton, A. M., M. D., LL. D., etc. Sixth American edition, revised and improved. Illustrated with three hundred and fifty-two wood-cuts. *Philadelphia: Henry C. Lea's Son & Co.* 1880. 8vo., pp. 909; half Russia, \$7.00.

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THE INDICATIONS FOR TREATMENT IN FRACTURES AT THE ELBOW. By Lewis S. Pilcher, M. D. Reprint from the *Annals of the Anatomical and Surgical Society.*

SCHOOL AND INDUSTRIAL HYGIENE. By D. F. Lincoln, M. D., etc. *Philadelphia: Presley Blakiston.* 16mo, pp. 152; cloth, 50 cents. American Health Primers. (Through the Hugh R. Hildreth Printing Co.)

## TRANSLATIONS.

## A STRICTURE OF THE TRACHEA, CONSECUTIVE TO AN OLD TRACHEOTOMY.

M. A. Chauffard reported to the Anatomical Society the case of a child eight years old, who had died in the hospital, of scarlatinous nephritis, complicated with broncho-pneumonia. At the autopsy, lesions were found, such as result from the diseases mentioned, but the point of special interest in the case was connected with the condition of the trachea. About a year and a half before this time, the child had undergone the operation of tracheotomy, for croup. The operation was performed, July 7, 1878; on the 18th, the cannula had been removed, and August 4, the wound was cicatrized. During life, one could feel distinctly a vertical median groove upon the anterior face of the trachea.

On careful dissection, it was found that at the site of the cicatrix, the skin was adherent to the superficial cervical aponeurosis, by firm, fibrous bands. Beneath this aponeurosis, in the whole length of the incision, that is to say, to the length of about one and a half centimeters from the lower border of the cricoid, the trachea is adherent to the neighboring tissues and seems incrustated in a resistant and firm fibrous tissue; below, on the contrary, it is surrounded, as in the normal state, with a loose cellular tissue. In the middle of its surface, it bears a vertical incision, an inch and a half long, filled up by a fibrous membrane about two millimeters wide, which unites the extremities of the cut cartilages. These playing freely, the one upon the other, presented at their middle part a veritable pseudarthrosis. Finally in the whole depth of the incision, the trachea is considerably constricted; its antero-posterior diameter is almost normal, but its lateral diameter is diminished a half. The passage is compressed laterally in the form of a triangular prism, with the summit anteriorly and the base posteriorly.

Below the incision, on the contrary, the trachea preserved its

normal form and dimensions; as to the walls themselves of the organ, they seem to be unaltered, supple and easily dilatable at the site of the stricture. There were no vegetations of the mucous coat.

Two principal lesions must be admitted as causes of this constriction. On the one hand the inflammation caused by the continuance of the cannula in the wound caused the proliferation of the peritracheal connective tissue, which at length has become cicatricial and retractile. On the other hand, by reason of the fibrous pseudarthrosis, the cut rings of the trachea have lost their force of physiological resistance. Instead of resisting like half-circles, they have yielded to the gradual and prolonged pressure of the fibrous ring which surrounded them. So is explained this double fact that the stricture was limited to the length of the incision, and that it was more marked in the transverse than in the lateral direction. During life this stricture of the trachea was indicated by no functional nor physical sign.—*Abstracted from Le Prog. Méd., July 17, 1880.*

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#### SUCCESSFUL TRACHEOTOMY IN A NINE WEEKS' OLD INFANT.

(*Dr. H. Steinmeyer, Braunschweig.*)

An infant of a phthisical mother, developed in the fifth week an abscess near the anus and on both palmar surfaces. After cure of these lesions, a cough appeared at the beginning of the eighth week. The child was much emaciated and became daily weaker, refused to nurse, and finally the respiration became so difficult that active interference was required. Upon examination the only unnatural condition of the respiratory tract that could be found was a slightly prominent fluctuating swelling over the right thyroid cartilage. Abscess in the neighborhood of the larynx was diagnosed and tracheotomy resolved upon, as, under the doubtful circumstances, the best measure to be adopted.

Owing to the anatomical difficulties attending operation upon so young a subject, and to the fact that the smallest cannula

procurable was rather large, and was not easy of introduction, the manipulations occupied an hour. The result was fortunate, and in the course of twenty-two days, the wound had healed and the patient was discharged. The abscess, a few days after the tracheotomy, became larger, febrile symptoms increased. Incision was made by the tracheal wound toward the swelling, and a sound introduced which penetrated the abscess; upon its point a fresh incision was made directly into the abscess and a quantity of pus evacuated; this afforded complete relief.—*Berlin. Klin. Woch.* October 4, 1880.

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A PECULIAR CASE OF MULTIPLE GROWTHS OF THE NERVOUS CENTRES AND THEIR ENVELOPES.

(*Prof. Fr. Schultze, M. D., Heidelberg.*)

Sarcomatous growths of the brain and spinal cord and their envelopes, are, as a rule, seldom multiple, and involve generally either the nervous substance alone, or the envelopes; implication of envelopes and nervous tissue at the same time by such multiple growths, is so remarkable that a full report of a case is of value.

A girl, 7 years old, previously in good health, at the end of March, 1879, complained of headache, prostration, and became markedly emaciated. The headache increased at evening, but ceased at the end of May; no information could be obtained as to the site of the pain. From May 18th, for ten days, vomiting; May 28th, somnolence rapidly set in and lasted three days, during which time there was no fever; the pulse was intermittent and 132. When the child was aroused for a short time by dint of energetic command, there was found to be no paralysis and no disturbance of sensation. There were also no contractions nor convulsions.

Ophthalmoscopic examination discovered double neuroretinitis.

May 31st, child again well and active and free from suffering.

June 5th, stiffness of the dorsal and posterior cervical mus-

cles; in addition, inability to sit up without aid, and paralysis of both legs. Sensation and reflex activity unimpaired. This paralysis lasted till death, before which bed-sores appeared.

July 7th, attacks of convulsions with unconsciousness, which did not recur. Intellect remained normal. The speech which had been for a time sluggish, had become normal again. At the end of July, the neuro-retinitis had disappeared. Without any new symptoms occurring; death ensued August 29th, about five months after the first decided symptoms. There were positively no contractions; the arms had at all times been free; the sensibility of the legs remained unaffected.

*Post-mortem.* Lungs, heart, abdominal organs, mucous membrane of the intestinal tract inclusive, normal.

Dura-mater and pia of the brain normal, latter slightly edematous. Nowhere miliary tubercle, also no meningitis.

On the under surface of the cerebellum, a white, smooth, superficial mass about the size of a silver dollar, which had made a marked impression upon the convolutions.

On the spinal cord at various heights were found similar masses; one about the size of an olive, situated lengthwise in the anterior dorsal region; one smaller likewise in the dorsal. At the level of the lumbar enlargement, an extensive tumor, 5 ctm. by 2 ctm., that had in general a smooth surface and was of a grayish yellow color, and of firm consistency. The cord itself was soft.

The lumbar neoplasm was the most marked and extensive. In the pia-mater covering the posterior half of the cord in that region, was a firm growth of the above given dimensions, and one-half centimetre in its greatest thickness. The arachnoid passed over it, while it included the nerve roots.

Within the posterior portion of the spinal cord, corresponding in situation with the pia tumor, was a neoplasm very soft and about one centimetre in thickness. Towards the conus terminalis the pia tumor greatly diminished so that in the lower third of the lumbar enlargement, only a minute thickening was observed, while the spinal tumor extended farther, involving the central portions of the posterior columns so far as the conus.

In the cerebellum was a tumor of the pia as above described, 0.7 centimetres in thickness. In immediate contact was a neoplasm involving the adjacent nervous tissue and also 0.7 centimetres in thickness.

Under the microscope the pia tumors proved to be of identical structure, a net-work of spindle cells inclosing round cells with large nuclei. The nerve roots were for the most part, uninjured. The neoplasms of the nervous substance consisted of round cells closely packed, but not containing spindle cells, and resembling the gliosarcoma.

The case evidently was one of multiple sarcomata. Tubercle and syphilomata could be plainly excluded.

Marked degeneration of the cord existed in the vicinity of the neoplasms which occupied chiefly the posterior columns in the dorsal and lumbar regions, to a less extent the lateral columns.

The spinal symptoms were explained by the site of the tumors and by the decided compression of the cord that they caused. It is remarkable that there should have been so little pain during the course of the disease, although a large number of the posterior roots were involved in the growths, though as stated, the roots themselves were not materially encroached upon. It is customary to distinguish between symptoms dependent upon meningeal and medullary tumors, as being painful and not painful. From the history of this case the symptom of pain can not be regarded as pathognomonic.—*Berlin. Klin. Woch.* September, 13, 1880.

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#### A NEW REMEDY IN DIPHTHERIA.

(*Dr. George Guttman, Cronstadt.*)

Knowledge of the physiological action of pilocarpin and of its effect upon bronchial catarrh, giving rise to moist râles, led me to believe that administered in diphtheria, it might loosen the diphtheritic membrane through the induced abundant salivary secretion, while it would not excite any inflammatory condition. The result of the proposed treatment was above all expectation brilliant and striking.

April, 1879, an entire family of seven fell sick, one after another, with diphtheria; three exhibited the severest typhoid symptoms. The second case I treated with pilocarpin in moderate doses. The next day I found a copious salivation, and

of the ear. The membrana tympani and the chain of ossicles must be capable of vibrating in unison with the sonorous oscillations, or hearing is impaired and in proportion to the hindrance. Hypertrophic changes impede the necessary movements, adhesions prevent them, necrosis destroys necessary parts, sclerosis renders elastic parts incapable of normal action.

Hypertrophic and adhesive changes when once thoroughly established, cannot, as a rule, be removed; in addition, these conditions tend to become more injurious as time advances.

Unhappily, our knowledge of aural therapeutics has not kept pace with our knowledge of aural pathology, hence, recognition of the first stages of otitis is imperative, then we may expect the same success in our treatment that we have in dealing with other organs. It is necessary, however, to keep in mind that otitis often commences insidiously, that it may escape superficial observation; the patient may not take note of the threatening disorder, until serious damage is already done. "Colds in the head" are frequent initiators of tympanic inflammation; the Eustachian tubes and middle ear become involved, and after the nasal and faucial disease has passed away, they remain more or less congested, and the foundation for further serious lesions is made ready. After an interval of months, perhaps, a slight deafness is noticed, a singing in the ear persists, the physician is then consulted, who finds a diseased membrane with still deeper lesions, or these symptoms may spontaneously subside and the patient be deceived by the hope of a permanent relief, only to suffer later from more pronounced symptoms that have gathered force during the period of treacherous calm; also the hearing of one ear may so supplement the deficiency of the other as to hide the defect until accident make the truth apparent.

Careful testing of the hearing will detect the incipient or lurking disease, which should never be neglected, nor should the case be dismissed so long as evidence of persistence is present.

W. R. AMICK, *Cin. Med. News*, June, 1880, records an interesting result in the treatment of a case of aural vertigo, occurring with deafness and tinnitus, in a laboring man, *æt*, 33, temperate and with no history of venereal. For twelve years he had, upon contraction of colds, a discharge from the right ear, it having first appeared after a sharp attack of earache. His treatment consisted in cleansing the ear with water. About three years ago he first noticed dizziness upon stooping and rising rapidly. These attacks became more frequent until work was impossible. At the same time deafness set in. The vertigo was such that he could not walk. Medical care relieved him so that he was enabled to work again, although still subject to vertigo. Recently this condition became more aggravated, and there was also pain in and about the eyes.

On examination both canals were found to contain considerable cerumen, though not impacted. The left membrane was sunken and opaque. In the right ear nothing satisfactory could be observed; the lining of the canal appeared to be thickened, the membrana tympani thickened and grayish. H. D., right, contact; left, two inches. The left ear only could be inflated, and this but slightly.

Under the administration of potas. brom. and iod., together with inflation of the ear, the hearing improved and the vertigo and ophthalmic pains lessened gradually. Is still under treatment.

DR. JAMES A. REID, *Australian Med. Journal*, February, 1880, describes the relief of severe intermittent neuralgia upon recognition and treatment of a present otitis media. A middle aged lady suffering from a catarrh affecting the naso-pharynx, was seized with an intense neuralgic pain on the left side of the head from brow to occiput, it being chiefly located in left temple and in front of the tragus. The paroxysm came on daily, lasting about three hours, after which she felt quite well again until the next regular attack, S A, M., a slight sense of fullness in the left ear being the only inconvenience left behind. Anti-neuralgic remedies were unavailing. Upon examination twelve days after the commencement of the neuralgic symptoms, it was found that she was the subject of sub-acute otitis media, left ear, watch heard only one inch. After inflation of ear, hearing became normal, the sunken membrana tympani was restored to its proper position, and from that moment the very severe neuralgia disappeared.

The Antiseptic Treatment in Aural Discharges was discussed at the International Congress, held this year in Milan. M. Loewenberg upheld the theory of Pasteur as to the nature of furuncular disease of the ear, it being due to the presence of microbia. [The views of Pasteur on this subject as explained by him before the Paris Academy, have already been stated in the *COURIER*]. Loewenberg thinks these microbia which he has seen in the furuncular discharge, give rise to the disease, and transmit it. Boracic and carbolic acids are recommended as preventive of microbion development. He very fitly called attention to the fact that the most of aqueous solutions contain organisms, and thus tend to maintain diseases in aural practice. He suggests tinctures in place of such preparations.

His testimony delivered upon so important an occasion, adds strength to the arguments advanced in the *COURIER* for the dry treatment of aural discharges using pulverized borax, or boracic acid as the antiseptic, while omitting all use of solutions, the fundamental principle of this scheme of treatment being to keep the ear as free as possible from moisture and using antiseptics liberally, especially borax as best fulfilling all indications.

C. A. TODD.

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## SURGERY.

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Diagnosis of Fracture of the Neck of the Femur.—DR. LAGORIO, an Italian surgeon writes as follows to the *Chicago Medical Journal and Examiner*: He refers to a pathognomonic symptom very little known in the fracture of the neck of the femur. It is a traditional practice in his hospital to explore, whenever the fracture is suspected, the small space that is found between the trochanter and the crest of the ilium. In placing the two extremities in the same position, instead of the considerable resistance given in a sound limb by the tension of the tensor femoris vaginae and of the gluteus medius, a deep hollowness is found in the affected limb, due certainly to the diminished tension of the above named muscles by the approximation of their points of attachment.



**A Substitute for Tracheotomy.**—DR. WILLIAM MACEWEN, publishes a paper entitled *Clinical Observations on the Introduction of Tracheal Tubes by the Mouth instead of performing Tracheotomy or Laryngotomy.*

The writer has introduced cylindrical tubes by the mouth into the trachea and retained them *in situ* for thirty-six hours, removing them every twelve hours for the purpose of cleansing. Two cases of edema glottidis were thus treated with perfect success.

The practical deductions drawn at the conclusion of the paper are as follows:

1. Tubes may be passed through the mouth into the trachea not only in chronic but also in acute affections, such as edema glottidis.
2. They can be introduced without placing the patient under an anesthetic.
3. The respiration can be perfectly carried on through them.
4. Deglutition can be carried on during the time the tube is in the trachea.
5. The expectoration can be expelled through the tube.
6. Though the patient at first suffers from a painful sensation, yet this passes off and the parts soon become tolerant of the presence of the tube.
7. The patient can sleep with the tube *in situ*.
8. The tubes in the reported cases at least were harmless.
9. The ultimate results were rapid, complete, and satisfactory.

10. Such tubes may be introduced in operations on the mouth and face in order to prevent access of blood to the trachea; they answer the purpose admirably.—*British Med. Jour.*, July 31, 1880.

**Obscure Disease of the Rectum.**—DR. VANCE reports a case where the pathognomonic symptoms of anal fissure presented themselves in an individual pronounced to be free from any lesion of the terminal portion of the large intestine or anal orifice.

Several distinguished surgeons had said that the rectum and anus presented a perfectly healthy appearance. Dr. Vance made one examination and agreed with the others that there was no local lesion, but on a second examination he discovered, almost by accident, that an indurated ulcer had formed within one of the small sacculi of the anus. There was no evidence locally of the existence of such an ulcer, as there was no unusual sensibility in that vicinity, and it was only when a probe was passed through the orifice of the sacculus and came upon the surface of the ulcer within, that the sensitive point was found. After the ulcer had been exposed by incision of the sacculus, the patient was at once relieved by the usual treatment. The writer recommends a careful examination of these small sacculi of the anus, in cases of obscure rectal trouble.—*The Med. and Surg. Reporter, Philadelphia*, August, 1880.

C. W. COOPER.

## MEDICINE.

**Pilocarpin in Intermittent Fever.**—DR. GASPAR GRISWOLD, after an experience in the use of this remedy in one hundred cases, feels justified in coming to the following conclusions as to its merits: 1. The muriate of pilocarpin administered hypodermically, will promptly cut short the chill of malarial intermittent fever. 2. In a large proportion of the cases so treated, the paroxysm aborts, terminating in the sweat caused by the pilocarpin, there being no hot stage. 3. Such abortion of a paroxysm is in itself sufficient to effect a cure in many cases. 4. Such abortion of a paroxysm is a valuable adjuvant to treatment with quinine during the intervals. 5. A dose of pilocarpin, sufficient to produce this effect, acts gently without causing exhausting diaphoresis or unpleasant pyalism. 6. The promptness with which an adequate dose of pilocarpin interrupts a chill, is suggestive of its possible efficacy in cases of pernicious intermittent fever, where prevention of the full development of a paroxysm is often of the first importance.

In regard to the dose, he uses from one-fifth to one-sixth of a grain, hypodermically, and from one-fourth to one-fifth of a grain by the mouth according to the size of the patient. The hypodermic method is preferable. The proper time for hypodermic administration is about fifteen minutes before the time when the chill is expected, for administration per orem about thirty minutes before the expected attack. If the chill has already been in progress some time, the hot stage will not be entirely prevented, though the temperature will not rise high, and a second paroxysm will most likely be prevented. The action of the remedy should be assisted by warm coverings and hot drinks. Excessive diaphoresis was promptly checked in one instance by the hypodermic administration of one ninety-sixth of a grain of sulphate of atropia; no good ensues from the administration of pilocarpin during the hot stage.

Dangerous depression of the heart's action never occurred. Large doses of quinine need never be given during the intermissions, as the occurrence of the paroxysms can certainly be prevented. The hypodermic solution should be made fresh, for which purpose one grain-powders should be put up in such a manner as to prevent deliquescence.

℞. Pilocarpin muriat,           gr. i.  
Aque destil.,                       ʒi.

M.

For administration by the mouth it may be combined with sugar of milk.—*New York Med. Journal*, August 1880.

**Ipecac Treatment of Jaundice.**—DR. COOK, of Bombay, has obtained good results from large doses (twenty to forty-five grains) of ipecacuanha where small doses had been used without effect. In the ordinary so-called catarrhal jaundice it acts as a specific, and also in one or two cases of hæmatogenous jaundice, good results were obtained by its administration. In a child, three years of age, twenty grains were given by enema.—*Practitioner*, August, 1880.

DR. SEGUIN, in *Archives of Medicine* for August, reports two cases of Bright's disease, (contracted kidney) in which paroxysmal headache, confined to the occiput, was a marked feature. He calls attention to this phenomenon, as it has never been noticed before.

DR. STEVENS of London, and DR. ATLEE who have both had an immense experience in vaccination, declare that there has not been the slightest deterioration in the efficacy of the humanized lymph.

E. W. SAUNDERS.

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## SOCIETY PROCEEDINGS.

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### MOBERLY DISTRICT MEDICAL ASSOCIATION.

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The meeting of the Moberly District Medical Association, was well attended and was both interesting and profitable. Several patients were brought before the Society for diagnosis of conditions present and for suggestions as to treatment.

In one case, a negro 35 or 40 years of age, the committee appointed to examine the case, found cataract of both eyes and advised operation. In another case the patient had suffered for five years with cramps in the muscles of the left leg, later of the arm, and now of the right leg. There were also more or less distinct nervous disturbances. The committee reported *multiple spinal sclerosis*. This diagnosis led to a lively discussion, but no one was prepared to dispute it or to offer another.

Dr. Lucas reported a case of traumatic aneurism of the right subclavian artery, produced by an accidental gun-shot wound. It was treated first by digital pressure and then by mechanical pressure, and the condition was markedly improved.

Dr. Bailey related a case of a young man who had suffered great pain from an affection which was diagnosed as hysterical gout, though he had previously been treated for morbus coxarius. Immense quantities of morphine had failed to afford him relief. Jaborandi effected noticeable improvement for a time, but not permanently.

Dr. Yates suggested that the suffering might be the result of some morbid growth pressing upon sensory nerves, and reported a case of cancer of the stomach and liver.

Dr. J. H. P. Baker read a paper in which he took the ground that "cutaneous epithelioma," is of local origin, and affects the constitution only secondarily. In the discussion which followed, it became apparent that most of the members of the Society support the contrary view and hold to the constitutional origin of the disease.

Most of the time of the evening session was occupied with a discussion of the subject of tetanus and its treatment, which was brought up by the report of a case treated by Dr. Vaughn, with the actual cautery. A nail had been thrust into the foot of the patient and the symptoms of tetanus were well established. The actual cautery was introduced into the wound and a violent spasm was produced, but after this passed off the patient was disturbed by no recurrence of the spasms and made a rapid recovery. Dr. Vaughn reported another case in which recovery had taken place under the use of chloral, ammonia, whiskey and bromide of potassium. His theory of the action was that as tetanus results from irritation in the course of a nerve, any measure which destroys the irritability of the nerve will be an effective treatment. In the case of tetanus produced by burns, which Dr. French mentioned, the expanded nerve extremities were not destroyed, but rendered more irritable by superficial burns.

Dr. Sinclair reported a case terminating fatally under the influence of chloroform, where the cause was a slight injury of the toe.

Dr. Forrest had treated a case successfully with bromidia morphia and chloroform.

Dr. Langsdale related a case in which similar symptoms had been relieved by chloral, potassium bromide and quinine.

Dr. Baker had suffered from the disease himself, the cause being a wound of the finger incurred in extracting the tooth of a patient. He laid open the finger and dipped it in turpentine.

Dr. Gore related a case in which a young man was supposed to be suffering from tetanus, caused by a thorn thrust into the knee. Closer investigation, however, showed that there was dislocation of the lower jaw.

Dr. Vaughn noted the shortness of the time that frequently intervenes between the injury and the development of tetanus, relating cases in which tetanus supervened in less than an hour.

Dr. Baker, as one of the committee, introduced the subject of dysmenorrhea, causing or accompanying sterility. He had found the treatment with slippery-elm tents very satisfactory. He preferred them to the sea-tangle or sponge tents. Dr. Humphrey had used the latter with success.

Dr. French, of Mexico, a visiting member of the Association, opposed mechanical treatment of dysmenorrhea. He was invited to read a paper upon this subject at the next meeting of the Society.

Dr. Lloyd reported a case of typho-malarial fever which had occurred in his practice.

Dr. French extended to the Association, an invitation to meet with the Linton District Association, on the second Tuesday in November.



## ST. LOUIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY.

Stated Meeting, Sep. 16, 1880.—Dr. Boisliniere, President, in the Chair.

### ABSENCE OF UTERUS, OVARIES AND VAGINA.

*Dr. Geo. J. Engelmann.*—I have here the entire sexual organs of a woman fifty or sixty years of age, who died in the female hospital, of cancer of the breast. The external sexual organs were fairly developed; the breasts were even at this advanced age quite marked, and one, let it be remembered, was the seat of the fatal neoplasm; labia, nymphæ and clitoris are all distinct, yet incompletely developed, whilst a mass of connective tissue represents the vagina, which is absent, and an irregular nodular mass takes the place of the uterus and ovaries; a distinct trace of the ovaries or tubes I could not detect. The urethra is normal. Beneath, a small pouch half an inch in depth has been formed in the vaginal orifice, probably by attempts at coition. Frequently when the vagina is undeveloped, the urethra has served as a receptacle for the male organ.

Unfortunately, nothing is known of her history previous to entering the hospital for the malignant disease of which she died.

There is complete absence of the vagina, the bladder and

rectum being separated by connective tissue. Usually the vagina is either partially developed either above or below, or both, or it may be represented in rudimentary form by a fibrous cord, here we have nothing.

The hard nodular, fibrous mass representing the uterus, is perhaps somewhat oblong in shape, a little broader at the upper portion, and has upon it a nodule, something like a small fibroid, this is imbedded in the folds of the broad ligament, but by no means resembles a normal uterus.

The total absence of the uterus is extremely rare, and when found, the peritoneum, of course, passes over the bladder to the rectum, and the appearance presented is identical with that of the pelvic viscera in the male. In this case of rudimentary uterus, we of course have a duplicature of the peritoneum, the broad ligament extending along the small pelvis from side to side, but in it I can find only this irregular fibrous mass; then there is a thickened mass attached to this which might perhaps be a rudimentary ovary; in the other broad ligament, I could detect nothing at all like a tube or an ovary.

