CANCER OF THE PENIS.—The subject of the present sketch was a man aged 54 years, who had been very intemperate during the whole course of his life, besides being a most excessive libertine: in fact, his whole desire to live seemed to be for the gratification of his animal passions. One of the consequences of his loose life, was a phimosed prepuce; and, in September, 1849, he sent for me to circumcise him. At the time appointed, I repaired to his house, and found the prepuce in a state of phimosis, thickened and firm to the feel; I could also detect, by a close examination, an ulcer within the prepuce, the nature of which I could not ascertain, because of the unyielding nature of the prepuce. My patient’s heart failed, and he refused to submit to the operation. After this, although I frequently saw him, I did not examine his penis until February 20, 1852, when he sent for me again to operate on him. The ulcer had made its appearance externally, and the prepuce had a hard and scirrhous feel. I operated by making a longitudinal incision before and behind, and taking off one side of the prepuce at a time. The ulcer had extended to the glans penis on the left side, and was about the size of a thumb-nail. The cut edges
healed very well in a couple of weeks, but the ulcer on the glans gradually extended, in spite of my efforts to prevent it—I was satisfied that the ulcer was cancerous. The rest of the glans gradually became hard and knotty to the feel. I proposed, as a last resort, to amputate the penis beyond the diseased part, and requested a consultation. Dr. Haygood, of Montgomery county, was called in, who fully concurred with me as to the nature of the disease and the necessity for the amputation. To this the old man refused to submit, and passed out of our hands. He then put himself under the care of a "conjure cancer Doctor."

I saw him occasionally in passing, and perceived that the ulcer was extending its ravages toward the body. I ceased to see him from September, of the same year, until about the middle of January, 1853. His condition was now as follows:—The penis was entirely destroyed, up to the arch of the pubis; a large bubo had broken in the left groin, and produced a cavity that could conveniently hide a turkey's egg, and in the right groin there was another bubo nearly ready to burst. The scrotum was about the size of the head of a child a year old, hard and solid to the feel. On the 22d of February he died, just about one year after I excised the prepuce.

In all probability he might have lived a longer time if he had submitted to the amputation of his penis. When the operation was proposed to him, as a last resort, he said he would die before he would submit to it—and sure enough he did; but not before he lost his penis.

Retroversion of the Uterus, with Paralysis of the Lower Extremities.—August 5th, 1852. I was called to-day to see Mrs. S., a lady aged about 45: she had enjoyed good health until about two years past, when she took a cough, which has been gradually wearing her down; she is the mother of six or eight children; has been confined to her bed only four days. I found her in the following condition:—She was sitting up in her bed, and propped up with pillows; she said that she could not lie down, for every attempt to do so would cause violent pain in the back, hips, and pelvis generally. I was given to understand that there was some deranged condition of the uterus.
After much persuasion, I succeeded in inducing her to lie upon her back.

By a very careful digital examination per vaginam, I detected the most perfectly marked case of Retroversion of the Uterus I have ever seen. The fundus of the uterus could be plainly felt in the hollow of the sacrum, and the os tincae was resting against the pubes. She complained of a great deal of difficulty in evacuating both rectum and bladder. The difficulty in evacuating the bladder had existed for some months. With one index finger in the rectum and the other in the vagina, I gradually returned the uterus to its proper position. She experienced instant relief from her more distressing pains. I advised the recumbent posture, (which now could be borne without suffering. After waiting an hour, I questioned her as to her feelings: she replied, that she was free from all acute pain. There was some soreness of the back and hips.

She was very much troubled with a cough. The upper part of the right side of the chest presented a very dull sound upon percussion; I suspected the existence of a cavity in the lung; but was not expert enough to detect any. The matter expectorated was a mixture of blood and pus.

She said the flesh on her legs felt dead. As there appeared no urgent necessity, I simply prescribed rest and an opiate, and promised to see her again on the 7th inst.

7th inst. I was sent for in great haste, before day this morning, to see Mrs. S. On my arrival. I found her suffering very much from retention of urine. Not only was this the case, but I found the lower extremities completely paralysed, as well as the bladder; the rectum would empty itself, but she said she was not aware of the act of defecation. The uterus occupied its normal position. The opiates prescribed on the evening of the 5th procured no rest; I drew off the urine by catheterism, and prescribed $\frac{1}{4}$ gr. strychnine every six hours, and frictions to the spine and posterior parts of the thighs with stimulating linctum.

8th. Patient very much as yesterday; has passed no urine since yesterday morning; some slight motion in knees. Used the catheter again, and drew away 35 or 40 ounces of pale-colored urine; ordered muriated tincture of iron 15 drops, three
times a day, in connexion with the strychnine, as before; fric-
tion to the back and thighs continued; to keep the bowels open.

10th. Patient but slightly improved since last report—there
appears to be a little more power to move the knee. She is
still unable to evacuate the bladder, without the aid of the ca-
theter; still complains of pain in the back and hips, (which she
has done all along); bowels open enough; appetite good; cough
and expectoration about the same. I applied a large blister
over the sacrum and lumbar vertebrae, instructed the husband
how to use the catheter, and ordered a dose of castor oil to be
given in the morning.

12th. The oil had operated well; the husband had to intro-
duce the catheter once or twice every twenty-four hours—I
directed the blister to be dressed with strychnine ointment. In
every respect, she appeared to be the same as at last report.

One fact I forgot to mention in my previous reports, and that
was with regard to the pulse. At each of my visits I found it
perfectly natural in frequency, but weak and small.

In addition to the strychnine and tinct. iron, I gave vegetable
 tonics, and ordered the catheter to be used as often as neces-
sary; also, the use of enematas, if the bowels should become cos-
tive.

I saw her occasionally; there was no improvement. My
treatment was persevered in faithfully. I used every means in
my power to relieve the paralysis, but failed. She gradually
sunk lower, and died on Oct. 1st, 1852.

My principal object in the report of this case, is to notice the
very unusual complication of paralysis with a mal-position of
the uterus. That the woman had phthisis is true, and that this
seemed to hasten a fatal termination, I believe to be the case;
yet the point of interest was the occurrence of the paralysis at
that particular time. She had had nothing like apoplexy, and
but a few hours before I paid my first visit she had stood upon
her feet. She was setting up when I first saw her, and said she
could not lie down. After a good deal of persuasion, she was
prevailed upon (not forced) to lie down—and by as gentle means
as the nature of the case would admit, the uterus was examined
and replaced. There was no more difficulty in this, than is in
ordinary cases; yet after this she never was able to move her
legs, or but very slightly. When I became aware of the existence of the paralysis, on my second visit, I suspected the existence of a tumour pressing upon the sciatic nerves; but a careful examination failed to detect any.