The total absence of the tubes is also a very rare occurrence, but they are frequently represented by solid, more or less thick, fibrous strands, which is probably the case here, hence I did not detect them in the broad ligament. There is a total absence of ovaries, unless we consider one of the smaller fibrous thickenings as a rudimentary ovary.

I have seen three similar cases, one, a young lady whom I examined lately, who had well-developed mammae, but a rudimentary childlike vulva; labia and clitoris only slightly developed; mons veneris nude; the uterus was less than infantile. Bi-manual examination discovered an irregular mass in the place where the uterus should be; patient had never menstruated. I recall another case upon which my father operated, to open the way to the uterus, some seven years ago. This was a lady in whom both the external sexual organs and the instincts were excessively developed, but the vagina was a narrow, undeveloped canal, and the uterus was rudimentary, yet sufficiently well-developed to allow of some menstrual discharge when a passage was opened through the vagina.

In a third case, all the internal organs were apparently somewhat retarded in their development; the girl, 22 years of age, had not menstruated until a persistent, long continued stimu-

lating treatment brought about an occasionally returning flow.

*Dr. Boisliniere.*—I recall a case which I saw two or three years ago, of a well-developed young woman, with all the appearance of healthy womanhood, large breasts, etc., but she complained that she didn't have any menstruation. She was a girl about 22 or 23 years of age, and had been married two years. I examined her and found that the vagina was about two inches in length, terminating in a cul-de-sac, without any appearance of a uterus. By palpation I could not find any uterus, and I verified the fact by passing a large sound into the bladder and the finger into the rectum, and I could ascertain beyond a doubt, that there was no uterus there. I could feel a slight doubling up as it were of little bodies; there was complete development of the other parts. She had sexual desires, and the menstrual congestion gave rise to difficult breathing and slight vomiting of blood, vicarious hemorrhages. Of course in such a case my hands were tied.

#### INTRA-UTERINE APPLICATIONS.

I show here an appliance which I use to make applications to the neck of the uterus. You all have used medicated pessaries. Now these medicated pessaries have the objection that if they are hard they don't melt, and if they are soft enough to melt, unless introduced through the speculum, they will break up in the effort of pushing them into the vagina. In order to avoid this difficulty I have a little bag made of mosquito bar, like a purse, and in that I introduce the different medicines which I wish to use. The patient can place it herself and it has the advantage of being cleanly.

Here is another method of medication which I have adopted. It is a rectal capsule. These are made in a neat way like other gelatine capsules, but sharp-pointed. They are filled with the medicament. In cases of endo-cervitis and endo-metritis, I put in that form, sulphate of zinc, iodoform, tannin, nitrate of silver, etc., pass it into the cervix and leave it there. It will melt readily in five or ten minutes.

*Dr. Papin.*—I would ask whether you do not find some inconvenience in introducing these gelatine capsules into the cavity of the uterus?

*Dr. Boisliniere.*—In the acute stages only. In the sub-acute, where the sound produces no pain, neither do the capsules give trouble. I would not reintroduce the sound where it produces pain or a flow of blood. Dr. Moses uses pure turpen-

tine in cases of diphtheria as a local application to the mucous membrane with the greatest benefit, and I find it admirable as an intra-uterine remedy; for the same reason I use it in intra-uterine chronic diseases, endo-metritis, etc.

*Dr. Papin.*—If your sound produces no pain and brings away no blood, what are the symptoms of intra-uterine inflammation.

*Dr. Boisliniere.*—Intra-uterine leucorrhœa.

*Dr. Papin.*—That is from the neck.

*Dr. Boisliniere.*—No, from the fundus.

*Dr. Papin.*—I never saw a case in which the introduction of the sound would not produce pain. I have produced intense pain by introducing simply a probe armed with cotton which was carried within the uterus. The bi-manual examination produced pain, and, in one instance, the introduction of the sound into the cavity of the uterus produced intense pain, in fact the woman died four days after.

She also had pain in the region of the heart. In regard to the cases spoken of before, I would say that I once saw a man with very large breasts. He was helping to dig a cellar, was stripped to the waist, and from the nipple of the breast the milk would drop. It somewhat corresponds to the case of the man who nursed a child. Speaking of the absence of uterus and ovaries, a young woman aged about 30 years called at my office to inquire about the probable time at which she would be confined. She was very large, and stated that she could feel the child's movements within the abdominal cavity very distinctly. The breasts were large and contained milk. A digital examination per vaginam showed that it ended in a cul-de-sac. I passed a sound into the bladder and my finger into the rectum to find the uterus. There was no uterus. She had never had the least sign or symptom of menstruation, she said. I could detect neither ovaries nor womb. On questioning her closely, I learned that she was somewhat given to gormandizing and that her bowels were somewhat irregular. Four compound cathartic pills relieved the symptoms in a short time.



## ST. LOUIS MEDICO-CHIRURGICAL SOCIETY.

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Stated Meeting, September 13, 1880.—Dr. Michel in the Chair.

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## EFFECT OF QUININE ON SIGHT AND HEARING.

*Dr. Michel* reported the case of a man thirty-eight years of age who was led to his office about six months ago, being completely blind. He had been perfectly well until about four weeks previous to the time he was first seen, when he began to feel badly and sent for a doctor who treated him for intermittent fever. He had never had intermittent fever before. On the third day the physician pronounced his disease intermittent fever of the congestive form and gave him in addition to about three drachms of quinine already taken, about four drachms more in the course of twelve hours. When he had taken about half the last named quantity he suddenly became blind. His own expression was, that his "sight went out as a candle might be blown out," and from that time he has had no perception of light. On careful examination of the retina the nerve was seen to be very pale, the veins threadlike, and arteries scarcely perceptible and bloodless. *Dr. Michel* said that he had never before seen a case of permanent blindness caused by quinine. He employed all the usual remedies including electricity. Nitrite of amyl was freely administered while the retinal vessels were under ophthalmoscopic observation, without any perceptible effect. He sent him home without any hope of restoration of his sight which at the time of report had not improved. In answer to a question from *Dr. Bryson*, as to what change was observed in the arteries of the retina, he replied that they were perfectly bloodless. He said that he did not feel at all satisfied as to the *modus operandi* of the quinine in effecting such a result as the one in question. He did not think that atrophic change could take place in so short a time as had elapsed when he first saw the case.

*Dr. Spencer* said that he had taken great interest in the subject of the influence of quinine upon the circulation, and some years ago had made some experiments giving large doses (80 grains) of quinine to a gentleman then attending medical lectures here, and studying the effect upon the circulation, especi-

ally of the ear. In a few minutes there was general congestion of the vessels of the membrana tympani which gradually subsided. There was deafness and tinnitus which disappeared as the influence of the quinine passed off. He afterwards experienced no unpleasant effect from these large doses of quinine. He did not observe whether the tinnitus was at its maximum at the period of most marked congestion. The case was kept under observation for some three hours after the administration of the quinine. The membrana tympani resumed its natural appearance gradually without any appearance of anemia succeeding to the hyperemia.

*Dr. Baumgarten* related the case of a lad who was brought to the Sisters' Hospital one night in 1853. No history accompanied him, and at the clinic in the morning, nothing could be made of the case until some one called and gave the following account: The boy had been working on the Pacific railroad and had been so much annoyed with chills that he had invested all his money in quinine, and eat the whole quantity, supposed to be about five drachms. At this time he could not see at all, he could not hear at all, and when set upon his feet he would stagger and could not walk. He recovered in five or six days.

*Dr. Spencer*, in answer to a question from *Dr. Boisliniere*, whether he had seen many cases of permanent deafness resulting from the use of quinine, replied that it was a difficult question to answer. Patients continually ascribe deafness and tinnitus to the use of quinine, and it is impossible to determine in what proportion of cases this is really the cause of their troubles. He believes it possible that in some cases, the quinine has a permanent injurious effect upon the hearing, just as vaso-motor disturbances from other causes than quinine may produce such effects. Some persons are specially susceptible to such influences.

*Dr. Boisliniere* asked whether there are not more cases of deafness in the West, in malarial regions, than in other regions.

*Dr. Spencer* replied that he thought as large a proportion of the population of New York and Boston are troubled in this way, as is the case in the West. In no case that has come under his care has he been fully satisfied that permanent deafness had resulted directly from quinine. He has always found other causes sufficient to account for the condition existing.

*Dr. Boisliniere* said that it was a most important question for

practitioners in this part of the country. He had made some patients deaf and some blind, but only for a short time. In one case, a patient had a regular chill on Monday, and on Wednesday, instead of the chill, had an attack of eclampsia, occurring at the same hour. There was very marked cerebral congestion. In order to combat this congestion, he gave the patient every two hours, 100 grains of quinine by the rectum, as he could not swallow. The result was entirely favorable. He considers that quinine produces anemia of the brain, and thus acts in averting the convulsions which so often in children take the place of the cold stage of intermittent fever. He saw blindness produced in the case of a young lady suffering from congestive fever. He gave 180 grains of quinine in twenty-four hours, and she was for a time perfectly blind but entirely recovered her sight. Two years ago he saw a lady suffering from erysipelas, affecting the whole body. He gave her 200 grains of quinine in eighteen hours, and her life was saved by it. For two or three days she was completely blind, but recovered her sight. In spite of such cases, he should continue to administer large doses of quinine in intermittent and congestive fever.

*Dr. Bauduy* had seen, with *Dr. Michel*, the case which he had reported, and had noticed specially the appearance of the optic disc, as described by *Dr. Michel*, strongly resembling a condition of atrophy. As atrophy is the result of some previous pathological process, and the time which had elapsed in this case was insufficient for the development of such a condition, it was somewhat difficult to account for this appearance and for the blindness. The appearance had suggested to him the possibility of the existence of a condition of spasm from vaso-motor irritation produced by the quinine. He had suggested to *Dr. Michel* to try the effect of amyl-nitrite, and had administered it while *Dr. Michel* observed the effect with the ophthalmoscope. Neither this nor any of the other remedies which might increase blood supply to the brain and eye had any effect. It did not seem possible that the anemic condition of the retina was produced by spasm, as this could not be indefinitely prolonged, as vaso-motor paralysis would soon take its place.

*Dr. Michel* believed that spasm of the muscular coats of the vessels might have occurred as an effect of the quinine, and

that, during the continuance of the spasm, clots might have formed, thus permanently obstructing the arteries of the retina; yet it would be very remarkable that clots should have been formed on both sides simultaneously.

*Dr. Baumgarten* thought there was a fallacy in *Dr. Bauduy's* argument. He did not assert that there was or was not vaso-motor spasm caused by the quinine, but did not think that *Dr. Bauduy* showed that it could not be. He thought spasm might have been so produced and kept up long enough to allow coagulation of the blood to take place and so occlude the arteries. *Dr. Bauduy* said that he intended merely to assert that the supposition that the condition of the retinae was the result of a perpetuation of vaso-motor spasm was antiphysiological. Fatigue would ensue and then paralysis.

#### LISTERISM.

*Dr. Carson* presented a specimen of pure *phenol* which he said they had adopted altogether in cases of antiseptic surgery, at least where *Lister's* method is practiced. It is recommended by *Lister* himself. It is less irritating, and on account of the odor, not so disagreeable as our ordinary carbolic acid. It causes a little tingling of the ends of the fingers after they have been in the solution for some time, though not nearly so decidedly marked as ordinary carbolic acid. It is expensive, costing four dollars per pound, and it requires considerable time, four or five months to procure it from the manufacturers. He said that *Dr. Gregory* is a complete convert to *Listerism*. Since the last report of cases of Ovariectomy made to this society, he has had two successful cases, thus making six successful cases out of seven since last Christmas.

#### HERPES PROGENITALIS.

*Dr. Steele* related the case of a patient who had long suffered from herpes progeneralis. As the man contemplated matrimony, and feared that his affection was syphilitic, *Dr. Hardaway* was asked to see him in consultation. *Dr. Hardaway* confirmed *Dr. Steele's* opinion, and advised circumcision as offering the best chance for permanent relief from his frequently recurring attacks of herpes. Since the operation was performed, more than a year ago, the patient has had no return of his disease.

*Dr. Hardaway* said that the diagnosis and proper treatment

of herpes progeneralis were matters of more importance than was generally conceded. The diagnosis, as a rule, was not difficult, but unscrupulous persons not infrequently pronounced these lesions syphilitic, and treated them by caustic applications; indeed many physicians are in the habit of cauterizing every lesion occurring on the penis, thereby often converting very simple sores into deep ulcerations. Indiscriminate cauterization is very bad practice—the true chancre never needs it, and the vast majority of chancroids get along better under the application of iodoform. It is a curious feature in regard to herpes progeneralis that although not a venereal disease, properly speaking, it is most common in men who have been the subject of either gonorrhoea, chancroid or syphilis. This probably results from peripheral irritation of the nerves of the penis by acrid discharges, cauterizations of venereal ulcers, etc. The eruption generally heals rapidly under some simple astringent powder or lotion; but to prevent its recurrence is quite another matter. The speaker stated that after the removal of all possible sources of peripheral irritation the general health should be looked to, since rheumatics and dyspeptics were particularly prone to the malady. Circumcision was a curative measure of great value in a certain proportion of cases. He had found the various lotions recommended to ‘harden’ the mucous membrane valueless for the purpose.

Drs. Engelmann and Papin, in reply to Dr. Hardaway’s query as to whether they had ever observed herpes in the genitals of women, answered in the negative.

#### EPITHELIOMA OF THE PENIS.

*Dr. Papin* mentioned the case of a young man who went to Hot Springs supposing that he had contracted syphilis. He was treated by several surgeons and expended two hundred and fifty dollars before a correct diagnosis was made and proper treatment advised. He had an epithelioma of the glans and the treatment was necessarily an amputation of the penis.

The appearance was a typical one of cauliflower excrescence.

#### SYMPTOMS OF HIP-DISEASE CAUSED BY ADHERENT PREPUCE.

*Dr. Carson* reported the following case: A boy aged twelve or thirteen years, had all the symptoms of hip-disease. Pressure on the head of the femur was painful, and also pressure on the groin laterally; and when the patient walked, he showed

a decided lameness upon the left side. On retracting the prepuce, an adhesion was found almost entirely around the glans; but after some little difficulty this was broken up and the prepuce retracted, exposing the glans entirely. The patient returned the next morning remarkably improved; and from that time experienced a decided change for the better. He was a delicate, pale looking boy, with brownish hair and clear complexion. He was raised in the country and the family history was good. On placing him on the table the body was relieved of that bowing of the back. Pressure on the head of the femur still showed some tenderness but not nearly so marked as before.

*Dr. Engelmann* referred to a case which had been published by him in a paper, entitled *Hystero-Neuroses*, in which he described affections of various organs which are simply reflex symptoms produced by ovarian or uterine disease. The case referred to had most thoroughly simulated hip-disease until examined under the influence of chloroform, when it was discovered that there was a marked displacement of the left ovary as well as cervicitis. Treatment gave relief and effected a slow disappearance of the trouble. She has been out in society for the last two years, but now there are appearances of a return of the old trouble which was wholly reflex as in the case reported by *Dr. Carson*. *Dr. Sims* saw the case in consultation with him, and it was only on examination under chloroform that they came to a correct conclusion as to the source of the difficulty.

*Dr. Leete* said that he had seen some cases in which an unbearable condition of the penis was occasioned by an accumulation of smegma. In some the symptoms had been like those of a boy who has stone in the bladder, pulling and pressing and changing the position of the organ within the clothes to get relief, and sometimes the prepuce was much distended with the accumulation. In these cases, the cure had been prompt by simply washing out the smegma, by means of a syringe with warm water, using an astringent lotion to bring down the swelling. The boy was taught to wash it carefully once a week, if he could uncover the penis easily. Many children suffer from this cause by reason of a tight prepuce. In a case recently under his observation, he had recommended instead of circumcision, the dilatation of the narrow prepuce. The result had been entirely satisfactory.

Stated Meeting, September 27, 1880.—Dr. Papin in the Chair.

DISCUSSION OF DR. BAUMGARTEN'S PAPER "SOME OBSERVATIONS ON THE PULSE."

In reply to a question by Dr. Papin, *Dr. Baumgarten* said that he used Marey's sphygmograph, but had also taken tracings with Pond's instrument, which is very much easier of application than Marey's. Pond's, however, has a radical defect in that it has vibrations of its own, which Marey's has not. There is a little ball that is projected upward, and necessarily has a momentum of its own which must exaggerate some movements and diminish others; and these influences of the instrument must be taken into account in interpreting the tracing.

*Dr. Papin* asked how far these instruments are of practical value in the diagnosis of organic lesions of the heart or arteries.

*Dr. Baumgarten* replied that in certain arterial and cardiac diseases, the circulation is greatly modified and such modifications the sphygmograph will indicate, but in other cardiac diseases no characteristic change of the pulse-curve is manifested.

For instance, the tracing in a case of mitral disease may not show any deviation from the ordinary, unless the disease is very far progressed. So long as there is compensation of the defect, the sphygmograph will show no variation at all, none that is indicative of the lesion. Aortic disease shows itself more directly in the sphygmographic tracings. This instrument is not so much for clinical use as for physiological investigation.

Upon the request of several members, *Dr. Baumgarten* explained the nature of the pulse-tracing, with the aid of the blackboard.

Every contraction of the heart distends the aorta, creating a sudden wave that is propagated throughout the arterial system. The sphygmograph registers it as a sudden ascent, an almost perpendicular ascending line. But the distension ceases suddenly, the artery is allowed to collapse by the onward flow of the blood through the capillaries; the instrument registers a

sloping line of descent. This sudden distension and more gradual collapse is what we perceive ordinarily when we feel the pulse.

In the normal pulse, the ascent is an unbroken, almost straight line, but the line of descent is interrupted by minor elevations. The normal tracing, as a rule, shows three elevations namely, the primary elevation which forms the apex of the curve, a secondary one nearly in the middle of the descending limb, and a third smaller elevation between the two. Hence the normal pulse has been called *tricrotic*, having three beats.

These three elevations are not produced by the same cause. The primary elevation is a positive wave caused directly by the contraction of the left ventricle. The secondary or dicrotic elevation is a positive wave produced by the sudden cessation of the heart's action.<sup>1</sup> It is a wave that travels from the heart toward the capillaries, and appears later in the curve according as the point of application of the sphygmograph is more distant from the heart. The formation of this event is favored by quick, energetic contraction of the ventricle, and by low tension of the artery. Hence, when the blood-pressure is diminished, as in fever, this secondary elevation becomes more prominent, while at the same time, the third elevation (between the primary and secondary) diminishes or disappears, leaving the pulse-curve *dicrotic*. This consists, then, of a steep line of ascent, a pointed apex and sudden descent, and



in the course of this a dicrotic elevation of some size. The dicrotism may become much more considerable; the dicrotic elevation may not occur until the descending limb of the curve has reached the base line, "full dicrotism;" this curve is made up of a larger and a smaller wave upon the same base

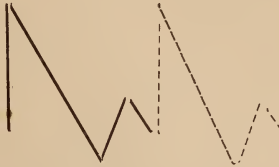



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1. A wave of closure. (Moens).



line. What is known as the hyperdirotic pulse, is produced in this way: the artery, after the primary distension rapidly collapses, the dirotic wave causes another distension (ascent of the line), but before the artery has time to collapse again, owing to the frequency of the pulse, another systolic distension causes the line to ascend again in forming the next pulse-curve, thus:



If the pulse is still more frequent, the systolic elevation of the succeeding curve may arrive before the dirotic wave is formed, and in this case the curve will consist only of an up-stroke and downstroke, thus, and is called *monocrotic*, obvi-



ously the worst form of the pulse in this direction, as indicating the highest degree of fever, [greatest frequency of pulse and lowest tension of the artery].

The third elevation in the descending limb of the normal (tricrotic) curve is the first of the elastic vibrations of the artery. In a delicately drawn tracing of the normal pulse, a second and even a third elastic elevation may sometimes be observed. These elevations, however, disappear entirely when the tension of the arterial tube becomes very low, hence they are absent in fever. They are also wanting in arteries that have lost their elasticity. On the other hand, in healthy arteries, when the blood-pressure rises, the number of elastic vibrations also increases, the first of them appearing sooner, i. e., nearer the apex, as happens in Bright's disease. Obviously the vibrations of an elastic tube, like those of a cord, must be more numerous (shorter) when the tube (or cord) is tense.

In normal pulses (of adults) the apex of the curve is sharp, pointed; the descent is, at first, sudden. But in some pulses, the distension of the artery is not so rapid, and the collapse of the artery not so prompt; the apex is blunt and often extended

into a sort of plateau. This marks the difference between a quick pulse and a slow pulse; the normal pulse is a quick pulse. The slow pulse occurs in hypertrophy of the heart, in Bright's disease, in atheromatous disease of the arteries, etc., it is brought about by loss of elasticity, by high blood pressure, by increased resistance to the flow of the blood in the periphery; hence the slow pulse is commonly a hard pulse also. In these slow pulses, the line of ascent may be interrupted by secondary waves. I had occasion, in the paper I read at the last meeting, to speak of this phenomenon of *anacrotism*, which is always pathological.

*Dr. Bryson* said that the sphygmograph had been recommended as furnishing an indication of Bright's disease, that is of the granular contracted kidney, in the early stages before there is any evidence of the disease to be found in the urine. The day before he had been called to see a man, aged 42, who suffered with a pain, neuralgic in character, about the region of the heart, stomach and liver. The pain was a little irregular, not exactly intermittent, but rather remittent. At one time he had a feeling of nausea; there was no fever; the tongue was not coated, there was no enlargement of the liver and no tenderness about the stomach or over the bowels, and no evidence of fever or organic disease of any kind. The pulse was 43 per minute. That morning he had taken a pulse tracing with *Pond's Sphygmograph*, and the tracing was perfectly normal. The question was, "What was the matter with this man?" He took it to be a neuralgia of the pneumogastric nerve, and put him on arsenic, *Fowler's solution*, with the effect of relieving him. In regard to the pulse tracings, the doctors said that its value, in this case, was the fact that it did not show a high blood-tension; the aortic tension was normal. Had it been high the slow pulse might have been attributed to that fact.

*Dr. Glasgow* thought that *Dr. Baumgarten* had hardly done justice to the value of the sphygmograph, as a means of differential diagnosis between different lesions of the heart, and between organic trouble and blood trouble. It is confirmative in a great many cases. It is often of great value in satisfying patients that they have no organic disease of the heart, by showing them that they have a normal pulse tracing.

*Dr. Baumgarten* said that he did not wish to undervalue the sphygmograph as an instrument of diagnosis. A great deal is

expected of any new instrument which is introduced into clinical use; it was just so with the microscope. It is expected to diagnosticate the disease. Now the sphygmograph is of no such use. It cannot diagnosticate a case of Bright's disease, or disease of the heart, but it may lead to, and assist the diagnosis. It is of the greatest value in determining certain points about the circulation, and is sometimes invaluable in prognosis. Of course, in order to derive all the advantage the instrument is capable of, we must learn in the first place how to take perfect tracings, and next how to interpret them correctly.

*Dr. Papin* thinks that if the instrument is of no more use than to make a normal tracing when the heart is abnormally affected by indigestion or otherwise, and so quiet the fear of the patient, it accomplishes a great deal.

*Dr. Baumgarten.*—With regard to the value of this instrument in determining organic disease of the heart, we can readily see what will be the effect of organic disease of the heart on the pulse tracings. In aortic disease, the effect upon the pulse tracing is very direct. In mitral disease, the influence upon the circulation is not immediate, and so long as the vigorous ventricle can compensate the mechanical defect of the valves, it may be that no change whatever is produced in the tracing. Disease of the right heart, finally, can have no *characteristic* influence upon the tracing of the radial pulse. It is true that these considerations may sometimes be used to determine the exact nature of a valvular defect, when the physical signs alone would not determine it.

*Dr. Bryson* said that the mere fact that the sphygmograph can be used to determine high aortic pressure when it exists, is of great advantage in clinical medicine. A patient with habitually high blood-pressure will bear fever badly; the heart will be apt to give out. It is well known that patients with Bright's disease, that is the granular contracted kidney, bear fever very badly on account of the habitual high blood-pressure. If a patient of this kind has fever, his heart has much more to do than another's, and at a time when it is apt to become weak.