No post-mortem examination was allowed, and consequently I could not ascertain the cause of the paralysis. The uterus remained in its natural position the last time I examined her.

Case of Occlusion of the Superior Portion of the Rectum.—The subject of the present case was a lady, aged about 24 years; been married 16 months—had one child, about four months old.

For ten months previous to her death, she had suffered with repeated attacks of colic and costive bowels; which was generally relieved by a dose of castor oil. The attacks became more frequent and more obstinate, until March 1st, 1853, when the fatal attack set in. This time, her accustomed dose of oil failed to relieve her, and enemas were used without any success. On the second day of the attack (March 27th) my friend Dr. M. A. Martin, of China Grove, Pike county, was called to the case: all his most strenuous efforts to open the bowels were unavailing. I was called to see the case (March 3rd) in consultation, and found it presenting the following appearance:—Excessive restlessness, with periods of repose which generally lasted about 15 minutes—then would commence again the restlessness, with loud complaints of pain which was referred to the right hypogastric region. She complained very much of pain when pressure was made on any part from the liver to the right iliac region; she felt no pain in the left iliac, though she had done so when first taken. She vomited every thing taken into the stomach. I gave it as my opinion that a stricture existed in some part of the bowel which had been gradually closing until it had produced total occlusion. She sometimes retained articles of medicine one and two hours; her tongue was moist, slightly furred and a little red at the tip. There was very little tympanitis; her pulse was firm and 100 to the minute. She had been freely blistered over the abdomen. I advised large and repeated doses of calomel—say 100 grains at once. The reason for such doses was obvious: because more easily retained,
and if retained, would be more likely to operate without further assistance. Every dose was vomited. Croton oil could be retained only a short time. This state of things continued for three days after my first visit—during which time the pain in the right hypogastric region increased, and we suspected that the peritoneal covering of the liver was becoming involved. Cups to this part gave temporary relief. We made repeated attempts to introduce a tube high up the rectum, so as to facilitate the use of injections; but without success. She continued to grow worse, and died on the 8th of March in convulsions.

A post-mortem examination was allowed six hours after death. The first thing which attracted attention after opening the abdomen was the intensely inflamed cæcum and colon. At that point where the cæcum and colon passes under the edge of the liver, the inflammation was so intense as to involve all the coats of the intestine and the peritoneal covering of the liver. The liver and intestine had become agglutinated. We took out all that portion of the large intestine which was inflamed, to examine it more carefully. On opening the bowel, the mucous coat was almost black, and each coat was very dark until they passed to the peritoneum, which was of mahogany colour. One small spot, about the size of a twenty-five cent piece, was very little removed from sphacelus. The mucous, cellular and muscular coats were very much softened and the peritoneal covering of the bowel at this point was agglutinated to the corresponding covering of the liver. The colon, as it passed on to become flexed, was more healthy, and at the termination of the sigmoid flexure, and commencement of the rectum, we found the strictered portion of the bowel. This had evidently been caused by a deep seated inflammation of the tissues of the section; producing an extensive thickening of the mucous membrane, in a circular direction. There was no ulceration of the mucous membrane, but at one point an ulcer appeared to be about to burst in the peritoneum. At this point the bowel was very easily torn in the examination. The bowel was as firmly contracted, circularly, as if a cord had been tied around it. When the strictered portion of the bowel was taken out, we found the contraction so perfect that water would not pass through it.
Operation upon the Hand to relieve a Contraction caused by a Burn.—Gabriel, a little negro boy, aged 4 years, was presented to me, by his master, Oct. 19th, 1851, to devise some operation to relieve a very bad deformity of the hand, caused by a burn, when he was about eight months old. The left hand was the one affected, and the contraction of the burn was so great as to draw the hand backwards and confine it closely to the arm. The burn extended all around the arm, so as to make it impossible to get any sound skin on that arm near enough to answer my purpose.

My plan of operation was that adopted by Professor Mutter, of Philadelphia, in cases of a similar nature—viz., to divide the contracted skin, and, if necessary, to dissect away a section across the old cicatrix, and fill up the space with sound skin.

In my case, I divided the contracted skin which confined the hand down, and found that motion of the wrist-joint was good, but a little stiff. The whole of the metacarpal bones were confined, and when dissected up there was about three inches in length and about one and a half in breadth of denuded surface exposed. I drew upon the right arm for skin to supply at least a part of the deficiency. I dissected from the right forearm a flap about one and a half inches long by one inch wide, leaving one edge attached to keep up the vitality, turned the skin up and confined the free edges with sutures across the wrist of the left hand, then, by splints and bandages, firmly secured the forearm of the right side to the back of the left wrist.

At the end of eight days, I carefully examined the condition of the parts, and found the patch adhering. I then carefully separated the right arm from the left. The skin adhered firmly, and the rest of the wound healed up by granulations. The flexibility of the hand remained good, and at this date (July 1, 1854) the left hand is almost as good as the right.

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Article XXV.


I see it stated in the May No. of this Journal, that Dr. Wooten wishes to collect all the facts relating to Dysentery
that can be obtained from different localities. As I have prac-
ticed in several sections of Georgia, and have treated dysentery
under a variety of types, I will contribute my mite of experi-
ence. The first of my practice was in the year 1842, when I
saw dysentery prevail in the most violent inflammatory form,
in Harris, Talbot and Muscogee counties, carrying off a num-
ber of both children and adults. The attacks, generally, were
sudden and violent, commencing with high irritability of the
stomach and bowels. The tormina and tenesmus were very
great, and if not checked by opiates, warm fomentations to the
bowels, or warm hip-baths, soon terminated in great prostration
of all the vital powers, and death. The diseases most frequent
in that section, then, were remittent, scarlet, typhoid and
typhus fevers, in the spring and summer months; and in the
winter and early in the spring, pneumonia, pleurisy, bronchitis,
and influenza.