## SELECTIONS.

## INEBRIETY.

The points in the differential diagnosis between the *vice* of drunkenness and the *disease* inebriety, are these four:—First, inebriety is irresistible to ordinary efforts of the will, and is, oftentimes, quite independent of any temptation from outside; depending more upon the *subjective* state of the individual; while the habit of drunkenness depends more upon the *objective* conditions. Secondly, inebriety is liable to be *periodic, intermittent*, like attacks of malaria, neuralgia, hay-fever and insanity; while the *vice* of drunkenness is constant, or modified only or chiefly by external conditions. Thirdly, it is often very liable to be *hereditary* and an inheritance of the nervous diathesis, subject to the law of transmission, like other diseases of the family to which it belongs. Vice also is hereditary as well as disease—but when a case of suspected inebriety occurs in any individual in whose family the nervous diathesis prevails or whose ancestors or relatives have been inebriates, the diagnosis of inebriety as distinguished from drunkenness may be made with safety in almost all cases. Fourthly, Inebriety is sometimes distinguished by the suddenness, sometimes instantaneousness of the attack, while the *vice* of drinking is always gradual. A person who has never been accustomed to drink even moderately may, after an attack of heat prostration, or during nervous exhaustion, or in the preliminary stage of hay-fever, or on exposure to sea air, or after a depressing disappointment, be almost instantly seized with inebriety—against which his own will is as powerless as the hand of an infant against Niagara. The *vice* of drunkenness never comes on in this way, but is always gradual in its invasion. The *vice* of drunkenness comes like a thief in the night, the *disease* inebriety is sometimes as bold as a lion. \* \* \* \*

The one chief predisposing cause of inebriety, the one to which all other causes are secondary and incidental, is *civilization*, with its necessary expenditure of nerve force. Without

civilization, with its in-door life, its printing-press, telegraph and railway, by which nerve force is drawn upon constantly, inebriety could not exist, even though alcohol were freely used.

The habit of drinking alcoholic liquors even to relative excess, is thousands of years old; is probably coëval with barbarism, everywhere, if not with savagery; and among barbarians and savages is incomparably more extensive than among the civilized and enlightened; whereas the disease inebriety is of modern development, if not of modern birth, and did not attain imposing magnitude prior to our century, and is now observed and recognized only among the few leading nations of civilization. At present, the vice of drunkenness is more common by far, among the lower orders of civilized countries; but the disease inebriety, is chiefly, if not almost exclusively observed among the higher or middle classes, who live by brain and nerve, and usually by indoor employments. \* \* \* \* \*

Of the *exciting* causes of inebriety, the chief are the stimulants and narcotics used in our civilization, notably, alcohol, opium and chloral. These exciting causes are, however, *secondary*, not primary; unless they act on a nervous system predisposed by circumstance, they rarely, if ever, cause the disease inebriety, as herein described. \* \* \* \* \*

*Why is inebriety more common in America than in any other civilized country?*

The answer to this question is to be found mainly in climatic conditions. In two respects the climate of the United States, and especially the northern and eastern part, differs from the climate of Great Britain and Europe—first, the dryness of the air, and secondly, the extremes of heat and cold. These two factors of our climate are the main causes of American nervousness. To these causes we are to look chiefly for the philosophical clearing up of the now noted fact that in the northern and eastern portions of our country, functional nervous diseases such as neurasthenia, migraine, general neuralgia, hay-fever and inebriety are more frequent and more severe than in all the rest of the world beside.

Herein, also, is the explanation of another paradox—that in America, where, among the better classes at least, there is less excessive drinking, more of total abstinence than in any other

country, there is also more of inebriety. Yet further, in the southern part of our country, particularly in the Gulf States where the climate is warm and moist, and the temperature more even, as in Spain and France, there inebriety is comparatively rare, although intemperate drinking is fully as common as in the north, perhaps more so. The intensity and concentration of brain activity in America, made necessary by our youth and our poverty, is an important element, but this very intensity is in turn the result of climatic conditions.

America, during the past half century has presented a social spectacle to which in human history there is no parallel or approach, namely, that of a large body of intelligent citizens voluntarily and systematically abstaining from alcoholic liquors in any form. Not moderation, but abstinence—not only abstinence, but total, habitual, life-long abstinence from every drink that contains alcohol, is, and for half a century, more or less, has been the rule in thousands of the best families of the United States. In no other country, in no former civilization, in no great class anywhere has there been, or is there now, any parallel to this phenomenon. The philosophy of this striking historical fact is, that the peculiarities of our climate compel large numbers to abstain, while the evil effects of even moderate drinking are so quickly felt, that for the sake of example vast numbers abstain, even though they themselves, might perhaps, without great injury, follow European customs in respect to drinking. The American, on his first visit abroad, is amazed at the universal habit of drinking, among all classes; the European, on his first visit to America, after he becomes intimate in many private families, especially the professional classes, is equally amazed at the absence of alcoholic liquors. These differences of custom among people of the same race and class and tendencies, take their root in differences of climate.

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Inebriety is to be treated on precisely the same general principles as all nervous diseases of the family to which it belongs. First, by removal of the exciting causes, and, secondly, by fortifying the system with sedatives and tonics. These are the principles by which we treat neurasthenia, general neuralgia, certain forms of insanity, sick headache and hay-fever.

In the case of inebriety, the exciting cause can be best removed by confinement in an asylum; for only in that way is

it within our power in many cases to keep the patient separate from alcohol, opium or chloral, which are the exciting causes of this disease. The period required to accomplish a cure in curable cases, ranges from a few months to a few years; usually only pretty severe cases are referred to asylum treatment; therefore, it is usually necessary to be prepared for a number of months, if not a whole year. There are cases that can be treated successfully at home, provided the physician understands the disease and its treatment.

The second indication, fortifying the system by sedatives and tonics, is met by the use of such remedies as the bromides, in enormous doses ʒi-ʒii freely given, electricity in general, central and local applications, caffeine, cannabis indica, strychnine, nux vomica, quinine, cod liver oil in the form of emulsion with glycerine and phosphoric acid. To these objective and familiar remedies are added what I call mental therapeutics, in the shape of philanthropic work on the part of the patient—the rescuing of others who are similarly distressed, and the laboring with and for others, for mutual aid and inspiration in making the cure permanent.—*Geo. M. Beard, in Gaillard's Journal. Oct. 1880.*

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## NOTES AND ITEMS.

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**MEDICAL LITERARY JOURNAL.** With no note of introduction nor card of endorsement; with no name of editor or publisher, to give it credit, comes this new candidate for the support of the medical profession. The title indicates, we suppose, the intended scope of the journal, to exercise a censorship over the medical literature of the country. The "Leading Articles" are reviews of four recent publications. Editorials, Literary Notes, Brief Biographies, Minor Notices, "Men and Things," and a list of Leading Medical Publications, January to June, 1880, fill up the remainder of the dozen two-column quarto pages, which make up the journal. We wish success for the unknown editor and publisher.

CEREBRAL THERMOMETRY ONCE MORE.—Before the cerebral thermometrists can even claim a respectful hearing, they must demonstrate: I. That the heat evolved in a solid body suspended in a fluid, is not instantly dispersed in that fluid, as the science of physics teaches, for the cerebral cortex is bathed in the arachnoid fluid: II. That a body of the temperature of the blood, the brain, containing chiefly elements of a semifluid consistence, and riddled by vascular and lymphatic passages, and supplied continuously and at a rapid rate from a distant source, (the heart,) by a fluid of uniform temperature, can have its temperature raised at any point without that rise being diffused in the surrounding substance: III. That a solid body whose temperature is continually exposed to the sources of diffusion mentioned, will indicate its temperature through three layers of substance kept at a certain temperature by the blood supply and by conduction, namely, the cerebro-spinal fluid, the cranium, and the pericranium. IV. They must demonstrate that their experiments have not included sources of error such as the greater temperature directly over the arterial trunks, and the afflux of blood sympathetic with voluntary muscular exertion.—*Chicago Med. Rev.*, Aug. 20, 1880.

ARCHIVES DE NEUROLOGY. It seems that there has been heretofore, no journal in France, that was devoted to affections of the nervous system except the "*Annales Médico-psychologiques*" which deals specially with mental diseases. In July last, appeared the first number of a quarterly review which is intended to fill the same field for the profession in France as is cultivated in England by "*Brain, a Journal of Neurology*," and in this country by "*The Journal of Nervous and Mental Diseases*," and "*The Alienist and Neurologist*." It is published under the direction of M. Charcot, with a number of other distinguished names upon the list of collaborators, with M. Bourneville, as chief editor, and M. DeBoyer, secretary. Under such management, it promises to be a most interesting and valuable journal.

AN INSTITUTE OF HEREDITY has been proposed in Boston which shall have for its object the improvement of the human race by the diffusion of knowledge on the common causes of deterioration, by the inculcation of a wholesome sentiment against the marriage of persons afflicted with hereditary disease or dominated by vicious habits.—*The Sanitarian*, Sept. 1880.



HEALTH JUBILEE AT MEMPHIS.—In the latter part of September, the City of Memphis held a celebration to commemorate the fact that for the first time in three years the city has passed through a summer without devastation from yellow fever. They had a procession more than three miles long, representing all the different branches of business and manufacture, and flags and other decorations were displayed along the line of march. Thousands of visitors accepted the invitations of the business men to join in the festivities of the occasion.

The authorities of that city have done all in their power to remedy the defects of drainage, which, if not the sole cause, were certainly powerful accessories in the production of the fearful epidemics of the preceding years, and their efforts have secured that the city is cleaner and in a better sanitary condition than ever before. It is to be hoped that continued vigilance will preserve them from further recurrence of such plagues as have visited them during the last years.

TEST FOR ARSENIC. The following test is of easy application and is specially applicable for paper hangings or suspected fabrics: Immerse the suspected paper in strong ammonia, on a white plate or saucer; then drop a crystal of nitrate of silver into the blue liquid, and if any arsenic be present, the crystal will become coated with yellow arseniate of silver, which will disappear on stirring.—*Practitioner*, Sep. '80.

THE *Lancet* editors and publishers gave a reception to Dr. Jos. H. Warren, of Boston, during his visit to London last summer, and much attention was shown him by leading men in the profession. Sir Henry Thompson has accepted the dedication of Dr. Warren's new work on *Hernia*, which is to be issued in London and Boston simultaneously. The Boston publisher is Chas. N. Thomas. It is to be sold only on subscription.

THE SPECIALIST AND INTELLIGENCER.—This latest venture in the field of medical journalism, comes from Philadelphia, published by Presley Blakiston, and edited by C. W. Dulles, M. D. It is to be a monthly, with twelve double-column pages, and subscription price of one dollar and fifty cents. We hope that the success of the enterprise will be such as to satisfy the editor and publisher.

A LARGE CALCULUS.—One of the largest calculi on record was removed a few weeks ago by Dr. Bigelow, at the Massachusetts General Hospital. It measured  $3\frac{3}{4} \times 3\frac{1}{2} \times 3$  inches, and weighed 6166 grains. The patient had worked until within three months; his occupation being that of a factory-engine fireman. Dr. Bigelow attempted to crush the stone but it was too large and hard to be dealt with in this way, and accordingly he decided to cut. It was extracted with  $\frac{7}{8}$  difficulty, being adherent to the left side of the bladder.

INTERMITTENT FEVER IN RHODE ISLAND.—Dr. S. S. Keene reports five cases of intermittent fever that occurred at Drownville, (Barrington) Rhode Island, last August. A number of other similar cases have been reported in the same vicinity. He says this is the first time that *epidemic intermittent fever* has been observed in Rhode Island, there being no record of it anterior to the present.—*Boston Med. and Surg. Journal*, September 30, 1880.

OIL OF TURPENTINE AS A DEODIZER.—James Foulis finds the application of oil of turpentine an efficient means of preventing the extremely offensive odor so often persisting upon the hands after making a post-mortem examination, or handling other substances with foul odor. He advises to wash the hands with the oil before making any such examination. After the work is done, the hands are to be washed again with the oil and scrubbed with a nail-brush. Hot water and soap then remove all the turpentine from the hands. The turpentine should always be used *before* the soap and water.—*Edinburgh Med. Jour.*, August 1880.

THE END OF A LONG FIGHT.—On the 30th of September, the charters of the bogus colleges, known as the Eclectic Medical College of Pennsylvania, and the American University of Philadelphia, were forfeited, the counsel for the defendants confessing judgment of ouster in favor of the commonwealth, and filing a letter from Dr. Buchanan authorizing him to do so.—*The Specialist and Intelligencer*, October, 1880.

OVARIOTOMY.—Spencer Wells performed his thousandth ovariectomy June 11, 1880. In his first 500 cases the mortality was 25.4 per cent.; in the next 300 it was 25.6 per cent.; in the next 100 it was 17 per cent.; and in the last 100 it was 11 per cent.

AT IVRY-SUR-SEINE, there is a prosperous manufactory of toilet soaps from the soap-suds collected in the laundries. The suds, instead of being run into a sewer as formerly, are collected in casks, and then by chemical treatment, the fatty matters are separated and taken to Ivry to the manufactory.

A LIVING FISH IN THE BRONCHI. A translation from *Le Reveil Medical*, relates two cases wherein death was caused by small living fish slipping into the throat of Italian fishermen. In one case the man was trying to crush the head of a small fish between his teeth when it slipped into his throat. At the autopsy it was found lying partly in the right bronchus, its tail acting as a valve to obstruct the entrance of air into the left one. In the other case, a fish, four inches long, filled the larynx with one-third of its body while the tail rested upon the root of the tongue.—*Ohio Med. Record*, Sept., 1880.

WE regret to learn from the *St. Joseph Medical and Surgical Reporter*, that DR. GEIGER, of St. Joseph, was quite seriously injured by one of his horses early last month. Curious enough, several persons, among whom were three physicians, were more or less seriously injured on the same day by horses that never before manifested any vicious tendencies. Dr. Geiger is to have charge of the business and financial interests of the *Reporter*, and will be a most efficient man for the position.

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## SOCIETY MEETINGS.

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THE AMERICAN PUBLIC HEALTH ASSOCIATION will hold its Eighth Annual Meeting in New Orleans, commencing Tuesday, December 7th, 1880, and ending Friday, December 10th, 1880.

Papers will be presented on Abattoirs, Epidemics, Life Insurance in its Relation to the Public Health, The Storm-water question in City Sewerage, The Sanitary Engineering Problems of the Mississippi River, The Hygiene of Emigrant Ships, The prevention of Venereal Diseases, Voluntary Sanitary Associations, etc., etc.

The special questions suggested for discussion at this meeting in addition to those connected with the papers above referred to, relate to methods of preventing the spread within a town or city—after they have once been introduced—of such

contagious or spreading disease as Diphtheria, Scarlet Fever, Yellow Fever, Measles, Small-Pox, etc., and are as follows:

A.—What are the best means of securing prompt and reliable information as to the presence and location of cases of such diseases?

B.—What are the best means of securing isolation of the first or of single cases of such diseases, and what are the chief difficulties in securing such isolation?

C.—Under what circumstances is it proper to declare such diseases epidemic in a place?

D.—Under what circumstances is it proper to recommend the closure of schools on account of the prevalence of such diseases?

E.—What precautions should be taken at the termination of each case as to—

a.—Care and disposal of the dead?

b.—Disinfection and cleansing of the room and house?

c.—Period of time at which it is safe to allow the convalescent to return to school or society.

Brief practical papers upon any or all of these points are earnestly requested, and it is hoped that those attending the meetings will come prepared to give the results of their experience upon the questions, and to make positive recommendations.

Gentlemen who propose to present papers at this meeting are respectfully requested to notify the President or Secretary of their intentions, and of the title of their papers, in order that they may be assigned a proper place in the programme.

By order of the Executive Committee,

[Signed]

JOHN S. BILLINGS, M. D.,

*President.*

E. H. JANES, M. D.,

*Secretary.*

THE FOURTEENTH SEMI-ANNUAL MEETING OF THE ROLLA DISTRICT MEDICAL SOCIETY will be held at Steelville, Crawford County, Mo., on Thursday and Friday, the 25th and 26th days of November, 1880.

THE TRI-STATE MEDICAL SOCIETY will meet at Louisville, Ky., on the 9th, 10th, 11th, and 12th of November. There is promise of a large attendance and a profitable meeting.

ST. LOUIS  
COURIER OF MEDICINE  
— AND —  
COLLATERAL SCIENCES.

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ORIGINAL ARTICLES.

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THE RESULTS OF TREATMENT IN OVER EIGHT  
HUNDRED CASES OF ALCOHOLISM.

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BY J. K. BAUDUY, M. D., ST. LOUIS, *Professor of Diseases of the Mind and Nervous System, and Clinical Medicine, Missouri Medical College; Physician to St. Vincent's Asylum.*

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[*Read before the St. Louis Medico-Chirurgical Society, Oct. 11th, 1880.*]

FOR over fifteen years I have enjoyed excellent, if not unusual opportunities for the observation and treatment of all forms of alcoholism. The *official records* of St. Vincent's Asylum, show that during the period just named, eight hundred and thirteen cases have been under my professional care, and that fourteen deaths have occurred. As this record embraces all forms and varieties of the disease, both acute and chronic, including also many re-admissions of the same cases previously treated, in which the mortality ought necessarily to be proportionately greater than in comparatively recent or strictly new cases, it occurs to me that the therapeutic means which have contributed to these results, well deserve consideration as of the utmost medical interest and importance.

To the frequent re-admissions I attach much emphasis, as bearing directly upon the results of treatment. As a distinguished author observes, "Very few die of the earlier attacks. Each successive one becomes more dangerous, because usually occurring in a more debilitated constitution and associated with a greater amount of organic disease." The object of the present paper, therefore, is to more forcibly combat some old prejudices connected with the literature of this subject, and with which, unfortunately the minds of not a few practitioners are still imbued; and to place upon a more solid basis some therapeutical deductions derived from the observation of the eight hundred cases treated in hospital practice as well as, by an attentive study of the natural history of the disease, to modify practices still extant and fraught with danger to the patient. The cases treated were nearly all admitted in the acute stage of alcoholism, not all pronounced cases of delirium tremens, yet requiring medical care for excesses in the use of alcohol. I claim no originality for any views which I present, as I have simply put in practice doctrines inculcated by the immortal Anstie of whom I am but an humble follower and an ardent admirer.

To better elucidate my position, I will enunciate certain principles very briefly, which I consider indissolubly associated with the philosophy of the subject we are considering.

1. The various, nay almost Protean forms of acute alcoholism, have, like most diseases, a tendency to self-limitation. I deliberately apply the word, Protean, to the manifestations of alcoholism, as according to my experience, very few cases present identical features; age, temperament, habit, sex, hereditary predisposition, idiosyncrasy mould the characteristics of individual cases.

2. Acute alcoholism as well as the chronic variety of the affection results from excess or abuse of alcohol, not from the sudden withdrawal of the accustomed stimulant, as was formerly taught. In doses to produce such disastrous effects upon the nervous system, alcohol is not a stimulant but a powerful sedative.

3. If the first principle proclaimed be true, it follows as a corollary that the most rational plan of treatment must needs be *expectant*; that forcing sleep is prejudicial and dangerous; and that, especially, the systematic administration of opium is a practice both unjustifiable and fraught with pernicious results to the patient.

As regards the self-limitation of acute and even chronic alcoholism, we have only to open our eyes and carefully watch cases in order to be convinced. Just as uncomplicated pneumonia, typhoid fever, the exanthematous and other very dissimilar diseases are known daily to recover with little or no treatment except judicious nursing and hygienic surroundings, so will the various phases of alcoholic toxemia tend to rapid recovery by rest, proper diet and the withdrawal of the noxious agent whose abuse culminated in such unfortunate consequences.

We will admit, for sake of argument, and we shall recur to this point hereafter, that such a successful termination or solution of the cases just alluded to, can be accelerated by the aid of measures productive of, or favoring elimination, yet in the vast preponderance of cases, the *vis medicatrix nature* is all sufficient, as all the excreting organs, more particularly the lungs, skin and kidneys, certainly materially aid in this direction.

In fact, Anstie claims "that there is some reason to think that as much as a fourth to a third of the dose taken, leaves the body in an unchanged condition within the course of forty-eight hours." The probabilities seem conclusive that just in proportion to the functional activity, in different persons, of the various organs whose office consists in the elimination of excrementitious material will be the toxic or innocuous effects of the doses absorbed. It follows that in the absence of certain forms of disease, especially *renal* disease, the natural efforts will serve to eliminate the poison.

*Secondly.* That the various forms of alcoholism do not depend, as was formerly taught, upon the sudden withdrawal of the alcoholic potations, it seems hardly neces-

sary at the present day to discuss; but as some important features of Anstie's treatment are inseparably connected with the truth of this proposition, I shall cursorily, advert to some essential facts.

Clinical observation will prove incontestably that the patient is usually overwhelmed in the very midst or height of his debauchery. Abstinence plays, in recently recorded cases, no prominent feature in the history of the outbreak. The nervous centres in consequence of their elective affinity for the alcoholic poison become more and more impregnated with it and consequently grow more and more intolerant of its effects. Their functional activity becomes proportionately more and more impaired; the blood becoming more and more hypercarbonized, its power for the appropriation of oxygen becoming more and more reduced, a period of culmination consequent upon these conjoined deleterious effects is attained, and the phenomena or symptomatic manifestations of alcoholism are developed.

This occurrence is not to be marvelled at when we take into consideration the effects of these increasingly toxic doses of such a powerful depressing agent. If, as Anstie claims, we dissect a nerve or a bundle of nerves, and then immerse it in strong alcohol, we shall find that after a certain period the nerve will no longer be a conductor of nerve force, but will become absolutely paralyzed. If, on the other hand, we take only a weak or diluted alcoholic solution, we shall not find the effects so deleterious, the paralytic phenomena which ensue will not become so completely developed.

The non-oxidation of the tissues acts as another powerful factor in the development of the symptoms. The red corpuscles diminish, the hydro-carbon appropriates for its own use the free oxygen of the system to a large extent, the blood soon becomes surcharged with fatty and effete materials, and the deleterious effects of the excessive retrograde metamorphosis, with the constructive efforts reduced to a minimum, sooner or later explode, the nervous system bears the principal brunt of the storm, and the phenomena of alcoholism supervene.



Then again we must recall the fact that alcohol in the quantities in which it is imbibed by the drunkard is in no sense a *stimulant*, but a powerful narcotic sedative, overwhelming the nervous system with each additional dose more and more, paralyzing the vaso-motor nervous system, and thus superinducing fluxion or hyperemia of the central nervous system, especially the brain.

Cerebral congestion, the result of vaso-motor paralysis developed by the immediate action of the alcohol, is the underlying pathological condition in nearly all cases, which requires the most of our attention, and upon which we can not place too much stress.

Therefore, as alcohol is dangerous in proportion to its *quantity*, which correspondingly increases its sedative or narcotic or paralyzing effects; how absurd it seems to talk about the withdrawal of an accustomed stimulant being the all-important factor in the superinduction of the phenomena of alcoholism, instead of the *direct poisonous* and paralyzing effects of alcohol upon the nervous system. Anstie, when referring to the fact that "in the multitude of instances the acute attack merely exhibits in full development, symptoms which had been partially recognizable for a long time previously," adds in another place the following observations:

"As a matter of fact it had frequently been observed that the sufferer from delirium tremens had ceased to drink for one, two, or three days before the access of his more acute symptoms, and the exhaustion caused by the loss of his ordinary stimulant was supposed to produce these symptoms. Dr. Ware, of Boston, (1831) was one of the first writers who pointed out that this statement includes a fallacy of observation. From an analysis of one hundred cases, he proved that the cessation of drinking, where this occurs, is in fact produced by a feeling of revulsion to strong liquors, which is a part of the early symptoms of the acute disease in many cases; and, on the other hand, that very many patients do not leave off drinking at all, but the delirious attack supervenes in the midst of a

debauch. This observation has been confirmed by Dr. Gardner, and many other excellent recent writers, and at present the classical theory of exhaustion from withdrawal of an accustomed stimulus has but a few upholders."

The expectant plan of treatment is therefore rational; the disease being a self-limiting one. In mild cases very little, if any special treatment is necessary. In severe cases my usual plan is to administer ten grains of calomel which has the action of an eliminant, acting particularly upon the portal circulation, and also a soothing, calming effect upon the gastric disturbance, in the very beginning enabling the physician to administer nourishment and other remedies which would otherwise well nigh be impossible, owing to incessant vomiting. Careful nursing and systematic nourishment, constitute powerful auxiliary measures in promoting the patient's comfort and cure.

Lime-water and milk, and beef essence highly surcharged with capsicum, are valuable agents. The capsicum possesses decided advantages. It quiets the erethism of the patient, promotes digestion and sleep. Its action is obscure, it possibly has a reflex influence upon the pneumogastric. I prefer its administration systematically with *fluid* nourishment, although in a case treated at St. Vincent's, my friend, Dr. Hodgen, administered it to his patient in bolus, which was productive of an equally happy effect.

It is rare that I administer bismuth, hydrocyanic acid and other stomachic sedatives, the habitual dose of ten grains of calomel rendering such measures *useless*. The bromides are given of course systematically, generally three times a day, to prevent eclampsia, one of the greatest dangers in these cases, to reduce reflex excitability to the minimum, and last, but not least, to obviate vaso-motor paralysis with its consequent attending cerebral hyperemia, one of the most common causes of death, whether directly resulting in cerebral or pulmonary fluxions. *At night*, chloral is administered in moderate doses of fif-

teen grains; sometimes in severe cases of insomnia, it is combined with thirty grains of bromide potassium and one fluid drachm of tincture of hyoscyamus. The nurse is ordered never to administer over three doses. *In other words, sleep is never forced.* If the patient is reported in the morning as not having slept, I do not feel uneasy or anxious to press the hypnotic remedies the following night.

Recollecting the self-limiting tendency of the disease, of which insomnia is only a symptom, we feel assured that like all other symptoms, it will yield as the case progresses favorably. In other words it does not constitute the crisis of the older authorities on this subject, nor is it the field upon which the battle is to be fought and lost or won. Like the harassing cough of pneumonia or the angina of scarlatina, or the diarrhea of typhoid fever, it will yield with the arrestation of the pathological conditions which predetermine its existence.

We believe our low mortality of 14 deaths in 813 cases, or 1 death in 58 cases, is attributable almost directly to this practice of not forcing sleep and to carefully avoiding the opium treatment.

The mortality of St. Vincent's Institution, namely, 14 deaths in 813 cases would be about 1 death in 58 cases.

Dr. Wood in his work on Practice of Medicine, fourth edition, published in 1855, gives the following mortality: "Of 1,241 cases of delirium tremens in all its forms and stages, and of *intemperance*, (italics our own,) expected to end in delirium, admitted to the Philadelphia Hospital, from May, 1834, to November, 1839, and subjected to a variety of treatment; 121 cases proved fatal, or somewhat more than one in ten." Dr. Aitken, Science and Practice of Medicine, vol. I, second American, from the fifth enlarged and carefully revised London edition, article, Delirium Tremens, says, "Calmeil states the mortality at 5 per cent., Bougard at 19 per cent. The most accurate records to be got at are those regarding the British troops at different stations.

The late Sir Alexander Tulloch, in his report for 1853, gives the following percentages of mortality among them:

Great Britain Infantry, - - - - -	17.6
Great Britain Cavalry. - - - - -	13.8
Bermuda, - - - - -	15.0
Canada, - - - - -	7.94
Gibraltar, - - - - -	13.6
Malta, - - - - -	8.8
Nova Scotia, - - - - -	9.1

When a student of medicine, my preceptor taught that two grains of powdered opium was to be administered in such cases every two hours, but after studying Anstie, I concluded forever to abandon the opium treatment, for the following reasons upon which he wisely insists.

“The idea that patients in delirium tremens require to be narcotized into a state of repose, may now be said to be abandoned by those best qualified to speak on the subject.”

Large and successive doses of opium are dangerous because “it has often happened that the patient without even sleeping at all, has passed into a condition of coma-vigil, next of stertorous breathing, and at last sunk, fairly poisoned with opium.”

Then again the depressing action of opium upon “the visceral nerves is well known, impairing and impeding, as it does, digestion, and rapidly tending to *paralyze the action of the heart.*”

Dr. Anstie contends again, that “in truth, the condition of the brain requires that sort of treatment which shall fortify and stimulate its functions. \* \* \*

“The typical member of the group of stimulants is simple, easily digested food, and the successful treatment of delirium tremens, in nine cases out of ten, depends on the regular and continuous supply of suitable nourishment, whereby the functions of the nervous system are supported during the struggle toward recovery.” In addition to the objections already urged to the use of opium, we would add that it constipates and seals up to a great extent the

excrementitious channels, thereby checking elimination, upon which, to a great extent, the safety of the patient depends in the earlier stages, and which is so largely contributed to by the large dose of calomel already alluded to, which I never fail to administer. I also make no allusion to the specific treatment of inebriety, as in my large experience I can record the permanent cures of not more than three or four patients. It is my candid opinion that inebriate reformatories are, to speak mildly, humbugs, which should be discontinued and replaced by some sort of penal institutions where practical results may be attained by severer measures, and more energetic and decisive treatment of a moral character.

There remains but one more question to discuss, which we shall summarily dispose of as our convictions are very decided in this connection. Should alcohol be administered during the attacks of acute alcoholism?

I answer unhesitatingly, No.

The mischief is effected when we are called to visit the patient, and the physician is not called upon to aggravate morbid states present by giving additional quantities of the poison which has produced the pathological conditions he is called upon to remove. With the moral features of the question, we have no interest in this paper, as we are simply viewing the question in its medical aspect. There are many cases where we are compelled to administer alcohol in moderate and judicious quantities, because the patient, not being absolutely under our control, will not submit to a total withdrawal of alcohol, and the prejudices of his friends and relatives favor his determination. Under such circumstances administer the minimum amount possible. As regards the objection that the sudden withdrawal is injudicious, it is always in our power to recommend should violent, asthenic or adynamic symptoms demand its employment. Its use, in suitable doses, as a stimulant and not in sedative doses, will soon compensate for any obviously injurious symptoms produced by its withdrawal in the early periods. Its use when not needed is

permanently injurious and its withdrawal later, will hardly compensate for mischief produced. At any rate, in all cases we would again urge Anstie's advice, who says: "I wish to express the decided opinion that complete abstinence may always be carried out without any immediate danger to life or health, if proper care be taken to substitute a substantially nourishing diet." In very few, nay, most exceptional cases will we have to resort to its administration, once we have boldly withheld it from the very earliest commencement of our medical treatment.

"In every case, however, I think it is our duty to abstain as long as possible from the use of alcohol, and before resorting to a treatment of such doubtful propriety, we ought to try less harmful narcotic stimulants."

To recapitulate the conclusions of this paper, then, we may assert that practical observation upon the treatment of over eight hundred cases, proves that,

1. Acute alcoholism is a self-limiting affection.
2. Acute alcoholism results not from sudden withdrawal but from excess and abuse of alcoholic, "so-called stimulants," better called sedatives and narcotics in the doses in which they are taken.
3. The expectant plan of treatment is the most rational.
4. Opiates are dangerous because they additionally derange digestion, and acting as powerful cardiac sedatives, tend to paralyze the heart, and finally, because they check elimination, interfere with the normal secretions and digestion.
5. Sleep is never to be produced at risk or hazard to the patient, but is to be expected as one of the harbingers of a convalescence not to be forced.
6. In acute alcoholism, as in many other acute diseases, the *vis medicatrix naturæ* is fully adequate in most cases to produce the happiest of results.

IMPROVED PLASTER OF PARIS JACKET, OR  
"CUIRASSE" FOR POSTERIOR SPINAL CURVA-  
TURE IN THE MIDDLE AND UPPER DOR-  
SAL REGIONS.

BY EUGENE C. GEHRUNG, M. D., ST. LOUIS.

Read in abstract before the Medico-Chirurgical Society of St. Louis, April 12th, '80.

IN 1876, while attending Mrs. W., she asked me whether I could not do something for her son, who was the subject of posterior spinal curvature, and who had been for some time under the care of various physicians and surgeons without receiving much, if any benefit. The lady supplied me with the following history:

John, aged six years, was a healthy child up to the age of three years, when he had an attack of pneumonia, afterwards sore mouth and running ear. His mother thinks the otorrhea was checked too rapidly, on account of which the child became afflicted with a "disease of the eyes," lasting about two years. His eyes getting well, his gait became gradually worse until the spinal disease was finally noticed, and all that the parents knew how to do, and money could procure was done for him; as strapping down in bed, wearing of different braces, but without success.

I told the lady that I was convinced the disease could be arrested, but as this was out of my line of practice, she would better call on one of our orthopedic surgeons. Whereupon, October 27th, 1876, Dr. L. Bauer was called in, who treated the child with various orthopedic appliances for about six months without much benefit. On May 12th, 1877, Dr. Bauer had recourse to Sayre's plaster of Paris jacket, which was applied and re-applied *secundum artem* as often as necessity required for twelve months, with apparently little or no advantage. During this period

a very troublesome cough developed itself, that became gradually worse despite all treatment. On May 3d, 1878, when a new bandage was again to be applied, Dr. Bauer remarked to me, that unless something else was done, the disease would not probably get well. With this opinion I the more readily coincided, as I had arrived at the same conclusion some time before, and had devised a plan which I felt almost convinced from former experience gained by the use of similar means in dissimilar cases reported elsewhere,<sup>1</sup> would succeed, should the other fail. This plan I now communicated to Dr. Bauer who was well pleased with its (theoretical) *modus operandi*, and, instead of repeating the former apparatus, Dr. Bauer, with my assistance, applied the "cuirasse."

The curvature being in the upper dorsal region from the 2nd to the 6th vertebræ, the apparatus of Dr. Sayre, reaching from the axillæ to the hips, could evidently cover it but partially; the weight of the shoulders, head and neck derives its support, not from the jacket, but from the diseased spinal vertebræ. This permitted motion where at least partial rest is necessary, and *perfect rest* desirable. Thus consolidation was prevented, and nothing but the addition of the "jury mast" in addition to the already cumbersome apparatus seemed to promise relief.

*Perfect rest* could only be obtained by completely preventing the movements of the ribs, the scapulæ and clavicles, and by removing the superincumbent weight of the upper extremities, shoulders, head and neck. The experience with Sayre's "jacket" has clearly demonstrated (?) that such tight bandaging, as to fulfill these indications, is not admissible.

Nevertheless, one of the main features of my "cuirasse," consists in its tight application, even tight enough to obtain by it the requisites just mentioned. On account of the difficulty of obtaining a fixed point for the support

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<sup>1</sup> Rest in certain Diseases of the Chest, *St. Louis Med. and Surg. Journal*, November, 1873.

The Circular Bandage as a Remedy in Thoracic Affections.—*American Practitioner*, August, 1877.



of orthopedic appliances for spinal curvature, the crest of the ilium has from time immemorial been utilized for this purpose, and consequently even the most recent inventions depend upon it as a *point d'appui*. Without completely encircling the abdomen, this point cannot be utilized, since any movement would displace the apparatus.

Thus Sayre's jacket necessarily interrupts the abdominal respiration as well as the thoracic, and consequently would cause apnœa if tightly applied.

With the "cuirasse," support from the hips is not necessary, as it finds all its points of support in the thorax, and leaves the abdomen and loins entirely free. It can, for that reason, be applied much more tightly than the jacket, even to complete immobility of the ribs, clavicles, and shoulder-blades; and, in consequence of this immobility of the entire thorax, it carries easily the superincumbent weight without molestation of the affected structures.

The "cuirasse," or vest, as Dr. A. J. Steele calls it, may be made, like Sayre's jacket, of other material, or of plaster of Paris rollers and strips of tin or veneering. The patient being suspended and provided with a thin, tightly fitting undershirt, as directed by Dr. Louis A. Sayre, rolls of cotton or folded cloth are stitched to the undershirt on either side of the curvature. The bandage is applied first by a few circular turns around the chest, sufficiently tight to prevent the respiratory motion of the ribs, then obliquely across the shoulders so as to immobilize the clavicles and scapulæ. This is continued by means of an occasional reverse of the roller until the entire chest is covered, reaching down behind to the twelfth dorsal vertebra, from thence along the lower border of the ribs and costal cartilages to the inferior extremity of the sternum, and above from the vertebra prominens, along both sides of the neck to the upper border of the sternum in front, thus covering the thorax completely as by a shell. This bandage, when tightly applied and allowed to harden before the suspension is interrupted, will keep up every advantage gained by the suspension, since on account of its tight applica-

tion, it sustains the chest rigidly in the shape thus given to it. Respiration is henceforth altogether abdominal. The diseased vertebræ are free from pressure, and undisturbed by the motions of the loins and head, and by the fixation of the shoulder-blades and clavicles, of those of the upper extremities. They are also pressed as nearly as possible in a line with their healthy neighbors without pressure on the prominent spines, because of the lateral pads; their healthy parts sustain the weight, while the diseased bodies of the vertebræ are left free and unincumbered. Thus the "cuirasse" is to the chest as solid and complete a splint as ever was applied to any single fractured bone.

The necessary exercise for the maintenance of the general health is greatly favored by it on account of the perfect freedom of all the customary motions. When the patient is dressed it is so nearly invisible, that none but those initiated will notice its presence.

On May 3d, Dr. Bauer applied the bandage skillfully and neatly, not, however, without misgivings as to the consequences. After the application the patient was apparently comfortable. Dr. Bauer promised to return after about two hours, and requested me to call two hours later so as to keep the case under sharp surveillance. On my return I was informed that the apparatus had proved a complete failure, and that Dr. Bauer had promised to re-apply Sayre's jacket in the evening. The child complained bitterly of pain in the precordial region and of difficulty in breathing, and refused to sit or stand up. On inspecting the apparatus, I found that a few turns of the bandage had accidentally been applied lower down in front than desired, i. e., over the epigastric region, and thus interfered considerably with abdominal respiration. With my pocket-knife I scraped and cut a triangular piece out of the bandage so as to make it correspond to the line of the costal cartilages in that region, to the great comfort of the child. When we met in the evening for the purpose of re-applying the old apparatus, we found it unnecessary, as the patient stated that this felt very comforta-

ble, in fact much more so than anything he had worn before, and that it enabled him to perform a great variety of movements without the least inconvenience or pain, which he dared not, if he could have attempted before. The troublesome cough had ceased with the application of the bandage, not again to return. The "cuirasse" was comfortably worn for nine weeks. Being more tightly applied, it has to be removed sooner than the Sayre's jacket, as it is more quickly outgrown.

A new bandage was applied July 12th, but in consequence of the inferior quality of plaster accidentally used, the apparatus soon crumbled, and accordingly a new one was substituted on August 2nd. Dr. Bauer being out of the city at the time, Dr. A. J. Steele was called in for that purpose, and the apparatus now for the third time successfully applied. As the child was to be removed for the hot season to the North, his parents desired that the splint should be fixed so that they could easily remove it, should necessity require. To meet their wish, I cut it open over one (the left) shoulder and down on the same side, breaking the plaster with a dull knife and hammer by gentle blows on the opposite shoulder and side, so as to make the remaining cloth act as a hinge, then separating the cut edges made the boy, his right arm extended horizontally, step out of the shell to the left. Along the cut edge, over the side and shoulder I had buckles and straps attached.

During his sojourn in the North, the boy fell twice out of a skiff into the water, which weakened the splint to some extent, but, since he did not complain, he was allowed to wear it thus until his return. It was then (middle of September) found badly damaged, but it was considered unnecessary to make a new one, as the disease was apparently cured. He still continued, however, to wear it for two or three weeks, when it was entirely discarded.

On a verbal report of this case before the Missouri State Medical Association, May 22nd, 1878, it was objected by Dr. Wm. Porter, of this city, that such a confinement of the chest might be the cause of tubercular degeneration in

the apices of the lungs. I am now prepared to state that the boy never showed the least sign of trouble in the lung, and is to-day, more than two years after the removal of the "cuirasse," as healthy a child as can be found anywhere. The remaining curvature is probably not greater than it was during suspension.

The advantages of this "cuirasse" are obvious:

1st. Its useful action begins where that of Sayre's jacket, without the addition of a jury mast, becomes doubtful or ceases.

2nd. It makes an absolute splint for the whole chest, and consequently enhances the rapidity of the cure.

3d. All the natural motions of the body (except those of the thorax) are free and undisturbed, to the great comfort of the patient and benefit of his general health.

4th. It is less cumbersome and weighty than the jacket alone, and still less so than when a support for the head is added.

Its disadvantages are, that it is not applicable in curvatures of the lumbar region, nor in the cervical, unless a head rest is affixed to it.

The feasibility of immobilizing the chest to such an extent without detriment to the patient being once recognized, this "cuirasse" may find more extended application, as for instance in fractures or dislocations of the clavicles, scapulæ, ribs and vertebræ.

## DIVULSION IN STRICTURE OF THE URETHRA.

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By C. W. COOPER, M. D., ST. LOUIS.

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WHILE one of the Surgical Internes at the Massachusetts General Hospital several years ago, and having many cases of stricture of the urethra under observation, I had my attention called to the singular uniformity of treatment in that institution, and was led to study the results there obtained, making use of the hospital records.

The active interest manifested in the subject of stricture since its discussion before the British Medical Association at its last meeting, would seem to be a sufficient reason for referring to these observations at the present time.

For a series of years every case of uncomplicated stricture admitted at the Massachusetts hospital has been treated by one method to the exclusion of all others: a stricture, if sufficiently marked to be admitted at all, is never cut, and never dilated by the gradual method; it is invariably divulsed with Voillemier's instrument. This statement, of course, excepts certain isolated cases where there are special indications, also certain cases where a method or instrument is used incidentally by way of comparison, as well as all cases treated at the out-patient department; the results will have a bearing only upon the operation of divulsion, but in connection with the cases some points of general interest are brought out.

Before presenting cases in detail, I will give some statistics which show the advance that has been made in this department of surgery and which emphasize the saving in time and money brought about by the introduction of the immediate treatment of stricture.

Prior to 1865 the immediate treatment had not been introduced in Boston, therefore I have taken sixty consecutive cases occurring immediately before that date, and have

compared them with sixty consecutive cases occurring just previous to 1877 to contrast the old and new methods.

Sixty consecutive cases of stricture treated before the introduction of the immediate method, taken together, required— } 8 years and 61 days.

Sixty consecutive cases of stricture treated by divulsion, taken together, required— } 1 year and 39 weeks.

Therefore in this estimate of sixty cases, about six years and a half of hospital life were spared to individuals by the introduction of the immediate method; moreover, the average expense of each patient in the hospital at that time is known, and it can be shown that \$3,300 in money was saved to the hospital or to individuals. And when it is taken into account that there has been but one death following the operation during twelve years of trial, and this death in the case of an old and feeble patient, and that with this exception no alarming symptoms of any kind have presented themselves in a single case, it will be seen that the saving in time and money has not been made at the expense of any indirect loss. I will now present a few cases from those occurring under my own observation in the wards of Dr. J. C. Warren to illustrate the routine treatment, and will also select two cases which bear upon the tolerance of the urethra for the operation of divulsion.

CASE I. S. W. entered the hospital July 28th with a gonorrhœal stricture of twenty years' standing. After many trials on different days, a capillary bougie was introduced into the bladder. Two days after his admission, the patient being etherized, a guide was passed with some difficulty, and the stricture divulsed, Voillemier's divulsor being used for the operation, after which an English No. 12 catheter was fastened in. There was some pain that night, relieved by a suppository of one quarter of a grain of morphia. The patient was quite comfortable, making no complaint of pain during the remainder of the treatment, which was

as follows: the catheter was removed on the fifth day, and a metallic sound, English No. 12, was passed daily for a week; the sound was passed every other day for the succeeding week. The patient was then taught to pass the instrument himself, and instructed to perform the operation once a week for a time, and to gradually lengthen the intervals. This case was complicated by an attack of gonorrhœal rheumatism, through which complication he was kept under observation for several months, and as far as the stricture is concerned he had no trouble whatever, and experienced no difficulty in keeping up the after-treatment.

CASE II. G. G., an alcoholic subject, entered the hospital September 12th. The patient had contracted gonorrhœa several months before and never submitted to treatment for that disease. Twenty-four hours before entrance, complete retention came on. He was at once etherized, and a stricture was found to exist in the membranous portion of the urethra, which scarcely admitted the passage of the smallest bougie. The stricture was divulsed by the same operation as above, and a catheter was fastened in.

After a good night's rest, superinduced by morphia, he felt quite comfortable, and made no farther complaint or objection to treatment. The catheter was removed on the fourth day, and the sound put in requisition as above. In eleven days he was discharged, with instructions to pass a No. 12 sound at intervals.

CASE III. J. R. entered the hospital September 28th. Has had trouble in passing water for two years; the stream has been small and forked in character. For the last two weeks he has suffered from incontinence. On examination a stricture was discovered, through which a No. 6 French bougie passed without much difficulty.

In this case a trial was made of the treatment by gradual dilatation as follows: the largest bougie that the stricture would receive easily was left in for an hour. During the afternoon there was marked constitutional disturbance, a chill followed by febrile symptoms of some severity. On the next day the same instrument was left in for the same

length of time. This was followed in a few hours by more severe symptoms than those of the day before, well-marked urethral fever being the result. Four days were allowed him to recover from the effects of this treatment. At the end of that time the operation of divulsion was performed, and was followed by no bad symptoms. The catheter was removed on the third day, and in twelve days he was discharged, being able to pass an English No. 12 sound himself.

CASE IV. J. A. entered October 5th. Has had difficulty in micturition for four or five years, attacks of retention occurring every six months. In relieving retention it has been necessary to use a small instrument. On examination a No. 4 French bougie passed through the stricture. On the second day the operation of divulsion was performed. No trouble followed; the patient bore the catheter easily for three days, and in twelve days was discharged, well. Two weeks later he reported in good condition, having had no trouble in passing an English No. 12 steel sound, as instructed.

CASE V. J. E. entered October 20th. Has been troubled with stricture, following gonorrhoea, for two years, with the usual symptoms of occasional retention and a small stream of urine. As a No. 8 French bougie could be passed without difficulty, the method of gradual dilatation was tried. A bougie was left in the stricture for half an hour. The patient soon after had a chill, followed by febrile symptoms. On the next day the bougie was again passed and allowed to remain for a time. For the next twenty-four hours he suffered severely from urethral fever. Three days of rest were allowed, and the stricture was then divulsed as in the former cases. There was no chill that evening, and no trouble while the catheter was left in the bladder or during the after-treatment. In thirteen days he was discharged, with instructions to use a sound, English No. 12.

In cases III and V it is to be noted that while attempts at gradual dilatation were followed in each instance by severe constitutional disturbance, the violent rupture of the



stricture was not followed by such symptoms; such cases, not uncommon, serve to illustrate the fact that less urethral fever often follows divulsion than the simple passage of a small dilating instrument on the same person. I would simply mention here that the practice of placing a catheter for three or four days after operation is scarcely one to be defended in the face of existing evidence that such practice is unnecessary and useless.

The continuance of after-treatment by the passage of a sound, in all cases, was insisted upon because of the admitted fact that a perfect cure is never obtained by any operation, and therefore the constriction returns at an early date if dilatation is neglected. It is found essential to state this fact to the patient with great emphasis to secure his coöperation in the matter, but those who carry out the instructions have never complained of the procedure as especially troublesome.

In looking over the notes of a large number of cases from which the above were taken it was to be observed that patients as a rule had suffered from retention, incontinence of urine, etc., for several years, and that they were always completely relieved, without any serious symptoms, in four or five days, the remaining seven or ten days before the average time of discharge being occupied in teaching them the use of the sound.

Permanency of effect, where the after-treatment has been faithfully kept up, has been perfectly satisfactory, though not always complete.

In several consecutive cases the temperature was observed; there was found to be a rise to  $100^{\circ}$  or  $100.5^{\circ}$  F. on the first day after operation with a fall to normal during the second day.

In regard to the occurrence of one fatal case during an experience of twelve years, it is to be noted that the subject was of advanced age and in bad condition, and the general fact should also be taken into account that death has repeatedly been caused in unfavorable cases by the simple passage of a sound. Holt reports 670 cases of divulsion

with only 2 deaths, and Bumstead, in whose large experience with the immediate method, divulsion has played a prominent part, says that no death has ever occurred in his practice, and in only one case has he met with symptoms in any way alarming.

I am aware that such immunity has not always obtained, and indeed it would be unreasonable to expect it in the case of any such operation; comparative safety only is to be expected, and the comparative safety of this one is established.

The twelve years of continuous employment of divulsion on a large scale, with such satisfactory results that the surgeons are ready to continue the treatment and see no reason for a change, has been made the subject of analysis in this paper for a special reason; it is because the excellencies of internal urethrotomy have been dwelt upon to such a degree as to exclude divulsion from what is believed to be its proper position, a position nearly if not quite equal to that of its rival. In the discussion before the British Medical Association the most prodigious claims were advanced by some advocates of incision, but they went so far as to overshoot the mark, for the *London Lancet* felt called upon to rebuke them in an editorial in the following terms:

“Mr. Tevan spoke of the operation as almost devoid of danger and challenged any one to produce a case of death from it in a young man. If he will refer to our columns he will there find evidence that should make any one hesitate to speak lightly of the risk of this procedure. An operation that may be followed by death, abscess in the joints, severe hemorrhage, sloughing, extravasation of urine, permanent chordee, repeated rigors, and suppression of urine is surely as serious as many of those usually called capital. It is evidently an operation about which enthusiasm is superfluous.”

It is noticeable that at least two of the distinguished men who participated in the debate in England protested against the statement that the operation of incision was superior to that of rupture, and expressed their confidence in the latter

method and their marked preference for it in many cases.

One of the speakers formulated the modern treatment of stricture thus: "Internal urethrotomy or rupture, which shall be used? A direct challenge of the latter by the former." This is a most partisan and unscientific statement, implying that one operation or the other must be wholly discarded. In opposition, it was strongly urged that both operations should be employed, regard being had to special indications, urethrotomy being indicated in strictures near the meatus and in those of traumatic origin or of very long standing, rupture in all other cases.

Dr. Keyes, who may be fairly said to represent the latest American views, is far from taking ground against divulsion; he says that the danger is no greater than in urethrotomy and for the deep urethra he considers it the preferable operation.

The experience at the Massachusetts Hospital with divulsion may be summed up as follows: the operation has been employed there almost indiscriminately for ten years; etherization and divulsion have followed at once as a matter of course upon the admission of an ordinary case of stricture, and the results have been good; there has been no death except that of one man of advanced age, and, with the exception of this case, there have been no serious or troublesome symptoms of any kind. This clinical experience shows practically and conclusively what may be expected of the operation when performed with a reasonable degree of care and skill.