In 1843, I practiced in the upper edge of Harris and lower
edge of Troup counties: there I met the disease in its most
violent form again, spreading terror and dismay wherever it
prevailed. I now found some change in its peculiarities, owing
to a change in locality and atmospheric vicissitudes. The year
before, we had a very wet summer, but very dry fall. This
year, 1843, we had a very rainy winter, with a moderately
rainy spring and very wet, warm summer. The disease now
seemed more aggravated in its symptoms, commencing with
nausea and frequent bilious vomiting; tormina and tenesmus
very great; stools at first bloody mucus mixed with fecal mat-
ter, soon changing to bloody mucus, and sometimes bloody
serum without feces. Great prostration soon followed, and if
not met by prompt and efficient treatment, proved fatal in a
few hours or days. The treatment I found most successful in
this epidemic, was, at the onset, calomel and opium together, to
remove offensive matters from the alimentary canal, and quiet
nervous irritability; this, not unfrequently, cut short the dis-
ease; but if it failed, I generally kept up daily action on the
bowels with rhubarb or castor oil, and lulled the nervous system
with injections of starch and morphia, or opiates by the mouth,
if the stomach would retain them. This course failing, which
was sometimes the case, I then resorted to astringents by the
stomach and rectum, combined with morphia. The subacute or chronic stage of the disease, characterized by less heat of the surface, diarrhea and great prostration of the whole system, was very difficult to arrest. The diseases most prevalent, then, were remittent, intermittent and congestive fever; during the summer and fall and the winter following, we had pneumonia, which appeared to assume a remittent type, and was much benefited by the addition of quinine to the common treatment.

During the next two years I practiced in Hamilton, Harris county. There were not many cases under my observation, nor was the disease characterized by any great fatality or peculiarity. In 1846, I practiced on the line of Oglethorpe and Madison counties, where I treated a large number of cases; but they were much like those of former years. In '47 and '48, I again met the disease as an epidemic of great severity, as regards frequency and fatality: there were, those years, no unusual atmospheric vicissitudes; the summers were seasonable and warm; winters moderate; the spring of '47 was very cold and wet, and this year, the disease was most severe. The above-mentioned treatment was the one I now relied on, and was generally successful, when resorted to early in the disease; but if delayed, the disease was very fatal, particularly among children. The diseases that prevailed here these two years, were remittent, intermittent, and typhus fevers, in the summer and fall, and pneumonia, extensively and severely, in the winter, and early in the spring.

I now changed my location, left Oglethorpe, and settled on the corner of Walton and Gwinnett counties. Here I met the disease under its ordinary forms, until 1852, when, after a very cold and pretty dry winter, warm, wet spring, and seasonable, but not very wet summer, we had inflammatory dysentery, in all its malignancy, to such an extent that very few persons, in some localities, escaped it. It was now attended with high febrile excitement, excessive vomiting, headache, and sometimes delirium; constant torments and tenesmus; very frequent stools of blood and mucus, or bloody serum. This epidemic was unusually fatal for this climate; it proved fatal in a few days, if not arrested. The treatment I varied; where there was high arterial excitement, I resorted to venesection, with
marked effect; for the purpose of quieting the stomach and bowels, I resorted to calomel and opium together. I gave the opium, or some of its preparations, according to the case, in doses sufficient to produce its specific effects, and the calomel in doses sufficient to remove from the bowels all offending matters at once; after this, I gave some of the preparations of opium to keep the nervous system quieted and mitigate pain. I also used warm hip-baths, warm poultices, and exciting embrocations of turpentine, camphor, aqua ammonia, &c. I never suffered the bowels to remain locked up with the opiates; but, with oil, blue mass, or rhubarb, I kept up daily evacuations of the small intestines, until the stools became mixed with consistent fecal matter. If there was great tenderness of the bowels and very obstinate torinia and tenesmus, after the above remedies had been previously used, I usually applied a large blister, and let it remain on four or six hours, and gave injections of starch and morphia, which I found to be preferable to any other preparation of opium, and by injections, the best way of administration. When the disease assumed a chronic form, characterized by prostration, cold extremities, coolness of the surface, frequent thin or watery evacuations, I usually united to the morphia, the nitrate of silver, and gave a little old brandy, or wine whey, to support the system. In regard to diet, I enjoined the utmost strictness, in quantity and kind, during the continuance of the attack and during convalescence; for I found the relapses very frequent, from imprudent indulgence in improper kinds and quantities of food. I generally found most subject to it those who were enfeebled by dissipation and indolence, or those who lived grossly, &c. Among children, I found those who were teething, or wormy, most subject to dysentery.

**ARTICLE XXVI.**

*Two cases of Slow Action of the Heart in Fever.* By James Y. Carithers, M.D., of Hendricksville, Ala.

October 1st, 1853, was called to see Mr. S., aged 20, who was taken with slight chill, with pain in head, back and extremities; skin hot and dry; tongue covered with a white fur,
attended with nausea and vomiting; pulse 90. Ordered 20 grs. Ipecacuanha, which caused free vomiting to take place, to be followed at night with blue pill: on the following morning to take five doses of sulph. quinine, 3 grs. each. At 4 o'clock, P. M., had a light chill.

3rd. Slight fever, with great thirst— to have oil to act on his bowels; to take next day three doses sulph. quinine, 4 grs. each, and blue pill at night.

4th. No chill since last call; pulse 75— to take 1 gr. sulph. quinine every two hours during the day, and a blue pill at night.

On the 10th he relapsed—the skin became hot, and the pulse rose to 94; on the 12th, the pulse fell to 70, and continued to decline until the 17th, when it was down to 42 or 43, although French brandy was given freely. 18th. Pulse 40; has taken 10 ounces of brandy. 19th. Pulse 40; brandy continued. 20th. Pulse 40; ordered brandy with iron. 21st. Appetite good, and feels well; treatment the same. 22d. Brandy increased to 12 ounces. 23d. Pulse 50; spirits improved. The pulse continued to rise until the 26th, when it was 84, and 84 when the brandy was omitted, and the iron continued. I saw him again on the 30th, and found him apparently well with his pulse 64.

Case 2. Mr. A., aged about 34, was taken, Nov. 10th, 1853, with pain in the head, back and extremities: shin hot and dry; tongue moist, with a white fur; pulse 86. Ordered Ipecac. 25 grs., and five hours after to take 3 blue pills. 12th. To take quinine. 4 o'clock, P. M., had a heavy chill. 13th. To take 4 grs. quinine every hour until he takes 16 grs., with 3 grs. opii. 14th. Slight fever— to take castor oil. 15th. No chill to day. He continued to improve until the 22d, when he was caught in a shower of rain, and had a light chill and slight fever; pulse 74. 23d. Pulse 60. On the 24th, it was down to 52, when French brandy was resorted to, 6 ounces. 25th. Pulse 46; stimulants increased to 8 ounces, with iron. 26th. No change in pulse. 27th. Brandy, 10 ounces. 28th. Pulse 84; appetite good to day. 29th. Pulse 68; slight fever and headache— ordered castor oil to act on bowels. 30th. Pulse 50; brandy and iron continued. Dec. 2d. Pulse 56; his spirits good to-day, and
Ergot: its use during Labor.

says the brandy is the most palatable medicine he has ever taken. Dec. 4th. Pulse 60. He now considers himself well.

We are at a loss to account for the diminution of the heart's action in these cases—the number of beats per minute having ranged from 40 to 50 without any evident cause.

TRANSLATIONS FOR THIS JOURNAL, FROM FRENCH PERIODICALS.

Ergot: Circumstances which contra-indicate its use during Labor. By M. Paul Dubois.

Ergot, besides its well known hemostatic properties, is useful when, from inertia, the uterine contractions are insufficient to complete delivery. It is, however, to be regretted that this valuable remedy is so often improperly used. We have frequently known it given when it was entirely unavailing, because unsuited to the case. This abuse, and the sad effects consequent upon it, have contributed very much to discredit ergot in the minds of many practitioners. We should, nevertheless, not be deprived of so precious an agent from the mere fact that it has been injudiciously administered. We should rather endeavor to ascertain the circumstances under which it may be advantageously prescribed, and distinguish these from the contra-indications to its use. The circumstances under which the uterine contractions may be impaired without calling for the use of ergot are sufficiently numerous to merit attention. The following are some of the most common:

1st. Debility dependent upon a natural state, or induced by previous disease. This requires tonics, broth, wine, &c., for the purpose of improving the strength of the patient during labor.

2d. Extreme distention of the uterus from an excessive quantity of liquor amnii, which induces incomplete paralysis. The uterine fibres being inordinately distended, the membranes should be punctured whenever the os tinae is one-fourth dilated, or about the size of a half-dollar.

3d. Congestion of the face, attended with impaired contractions from plethora. The patient should then be bled.
4th. Mental disturbance from whatever cause, sometimes from the presence of particular persons in the chamber, may suspend the uterine contractions. The woman must be quieted and the causes of annoyance removed.

5th. Great elevation of temperature in the apartment may lessen the contractions by the cerebral congestion it induces. The room should, in such cases, be well ventilated and cooled if possible.

6th. Pain, other than that of labor. Retention of urine, may be so painful as to impair the contractions; catheterism should then be practiced. Very great pain in the loins may likewise affect them, in which case we should apply the forceps if labor is sufficiently advanced—if not, wait patiently. The same may be said with regard to the headache which sometimes attends each abdominal contraction.

7th. The premature discharge of the waters makes labor slow, because, like all hollow organs, the uterus contracts most forcibly upon unyielding contents, and that when the membranes are ruptured the descent of the fetus at each contraction lessens its force.

8th. The uterine contractility may become exhausted by the tardy rupture of the membranes in consequence of the firmness of these; rupture them.—Rigidity of the os tincæ from phlegmosis may do the same; resort to belladonna or to general bleeding.—If the cause be unyielding induration of the tissues of the cervix uteri, of which we have recently seen a case, the knife should relieve the resistance.

9th. There may be posterior obliquity of the cervix which will lessen the force of the contractions. If the os does not dilate of itself (and cannot be rectified by the finger—Ed.) we may have to divide its anterior lip with a probe-pointed bistoury.

Epilepsy treated with Hydrocyanate of Iron.

Dr. Jansion, of Bruyere (Tarn) published in the August No. for 1841 of the "Journal des Connaissances," a paper containing an account of several cases of Epilepsy cured with hydrocyanate of iron. The first of those cases was dated as far back as 1827. M. Fabre has also just published in the "Revue Méd.
similar facts derived from the practice of M. Roux de Brignolles, Professor in the Medical School of Montpellier. The first of these cases goes back to 1829. M. Roux's case was that of a general, who having in 1814 retired from the army, and changed from an active to a sedentary life, experienced various impairments of health, the most serious of which consisted of epileptic attacks, which were rare at first, but which subsequently recurred as often as three times a day. The patient felt the premonitory aura epileptica ascending from the lower extremities to his head. The general would stagger, sometimes with loss of consciousness, but most frequently with mere vertigo. In 1829 he was subjected to antiphlogistic treatment, which only aggravated the case. It was then that M. Roux prescribed for him the Hydrocyanate of Iron. Pills containing $\frac{1}{2}$ grain of this preparation and 1 grain Pulv. Valerian were ordered night and morning. The daily number of pills was gradually carried up to 16; at the end of three months the general was free of attacks—and he has had none since, although 24 years have elapsed.

M. Roux reports six cases cured by this remedy—one of which we have just related; the remainder will be briefly noticed. One of the most remarkable was that of a country lad 20 years of age, who upon being greatly frightened, had a complete attack of epilepsy; fell into convulsions, foamed at the mouth, urinated involuntarily, with prolonged unconsciousness. These attacks recurred frequently during four years. The hydrocyanate was administered, at first with pulv. valerian, without effect. The disease, however, yielded very soon upon the use of the Hydrocyanate alone, in doses of a grain (5 centigr.), and gradually disappeared entirely. The treatment was continued 8 months, and 20 years have now elapsed without a return of the disease.

An epileptic patient, aged 16 years, whose case was recent, but the paroxysms frequent and violent, was completely cured in six months by the use of the hydrocyanate and valerian. A girl of sixteen, who menstruated badly and was affected with complete epilepsy, was also restored to health by its use 8 months. The other 3 cases were equally successful. The quantity, in pills, was gradually increased from 1 to 16 grains per day.
Sciatica treated by medicated issues.