## CATARRHAL OPHTHALMIA.

BY W. A. ROTHWELL, M. D., MOBERLY, MO.

*Read before the Moberly District Association.*

UNDER the above caption I propose to treat of simple inflammation of the mucous membrane of the eyes, commonly called Acute Conjunctivitis. This essay is intended merely to embrace the more practical features of the disease as met with and combated by the general practitioner in his every day professional life.

The causes of catarrhal ophthalmia are numerous. It may be produced by exposure to great and sudden atmospheric changes; long exposure to cold and sudden transitions from marked degrees of heat to cold, may produce it; it may follow long continued exposure to wet; a residence in marshy and malarious districts is a fruitful source of the affection; damp apartments combined with insufficient clothing, poor and scanty food, with neglect of personal cleanliness, are very productive of the disease; hence we find it more often among the poor and indolent than among the more favored and industrious classes; exposure of the eyes to concentrated light, especially where the light is intense or glaring and the exposure is long continued, may cause it; over-work of the eyes, close and concentrated engagement of the eyes, as in work with a microscope, abuse of the eyes in reading, sewing and the like by artificial light, and especially if the light be dazzling on the one hand, or insufficient on the other, may produce the affection. Injuries, whether mechanical or chemical may give rise to it. Foreign bodies, as minute and unobserved particles of sand, ashes, lime, dust, etc., may be classed among the causes. It may be associated with certain exanthemata, as small pox, measles, scarlatina, eczema of the face and erysipelas. Contagion is a certain cause, es-

pecially where the discharge becomes muco-purulent, thick and of a creamy look and consistency; hence, persons using the same vessels, towels, etc., as those having the disease, are almost certain to suffer for their folly. The affection is sometimes epidemic, in which case the cause would seem to be some peculiar condition of the atmosphere. Cases may occur where the cause is so obscure that we are unable to discover it.

The symptoms of catarrha ophthalmia can hardly be mistaken by an ordinary observer. At the commencement of an attack the patient usually feels an uneasiness in one eye, seldom both becoming affected simultaneously, there being a lapse of from one to several days between them; this uneasiness is attended by more or less itching, which leads the patient to rub the eye from time to time. The difficulty getting no better, he concludes that there must be a foreign body in the eye, or that "wild hairs," so-called, are troubling him; and so he has some one examine the eye, but nothing special is observed more than an increased flow of tears with more or less congestion of the mucous membrane, with the usual redness attendant on such conditions. The uneasiness and itching give place to more or less pain, especially if the eyes are exposed to a bright light—the redness and lachrymation increase, and the patient begins to complain of a sensation in the eyes as if produced by the presence of sand. \* This symptom is so common that we may regard it as almost characteristic—it is produced by the injected cond of the blood vessels together with enlarged or swollen papillæ of the palpebral portion of the conjunctiva rubbing against the ocular portion. The irritation, redness, lachrymation, with more or less intolerance of light, increase; and, on examination of the eyes, we find streaks of mucus of a gray appearance floating in the tears, with a swollen condition of the conjunctiva, especially the tarsal portion which is highly vascular. As the disease advances, all the above symptoms become intensified; the hyperemic condition of the tarsal portion of the conjunctiva extends to the retro tarsal

fold, the caruncle, the semi-lunar fold and also to the ocular portion of the membrane; in the severer forms of the disease the ocular portion of the conjunctiva becomes so swollen that it rises around the cornea so as to form a cup-like appearance large enough to hold from one to two or or more drops of water. This condition is observable, however, in gonorrhœal ophthalmia, often destroying the eye so attacked in a few days. As the disease progresses, the mucus, at first scant, grayish and thin, increases in quantity, becoming thicker and of a yellowish color; and, in the worst forms of the disease, the discharge, from the stage now under consideration, soon assumes a muco-purulent appearance. This secretion during the night is poured out, and lodging on the edges of the eyelids and at the roots of the eyelashes, glues them together so firmly as to render it somewhat painful, as well as difficult, to get the eyes open in the morning, unless bathed for a time with water. Photophobia and stiffness of the lids obtains more or less in all cases; pain is not so uniform, at least I have not found it so. The cornea and iris usually remain normal throughout the attack, which may be known by the clearness and transparency of the one, and the contractility and dilatibility of the other.

The duration of catarrhal ophthalmia is from one to three weeks, and under judicious treatment the prognosis is very favorable. If the disease is neglected or wrongly treated, it is most apt to become chronic; and when it becomes so, the severity and stubbornness of the chronic form of the disease is generally in proportion to the severity of the acute form. A case now and then, in spite of all that can be done, becomes complicated with corneitis, and sometimes with abscess and ulceration of the cornea; such instances are rare, and, when they do occur, are more often the result of neglect and injudicious treatment, especially the latter, than to the original affection.

*Treatment.*—This for the most part consists in direct local applications to the eyes, constitutional treatment beyond keeping the bowels regular being unnecessary,

save in broken down constitutions and those that have been exposed to malaria, in which case quinine is very important.

In making external applications to the eyes in catarrhal ophthalmia, I would, first of all, remark that poultices of whatever composition cannot, in my opinion, be too greatly condemned, for the very simple and obvious reason that in order to be of any good, they must remain on the eyes so long that such an amount of heat is generated within the inflamed tissues, while at the same time evaporation is prevented, that the trouble instead of being made better is augmented; besides, when we add to this the fact that the pent up humors of the eyes, especially when of a muco-purulent character, can only act as a poison to the already inflamed parts, it must be obvious to the intelligent practitioner that poultices can but be productive of harm. We know that the hot scalding tears in the earlier, and the thick ichorous secretion in the latter stages of the worst forms of the disease, ought to escape from the eye as fast as secreted, because of their highly irritating character—poultices prevent the escape of either. Where there is great heat with or without a tendency to corneitis, I have found good to follow the application of a folded napkin wrung out of cold water and repeated as often as it becomes hot, for from twenty minutes to half an hour, or until the parts are cooled down; or what is a safe rule, repeat the application as often as the eyes become hot and painful, and continue it as long as it is grateful to the patient, which will rarely exceed half an hour; when too long continued, or too often repeated, the eyes might become chilled and the congestion deepened, resulting in either an overpowering of the vitality or tonicity of the tissues on the one hand or augmentation of the inflammation on the other by reason of the excessive reaction. Sometimes we meet with cases in which warm instead of cold applications seem to be of more service; this is most apt to be the case where there is ciliary neuralgia present. I am usually governed by the feelings of the patient, using either hot or

cold as may be most grateful to him. Where edema of the lids ensues on the use of either hot or cold applications, it will be best to discontinue them—under such circumstances we may suspect a rheumatic taint. Where there is much trouble with ciliary neuralgia, I have used for the past eight years, with good results, an ointment after the formula of Soelberg Wells, as follows :

℞ Ext. belladonnæ,	gr. x.
Hydrarg. ammon. chlorid.,	gr. v.
Adipis,	ʒi.

M. Sig. Rub a portion of this on the forehead three or four times a day and continue its use until a slight papular eruption appears, which will be in the course of three or four days.

But our chief reliance is on remedies addressed within the eyelids, direct to the inflamed mucous membrane ; and before doing this, it is all important to assure ourselves as to the nature of the trouble. Being sure we have a clear and uncomplicated case of catarrhal ophthalmia, a solution of sulphate of zinc or copper, one to two grains to the ounce of water, dropped into the eyes two or three times a day will cure the affection in its mildest forms in from one to two weeks. In the severer forms of the disease our action must differ somewhat. When the cornea is beyond all doubt uncomplicated, we may cut the trouble short with what I would term an abortive treatment. This consists in a saturated solution, say, of the sulphates of zinc and copper and rock alum, diluted one-half with water and dropped into the eyes, raising the eyelids so that the solution will come in contact with the entire mucous membrane. It will produce great pain in some instances, but this will abate in a few minutes ; and the eyes, which before may have been even very painful, are now easy. It will be best to follow this treatment in ten to fifteen minutes with a solution of sulphate of atropia, three to four grains to the ounce of distilled water. Often one treatment of this kind will cut the disease short and only a mild astringent will be necessary to complete the cure which will be in a few



days. In some cases the treatment may have to be repeated once and even twice before the eyes give evidence of relief. The repetition should be in from twelve to twenty-four hours. This abortive treatment is only applicable to the incipient, or early stage of the disease.

Where the abortive treatment has failed, or where we choose not to adopt it, or where we see the patient too late to use it, and where the case is violent, or when the discharge is muco-purulent, or both, under such circumstances, a solution of zinc and copper sulphates, two to three grains each to the ounce of water, instilled into the eyes three or four times a day, will be found sufficient, so far as an astringent goes. In connection with this treatment the eyes should be carefully and thoroughly syringed out with tepid water at least as often as the eye water is used; in other words, the eyes should be kept scrupulously clean and free from the constantly gathering secretions. In the tepid bath to the eyes it is best to use some simple astringent in the water, say ten grains of alum to the pint of tepid water. Where the eyes seem to be very irritable and susceptible to astringents, I always follow this, in five to ten minutes, with a solution of atropia, two to four grains to the ounce of distilled water, sometimes every four hours during the worst phases of the disease. In all severe attacks where the eyes are swollen, irritable, and hot water flows freely, especially if the case bids fair to become complicated with corneitis, I rely solely on the use of atropia until these untoward conditions have mainly subsided, and the hot water gives place to a straw-colored mucus or secretion; then I begin with caution, the use of astringents in connection with the continued use of the atropia, and have never been disappointed, all things else being equal.

If on examination, either at the onset or in the course of the treatment, you find that the subconjunctival tissue is involved, which is known by parallel vessels of a rosy tint radiating around the cornea, forming around it a pinkish zone, you cannot be too careful in the use of the stron-

ger astringents. Patients have come to me under such circumstances with eyes more or less ruined by the unwise and injudicious use of astringents, that might and ought to have been saved intact. I allude to provoked corneitis, abscess and ulceration of the cornea, to iritis, and to the destroyed glands of the conjunctiva, leaving the membrane thickened and permanently altered, looking as if the operator had intended to tan the membrane and leave it as a *living leather*, rather than cure it of the inflammation.

There often remains after a severe attack of catarrhal ophthalmia, or where strong astringents have been too freely or long continued, a certain amount of injection of the smaller capillary vessels of the conjunctiva, with a thickened condition of the eyelids, with some inability to raise them to their normal place; thus they seem to droop and the eye, in consequence, looks weak and a shade smaller than before the attack; this condition of things has been witnessed by every physician of a few years experience. Under the judicious and persevering use of the milder astringents the injected vessels disappear as a rule, but not always; under the use of a solution of tinct. ferri mur., the drooping eyelids may receive benefit, yet my observation has been that they never regain their original form and place. For the above difficulties I have a new remedy to offer the Society, in electricity. We all know, or should know the action of electricity, for it has to do with almost every thing with which we have to do. Its action on the human system seems specially directed to the nervous and muscular systems and hence comes its great use in the treatment of nervous troubles, rheumatisms and broken down constitutions generally. By the use of electricity in the troubles above enumerated, the capillary vessels receive a specific and direct stimulus, thus toning up and exciting them to contraction, thus relieving the congestion and also the redness of the conjunctiva; on the same principle and in the same way, we relieve the thickness of the eyelids by stimulating the fibrous coat of the blood vessels to contraction on the one hand and by toning them

up on the other—nor is this all; while we thus act on the blood vessels we also act on the absorbents which play a most important part in clearing up the eyes and reducing the enlargement of the eyelids after an attack of catarrhal ophthalmia as well as in all other ophthalmias. In relieving the ptosis, or drooping of the eyelids, we think electricity deserves a high place among our remedial agents; here, not only the blood vessels and absorbents require help but especially the mucous membrane, the muscles and the nerves—I know of no remedy that will meet the indications so fully and effectually as electricity. My remarks on electricity as above indicated are based upon a case recently successfully treated.

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## CASES FROM PRACTICE.

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### TETANUS TREATED WITH ARSENIC.

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COMMUNUTED FRACTURE OF THE FEMUR IN THE UPPER THIRD  
—COMPOUND, COMMUNUTED FRACTURE OF THE OS CALCIS  
—TETANUS—FOWLER'S SOLUTION OF ARSENIC HYPODERMICALLY—RECOVERY FROM TETANUS—DEATH FROM SEPTICEMIA.

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By J. T. HODGEN, M. D. ST. LOUIS.

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Charles Dauber, aged 35, a robust and healthy fireman, fell, September 14th, 1880, from a ladder, forty feet, and alighted with the right foot on a projecting point of stone, cutting the skin and dense tissue of the sole, and producing a compound, comminuted fracture of the os calcis, and a comminuted fracture of the right thigh in its upper third.

I was called at 4 o'clock in the morning, and found Dr. Shore in attendance. The patient was laboring under shock, from

which he was recovering. I enlarged the wound of the sole, and removed such loose fragments of the os calcis as could be readily detached, and washed out the wound with 1 per cent solution of carbolic acid, introduced a piece of linen soaked in the same solution, enveloped the foot and ankle in cotton wool, and covered all with a plaster of Paris bandage. I made extension of the thigh by Buck's method. The same day, in the afternoon, I suspended the limb in a wire splint. September 15th, Dr. Mudd cut away the plaster at the sole of the foot, thus permitting free discharge. A drain was arranged by which carbolic acid water was conducted constantly into the wound. On the 15th, the lower part of the abdomen in the right iliac region was much distended. On the 17th the upper part of the thigh was also much distended, the swelling of the abdomen having in a measure disappeared. On the 20th, the swelling of the thigh was less; the patient was comfortable from this time until the evening of the 29th, when he had symptoms of tetanus, had trismus opisthotonos.

Dr. Shore being called in the night gave morphia. September 30th, 12.30, P. M., I found the patient had suffered repeated tetanic spasms during the night and morning and he was quite rigid. I at once injected beneath the skin 10 drops of Fowler's solution of arsenic and ordered 30 grains of chloral every hour, if not at rest. I returned at 4 o'clock, P. M., and found the patient much more comfortable, though still rigid. He had taken 120 grains of chloral. I gave 10 drops of the arsenical solution hypodermically, and discontinued the chloral. At 8 o'clock Dr. Shore gave 10 drops of arsenic hypodermically. October 1st, at 8 o'clock A. M., Dr. Shore repeated the arsenic; at 12, M., the patient was quite free from rigidity, and was rational, cheerful, talkative, hungry, and taking food; at 4 o'clock the arsenic was repeated; at 8, he had a tetanic spasm. Dr. Shore gave him 10 drops of the solution. At 10 A. M., October 2d, the arsenic was repeated; the patient was free from spasms during the entire night and he vomited a frothy mucus, probably due to arsenic. October 3d, 8 A. M. He had had a good night, was taking food freely and he had no rigidity; Dr. Shore repeated the arsenic; no tetanic symptoms after it. This evening we found the thigh much distended with fluid, and tympanitic on percussion, some delirium, and the patient restless. I made an opening on the upper and outer part of the thigh and dis-

charged a large quantity of serous pus with some stinking gas; washed out with carbolic acid solution, one to one hundred, put in a drainage tube and directed the abscess washed every two hours. October 4th. The patient is weaker, has taken little food, has not vomited and has decided symptoms of septicemia. October 5th. Died at 2 o'clock, A. M.

Post mortem examination, 4 P. M., 14 hours after death. The cavity which contained the pus in the thigh, extended up along the *iliacus internus* and *psoas magnus* muscles, behind the peritoneum, to the upper part of the pelvis. The femur was found comminuted to the trochanter minor, the os calcis comminuted without fracture of the other bones of the foot. The effect of the arsenic was most marked, the symptoms being decidedly improved after the second injection; and he continued without further permanent rigidity. I have used arsenic in the treatment of tetanus for many years, Dr. A. S. Barnes of this city having first called my attention to its value.

As Dr. Shore had been in more direct attendance on the patient, I requested him to give expression of his appreciation of the value of arsenic in the case above reported. He has done so in the following letter.

ST. LOUIS, NOV. 8TH, 1880.

DR. JOHN T. HODGEN:

*Dear Sir:*—It is with great pleasure that I bear testimony, to the value of Fowler's solution used hypodermically in traumatic tetanus, as used in the case of George Dauber, and continued by me, at *your* request, in 10 drop doses, every four hours, for some days, which was attended with the happiest result, and the *entire relief of the disease*. Never during a practice of some thirty-nine years, have I ever seen a remedy produce a more prompt effect; in fact, there seemed to be an immediate relief from the painful contraction of the voluntary muscles after each injection, as well as relief to that violent spasmodic lancinating pain, which the patient complained of, shooting through the chest from the sternum to the spine, and which is so strikingly characteristic of the disease; it relieved also with equal promptness, difficulty of deglutition and inability to swallow, liquids especially. The injections also controlled the small, quick and fluttering pulse; in fact, such was the relief the patient experienced, that he would ask to have the injections repeated. During the continuance of the remedy there was

not the slightest unpleasant effect, not even nausea; I was so much pleased with the result of this treatment, that I was induced to use it again, in a case of chorea, occurring in a girl thirteen years of age. I commenced with five drops, night and morning for two days, and then five drops each day for ten days. The muscular twitches, or spasmodic contractions were promptly controlled by the injections and finally relieved entirely. This patient had not at that time menstruated, and fearing a return of the disease, as is often the case, after being arrested by treatment before the changes of puberty have been accomplished, I placed her on tonics, particularly iron, and occasional doses of aloes, with a regulated diet, exercise, etc., which had the effect of establishing the menses, and restoring her to comparative health. Hoping that other members of the profession will test the hypodermic use of Fowler's solution and report progress.

I remain very respectfully, your friend,

JOHN SHORE.

[So far back as 1875, Perroud employed the hypodermic injection of arsenic in chorea. Garin in the *Lyon Médical* for June, 1879, reports some very successful results by the same method. The advantages claimed are the avoidance of gastric irritation, and very small doses administered for two or three days. Four to five drops are usually injected under the skin, where there is least cellular tissue, and but few nerve filaments. No local inflammation is apt to follow. Rapid amelioration is the rule. Garin records the cases of sixteen persons cured under this sole treatment, with the average of eighteen injections on alternate days. Of thirteen other patients who had undergone various kinds of medication, ten were cured. These latter had been the subjects of obstinate, relapsing forms of chorea.—ED.]

A CASE OF PROBABLE PULMONARY THROMBOSIS,  
FOLLOWING PARTURITION, ON THE TWENTY-  
THIRD DAY.

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BY P. G. ROBINSON, M. D., ST. LOUIS.

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*Read before the St. Louis Obstetrical and Gynecological Society, Sept. 17th, 1880.*

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Mrs. G—, aged about thirty-three, mother of three children, was confined on the 21st of October, 1879. She usually enjoyed good health and has had no serious sickness except after the birth of one of her children, in consequence of post partum hemorrhage. Her parents were both healthy, and she has no inherited predisposition to any particular form of disease.

From within a few weeks after this conception she began to suffer from constant nausea and vomiting, which continued until within three weeks of the normal period of parturition. This distressing trouble was so constant and so severe as to interfere seriously with her proper nutrition, and produced an extreme degree of emaciation, reaching at one time during gestation such a degree of apparent gravity as to suggest the propriety of inducing premature labor. She was reduced in weight from 170 pounds to about 120 pounds. The usual remedies were employed to control the nausea and vomiting, and her strength and nutrition were sustained by oft-repeated doses of beef essence and milk, in very small quantities (teaspoonfuls,) nothing in larger quantity or more solid form could be retained.

She enjoyed the advantage of the best hygienic surroundings, with every luxury that wealth and refinement could afford. With the unfavorable circumstances of great emaciation and prostration, she was brought to bed at the completion of the full period of gestation. Her labor was easy and unattended by any complication except a slight perineal laceration on account of the rapidity of the second stage, due undoubtedly to the small size of the child, which was to be expected from the very limited amount of nutriment assimilated

by the mother. There was some anxiety felt by me, from her previous history, lest I might have to deal with "post-partum" hemorrhage; but, happily, labor was completed without any loss of blood, every precaution having been taken for its prevention, and the placenta delivered by "expression," the uterus contracting firmly and being so held for the space of at least one-half hour.

With the exception of an expected amount of prostration, there were no immediate untoward sequelæ of labor; food, in any quantity and kind, was well borne, and she *seemed* to progress favorably for about three weeks, except that the recuperation of muscular strength did not keep pace with the reaccumulation of flesh, and she complained from time to time of uneasy sensations in the region of the heart. About the end of the third week after confinement, she was able to move about her room with the assistance of her nurse. One evening about this time, November 13th, I was summoned in great haste to her bed side, and found her in what appeared to be a truly alarming condition. The most striking as well as alarming symptom, was great dyspnea, accompanied by extreme rapidity, feebleness and irregularity of the pulse; this was at times so small and threadlike as to be scarcely perceptible to the touch, and so rapid as to be almost uncountable.

There was pallor of the face, with coldness, almost icy, of the extremities, while the whole surface of the body was bathed in a profuse sweat. There was no elevation nor marked depression of the axillary temperature. Her voice was weak and husky, and while the face was expressive of anxiety her intellect was unclouded. Muscular debility was extreme and she seemed almost incapable of moving a limb. She complained of no pain but of the same uneasiness and sense of constriction about the heart.

On auscultation, the heart-sounds, though feeble, were sufficiently clear, and unaccompanied by murmur or any other evidence of organic trouble.

There were not present, nor had there been at any time, any indications of uterine trouble.

To sum up, the patient seemed to be in a most profound collapse, from whatever cause, and in most imminent danger. No one judging from her appearance as well as from the appreciable symptoms, could but be filled with fears of the most



rapidly fatal result. Without attempting a diagnosis of the true cause of so serious a condition, but following promptly the indications presented by the most prominent symptoms, counter-irritation was made by rubbing the limbs with dry mustard and by wet plasters over the heart, and kept up until good and satisfactory reaction was established, while internally stimulants were freely administered, the chief dependence being placed on the aromatic spirits of ammonia in tablespoonful doses repeated according to the effect apparent. As an adjuvant, artificial heat was applied to the whole body, more or less; the pillows were removed from the bed and the utmost quiet enjoined. She rallied from this perilous state in about two hours, the condition of the cutaneous surface becoming more normal, the pulse fuller and stronger, and the dyspnea gradually subsiding; but she continued extremely feeble and incapable of muscular effort, and complaining of the same sensations of uneasiness and constriction about the heart, especially when her head was even moderately elevated above the level of the bed. On November 26th, she had another decided paroxysm, similar, but seemingly graver than the first. She rallied more slowly from this attack and continued extremely low and feeble during the month of December, not however having more than what might be considered a threat of the previous attacks. During the first few days of January she had several paroxysms, precisely similar to the first, only less in severity, but we were kept in a state of anxiety from their frequent recurrence and from the absolute inability of the patient to lie with the head elevated, and she was thus kept lying flat on her back for several weeks; it must be observed, too, that she was unable during this period to lie upon either side.

From this time the disposition to these attacks grew less and less, and she slowly gained flesh and strength, but it was not until March that she was able to move about the house or even her room without assistance. In May, she took, by my advice, a change of air, spending about three weeks in the East, upon the Atlantic Coast, and to day she seems quite restored to health and vigor. During this visit she consulted, by my advice, Prof. DaCosta, as she seemed impressed with the idea that she had a disease of the heart. He could discover nothing beyond a certain amount of cardiac weakness.

I may remark here, that *decided* improvement seemed to date

from the establishment of menstruation, which made its first appearance early in January, at which time she was seen by my friend, Dr. Gratz Moses, with me. During the first week or two after delivery she was anxious to, and attempted to nurse her infant, which attempt, however, by my advice, was relinquished. She was kept for most of two months upon the daily use of ammonia, which seemed to become a necessity, agreeing much better than alcoholic stimulants; a variety of tonics were tried, none of which appeared to have any decided beneficial effect.

During the months of March and April, as she suffered from much leucorrhœal discharge and complained of back ache and a sensation of pelvic weight when standing, an examination was instituted, and an erosion of the os uteri discovered, with some elongation of the uterine canal; after a few applications of nitrate of silver to the erosion and of compound tincture of iodine to the uterine cavity, these symptoms subsided.

To me, at least, this case is unique and presents features so peculiar and exceptional that I have been unable to arrive at any diagnosis in all respects satisfactory, or in accordance with recorded experience.