M. Trousseau observes that morphia applied to blistered surfaces answers very well; but that this plan is both painful and expensive. He has therefore adopted the following method of introducing remedial agents within the tissues. The patient, lying upon his abdomen, a crucial incision is made over the sciatic notch with a bistouri, and a medicated pea is fixed in the centre; thus answering the double purpose of an issue and of a local anti-neuralgic application. This is M. Trousseau’s formula:


Each of these pills will therefore contain 3 grs. of active matter. They should be dried by gentle heat, and will, in consequence of the guaiacum become very hard. They ought not to be used the first day. The incision having been made, force down into the centre a common pea, which has the advantage of a fine polish, is unirritating, and will by swelling enlarge the cavity for the reception of the medicated pill. On the second day, one of the pills is to be introduced with two common peas and the whole covered with lint and adhesive plaster. If, on the third day, the patient has not been too much narcotized, two pills may be introduced—and thus the number increased to 3 or 4, according to the necessities of the case. In a week the cure will generally be nearly completed. As this disease is liable to return, M. Trousseau advises to keep up the suppuration of the issue for two or three weeks after the cessation of pain. We thus secure a good revulsive and at the same time keep open the door for the introduction of narcotics, if they again become necessary.

Perchloride of Iron as a Hemostatic.

M. Moisseneet has used a solution of this preparation, more or less strong, at the Salpetriere, in cancerous affections accompanied by hemorrhage, instead of cautereization and tamponing. As it has as yet been tried only in a few cases, its beneficial effects cannot be positively asserted; but in one case of cancerous breast, and four cases of uterine cancer, it has been of great utility in arresting the hemorrhage and prolonging life.
In cancers situated externally, within reach of the hand, M. Moissonet passes a small brush wet with the solution over the seat of the hemorrhage for two or three minutes. In the deeper parts, he inserts small pieces of lint, having first wet them with the solution. He washes the fungous parts for some days with a solution of 30 grammes of the perchloride and 250 grammes of water, (or 1 part to about $8\frac{1}{2}$ water). This solution is used in injections for uterine cancer.

**Solidification of Cod-liver Oil.**

M. S. Martin, apothecary, of Paris, proposes the following process for the solidification of cod-liver oil, by which its administration may be rendered much less objectionable.

Take of Cod-liver oil 125 parts—Spermaceti 23 parts in summer or 20 parts in winter. Mix, and heat in a closed vessel over a sand-bath—then pour it into a large-mouthed bottle and allow it to get cold without being agitated. The remedy may be made aromatic by the addition of some essential oil. Cod-liver oil thus prepared resembles jelly; it may be taken rolled up in bread moistened with sweetened water, or covered with pulverized gum, liquorice or starch.

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**On Irritability of the Bladder.** By Henry Thompson, Esq., F. R. C. S., M. B. Honorary Surgeon to the Marylebone Infirmary.

The phrase, irritability of the bladder, is a term which has long been employed both in and out of the profession, and which has become popular, rather on account of a certain convenient comprehensiveness and indefiniteness of meaning of which it is susceptible, than for any value which can be attributed to it as an explicit or perspicuous expression.

The usage of it, which is commonly adopted, comprehends a very wide and varied extent of signification, presenting at least two very distinct and different ideas; occasionally one of these only is implied, although much more generally the term is employed in a manner which renders it impossible to say which of the two is intended, or which conveys a confused notion, involving a joint consideration of both.

In one of these senses, irritability of the bladder denotes nothing more than the phenomenon of unnaturally frequent
micturition, and it is thus employed in describing one of the prominent symptoms of calculus or urethral stricture. In the other, it is used for the purpose of designating some affection of the bladder assumed to be present as the occasion of that symptom, especially when the cause does not appear to the inquirer to be very obvious or explicable.

Now, nothing can be more objectionable than the unguarded use of a term to which are attributed two such very different significations. Neither can it be otherwise than mischievous to employ it in the very loose and uncertain manner of which the latter is an example.

The simple condition described by the term in the sense which was first named is one of very frequent occurrence among individuals of both sexes, and it is always attended with much annoyance, and often with severe distress to the sufferer. It can rarely or never be overlooked by the patient, and can scarcely fail to be recognised by the surgeon, while the right interpretation of it is often of the greatest importance to both. It is a condition which constitutes the whole of the objective as well as the subjective signs in some diseases of the viscus in question; while in many it is the most distressing to the patient, and the most wearing to the constitution of all his symptoms.

It is not surprising, then, that it should, not only by the patient, but even by the medical practitioner, come to be regarded, not merely as a sign or symptom of some morbid state, the seat of which may in reality be very remote, but as the manifestation of a disease localized in the bladder itself—a state which, in the absence of the signs of inflammation there, comes to be denoted by a term which I think it will appear can be rightly applied only to the symptom in question. Hence we often find "irritable bladder" prescribed for, apart from any distinct views of its cause, and even without much investigation thereto—at all events with so much only as shall exclude its better known and more generally recognized causes, such as cystitis, prostatitis, urethritis, and stricture of the urethra; and if these are absent, there appears to be a tendency to refer the symptom to some ideal condition of the bladder assumed to be present, which it saves our trouble, and shields the imperfection of our knowledge, to express by this term of irritable bladder. Hence we find the subject treated somewhat in this manner by authors on Diseases of the Bladder. A chapter on "Irritability," as a disease, usually follows or precedes the sections which are devoted to the consideration of those morbid states which we understand by the terms acute and chronic inflammation.

Thus, Dr. Gross, of Louisville, in his large treatise on "Diseases of the Urinary Bladder," &c., after discussing the
acute and chronic inflammations, classifies "irritability" under
the "nervous affections of the bladder," and commences the
chapter with these words: "The characteristic symptom of
this disease is frequent micturition."* Mr. Coulson, in his well-
known and useful work on the same subject, remarks that "this
term is usually employed to denote any affection of the bladder
attended with frequent desire to void the urine. I wish, how-
ever, to express by it a frequent and often irresistible desire to
micturate, not arising from inflammation, nor from any organic
affection of the bladder or prostate gland, and sometimes, but
not always, attended with pain. The frequent desire to mictu-
rate is the chief symptom of this complaint."† Sir Benjamin
Brodie appears carefully to guard against the source of error
alluded to above, commencing an exceedingly short paragraph
upon the subject, in his valuable work on the "Urinary Organs,"
with these words: "In the greater number of cases of disease
of the bladder the most marked symptom under which the pa-
tient labours is a too frequent inclination to void the urine.
The bladder is irritable; and those who have not combined
with the observation of symptoms the study of morbid anatomy,
are apt to confound with each other diseases which are essen-
tially different, under the general appellation of irritable blad-
der."‡

Now, in harmony with the spirit of the last quotation, I
venture to suggest that we shall be more likely to advance the
true pathology of the important organ under consideration if
we will consent to exclude from the term "irritable bladder"
any kind of nosological import, to permit it to convey to the
mind no suggestion in the light of a disease, but to limit its
meaning to that which in truth is all that it possesses—viz., the
expressing a symptom, and a symptom only, of which it is the
province of the surgeon to determine, if possible, the true
cause; and if it should appear that the seat of the complaint,
the cause of the frequent micturition, is generally not in the
bladder at all, but in some adjacent or remote part of the body,
we shall, I think, at the same time, see the propriety of reject-
ing that usage of the term which involves a pathological sense
in connexion with the bladder, and limited to that organ alone.
At present its employment in the signification of a disease tends
greatly to prevent the formation of a true diagnosis, inasmuch
as a consent to accept the term in any given case satisfies some
minds, and checks further inquiry, so that the common error
of substituting an unmeaning name for a thing of reality is apt

* Page 192.
† Diseases of Bladder and Prostate Gland, fourth edition, p. 84.
‡ Lectures on Diseases of the Urinary Organs. Fourth edition, p. 90.
to be committed. On the other hand, its employment as the
designation of a symptom only will stimulate us in the attempt
to elicit from nature the real seat of the morbid action.

On these grounds, therefore, I propose to regard this com-
mon and troublesome cause of complaint on the part of the
patient, this symptom of frequent micturition, as a matter for
inquiry, in relation chiefly to its etiology, in the present and
two or three succeeding papers; and in order to prevent mis-
understanding, I shall propose to define irritability of bladder
to be a condition in which expulsive efforts are made by the
organ with unnatural frequency, whether contents are present
or not, whatever may be the cause which gives rise to the
contractions. This condition is found in practice to manifest
very widely-differing degrees of severity, and to be attended
with some concomitant circumstances of a varied character.
Generally speaking, irritability is denoted when a constant or
almost constant desire to pass urine exists. Of this sensation,
recurring exacerbations usually take place with more or less
frequency. These may be wholly irresistible, compelling the
patient to yield to overwhelming efforts at expulsion, in which
he passes a few drops of urine, or perhaps none at all, for the
bladder may be perfectly empty. So far from relieving the
sufferer, the effort of contraction is often productive of great
agony, and its recurrence is dreaded. In other cases the de-
sire is by no means constant, but is only felt at intervals of
some minutes, or it may be of half an hour or an hour, and then
great pain is experienced unless the wish be gratified. To all
those cases which exhibit much involuntary paroxysmal effort
the term spasm is commonly applied.

The usual number of times which a healthy man requires to
empty the bladder is from three to five in the twenty-four hours,
although perhaps a greater frequency may be occasionally as-
sociated with some peculiar idiosyncracy or particular state of
the system, which it would not be correct to characterize as
morbid. Any marked deviation from this habit in the direc-
tion of frequency becomes a symptom conveniently expressed
by the term "irritable bladder."

One of the most potent causes of irritability of the bladder
is inflammation, generally chronic, rarely acute, affecting most
commonly its mucous lining only, at all events at the outset of
an attack. Any degree of inflammation in this coat gives rise
to irritability; the extremities of the sensory nerves distributed
to it forming afferent communications with the neighboring
centres, from which motor impulses are propagated to the
muscular coat of the viscus, and to the auxiliary muscles em-
ployed in the act of micturition. Excito-motory acts, however,
are produced in a great variety of ways. Sources of irritation are to be found, not only in the organ itself, but at a distance from it. On taking a close survey of these, as far as my means of observation have enabled me, I beg leave to suggest the following classification of causes of irritability of the bladder, and by means of it to attempt an arrangement which shall be natural and comprehensive, and practically useful in assisting our diagnosis in relation to this important symptom. We shall do well, however, to bear in mind that its object is to facilitate the process and to improve the method of diagnosis, and that it should be regarded merely as a means to this end—a means necessarily imperfect, and in the details of its arrangement probably open to some objections, on account of the varied points of view from which many of the causes themselves may be regarded by different minds.

Irritability of the bladder, regarded as a symptom only, may be considered as resulting from various causes, which are classified under the following heads:

A.—Certain conditions of the bladder itself.
B.—Abnormal character of its contents.
C.—Some abnormal and acquired conditions of adjacent or allied viscera and other parts, the disease being of a local character.
D.—Certain derangements of the assimilating and nervous systems.

A.—Certain Conditions of the Bladder itself.

1. Inflammation, acute.
   
   chronic or subacute.

2. Cystorrhea or congestive catarrh, from atony and relaxation of the capillaries of the mucous membrane, and usually a sequence of inflammation.

3. Abrasions and ulcerations of the mucous membrane.

4. Abscesses in the walls of the bladder.

5. Thickening of all the structures of the bladder from inflammatory deposit, so that the capability of the organ for contraction and dilatation is much impaired. The capacity being thus considerably diminished in some cases, a frequent desire to pass urine exists.

6. Gouty and rheumatic affections of the bladder, when, as is sometimes the case, these are the only local manifestations of constitutional derangement. The rheumatic affection appearing to be occasionally a sequence of gonorrhœa, and probably belonging to the same category as gonorrhœal affections of the joints.

7. Increased or modified sensibility, usually of the neck of the bladder, no inflammation being present. Severe pain in the region of the bladder (neuralgia) from the same cause.

8. Tumours: simple—malignant.
On Irritability of the Bladder.

B.—Abnormal Character of its Contents.

1. Urine containing an unusual quantity of acid or alkali, especially in Oxaluria and Phosphuria, also when there is an excess of uric acid; often associated with some form of chronic dyspepsia. Urine passed in an unusually large quantity.

2. Urine containing an admixture of certain drugs; as caucharides, the turpentine, &c.

3. Foreign bodies in the bladder, giving rise to spasmodic contractions of its muscular parietes; as calculi, not only when large, but sometimes when of small size, and termed gravel; coagulated blood, and lymph.

C.—Some Abnormal and Acquired Conditions of adjacent or allied Viscera and other parts, the disease being of a local character.

   " " growths in the urethral canal.
   " " prostatic enlargement, whether from senile degeneration with hypertrophy, or other tumour.