At the time of the first paroxysm, I learned, during the investigation of the case, that the patient had been indulging to excess in the use of tea, and I was very much inclined to the belief that the cardiac depression was greatly due to this agent; and this belief was somewhat strengthened by the information that Dr. Marion Sims had some years previously, during a severe sickness marked by a tendency to syncope, declared that she was poisoned by this agent. Such belief on my part, of course, relieved me of much anxiety, and being expressed, had undoubtedly a cheering effect upon the patient; but this belief was very soon dispelled by the recurrence of these attacks in a more alarming form, and I was obliged to adopt some other theory to explain this distressing condition. It then appeared to me that I might attribute the symptoms to simple "*asthenia*," or general debility, a great diminution of the vital forces, as a result of the long continued a-nutrition to which the patient had been subjected. I had met with a case of this kind some years previously in which my views had been concurred in by a most distinguished "diagnostician," Prof. Eli Geddings, of Charleston, S. C., and where the patient having been very inadequately

nourished during gestation, on account of reflex digestive derangements, had a satisfactory and easy labor at full term—but, despite all endeavors, gradually lost strength and sank and died within three weeks after delivery, without any discoverable evidence of organic lesion in any organ or part of the economy; but that case, although in its general aspect resembling the one under consideration, differed in this respect, that there occurred no paroxysmal aggravations of the debility, no special cardiac nor respiratory disturbance, but, instead, there seemed to be simply a general and gradual diminution of vitality, so that the activity of the various organs became uniformly less and less and progressed "*pari passu*" to abolition of their function, so that it became almost impossible to say what, in that patient, was the mode of death. In this, the truly terrible symptoms occurring during the first paroxysm were such as immediately to suggest to my mind the possibility of heart-clot, but the absence of any peripheral thrombosis from which an embolus could be derived, and the remoteness of the accident, if such, from the period of delivery, had almost induced me to abandon this view of the case. At this time I happened to mention to Dr. W. H. Ford the features of this case, when he referred me to the several cases related by Playfair in illustration and support of the views advanced by him in the article contained in his "System of Midwifery," on "Puerperal Venous Thrombosis and Embolism." On careful perusal of that chapter I have been almost convinced that the case I have just imperfectly described was of the nature of those there recorded. Its resemblance to those is very great and differs alone in the greater period which elapsed between the delivery and first occurrence of a paroxysm.

This, to me, at any rate, is the most satisfactory explanation of a case which can not be understood upon any other theory. Playfair, so far as I know, is the first to consider the question as to the possibility of spontaneous in contradistinction to embolic pulmonary obstruction through thrombosis of the heart and pulmonary arteries, and, I presume, his article is so familiar to the members of this society that a rehearsal of his argument and the objections admitted would be a work of supererogation.

## EDITORIAL.

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## CHRONIC RHEUMATISM.

Dr. Wm. Pepper read before the Oxford Medical Society, last July, a very interesting and valuable paper on the subject of Chronic Rheumatism. In the first place he justly criticises the too prevalent custom of calling a case one of chronic rheumatism because it is characterized by the presence of pain in or about one or more joints; and asserts that in very many such cases it will be found, on careful examination, that the joints themselves are intact, and only the surrounding tissues are diseased.

He has observed a special susceptibility of the shoulder-joint to such painful affections, resulting sometimes from trauma, sometimes from cold and sometimes without any apparent demonstrable cause. Pain is always present, aggravated by movements of the arm, generally specially noticeable in the movements necessary to place the hand upon the head or behind the back. On pressure along the course of the brachial plexus, very noticeable tenderness is discovered, revealing a neuritis or perineuritis; and a condition of slight subluxation of the humerus in a direction downward and forward is found early in the course of the affection, which, if allowed to continue, seems to aggravate the neuritis and the painful irritation of the nerves by the pressure of the head of the bone upon them. "The circumflex and median nerves are those most frequently involved. The pain now radiates along the course of these nerves and especially extends down the arms and into the fingers; a feeling of numbness and tingling or burning, is apt to accompany it. Liquid effusion into the

synovial capsule is rare, but a tendency to adhesive inflammation rapidly shows itself, and in a wonderfully short time slight false ankylosis develops, which, if neglected, grows more and more close and firm, holding the head of the humerus with constantly increasing force in its abnormal position." Impairment of the power of the arm characterizes the affection from the outset. The arm can be raised but a short distance from the side, and rotation of the humerus is prevented, so that the hand upon the affected side soon becomes practically useless. In examination as to the range of movement of the affected arm, it is necessary to fix the scapula firmly, so as to eliminate the possible deception caused by the play of the scapula upon the thorax. The instinctive effort to avoid pain, is the first cause of this impairment of motility, but gradually, as the trouble progresses, adhesions take place, and in many cases muscular atrophy follows upon the neuritis.

The association of neuritis with arthritis is observed in other joints as well; but Dr. Pepper has found it most frequently in connection with the shoulder-joints.

If the case is seen early, he has found satisfactory results from the application of a bandage so arranged as "to support the arm and carry the head of the humerus upward and backward, thus obviating any pressure on the nerves or vessels; by active counter-irritation along the nerve trunks if they are found tender and swollen; by the internal use of full doses of quinia, together with iodide of potassium and bichloride of mercury; and, as soon as the acute inflammation has subsided, by the application of a galvanic current, the positive pole being placed over the affected nerves, and the negative pole over the deltoid muscle." In connection with these measures he lays great stress upon the necessity of practising regular, gentle and gradually increased passive movements of the arm after the first two or three days.

When the case comes under treatment later in its course, the diagnosis is less easy, and in some cases errors have been made and the trouble attributed to imperfect reduction of a dislocation. However, careful study of the history of the case in connection with the present conditions will enable the prac-

itioner to reach a correct conclusion. "The mode of development of the case in early impairment of motion in directions not requiring the action of the deltoid, the pain and tenderness, and, finally, the ankylosis will also enable him to distinguish this condition from that of paralysis with atrophy of the deltoid, and show that the conditions of the deltoid are purely secondary."

In the treatment of these cases of longer duration, "systematic passive movement and massage are the most essential parts of the treatment." He has obtained better results from the gradual destruction of these adhesions by repeated, comparatively gentle passive movements than from forcibly breaking them down under anesthesia. The process always involves much suffering, but must be persisted in, as other treatment without this is utterly unavailing. "Besides this the patient should be encouraged to use the arm as much as possible, instead of being allowed or directed to keep it quiet."

When the pain is very intense, more immediate relief than that which results from the removal of the adhesions is necessary. In these cases he uses morphia and atropia hypodermically or applies strong veratria ointment, or a strong liniment of aconite and chloroform or the constant galvanic current. The neuritis is treated with repeated small blisters along the course of the nerves, and the use of the galvanic current with the positive pole over the irritated nerve, and the negative over the fibres of the deltoid; internally the iodide of potassium is combined with small doses of mercury.

True rheumatoid arthritis or chronic rheumatism affects, specially, persons residing in a damp house or damp locality, and subjected to debilitating influences. Dr. Pepper thinks that "the defective action of the skin caused by prolonged action of damp or by repeated chillings of the surface," brings a morbid condition of the synovial and adjacent tissues. "Some effusion occurs at first into the synovial capsules, but later this is apt to be absorbed; the synovial tissue is thickened and roughened; in places destruction occurs both of the membrane and of the subjacent articular cartilage. Meanwhile the margins of the joints are involved, and ridges

or nodules of new-formed bony tissue appear; the fibrous tissues become thickened, and the tendons no longer play freely through their sheaths; the whole joint becomes more and more distorted and useless; motion grows more and more painful and difficult; finally, firm ankylosis occurs with great deformity, and the functions of the joints are utterly destroyed." He notes also as of special importance, the setting up of an ascending and descending neuritis, which aggravates the suffering and causes serious "nutritive changes," such as a more rapid and extreme atrophy of the muscles than would result from mere disuse.

After extensive experience and observation and careful study of the subject, Dr. Pepper is satisfied "that little is to be expected from the use of any of the well-known anti-rheumatic remedies in rheumatoid arthritis," but that in many cases even of severe type, "vast relief can be afforded to the symptoms, the progress of the disease can be checked, and even a considerable degree of usefulness be restored to badly crippled joints."

He regards as probably the most important element in the treatment, systematic daily manipulation, including persistent movement of the affected joints. This is, of course, very painful, but must be persevered in, as he regards it as absolutely essential to the securing of any satisfactory results. Of course when an acute inflammatory process is going on, he would wait for the abatement of those symptoms before instituting such manipulations.

By such treatment, not only is the mobility of the joint maintained and increased, but the circulation in the surrounding tissues is stimulated, and absorption of the exudation is promoted, nutrition of the muscles is kept up, and the atrophy which threatens is averted. Besides this the tone and activity of the skin is improved, the impairment of which he regards as a predisposing cause of chronic rheumatism. The manipulation may be accompanied with the use of suitable baths, or with inunction of the surface with some vegetable oil, as cocoa or olive oil.

The diet almost always needs attention, and it is generally

necessary to secure the ingestion of a larger quantity than formerly of simple, digestible food. He often finds this result most easily attained by adding two or three pints of skimmed milk to the regular daily diet. Anemia is almost always present, and iron in large doses has proved a most valuable tonic in these cases.

In addition to the above treatment he has found in cases where the neuritis is a marked element, that "the prolonged use of nitrate of silver with or without minute doses of opium and belladonna, has seemed to exert a favorable alterative effect." The use of opium as an anodyne is to be the most sedulously avoided on account of the danger of establishing the opium habit. Local applications of veratria, aconite or chloroform, or counter-irritation may be used to relieve the pain.

Other drugs may be found necessary in some cases; among them he has at times found it best to substitute iodide of potassium and minute doses of bichloride of mercury for the nitrate of silver, or in other cases to use lithia. Electricity he used uniformly both to relieve local pain and for its effect upon the muscles and nerve trunks, as well as to modify the superficial circulation over the affected joints.

He summarizes the indications in ordinary cases of rheumatoid arthritis as follows:

"To remove the cause, having special reference to residence, soil, moisture, etc.

To maintain at all hazards the mobility of the joints.

To exercise the muscular system.

To restore and maintain the tone of the skin.

To improve the blood and nutrition.

To quiet the pain as far as possible by local means.

To modify the articular inflammation, (and that of the adjacent nerve trunks when it exists) by counter-irritation, electricity, and the internal use of alteratives."

For the efficient application of such treatment it is generally best or necessary that the patient should be treated in a suitable institution rather than at home.

In cases of ordinary chronic rheumatism, where there is a



considerable quantity of liquid effusion into the synovial sac, as also in those cases where the arthritis is very acute and painful, not only is passive movement and manipulation to be avoided, but absolute rest is to be secured together with uniform pressure by the application of a plaster of Paris bandage or a splint. He formulates the proposition "that just in proportion as liquid effusion exists in a diseased joint, is passive movement or active exercise undesirable; while in proportion as the joint is free from such effusion and presents, instead, thickening, stiffness or adhesions, is manipulation, (of course, carefully graduated by the activity of the inflammatory process and the sensitiveness of the part,) advisable.

When plaster bandages are used, they are to be reapplied as often as the reduction of the swelling loosens them.

In some cases mineral baths and waters are very valuable agents, but they must be associated with most careful dietetic, hygienic and medical treatment. A most careful attention to the condition of the skin is absolutely essential in the treatment of chronic rheumatism.

Alterative medicines are often of the greatest value. Where only one or two joints are affected and there is considerable effusion, he often uses iodide of potash and bichloride of mercury in compound syrup of sarsaparilla, or bichloride of mercury in compound infusion of gentian. The dose of the mercurial being  $\frac{1}{60}$  to  $\frac{1}{40}$  of a grain. When a number of joints are involved, especially where there are gouty complications, he uses the following:

R. Pulv. guaiaci,	ʒi.
Vin. colch. rad.,	ʒij-ijj.
Potass. iodid.,	ʒi.
Pulv. acaciæ,	q. s.
Sp. lavand. comp.,	ʒss.
Aq. cinnam.	q. s., ad. ʒvj.

M.

Fl. sol. S. Desertspoonful three times a day in water.

Other salts of potash may sometimes be used with advantage instead of the iodide, and lithia is also of marked value in some cases.

## ANTISEPTIC SPRAY DURING OPERATIONS.

By many surgeons the use of the spray medicated with carbolic acid, thymol or other antiseptic, is regarded as an essential element in surgical operations requiring incision. Some are so careful in this particular as to regard the interruption of the antiseptic cloud even for a few seconds as a great error, one that tends to nullify all subsequent precautions.

Theoretically such a precaution forms an indispensable factor in the antiseptic treatment, but practically it is most annoying, and cannot be said to have the endorsement of the entire profession even as to its efficacy. No one would wish to throw discredit upon any of those measures which have of late years added so much to the certainty of surgical treatment, but if in the first excess of zeal, in the anxious care to omit no precaution, there be introduced methods which are vexatious in their application and at the same time mere superfluities, perhaps absolute incumbrances, the sooner they are dropped the better.

Dr. V. v. Bruns of Tuebingen, reports in the *Berliner Klinische Wochenschrift* No. 43, of this year, 144 operations involving the bones, all treated according to the strictest antiseptic plan excepting the spray, and all resulting fortunately. These operations included the most serious that come under hospital service. The doctor instead of using the spray, employed during operation occasional irrigation with antiseptic solutions; he also lays stress upon the fact that he leaves the dressings undisturbed for several days; in two cases of complete exsection of knee joint the first dressing remained 28 days, in two other cases 30 days. Occasional irrigation of the wound during operation is easily affected. Indeed, this is accomplished if the sponges used to remove the blood are, as is now customary, washed out in carbolized water. It is an impressive sight, the steam atomizer sending forth its mysterious cloud of germ destroying vapors; but if the medicated fog can be dispensed with, even at some cost to the pride and circumstance of the operating room, let no man stay its final exit.

## BOOK REVIEWS AND NOTICES.

A PRACTICAL TREATISE ON NASAL CATARRH. BY BEVERLY ROBINSON, A. M., M. D., Lecturer upon Clinical Medicine at the Bellevue Hospital Medical College, New York, etc. *New York: Wm. Wood & Co.* 1880. 8vo., pp. 182; cloth. (Through C. C. Pease, St. Louis.)

There is such a scarcity of any high standard of literature upon this subject, and the subject is attracting the attention of the profession to such a degree, that a contribution to it from a promising source is gladly welcomed at the review table.

The book before us may be considered more as embodying the results of a personal experience with the treatment of the diseases, to which the nasal cavities are liable, than a contribution to the anatomy or pathology of this organ or to the physiology of olfaction. Indeed the author disclaims any attempt at a scientific treatise founded upon original research. Our object then shall be to consider the work in its true character, as really presenting the claim it has upon the professional attention; and we shall pass over that portion which has only been introduced for the convenience of the student. 176 pages are divided into nine chapters, presenting:

I.—*Introductory Chapter.*

II.—*Division of the Subject.*

III.—*Considerations of Anatomy, Physiology and Pathology.*

IV.—*Instruments for Examination of the Nasal Cavities.*

V.—*Instruments for Treatment of the Nasal Cavities.*

VI.—*Anterior and Posterior Rhinoscopy.*

VII.—1. *Prophylaxis and General Remedial Treatment of Various Forms of Coryza.*

2. *Acute Coryza.*

3. *Varieties of Acute Coryza.*

4. *Chronic Coryza.*

VIII.—*Hypertrophy of Turbinated Bones.*

IX.—*Follicular Disease of the Naso-pharyngeal Space (Post-Nasal Catarrh).*

II. The author has modified a division from *Thèse de Paris*, No. 76, 1873, and refers all discharges from the nose to either diopathic or symptomatic origin, and sub-divides each of these

forms under the heads of 1. *a.* Idiopathic mucous and mucopurulent discharges. *b.* Symptomatic mucous and mucopurulent. 2. *a.* Idiopathic purulent. *b.* Symptomatic purulent; in such a way that a rigid differential diagnosis is assisted, and a "thorough study of the diseases mentioned" is facilitated. We commend this division of Dr. Robinson, as a step in the direction of a more scientific therapeutics

IV. and V. These chapters are profusely illustrated. I trust that we shall be pardoned for the suggestion that if some of these illustrations had been omitted, it would have detracted nothing from the value of the book. We question the propriety of inserting a cut of an instrument merely to condemn its use or to pronounce upon its little value. If we earnestly desire advancement in this department of medicine, which unworthy men have brought into opprobrium, a first step should be to destroy this sort of machinery, which is the "stock in trade" of many.

VII. VIII. IX. These are the really valuable chapters of the book. There is so much in them that is good and so little to take exception to, that we find it easier to pass over the great part with a sweeping commendation and to call attention in our limited space to views which are at variance with the general experience of others.

We cannot refrain, however, from quoting first the author's very sensible (as it seems to us) and forcible condemnation of the employment of the nasal douche (p. 82). "I regret that I cannot agree with classical authors, such as Duplay, Fränkel and Cohen, in regard to the efficacy and necessity of the use of some form of nasal douche for the successful treatment of this (*chronic coryza*) and allied affections. I formerly tried the nasal douche in a large number of cases, but gave up its employment, first, because I found it injurious to the ears of my patients, and then, too, it aggravated the inflammatory condition of the nose, produced hypertrophy of the turbinated bones and increased rather than diminished the formation of crusts in the nasal passages." *En passant*, the dry treatment, we would remark, as might be inferred from the above, receives the prominence among therapeutical measures which it certainly deserves.

The statement (p. 89.) that the nasal twang, associated with impeded nasal respiration is, at this day, commonly referred to

a "faulty or improper use of the laryngeal muscles or those of the palate to produce phonetic sounds,"<sup>1</sup> is, we think, not warranted.

Our reference is to English authors in order to refute also an imputation which the author "aids and abets," that it is more peculiar to Americans. This does not correspond with our observations abroad, and Woakes (*id.* p. 97.) after referring to the remark of a German physician "to the effect that in England he had observed doctors, as a rule, did not interrogate the nose," adds: "The comparative neglect on the part of English aurists and surgeons of a subject of such great importance cannot certainly be referred to its rarity, etc."

On page 84, the single ball is recommended to be used with the hard rubber spray producer, for the reason that "if two balls be employed, the spray continues to come from the capillary tube for a moment or two after compression of the bulb has ceased." This is easily remedied by a simple device, which Dr. Todd of St. Louis originated, of perforating the bottle—the perforation to be covered with the index finger during the operation of the spray and to be uncovered when it is desired to suspend it.<sup>2</sup>

Our own experience coincides with that of the author in respect to the usefulness of the spray. "The use of any form of spray is only required in aggravated forms of chronic coryza."

In the list of agents recommended (p. 162) to be employed in the form of powders for insufflation in the treatment of follicular disease of the naso-pharyngeal space, two very valuable ones, as it seems to us, are omitted—boracic acid and oxide of zinc. The use of nitrate of silver in powder, which is advised, we have found so severe even in milder composition than the author suggests, that we have practically abandoned it and use the solution instead, applied with a mop of cotton.

Taking the work in its integrity, as we have said, it has many excellences and few blemishes. We recommend it as a fair exposition of the present state of our knowledge and more reliable and more readable than any other book on the subject that we know of.

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<sup>1</sup> Consult Spencer Watson, *Diseases of the Nose*, 1875, pp. 19 and 20; also Woakes, on Deafness, Giddiness and Noises in the Head, 1880, p. 39.

<sup>2</sup> A Simple Modification of the Hand Atomizer. C. A. Todd, M. D., in the *American Journal of Otology*, January, 1880, and *The Mechanics of Naso-pharyngeal Practice*, H. N. Spencer, M. D., *Saint Louis Courier of Medicine*, July, 1879

The subject is one which practitioners should be more familiar with, and it has a significance beyond what is written on the mere face of it. The writer has drawn this graphic picture, illustrating a common result of the disease considered, to the truthfulness of which every aurist will subscribe. "But this is not all; the hearing is soon affected. Adults and children of advanced years are conscious of uneasy sensations in their ears, (itching, tickling, etc.), and by degrees their auditory function is surely rendered less perfect. With such persons, these symptoms occasion solicitude, awake reflection, and a physician's advice is usually sought. With infants or very young children the case is different. They have repeated attacks of acute coryza, which yield sooner or later to time and household remedies, and the mothers or guardians have no concern about the ultimate impairment of hearing. The child grows and reaches the age of six or eight years then it is noticed for the first time, with regret and astonishment, that the little one is decidedly deaf and unable, perhaps, to keep up with his class at school.

At this period, however, there may yet be hope, and if the disease be at once properly attended to by a competent aurist, it may be in great measure or entirely cured in time.

Unfortunately, such is not the sequence of all these cases, for frequently audition will remain imperfect through life, in spite of the most perfect after-treatment. Hearing power being thus permanently disabled, future usefulness and enjoyments are likewise greatly lessened. In a few and rather exceptional instances, hearing becomes progressively worse, and amongst the very poor and ignorant it may be entirely lost. In the latter class are found those who have been treated empirically or not at all. The result is woeful, as the inmates of our deaf and dumb asylums can testify."

In regard to the typographical execution of the book it is only necessary to say that it emanates from the house of William Wood & Co.

H. N. S.

CONTRIBUTIONS TO THE ARCHEOLOGY OF MISSOURI. BY THE ARCHEOLOGICAL SECTION OF THE ST. LOUIS ACADEMY OF MEDICINE. Part I. Pottery. *George A. Bates, Naturalists' Bureau, Salem, Mass.* 1880. 4to; plates, 24; charts, 5.

As our country grows older, so much the greater interest attaches to all reliable information in regard to the customs

and habits of the nations who formerly inhabited this continent.

Among the most interesting studies in this direction are those relating to the remarkable people known as the "mound builders."

Considerable attention has been paid to the subject, and a number of works have appeared from the pens of various observers, who have, however, materially depreciated the value of their work, in many instances, by the endeavor to establish preconceived theories of interpretation. The work before us consists of two sections; the first, by Prof. W. B. Potter, of Washington University, entitled "Archæological Remains in Southeastern Missouri," is the result of careful observations and explorations made in the extreme southeastern part of the state in the "swamp region." It is a description of the structure, situation and contents of "earthworks," "mounds" and "settlements," in two different localities of the "swamp region."

The second section, by Dr. Edward Evers, is entitled "The Ancient Pottery of Southeastern Missouri."

In the commencement of his paper, Dr. Evers says, "We believe that our knowledge of the facts relating to the prehistoric inhabitants of our continent, especially to those who inhabit the Mississippi Valley, is still too meagre and uncertain to warrant any *definite* inference as to their origin, character or civilization. What we need most, therefore, is a thorough knowledge of all that relates to them; an accurate description of their monuments, implements and works of art, unprejudiced by any preconceived notion of their descent, or of their relation to other nations, untrammelled by any theory as to the 'hidden meaning' or symbolic significance of the articles we find or of their forms and decorations."

Approaching the subject in this spirit, Dr. Evers has given us, in well chosen language, a clear and accurate description of the various types of ancient pottery which have been found in the part of the state mentioned.

There are accompanying the letter-press five large charts or outline maps of the several "settlements" and twenty-four plates containing accurate representations of typical specimens of pottery.

The drawings were made upon stone by Dr. G. Hambach,

and give evidence of painstaking fidelity, as well as artistic skill. The lithographs were printed by A. Gast & Co., of this city, the letter-press by George A. Bates, of the Naturalists' Bureau, Salem, Mass. The mechanical execution of the work throughout is most admirable.

The Archæological Section of the St. Louis Academy of Science, have made a valuable addition to the literature of archæology in this country and we doubt not that the reception of this part will be of such an encouraging nature as to warrant the publication of other volumes upon kindred topics of archæological research.

A MANUAL OF MINOR SURGERY AND BANDAGING. BY CHRISTOPHER HEATH, F. R. C. S., etc. Sixth edition, revised and enlarged, with one hundred and fifteen illustrations. *Philadelphia: Lindsay & Blakiston.* 1880. 12mo; pp. 342; cloth, \$2.00. (Through Hugh R. Hildreth Printing Company.)

This admirable little volume was prepared specially with reference to the needs of young surgeons holding positions as hospital internes or dressers, and contains a great many practical directions and hints as to various surgical manipulations and applications that are not to be found in the larger and more pretentious works upon surgery.

The book will be of material assistance and great value to any young practitioner, and we would recommend medical students to note this as one of the volumes to be included in their outfit.

THE MEDICAL RECORD VISITING LIST. Published by *William Wood & Co.: New York.*

Every physician recognizes the necessity of having a convenient visiting list, and we think that any who procure the one mentioned above will be well satisfied with the purchase. Besides convenient arrangement of pages for the different classes of memoranda as to engagement, visits, charges, etc., there are a number of tables and lists for reference that may often be of great value. We would suggest that there are material advantages in procuring the list *without dates* or "perpetual," instead of that with the year and month printed in, as by this means it is possible to utilize the whole page, and no confusion is created if in any week the number of patients visited exceed that provided for upon one page. The price of the list arranged for thirty patients is \$1.25; for sixty patients, \$1.50. Orders for this as for any of the publications of Wm. Wood & Co., should be addressed to C. C. Pease, General Agent, Wm. Wood & Company, 514 Olive street, St. Louis.



TREATISE ON THERAPEUTICS. TRANSLATED BY D. F. LINCOLN, from French of A. Trousseau and H. Pidoux. Ninth edition, revised and enlarged with the assistance of Constantine Paul. Vol. III. *New York: William Wood & Company.* 1880. (Wood's Library of Standard Medical Authors.) 8vo., pp. 379; cloth. (Through C. C. Pease, general agent, Wm. Wood & Co., 514 Olive street, St. Louis.)

This third volume of the translation of Trousseau and Pidoux's treatise on therapeutics, contains the chapters on Anesthetics, Antispasmodics, Neurasthenic Tonics, Excitants, Sedatives and Contrastimulants, and Anthelmintics. At the close of the volume there is an index to the three volume together. This completes the number devoted to the subject of therapeutics in the Library of Standard Medical Authors for 1880.