2. Malformations of the prepuce, when its orifice is small, or when it is long and narrow.

3. Urethritis, balanitis, and inflammatory phymosis.

4. Prostatitis, acute and chronic.

5. Vaginitis.

6. Painful vascular tumour of urethra meatus in the female.

7. Perineal, ischio rectal, or other adjacent abscess.

8. Hæmorrhoids.


10. Prurigo about anus.

11. Seyba'a in the intestines.

12. Intestinal worms, particularly ascarides.

13. Organic diseases of the kidney; the irritability not being caused by the unhealthy character of urine secreted (Division B), but by means of some other medium of relationship between the kidney and bladder.


15. Diseases of the uterus and appendages. Misplacement of uterus, as prolapse, retroversion, &c.

D.—Certain Derangements of the Assimilating and Nervous Systems.

1. The gouty and rheumatic diathesis, no evidence of distinct local implication existing.

2. Hysteria, "spinal irritation," as associated with irregularities of the menstrual function.

3. Irritable or mobile conditions of the nervous system; in elderly patients, probably connected with organic cerebral changes; in middle age and youth generally resulting from anaemia and spanaemia, caused perhaps not unfrequently by venereal excess.
es; in childhood and infancy, a naturally active state, in which
dentition and other remote sources of irritation are exciting causes.
4. Diseases and injuries of the brain and spinal cord.
5. Mental emotions. Anxiety, fear, &c.
Frequent micturition may be a habit due entirely to false mental
impressions; it may have been induced by some of the causes above
mentioned, and persist in this manner after the cause is removed.

PART II.

It is no part of my intention to expatiate here on the more
generally recognized causes of frequent micturition—those, in
short, with which all are sufficiently familiar; but rather to re-
fer to some of those which have received less attention, and
appear to be capable of less easy solutions. Instead, however,
of indicating them at once, it will be more advantageous, per-
haps, to arrive at their consideration through a brief notice of
the diagnostic signs, presented by the various morbid affections
named in the Table, commencing with those which are most
commonly known and readily identified.

In attempting to form the diagnosis of any case of difficulty
or obscurity, it will be desirable to proceed by process of ex-
clusion, and set aside in their order as many as possible of the
affections to which it is known irritability may be due. Thus,
in the first place, there will be no difficulty in detecting a form
of disease, very uncommon, but sufficiently marked—viz., the
acute inflammation of the bladder—by the intense pain felt
about the pubes and perineum, with excessive tenderness,
especially in the former situation; by severe and darting pains
constantly experienced in the groins, sacral and lumbar regions;
while incessant spasmodic straining is present, with fruitless
attempts to micturate, often of a most agonizing character.
Together with these, severe constitutional symptoms are invar-
ially present. The subacute form, much more frequently
met with, is easily recognized by the presence of pain, gener-
ally dull and heavy, referred chiefly to the suprapubic region,
often to the penis, testicles, and thighs; and by the tenacious
mucous discharge, in greater or less quantity, which, mingling
with the urine, is so characteristic of this condition of the ves-
cal mucous membrane. In connexion with these symptoms,
the patency of the urethral canal is to be determined by the use
of the catheter, in order to ascertain the presence or absence
of obstruction either from organic stricture or prostatic disease.
The complication of calculus is indicated by the ordinary
symptoms superadded to the foregoing, such as occasional sud-
den stopping of the stream of urine, some haematuria, pain in
the glans penis and at the neck of the bladder after micturi-
tion, these pains being increased at all times by sudden or
violent movements of the body, such evidence being confirmed by the practice of careful sounding, repeated as frequently as may be necessary. The same process may reveal the presence of any growth within the viscus, from which all the subjective symptoms of calculus may arise, and even physical sign of rough grating to the sound may be communicated from adhering sabulous matter. The careful employment of exploring instruments, generally in such cases a painful and somewhat injurious process, repeated as often, and not oftener than is absolutely necessary, with the simultaneous examination of the base of the bladder from the rectum, will assist in determining the size and situation of the growth. This may spring from the prostate, generally from the neck or base, rarely from the sides of the bladder. There will be bloody and frequently offensive urine, often with thick, clotted, or sanious discharge; and in a later stage, the débris of tissues may appear by the urethra, if the disease be of malignant character. Among these, the microscope will sometimes—but it would seem not invariably, according to the experience of observers—detect the existence of cells similar to those met with in carcinomatous formations found elsewhere. One of the strongest confirmative signs of the malignant character of the complaint will be found in the cachectic condition of the patient, and in the presence of that peculiar sallow tint, which never appears more strongly marked than in these cases.

The fluid contents of the bladder must, in all cases, be submitted to close inquiry, a proceeding which is of the first importance, in order to ascertain correctly the chemical and microscopical character of the urine and its deposits—that is to say, the degree of acid or of alkaline reaction, the nature of the salts present, the existence of albuminous matters, of sugar, &c. Following these inquiries, the condition of the kidneys should be the subject of careful investigation. Some organic renal diseases, or some stages of such diseases, are not attended with vesical irritability, but the reverse is more commonly the case. The evidence of structural degeneration will be found in part from the constant appearance of albumen in the urine, from the presence of diseased epithelium and urinary casts under the microscope, generally found co-existing with increased quantity and low specific gravity of the secretian itself, as well as from the cachectic condition of the patient, the dry and pallid skin, the stomach derangement, pains in the loins, and about the pubes, and, lastly, from the anasarca of the cellular tissue which more or less at some period or another, makes its appearance.

Simple inspection is sufficient to determine the existence of
malformation of the prepuce, as when it is unusually long and narrow, of the meatus externus, of balanitis, of phimosis, or paraphimosis. An inquiry for recent attacks of urethritis in any form, but particularly the gonorrhoeal, and an examination of the prostate gland per rectum, where other symptoms indicate such a course, together with the presence of perineal swelling or tenderness, will furnish evidence respecting inflammation of that organ. The various affections of the rectum are febrile sources of too frequent micturition, and must be strictly inquired for, especially with patients of the female sex, such being exceedingly prone to consult their medical adviser respecting the symptom in question, and at the same time, failing to mention or denying the existence of any hæmorrhoidal or allied affection, which is very often the sole cause of the evil complained of. Vaginal, uterine, and ovarian affections of various kinds, come next in course, and are by no means unfrequent causes; such are ulcerations in any part of the female passages, misplacement of the womb, &c. Among them, a small growth of the so-called florid vascular tumour of the urinary meatus is by no means an uncommon cause of a whole train of painful symptoms, among which vesical irritability is prominent. It may be no bigger than a full-sized pin's head; its existence, perhaps, is unobserved and unsuspected by the sufferer; nevertheless, it may be the sole cause of all her sufferings. I have but very recently met with an apparently very obscure case, in which a distressing irritability was due to one of these growths, situated entirely within the urethral orifice, and, therefore, unseen except by opening the meatus. On the other hand, in young patients of both sexes we daily find intestinal worms, and, in elderly people, hæmorrhoidal and pruriginous affections occasioning unnaturally frequent micturition.