A TREATISE ON COMMON FORMS OF FUNCTIONAL NERVOUS DISEASE. By L. PUTZEL, M. D., Physician to the Clinic for Nervous Diseases, Bellevue Hospital Out-Door Department, etc. *William Wood & Co.*, 1880. 8vo. pp. 286. Cloth. (Wood's Library of Standard Medical Authors.)

In this volume Dr. Putzel has given us a treatise upon a group of nervous diseases, with reference to some of which, though they have been studied long and faithfully by careful and judicious observers, the sum of actual knowledge is pitiably deficient. Since the days when attacks of epilepsy were universally deemed the evidence of demoniac possession, many a conscientious and earnest physician has put forth his best efforts to elucidate the pathology of the disease and to relieve those suffering from it; and yet the results are far from satisfactory, although the treatment that is now generally advised by the most skillful gives far better results than of old, and affords the patient greater hope of relief or even ultimate cure than could be granted him formerly.

Dr. Putzel gives forty-seven pages of this book to the consideration of Epilepsy, which enables him to summarize quite efficiently the present status of our knowledge as to the disease and its treatment.

The first section of the book treats of Chorea, then follows that on Epilepsy, just mentioned. Then seventy pages are devoted to Neuralgia, and ninety pages to Peripheral Paralysis.

On the whole we think the book fills quite satisfactorily its place in the series for 1880 of Wood's Library of Standard Medical Authors.

WALSH'S PHYSICIANS' COMBINED CALL-BOOK AND TABLET, from 18—to 18—. Fourth Edition, price \$1.50.

WALSH'S PHYSICIANS' HANDY LEDGER, a companion to Walsh's Combined Call-Book and Tablet. Published by *Ralph Walsh, M. D., Washington, D. C.*, Price, \$3.00.

Many thousands of well-earned dollars are lost to the physicians of the country every year by negligence and want of system in the keeping of accounts; and any one who devises a system which shall facilitate accurate book-keeping by physicians, deserves well of the profession. The call-book of Dr. Walsh is so arranged, that the whole of every page can be utilized, the days of the week only being printed, the days of the month being left to be filled in as needed. The printed matter is well selected and such as will be found valuable for reference.

The "Handy Ledger" is arranged to contain upon two pages, facing each other, a detailed statement of the account of a patient for the entire year showing date of service rendered, its nature and charges made, as also cash payments made, so that it is easy to ascertain at a glance the amount due from any patient. While intended as a companion to the call-book, it can be used with equal facility in connection with any other visiting list.

Both books are for sale by the St. Louis Book and News Company, and by the Hugh R. Hildreth Printing Company.

A NEW SCHOOL PHYSIOLOGY. By RICHARD J. DUNGLISON, A. M., M. D., ETC. Illustrated with one hundred and seventeen engravings. *Porter & Yates: Philadelphia.* 12 mo., pp. 314.

It is frequently the case that to physicians who are members of the Boards of Education in the towns where they reside, is referred the selection of text-books, especially such as relate to science. To write a good text-book upon physiology is by no means an easy matter; to write one for children or youth is a difficult one. This work of Dr. Dunglison's is one that can be heartily commended. The comparisons between the structure and action of the various organs in man and other animals both add interest and tend to facilitate the learning of the lessons.

THE PHYSICIAN'S VISITING LIST, for 1881. *Lindsay & Blakiston.* Thirtieth year of its publication. (Through Hugh R. Hildreth Printing Company.)

No description is needed of this well-known pocket companion. Like an old friend, familiar by long acquaintance and

efficient service, it comes each year from the press of its publishers and needs only the announcement that the new edition is ready to secure large sales. It is published in different sizes, for 25 to 100 patients per week, in one or two volumes, and in prices varying from \$1.00 to \$3.00.

SCIENCE AND THE HEALING ART, OR A NEW BOOK ON OLD FACTS. BY JOHN CURTIS DARBY, M. D., Mount Sterling, Ky. *Louisville: John P. Morton & Company.* 1880. 8vo., pp. 403; cloth.

This book was prepared under very remarkable circumstances, as the author tells us in the preface, that he has been unable to see to read or write for over eighteen years. That one so situated has been able to prepare a volume for publication at all, is proof of commendable energy; and the work itself shows much study and thought upon the subject.

He places himself in direct opposition to the teachings of the modern school of physiology in some particulars; and asserts his position with a dogmatic positiveness, which we must say fails to carry conviction of entire reliability.

There are many points of interest for the reader; and some questions are presented that are of practical importance both from the standpoint of the physiologist and therapist. We do not think the answers to all these are entirely satisfactory.

We will make some few quotations to show the course of Dr. Darby's teaching, and refer our readers for further information to the book itself, if they wish to pursue the subject further.

On page 15 he says: "The living part of the bioplasm found in the embryo or fetus in utero continues to be developed into organs, and to increase in size until we have a perfectly formed man or woman. The tissues composing the body of this man or woman continue to exist until death. The non-living parts of the several organs, like the non-living fluid which surrounds the threads in bioplasm, are continually changing; but the original structure remains unchanged. It may be distorted by disease or accident, but that does not alter its identity. The laws of constructive assimilation and of destructive metamorphosis are like the tides—the ebb-tide never begins to flow until the flood-tide ceases, and so the flood-tide until the ebb-tide ceases."

Page 39. "Trees and plants, convert inorganic matter into organic living forms. It is the labor of their lives. All animals convert what we call food, whether it be grasses, grain, fruit or meat, into blood, and blood into living tissue. In trees the wood of which the bodies consist, remains unchanged, and

continues to increase from year to year, so that the rings of annual growth, show unmistakably the age of the tree. There are trees a hundred, perhaps a thousand years old. It is because, unlike the tides, physiologists, suppose that constructive assimilation or the formation of tissues (in the sense of Bichat), and disassimilation or the separation of effete matter from the tissues, go on at one and the same time in an animal body, that animal bodies are completely renewed, according to Drs. Draper, Dalton and others, in twenty days."

In the chapter devoted to the liver, as elsewhere, he maintains that there are two kinds of bile, one formed from the food in the process of converting it into blood and the other from effete matter or effete blood. He denies *in toto* the existence of a glycogenic function of the liver. He also denies that in health the kidneys separate effete matter from the blood. (vid. p. 116.)

He lays great stress, and we think correctly, upon the use of cathartics and emetics in certain cases, not merely for the purpose of removing irritating matters from the intestinal tract, but to stimulate a healthy action of the liver. He alludes especially to the action of calomel as a stimulant\* of bile formation in cholera and in miasmatic fevers. He lays great stress upon the opposite effects produced by large and small doses of calomel, the former having a sedative and soothing effect when the stomach and bowels are irritated, while small doses increase the irritation.

On page 289 he gives his treatment for intermittent fever: "As I know that two men are selling my remedies under their own name, and for their own exclusive benefit in half a dozen states on the Ohio and Mississippi rivers, I will here give them. The first, I call ague pills or powders. They are composed of prussiate of iron sixty grains, sulphate of quinine sixty grains, capsicum thirty grains, Soc. aloes thirty grains, arsenious acid one grain, to be made into thirty pills or powders. I commence from eight to ten hours before the expected chill, and give a pill or powder every hour, till six doses are taken, This will almost always prevent the chill or ague. On the next day I commence at the same time and give a pill or powder, every two hours until four doses are taken. On the third and all subsequent days, begin at the same time and give a pill or powder, every three hours until four doses are taken. I also use what I call cathartic pills. They are composed of sulphate of iron twenty grains, Soc. aloes twenty grains, to be made into twelve pills. I give from one to two of these pills every night or every other night until all are taken. If this course is followed, it will very rarely happen that there will be any recurrence of this troublesome malady."

The coolness of the following paragraphs would be very refreshing in midsummer :

“I have pulled down the temple of medical science of the nineteenth century ; but I am not an Erostratus ; I have laid the foundation for a nobler and more enduring temple in its stead.

Kepler explained the laws which govern the solar system. I have undertaken to explain the laws which govern the animal economy, both in health and disease.”

Taking the position which he does with reference to the teachings of our leading physiologists, we do not see how he can say, as he does on page 291. “I cheerfully recommend these works, [Flint’s and Dalton’s works on physiology] to all medical students and to young physicians, for I am convinced that a successful practice must depend upon a correct and thorough knowledge of physiology.”

The later chapters of the book are devoted to Chronic Diseases and Cholera, and an appendix upon the Use of Cold Water in the Treatment of Fevers.

There are many practical lessons of value in this book, though we cannot accept all the theories upon which Dr. Darby undertakes to explain them.

[Lack of space necessitates our deferring to the next number some additional book reviews, and the list of Books and Pamphlets received.]

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## COMMUNICATIONS.

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MESSRS. EDITORS :—A typographical error of material importance found its way into my article on the use of aconite in tonsillitis, in your November number. Near the close of the communication where appears the following—“children whose pulses were very feeble and irregular and numbered near one hundred and forty beats per minute, while their temperature would only be about one hundred and five or one hundred and one degrees, Fahrenheit,—it should read “their temperature would only be about one hundred and five-tenths degrees, or one hundred and one degrees Fahrenheit.”

While on this subject I would like to add a few brief remarks: In reviewing McKenzie's new work on the "Diseases of the Pharynx, Larynx, and Trachea," the *N. Y. Medical Record*, of November 13th, says regarding his treatment of tonsilitis by aconite: "One might hesitate long before administering the drug in such large doses"—"doses of two to five minims every three hours," "especially as the *British Pharmacopœia* directs that the tincture shall be prepared from the root." It is evident that the editor does not know that the only tincture of aconite which has been officinal in this country since the revision of the *Pharmacopœia* in 1870, is the one prepared from the *root*, which, as stated by the U. S. Dispensatory, 13th edition, is three times as strong as the British preparation, and the dose of which, by the same authority, is two to five minims or five to ten drops, while the dose of the British tincture, which is the form McKenzie uses, is given as five to fifteen minims or ten to thirty drops. Bartholow says "the whole duration of the effect is about three hours." So to secure and maintain its peculiar influence it is necessary to repeat the dose after intervals of about that length of time.

It seems clear that, to order a dose of a drug which is given constantly by an exceedingly good authority, and which is only a third of the quantity often used by competent practitioners, should certainly not be sufficient cause to make an experienced physician "hesitate long" even if he had never given it before

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## TRANSLATIONS.

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### NEW METHOD OF EXSECTION OF THE INFERIOR MAXILLARY NERVE.

*Dr. Carl Langenbuch, Berlin.*

Neuralgia of the third branch of the trigeminus through its etiology—including malaria, chronic metallic-poisoning, rheumatism, osseous changes in the inferior maxillary canal or near the lingual—is chiefly a surgical disease, and unaffected by drugs. Neuralgias in the present time are treated by section, excision

and stretching; particularly has neuralgia of the inferior maxillary occupied surgical attention. Surgeons have attacked the nerve in the most various ways, operating internally through the mouth, externally by laying open the bone or by penetrating into the soft parts behind the inner surface of the maxilla.

Simple section and even excision have failed through reestablishment of the nerve continuity and through the fact that the focus of irritation lay more central than the site of operation; the osseous change may be at the entrance of the inferior maxillary canal; when the neuralgia is due primarily to a diseased tooth but has become chronic, dental extirpation may no longer suffice for relief.

I hold, therefore, that in order to cure an obstinate neuralgia of the inferior maxillary nerve the operation must aim at exsection of the trunk from its point of cranial exit, including as much as possible. The strictest antiseptic after-treatment must be followed.

This cannot be insured after operation through the mouth for obvious reasons. hence I adopt the external method.

CASE.—Mr. —, 56 years old, entered the hospital July 12, 1880. Nine years previously, in consequence of a cold, he suffered from continuous and violent pain in the lower jaw, which, in the course of years, increased in intensity, and through radiation involved the rest of the trigeminus. In 1878 he was subjected to the operation within the canal, without good result.

*Present Condition*—He is well nourished, but suffers from intolerable shooting pains in the left side of the face, especially in the under jaw; during the attacks the skin over the painful region will not endure the touch.

*Operation*—A flap was made by cutting along the zygoma to the tragus and from the distal portion to near the angle of the mouth, and thence backwards about 3 centimeters. This rectangular flap was freed by severing the masseter from the zygoma, cutting, and with the raspatorium laying bare the ascending ramus of the lower jaw; any opening into the mouth was carefully avoided; the temporal artery was of course ligatured before the deep incision. The jaw was then drawn downward and a deep notch cut in the sigmoid notch through which the lingualis could be easily felt.

The nerve trunk was next bared by use of the sound and when necessary by cutting through fibres of the temporal and ptery-

goid. The trunk of the interior maxillary was avoided, though several branches were unavoidably severed. The nerve was seized with a hook and denuded to the very basis cranii, when a ligature was tied about the peripheral end, and after considerable traction, especially upon the central portion, it was cut off as close as possible to the cranium and the lingualis.

Sutures were inserted and drainage provided for with anti-septic dressing.

After recovery from the anesthesia the patient declared himself entirely free from the neuralgic pains. The wound healed promptly without suppuration. Up to the present time—September 15—the pains have not recurred, the radiating pains also have completely disappeared.

The facial paralysis consequent upon the flap incisions was met with the faradaic current as soon as possible and overcome. The interference with mastication lasted but a short time. Through injury to the duct of Steno there resulted a local accumulation of parotid secretion and eventual fistula, which healed spontaneously and the natural channel into the mouth was restored.—*Berlin. Klin. Woch.*, Oct 18, 1880.

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THE REAL CAUSE OF THE MIASMATIC CONTAGIOUS PHTHISIS  
PULMONUM TUBERCULOSA AND CHRONIC PNEUMONIA AND  
THEIR PROPHYLAXIS.

By *Dr. F. Ecklund, Stockholm.*

*Translated and condensed by B. C. Anderson, Missouri Medical College.*

With the advance of our knowledge, the truth seems to be that the real cause of phthisis is an irritant, and that a positive difference exists between the real contagious phthisis pulmonum tuberculosa, (which must be ascribed to the presence of specific parasites) and the cheesy, scrofulous infiltrations or chronic pneumonia. The dispute between Laennec, Waldenburg, etc. on the one side and Villemieu, Jaccoud and Virchow on the other, is by no means yet settled. I have made microscopical investigations to verify my suspicions that the sputa from real phthisis patients contain specific and characteristic elements different from those of the cheesy pneumonia. This suspicion



I have had the sad satisfaction to find well founded. For this purpose I have had at my disposal both hospital and private patients, and have obtained fresh sputa and urine twice a week. I ascertained that the sputa of real phthisis (which to a certain degree must be considered as a true expression of the changes in the lungs) contain, besides other matters, *three* specific and characteristic cell forms, numerous in proportion as the disease is graver or more advanced, viz.: 1st. Small, round lymphoid cells, generally entirely filled with phthisis bacteria. 2d. Round cells with from 3 to 5 nuclei, cells as large as pus, mucus or white blood corpuscles, either filled with bacteria or partially so. 3d. Elliptical and egg-shaped cells, larger than those described under No. 2. Besides there are found remains of phthisis bacteria, fragments and shrunken cells, *i. e.*, Lebert's tubercle cells, elastic threads, detritus, etc. I may remark here that Biermer in '*Die Lehre von Auswurf.*' Würzburg, 1855, page 5, very pointedly warns us against confounding the movements of the remaining molecules of destroyed cells with the movements of infusoria.

It behooves me now to prove that specific bacteria exist in the phthisis cells (which bacteria also exist in the intercellular fluid) in contrast with pus and mucus cells and such as contain free fat.

What strikes us especially at first sight is the very active, raging life within these cells. If, for instance, only two or three micrococci, which are in shape spherical or slightly cylindrical and perfectly hyaline and glistening, exist in a cell, we see how they vibrate from side to side and against each other, precisely as if they were wrangling over their food and trying to steal nourishment from each other.

If, again, the cells are entirely filled with micrococci, then a pandemonium exists compared with a snake-pit, and a furious fight seems to be going on.

When we observe that micrococci are of noticeably different sizes, we cannot conclude otherwise than that they take up nourishment from the cells and intercellular fluids and *grow*; and when again we see how those which are alone and in a free state, are very lively in their movements, but when they lie two and two together are quite still, we may suppose that a division (segmentation) has taken place, or, in other words, that they are in their nature schizomyces. These bacteria (Micro-

coccus Phthisis Dryotemenos) are much smaller than those of leprosy. In order to establish the fact that these bacteria are not to be found in healthy persons, nor in the various secretions of persons suffering from catarrh, etc., etc., I have, of course, made comparative investigations and employed chemical re-agents in order to avoid confusion or mistake. For instance, on trying to dissolve them in ether, in the prescribed manner, I have found them to continue their movements as well *after* as *before* the treatment; also that in contrast with other bacteria and the different histological elements, they are not colored (or at least very slowly and imperfectly so) by anilin-red in solution. By virtue of my investigations compared with our present knowledge of physiology and anatomy, I conclude that these cells are not a normal part of either the salivary-gland secretions or of the bronchial, Schneiderian membranes, etc.

In conformity with the views now held, warmth can be considered as a result of molecular movement. M. Peter and Mealdowie have in their investigations of phthisis patients, found the temperature of the chest increased locally, and if the physical examination has established one of the lungs principally involved, the local temperature of said side has also been found to be increased.

The theory of irritating parasites as the real cause of the contagious consumption establishes satisfactorily this increase of temperature of the chest.

The following deductions are made from clinical cases:

That no antagonism exists between consumption and malaria.

That the micrococci in phthisical patients are often also to be found in the kidneys and even in the red blood corpuscles.

That no micrococci are found in patients suffering from chronic pneumonia *vel* *scrofulosis*.

That persons suffering from chronic pneumonia easily become phthisical by inhaling air that contains micrococci and by reason of their debility are not able to throw them off as in the case of healthy persons.

It is not my duty to establish the source from which the micrococci are derived. I can not admit that they are generated spontaneously by the lung diseased, less so, that they occur at the birth of every person, and exist as a part of the natural tissues, but that they are derived from without. I have collected from different places in Sweden where consumption is

prevalent, earth, mud, water, decomposing vegetable and animal material, from shallow lakes and sea-coasts, and have found by microscopical examination constantly existing micrococci identical with the phthisis bacteria; thus showing that they are of miasmatic origin.

Proof that the real phthisis is a contagious disease is amply illustrated in military barracks, where men are rather crowded and allowed to breathe air that is contaminated by phthisical persons (through dried sputa, etc.).

As regards the prevention of the miasmatic contagious consumption and at the same time the chronic pneumonia in toto, I will only invite attention to a few points.

The necessity of dry ground by means of deep and large porous tile-pipes in the ground under and about the dwelling houses, and of isolating the foundation and walls of houses by means of asphalt, cement, etc., from under- and around-lying grounds, to prevent its contamination with decaying organic matter.

To lead the ground air through chimneys from rooms, halls, etc.

To isolate one story from another.

In short, to be surrounded by the best known hygienic precautions.

To isolate phthisis-patients from healthy persons as much as possible.

In conclusion, to avoid everything that weakens the body and mind, such as drunkenness, nicotin, sorrow, trouble, over exertion and especially cold and lung inflammations.

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## REPORTS ON PROGRESS.

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### THERAPEUTICS.

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Quinia with Nervous Sedatives.—DR. LANDON CARTER GRAY states that he is a firm believer in the efficacy of bromides in epilepsy, as a general rule. He is highly pleased with the result obtained by prescribing quinia in connection with the bromides. All his experience proved to him that quinine increased the effect, not only of the bromides, but also of hyoseyamin and belladonna. He also discovered that these agents were much better borne, as well as more efficient when administered in combination with quinia.—*Boston Med. & Sur. Journal*, July 8, 1880.

**Masking the Odor of Iodoform.**—DR. LINDEMAN, of Münster, after many experiments, has found that two parts of balsam of Peru combined with one part of iodoform masks the odor of iodoform completely.

He recommends vaseline as the best vehicle for an ointment. The combination, however, may be used in solution with water, dilute alcohol or glycerine.

**Potassium Chlorate.**—DR. ALEXANDER HARKIN claims that potassium chlorate induces a development of vital force in weakened and debilitated constitutions; retards tissue degeneration and exerts a marked beneficial influence in defective nutrition, secretion, aeration and molecular metamorphosis. He attributes its beneficial effects to two elements, indispensable to the formation of healthy blood, oxygen and potassium. The dose should be one ounce of a saturated solution (1 to 20) thrice daily.

He uses a lotion in burns and scalds, indolent ulcers, sinuses of the breast in strumous abscesses. While applying it externally he also uses it internally.—*Dublin Jour. Med. Science*, May, 1880.

**Ether Spray in Whooping Cough.**—JAMES WEAVER, M. D., has found ether spray thrown into the child's face and over its clothing and about the room from time to time, very efficacious in relieving the severity of the spasmodic cough.

A nurse can use it with a simple cologne spray-producer.—*London Lancet*, October, 1880.

**How to Prescribe Pepsine.**—DR. JUDSON BRADLEY claims that the negative results obtained from the use of pepsine are due to one or both of two causes, viz., the use of an inferior article or a prescription containing substances incompatible with the pepsine. Pepsine is a peptone so concentrated that it will effect a fermentation in materials and foods, thereby carrying on a real digestive process; understanding this, a feasible plan of its administration may be reasoned out. Alcohol arrests the action of pepsine, hence, all wines, elixirs, &c., must not be combined with it. Then, again, alkalies are essentially incompatible with pepsine, and should never be prescribed with it; bismuth subnitrate, although not strictly an alkali, is an ant-acid, consequently neutralizing the effect of the pepsine when prescribed with it, as is so frequently done.

It must not, however, be given in powder, as in this form it is almost inert, but may be given in a slightly acidulated mixture, with great advantage, provided the drug is a good article; probably the best plan is to administer a proper dose in combination with hydrochloric or lactic acid and water, one-half hour before meals, and immediately afterwards a small portion of albuminous or fibriuous food to be taken; never in a mixture containing other articles.

**Anesthesia.**—DR. GUBERT claims that anesthesia should be produced without causing total unconsciousness, which may be accomplished by administering one fourth of a grain of morphine fifteen minutes before the administration of the chloroform. Morphine lessens the bronchial irritation induced by the vapor, diminishes the tendency to vomit and the danger from shock.—*Le Concours Médicale*.



**Glycerine in Acidity, Flatulence, and Pyrosis.**—SIDNEY RINGER, M. D. and WM. MURRELL, M. D., have found that glycerine in one or two drachm doses will often relieve flatulence, acidity, pyrosis and sometimes pain and vomiting.

They suggest that its action is due to its retarding or preventing some forms of fermentation and of putrefaction.

One or two drachms are to be given either before, with, or immediately after food. It may be given in tea or coffee, replacing sugar.—*London Lancet*, October, 1880.

J. P. KINGSLEY.

## DISEASES OF THE GENITO-URINARY ORGANS.

**Excision of Obstruction at the Neck of the Bladder.**—GOULEY, of New York, takes part in the discussion of the question of the advisability of performing the above operation, widely known as Mercier's. He says, Mr. Browne's statement that the "operation is rarely if ever employed by more than one surgeon in Paris, and that many years ago, and now abandoned there," is not correct, that it has been performed by other surgeons in Paris within a few years, and that it has never been abandoned, at least by Mercier.

He declares that Mercier has performed this operation on upwards of four hundred patients. Hemorrhage has been more frequent and abundant in incision than in excision, but has never been fatal. Mercier considers it a mere bugbear: consequently the Italian method [one in which the galvanocautery is employed instead of a blade for incising, R.] is unnecessary.

Reference to our last mention of this subject will show that we had the idea that this operation had not been done by any American surgeon. Dr. Gouley's communication proves us to have been in error. He says, "In a prostatectomy followed by prostatomy (the excision and incision giving a depth of two centimetres) performed by me a week ago, the patient lost half an ounce of blood, and the urine was tinged with blood for two days only. He sat up half the day following the operation, and was up and dressed every day thereafter. He has not had a bad symptom. I may say the same of another patient, sixty-seven years of age, operated upon two months ago, who sat up in bed in a few days, and was up and dressed in a week. My oldest patient was seventy-six, was operated on nearly two years ago, and is now in fair health and better of his urinary trouble than he had been for several years before."—*Lancet*, American Edition, October, 1880.

**Structure of Spermatozoa.**—HENNAGE GIBBES, in the *Journal of Microscopical Science*, states that he has found the spiral filament discovered by him, in the spermatozoa of several species of animals. In the examination of different specimens of human spermatozoa, he has noticed a variation in the length of the tails, and in one specimen he found a number of heads with no corresponding tails. These variations, he suggests, may have some important bearing. It is possible, for instance, that tailless spermatozoa may be unable to fertilize the ovum, while the greater the length of the tail the greater will be the power of locomotion and, probably, their power to fertilize.

Fleming, of Kiel, has confirmed Gibbes' observation as to the different reaction to staining fluids of the head and middle part of spermatozoa. (*Ibid.*)

[The question of the fertilizing power of the different parts of the spermatozoon is one of very great interest, not only to the surgeon but to the gynecologist. It appears to be already proven (Casper) that the mere frequency of coitus has something to do with the matter, at least in those of advanced age. In all such investigations, as those of Mr. Gibbes, the question of age, frequency of evacuation, condition of the glands and their ejaculatory ducts are of the greatest importance, especially when we come to apply knowledge thus gained in deciding questions of sterility. Aspermatism and azospermism, are conditions now well known to exist, but the question of power of locomotion and that as to what part of the spermatozoon is necessary to fertilization of the ovum, remain unsolved. Rep.]

JOHN BRYSON.

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## SOCIETY PROCEEDINGS.

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### THE TWELFTH CONGRESSIONAL DISTRICT OF MISSOURI MEDICAL ASSOCIATION.

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This Society held its regular semi-annual meeting at Kirksville, November, 10th, being called to order by the president, Dr. W. S. D. Johnson, with the secretary, Dr. T. J. Norris at the desk. After the members had been enrolled, it was found that there were present twenty-eight associate members. At the afternoon session the election of officers for the next year was held with the following result:

For President after the first ballot Dr. W. O. Torrey, of Hannibal, was declared unanimously elected. Upon motion Drs. Helm and Neeper were appointed a committee to conduct the president elect to the chair. After being introduced to the association by the retiring president, Dr. Torrey, in a neat little speech, thanked the association for the good will and confidence expressed in honoring him by so responsible a position.

The other officers elected were: Vice-Presidents, Adair, Dr. J. Moran; Scotland, Dr. Parish; Clark, Dr. Sam Neeper; Schuyler, Dr. W. F. Mitchell; Putnam, Dr. A. C. Berry; Knox, Dr. E. D. Helm; Macon, Dr. J. M. McCully; Shelby, Dr. D. H.

Matthews. Recording Secretary, Dr. T. J. Norris of Macon; Assistant Recording Secretary, Dr. John Downs of Edina; Corresponding Secretary, Dr. W. F. Crawford of Knox; Treasurer, Dr. W. F. Morrow of Macon.

As several new members had arrived, the reading of the constitution was called for.

After some time spent with miscellaneous and unfinished business, the president announced the next order of business to be the reading and discussion of medical papers.

Dr. O'Brien of Edina, read a very able paper on criminal abortion, which was heartily approved by the association and referred to the committee on publication.

Dr. T. J. Norris of Macon, read a paper on "The Effects of Education on the Physical Development of Children," which was also referred to the committee on publication.

The committee on publication asked instructions from the association in regard to the manner of publishing the transactions of the association. After discussion it was decided to publish the transactions in full in pamphlet form, securely and neatly bound in cloth, and printed in elegant style on good book paper; also to publish with the transactions, the constitution and by-laws of the association, and the code of ethics and such other matters as relate to medical organization. At the evening session the association met in the large hall secured for the occasion, Vice-President Hearne in the chair. This session was an open one and very well attended considering the inclemency of the weather.

The programme for the evening was a paper on medical ethics by Dr. E. D. Helm, President Johnson's Valedictory, an address by President Torrey, an original poem by Dr. E. D. Helm, on the "Spirit of Times." The papers were all well received, and Dr. E. D. Helm was frequently interrupted with applause. The doctor has become a great favorite with the association.

The association decided to adopt as a rule the holding of an open session the last evening of the meeting of the association. By open session is meant the admission of ladies and children, as gentlemen are admitted to all sessions and at all times.

The association then adjourned to meet at Hannibal, April 13th, and 14th, 1881.

W. O. TORREY, M. D., *President.*

T. J. NORRIS, *Secretary.*



## LINTON DISTRICT MEDICAL SOCIETY.

The semi-annual meeting of the Linton District Medical Society opened November 9th, with an attendance of thirty-six members. Ten new members were elected during this meeting and the outlook for valuable work in this association is excellent.

In the evening Dr. Middlekamp read a highly eulogistic paper upon the late Dr. W. S. Hutt, of Troy.

Dr. Adams was appointed to write a biography of the late Dr. J. R. Bodine, of Montgomery City.

Dr. Moore read an essay on malarial fever, considering its cause, cure, etc.

Dr. Hanna, on behalf of the committee on credentials, reported favorably to the admission of Dr. McComus, of Sturgeon, the validity of whose diploma had been questioned. The society adopted the report.

Dr. Moore's paper on malarial diseases was then taken up, and the subject exhaustively discussed.

Dr. J. F. Keith read an essay on typhoid fever, which elicited a lively discussion, various methods of treatment being espoused.

At the morning session on the 10th, an hour was given to the discussion of each of the three subjects, erysipelas, epidemic cholera and ovariectomy.

The following gentlemen were appointed by the President to read papers on the subjects assigned: J. A. Matthews, of Ashley, Chronic Gastritis; B. H. Clark, of Boone County, Asthma; W. T. Lemon, of Ashland, Hepatic Abscess; Wesley Humphrey, of Moberly, Lithotomy; W. W. McFarland, of Mexico, Insanity; H. H. Middlekamp, of Warrenton, Ovariectomy; A. W. McAlester, of Columbia, Delirium Tremens; Ferdinand Smith, of Frankfort, Electricity as a Remedial Agent; T. J. Baskett, of Auxvasse, dysmenorrhea; J. M. Foreman, of Jonesbury, Nasal Catarrh.

A motion to change the by-laws so as to allow meetings of the society at other points besides Mexico, elicited a lively discussion and was voted down almost unanimously. The subject of dysentery was discussed for an hour. The society then adjourned for dinner. One hour was devoted to the discussion of dysentery. This was participated in by several members.

One hour was also devoted to the discussion of epilepsy, nearly all the members taking part. The subject pneumonia was considered by the body for one hour. After which Dr. Hanna, of Pike County, offered the following resolution, which was adopted:

*Whereas*, Certain irregularities in the action of Hospital Medical College and Kentucky School of Medicine, of Louisville, Ky., in giving out diplomas to parties without a corresponding attendance being required upon their lectures, comes fully to the knowledge of this association. *Resolved*, That hereafter prerequisites of membership to this association shall be the exhibition of diploma in due form; and the presentation of full courses of professors' tickets as required by colleges for graduation, shall accompany each application for membership herein, when said applicant is or claims to be a graduate of said Hospital Medical College or Kentucky School Medicine, of Louisville, Ky.

Chair appointed Dr. Woodson Moss, of Columbia, Mo., and Dr. Pinckney French, Mexico, Mo., delegates to next meeting of Moberly District Medical Association.

Dr. French, delegate to the meeting of State Medical Association, May, 1880, made a report, which was adopted. Society adjourned to 7 1-2 p. m.

Society met at appointed hour. The evening was consumed with reports of interesting cases and discussions thereon.



## INTERNATIONAL SANITARY CONFERENCE.

Among the propositions which our government would desire to submit for discussion to the proposed international sanitary conference, are the following:

A. The establishment of a reliable and satisfactory international system of notification as to the existence of contagious and infectious diseases, more especially cholera and yellow fever.

B. The establishment of a uniform and satisfactory system of bills of health, the statements in which shall be trustworthy as to the sanitary condition of the port of departure, and as to the condition of the vessel at the time of sailing.

The discussion of these points would involve, among others, the following questions :

1. Who should be the certifying officer or authority as to the sanitary condition of ports and places and of vessels ?

2. How can the certifying authority obtain trustworthy information as to the actual sanitary condition of ports and places, and as to the presence of contagious and infectious diseases ?

3. When yellow fever or cholera exists at or in the vicinity of a port or place, what examination should be made of a vessel sailing therefrom to secure a trustworthy knowledge of her sanitary condition ?

4. To what extent, and under what conditions, should a clean bill of health be considered as affording satisfactory evidence that the vessel is free from danger of conveying infectious disease ?

5. In what way can trustworthy information be obtained from ports or places in countries which have imperfect or unsafe quarantine and sanitary regulations, and which may be unwilling or unable to adhere to the proposed international system ?

6. Whether a schedule of graduated penalties could be fixed to be exacted from vessels for various offenses arising under the proposed international system ?

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## ST. LOUIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY.

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Stated Meeting, Oct. 21, 1880.—Dr. Boisliniere, President, in the Chair.

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*Dr. Robinson* gave an abstract of his paper read at the last meeting of the Society. *Vide* page 519.

*Dr. Moses*.—Vomiting in pregnancy depends on either a peculiarly vicious condition of the system, or upon uterine irritation. It may depend on a deranged stomach, or as it very often does, upon excoriation of the neck of the uterus, and any of the simple plans of treatment will be successful. I have seen several cases in which a single application to the os gave relief. At times laudanum or chloral enemata may be used with good effect, and I have seen leeches over the stomach

answer the purpose; but I have seen everything fail. I have had cases myself, and have seen others in consultation in which all these measures were used without avail, and not until natural or artificial abortion had been induced, did the patient find relief. The relief was instant on the death of the fetus. About four or five years ago, I was called in consultation with Dr. McPheeters to the case of a woman suffering with continuous vomiting for six weeks, until she was on the verge of starvation. Every means which I have spoken of was tried in this case and without the slightest effect; she vomited all the time, retaining nothing whatever. Nutrient enemata had no effect. Finally I concluded that it was justifiable to produce abortion. A sound was introduced between the membrane and uterine walls with the result of at once arresting the nausea; abortion was so tardy that I almost doubted whether she was pregnant. It was ten days after the introduction of the sound before she cast off the embryo. While this is a dernier resort, I think it justifiable where all the means which are known have been tried in vain. I consider it criminal to allow a patient to starve herself to death if it is possible to relieve her; and I would not hesitate one instant, when all other means had failed, to bring on an abortion. I have done it three times, once without avail, for the patient was dying at the time of the operation. In another case everything that was known was done to relieve this symptom without avail, and as the woman was starving to death, I produced abortion; she got perfectly well, afterward giving birth to four or five living children without any great amount of nausea during pregnancy. With regard to the case which Dr. Robinson relates with so many interesting details, I myself, recall a case somewhat similar, which did not occur in a person reduced from nausea. She was a healthy, vigorous woman, perhaps a little inclined to be fat. She never had any organic disease; she was in fine health; her labor was an ordinary one. In a couple of days a condition came on and continued for six or eight weeks, such that this lady could not possibly be moved in any way; we could not lift her feet without her complaining. If her head was raised from the pillow, she fell into a condition of coma. In order to change the sheets, which was required regularly, we slid them under her. She was stimulated, and fed with three pounds of beef broth every twenty-four hours.

Whether this case was dependent on heart clots or not I am unable to say, but think now it was. The patient is living now in fine health. In this case there was no peripheral thrombosis.

*Dr. Prewitt.*—I think Dr. Robinson's view of it, so far as establishing the heart clot is concerned, is probably a correct one. The condition was certainly such as favored the formation of heart clot. The symptoms were such as to point to this condition. You will recall that we are indebted to Dr. B. W. Richardson, of London, for the investigation of this subject, a very admirable treatise on the symptoms attending heart disease in which are formulated the symptoms. The patient was in such condition as would result if bled profusely. Dr. Richardson goes to the extent of showing that we can not only make a diagnosis, but that it can be determined upon which side of the heart the clot is located, that the heart-sounds are influenced by the presence of the clot, and, if the clot be upon the left side, for instance, the sound will be greatly diminished or absent, while on the right side they could be heard. Now if the heart-clot could be dissolved gradually, it could be done probably without ill consequences; but if it be detached in fragments, there would be emboli; and Richardson cites a case where he had gone out of London to see a patient in consultation. The patient was almost moribund. He made a diagnosis of heart-clot on the left side. There was one chance for the patient to live, and that was the loosening of the clot and its floating away. Of course if it did so, there would be embolism somewhere. During the night this thing occurred, the patient was relieved, and there was evidence of embolism of the femoral artery. The patient recovered. Now in these cases where the heart-clot is large, and relief is dependent on its dissolution, I should imagine the chance would be very small; in case it had been detached and had blocked the pulmonary artery, of course death would have been instantaneous, whereas having occurred upon the left side in the case which Dr. Richardson cites, having taken the direction of the leg instead of the brain, the patient recovered with the symptoms of embolism of the artery of the leg.

*Dr. Boisliniere.*—I wish Dr. Robinson would report the case he saw in connection with me, the case of the lady who had puerperal phlebitis. At one time she began to have a cough, and then he was called in; there was a sudden occurrence of

eclampsia. Eclampsia begins, usually, with a spasm of the small muscles of the face, and finally the large muscles. This case did not begin thus. It began by violent convulsions. She occasionally complained of intense pain in the back of the head. A diagnosis was made of thrombosis occurring in the right side of the heart, followed by pulmonary embolism and later, embolism of the cerebral arteries.

*Dr. Robinson.*—There is not much more to say in regard to the case, but it resembled very much a case I saw occurring in a young man about 20 years of age who had thrombosis of the left femoral vein with inflammation of the vein; he suffered from abdominal trouble, apparently the result of embolism. That was followed by an embolism of the cerebral artery upon the left side and hemiplegia on the right side of the face and body. The case was strikingly like that of the lady whom Dr. Boisliniere referred to. There is one point in the case I reported, that should be noted, that is, although she had attacks of syncope, she was not exactly like a patient suffering from syncope. She did not lose consciousness entirely at all times. At times she would be in a state of most profound collapse, and then at other times she could speak only in whispers. She was so weak that she could not raise her arm or scarcely lift the fingers. During the severest attacks, I may say she had no muscular power at all. She was like the patient spoken of by Dr. Moses, being kept for weeks without anything under her head at all, and we changed the bed clothes by sliding them under her. I recall a case now, which Dr. Prewitt will, no doubt, recollect, in which there could be no other cause assigned but thrombosis, which ended in the death of my patient at the City Hospital some years ago. It was a thrombosis of the left femoral vein, and it extended up to the bifurcation of the ascending cava. There was a much enfeebled heart action. We did not recognize the exact condition, for the pericardium was partially filled with pus. If I remember correctly, there was a perfectly sacculated condition of the pericardium, a sac communicating with the proper cavity of the pericardium, and it was filled with pus, which ran from one to the other. The cardiac action was very much diminished. The enfeebled circulation in this case may have been the immediate cause of the thrombosis.

*Dr. G. A. Moses.*—I think the diagnosis made in this case is

satisfactory, though at the time I witnessed the case in consultation very frequently, I couldn't help feeling great uncertainty. I think Dr. Robinson shared my feeling. The patient was extremely nervous. There were no symptoms pointing to any uterine trouble, no inflammatory complication, so far as regards the recovery of the genital organs after labor; but after this condition had continued for some time, with scarcely any change, one day at 12 o'clock I was called in haste, by reason of the discovery of blood in the bed, and upon the bedpan. I found the discharge was not from the bladder, but from the uterus. Upon examination this was found to be the first return of menstruation. The patient has had no serious trouble since that date. It is a very peculiar coincidence that this return of the menstrual flow was normal, it only lasted the ordinary time and produced no extraordinary symptoms, convalescence immediately commencing. The gradual solution of the clot takes place by very slow degrees necessarily, and although there is no other diagnosis by which to explain the condition, satisfactorily the case was accompanied throughout by very many singular associated symptoms.

At the annual meeting of the Obstetrical Society, November 18th, the following officers were elected:

*President.*—Dr. L. Ch. Boisliniere.

*Vice President.*—Dr. G. M. B. Maughs.

*Recording Secretary.*—Dr. G. A. Moses.

*Corresponding Secretary.*—Dr. George J. Engelmann.

*Treasurer.*—Dr. W. Hutson Ford.

ANNUAL ADDRESS BY THE PRESIDENT, DR. L. CH. BOISLINIERE.

*Gentlemen:* This is the third anniversary of the St. Louis Obstetrical Society. It has been a successful Society, and the success of the past is an earnest of better achievements for the future, in the special work we have chosen.

The field of medicine is so vast, the scope of its investigations so varied, that a demand for a division of the labor has become necessary in order to arrive at perfection in the various branches of medical science. But let it be remembered that specialism is the lowest grade of the art, unless guided and enlightened by a thorough knowledge of the "essentials," in medicine.

In order to become a safe and successful specialist, one must be well instructed in the teachings and experience furnished by

general pathology and clinical observations; without these aids one becomes a narrow-minded and often dangerous empiricist.

The work done by this society has been excellent, consisting of many learned original papers, very full and interesting debates, presentations of rare pathological specimens, and exhibition of new and useful instruments. The details of your labors in these various fields have been presented to you, to night, by our faithful and reliable recording secretary, Dr. G. A. Moses.

Permit me here to add that our work has met with the appreciation of the medical public, from which we have received encouraging praises. A highly appreciative compliment has been offered to us by the talented editor of the *Obstetric Gazette* stating that our society has done the best work of any society of the kind in this country.

Allow me to compliment our society upon the spirit of scientific research, the high-toned courtesy in debate, and the sincere cordiality which have not ceased to lend their charms to our meetings and made them so attractive. There is every reason to believe that the same spirit will continue to prevail.

In closing these hasty remarks, I beg to be permitted to express to you my sincere thanks for your kind coöperation in assisting me to perform the duties of my office, and also to offer you my sincere wishes for your continued prosperity.

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## ST. LOUIS MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, October 11, 1880. Dr. Pollak in the Chair.

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### TREATMENT OF ALCOHOLISM.

*Dr. Bauduy* read a paper on the "Treatment of Alcoholism."

In the discussion that ensued upon the reading of *Dr. Bauduy's* paper (*vid.* p. 485),—

*Dr. Robinson* said that the principles enunciated were very sound. He would like to ask, however, if *Dr. Bauduy* ever gave digitalis? Many years ago he had learned its value in large doses. He thought the drug was indicated for its pow-



erful stimulant effect on the heart, especially since there was always much cardiac debility in sufferers from alcoholism. In the beginning of his practice he had made use of the large doses of opium then in vogue, but he felt satisfied that such treatment was highly pernicious, and he was afraid that many deaths had been hastened by the administration of opium in *mania. a potu*. His usual dose of digitalis was a half drachm every four hours. He had had the opportunity, however, of observing the expectant treatment of alcoholism carried out on a large scale, and quite agreed with Dr. Bauduy as to its utility, and more particularly the happy results which arose from systematic feeding.

*Dr. Bauduy* had given digitalis, but never in the large doses advocated by some authorities. His principal objection to its use was due to its prejudicial effect upon the digestion, and since attention to the gastric functions was one of the principal ends of treatment in drunkards, anything which interfered with that object was, to his mind, contraindicated. Then experience had taught him to fear the cumulative property of digitalis, and he could recall cases when very dangerous symptoms had been set up consequent upon the continued use of large quantities of digitalis. *Dr. Prewitt* concurred with the writer so far as acute cases were concerned, but he thought that in old chronic debauchees alcohol, in stimulant doses, would prove useful as an adjuvant. In these cases he had found *post mortem*, considerable effusion and venous congestion in the brain. Here opium and chloral would be very apt to cause death, but he thought that such patients needed stimulation, alcohol, ammonia, together with the bromides. *Dr. Briggs* liked the idea of expectancy combined with systematic nourishment in alcoholism. He would be timid about pushing chloral; indeed would avoid both chloral and opium in excess. He had enjoyed large experience in the treatment of alcoholism, and his preference was for Grave's mixture, in the delirium. His success had been quite remarkable. The Grave's mixture consisted of small quantities of opium and tartar emetic in combination, and was first recommended by that famous Irish physician for those cases of typhus in which at an advanced stage of the attack there is cerebral excitement with total want of sleep and persistent delirium, often of a furious kind. He thought there was quite a parallel in these cases to the delirium tremens. *Dr. Robinson* forbids the use of alcohol

in either the acute or chronic stages, but substitutes a tonic, particularly iron and digitalis, and also pepsine to favor digestion, and some mineral water for its action on the portal circulation. Alcohol given medicinally is of only temporary benefit, and inevitably increases the irritability and weakness of the heart. *Dr. Bauduy* said, in conclusion, that he considered *Dr. Prewitt* wrong in his pathology; that the effusion mentioned by him was the result of collateral edema, due to hyperemia from alcohol, and that he would regard the further administration of alcohol as very bad practice. In regard to *Dr. Briggs'* method of treatment, he thought his observations worthy of much attention, since he was personally cognizant of the very favorable results obtained by that gentleman. Here, however, the opium was given in minute doses, combined with tartar emetic, and the combination probably acted as an eliminant. Opium kills many patients who are coincidentally suffering from renal disease. In reply to a question the speaker said that cirrhosis of the liver does not exist in drunkards with the frequency once supposed; that kidney disease was also not so common. *Dr. Pollak* stated that over twenty years ago in Vienna he saw a patient with delirium tremens in the ward of *Prof. Oppolzer*. It was a very rare disease there and attracted a good deal of attention. The treatment adopted by *Prof. Oppolzer* was a purely expectant one. *Dr. Kingsley* thought that chloral hydrate was of great value in some cases, especially such cases as must be treated at home. He said that *Trousseau* had characterized it as a great treasure. He had no doubt that deaths had resulted from overdosing with chloral and bromide of potassium in cases of delirium tremens, yet he had seen the happiest results from administering it to the amount of 30 to 60 grains. He had found capsicum a valuable remedy; and had derived advantage from digitalis in some cases. *Dr. Robinson* said that he had used digitalis in the form of an infusion made from the English leaves. When he desired to secure a prompt diuretic effect he usually prescribed an eight ounce infusion of digitalis (English leaves) with acetate of potash and two drachms of the tincture of digitalis—a desert-spoonful every two hours. *Dr. Steele* said that when he was resident in the Buffalo General Hospital the treatment of delirium tremens was by administering a brisk cathartic and then giving large doses of opium. He thought the treatment that had been advised that evening promised much better results.

## ANTISEPTIC SURGERY.

*Dr. Carson* gave a very brief résumé of the results of antiseptic surgery as observed in the practice of *Dr. Gregory* and himself. 1st. A case of exsection of the knee joint. The operation was made under the spray and *Lister's* dressing was applied. The patient was a delicate boy with thin skin and no hair. The case progressed favorably and the result was good. The second case was a compound fracture of the femur. He had had a simple fracture of the same bone three years before. The *Lister* treatment was used with excellent results. Several other cases had shown equally favorable results.

They had had seven cases of ovariectomy with six recoveries. The last case left the hospital two weeks and one day after the operation. In five cases out of the six which recovered, the temperature did not rise above  $101^{\circ}$ . They had had two cases of cancer of the breast. The first was a large, fleshy woman. The dressing was oakum with oiled silk and drainage of horse-hair. There was no elevation of temperature and no suppuration and in two weeks the wound had healed entirely. In another case the wound healed in four or five days without any elevation of temperature. *Dr. Carson* finds the gauze which he prepares himself much more satisfactory than that bought at the stores. Some have thought that carbolic acid favors hemorrhage; but his experience leads him to a contrary opinion.

## NOTES AND ITEMS.

COURIER, for 1881.—At the annual meeting of the MEDICAL JOURNAL ASSOCIATION OF THE MISSISSIPPI VALLEY the following officers were elected for the ensuing year:

*President*,—H. N. Spencer, M. D.; *Secretary*,—A. J. Steele, M. D.; *Executive Committee*,—G. Baumgarten, M. D., W. C. Glasgow, M. D., C. A. Todd, M. D.

The following gentlemen have been appointed by the executive committee as editors for 1881: E. M. Nelson, M. D.; Jno. Bryson, M. D.; W. A. Hardaway, M. D.; G. A. Moses, M. D.

CLUB RATES.—For the year 1881, we shall be able to offer a reduced rate to subscribers for the *COURIER*, with the *Archives of Medicine*, or with the *Alienist and Neurologist*.

THE POPULAR SCIENCE MONTHLY.—More and more, year by year; is this journal making for itself a place among the absolute necessities in the estimation of scientific readers and workers. Every physician recognizes the imperative demand that in order to keep himself in line for efficient and successful professional work he shall take and read one or more professional journals. Next after his chosen medical journals comes the *Popular Science Monthly* with its rich store of valuable papers upon all forms of kindred scientific subjects; the December number contains some papers of special interest to physicians. Dr. Beard's paper, "Experiments with the Jumpers of Maine," is an exceedingly entertaining one. Dr. J. Lauder Brunton's paper on "Indigestion as a Cause of Nervous Depression," is reprinted from the *Practitioner*. Prof. H. Carrington Bolton contributes a paper upon "The Early Practice of Medicine by Women." We note also a brief sketch of the life of Dr. Edward Seguin, who died October 28, 1880. Besides these we have only space to mention the papers of Herbert Spencer on the "Development of Political Institutions;" Professor Huxley's address, "Science and Culture;" "The August Meteors," by W. F. Denning; "Methods in Industrial Education," by Prof. S. R. Thompson; "Oriental Music," by S. A. Pearce, and "The Sabbath," by Prof. John Tyndale. If our resources would admit of such a luxury we would make a Christmas present to each of our own subscribers of a year subscription to the "Popular Science Monthly;" but as we cannot do that at present, we advise them to send on the subscription price, five dollars per annum, to D. Appleton & Company, New York.