Such as these are some of the more easily recognised and common causes of irritability of the urinary bladder. Still it is obvious enough that there are not unfrequently cases presenting themselves to the surgeon, in which, having excluded all these by rigid inquiry, the morbid symptom remains unexplained and obscure. Such are the cases termed nervous or neuralgic, or simply irritable bladder, by some writers. I have contended that we are not justified in stopping here to employ such terms, but may with advantage push our inquiries further in search of the pathological seat of the disease, whether it be of a functional or an organic character.

Among the less obvious causes of irritable bladder, no organic lesion having been detected, is some abnormal condition of the urine itself, which, while it often indicates certain errors either in the assimilating or in the excreting functions, may
also be an early sign of organic changes occurring in the kidney. I believe that a chronic and insidious form of kidney disease is sometimes presented first to the surgeon, in an early stage, in which a superficial examination of the patient will detect no other sign than a somewhat unintelligible and obscure irritability of the bladder, although close investigation may render probable the existence of incipient organic disease; while in more advanced stages of the affection other signs manifest themselves, and the patient is often committed to the care of the physician, to whose province the treatment of renal disease is commonly supposed to belong. In the absence of apparently serious lesions, the persistent deposit of an undue amount of oxalic acid in the urine, in the form of the oxalate of lime, is often associated with irritability of the bladder, and may occasionally be the only marked deviation from health which can be noted respecting it. Dyspeptic ailments, are, however, commonly present, and a more or less impaired condition of the vital powers generally. Individuals who are much engaged in close mental occupation, or who are the subjects of excitement and anxiety, seem especially prone to manifest this particular derangement. Too much attention can scarcely be given to the continuous examination of the urine, where the concurrence of obstinate dyspeptic symptoms and vesical irritability, pain, or uneasiness are presented. If oxalates appear in a regular and persistent manner, we shall in very many instances of this really frequent affection find reason to regard the whole train of symptoms as due to that form of mal-assimilation which has been indicated by the phrase oxalic-acid diathesis. The researches of Dr. Prout especially, as well as of Dr. G. Bird, of Dr. Begbie of Edinburgh, and others, have rendered this subject familiar to practitioners. I have met with some examples of supposed local disorder of the urinary organs among patients who were labouring under the derangements alluded to, but who proved to be quite free from vesical or renal disease. In one of these, the urine, which was daily examined, exhibited on three occasions the rare form of dodecahedral in the place of octahedral oxalates. In that, as well as in other cases, I have found great benefit to accrue from the persevering use of the nitro-muriatic acid, as first recommended by Dr. Prout, combined with attention to the functions of the bowels and skin. Under the remedy named, the oxalate of lime disappears, the uric acid gradually replaces it in normal quantity, and the irritability of the bladder ceases to be complained of. As convalescence advances, the addition of the tincture of the sesqui-chloride of iron to the acid appears to be often exceedingly serviceable.
Uric acid in excess, met with, however, in a very different class of patients to those last considered, is very often associated with unnaturally frequent micturition, generally perhaps in cases where there appears to be some tendency to the gouty or rheumatic diathesis. That vesical irritability and even urethritis, may be the only very obvious manifestations of the gouty tendency exhibited by some patients, is a belief, now at all events commonly accepted. That they sometimes appear in conjunction with the most common manifestations of the gouty diathesis is well known. When any doubt in relation to this cause exists, inquiry into the family and personal history of the patient will assist the diagnosis; at the same time we shall seek for the presence of other signs of gout, appearing usually in persons of middle age; the predominance of lithic acid in the urine; undue vascularity of the skin and mucous membranes; disposition to chronic cutaneous eruptions; the better recognised symptoms of masked gout, as it is termed, such as sudden pains in the precordial region; palpitation of the heart; wakefulness and restlessness at night, &c.,—all these taken together, will confirm the existence of a complaint, the judicious treatment of which, on principles which are generally recognised, will do more to allay the irritability of the bladder than any other means supposed to have a more direct influence upon that organ. Thus it is not uncommon to meet with these patients believing themselves to be suffering from stricture or prostatic disease, but whose symptoms disappear under a careful regulation of the diet, with sufficient exercise, and the judicious use of mild mercurial alteratives, with colchicum and alkalies. In regard of these latter most useful agents, in cases for which they are indicated, perhaps there is no form so sufficient or so well borne by the stomach, and certainly none so agreeable, as solutions of the carbonates and citrates of potash which have been well charged with carbonic acid. They are prepared in the ordinary form of aerated waters, and are greatly preferable to water containing the carbonate of soda. On this ground, and on that of practical observation of their use, I believe them to be more potent and more certain than the Vichy water, for most of the purposes for which that agent is commonly employed, while at the same time they are so much more economical. Thus, where deposits of uric acid assume the form of gravel—a condition very frequently associated with irritability of the bladder—the potash water may be most advantageously taken as a solvent, while relief of the symptom referred to is experienced simultaneously. There is another good reason, also, why these waters should be more valuable agents than the same doses of alkali given in the usual form of
draught or mixture. Pure water itself is the best solvent of saline matters in the urine, and the large quantity taken with the dose by the former mode probably accounts to some extent for its efficacy as compared with the latter. Besides, water in quantity acts as a diluent to all the urinary principles, and so renders the urine less irritating to the vesical mucous membrane already become more susceptible than in health, a condition arising in part from continued exposure to the unduly acid secretion, and in part from the primary malady, whatever it may be, which more or less induces a morbid condition of the mucous tracts of the body generally. The action of the carbonic acid extricated in the stomach appears also to be beneficial, and when we take into account the fact that some derangement of the assimilating functions lies at the root of the evil, that deficiency of tone is manifested in the reducing organ itself, it is not improbable that the gas may be regarded as an additional element of some value in the compound.—[London Lancet.

(To be continued.)

The Pathology and Treatment of Diseases of the Scalp, popularly known by the name of Ring-Worm. By Dr. William Jenner.

[The difficulty of diagnosing (diagnosticating—Ed.) eruptive diseases of the scalp, is owing partly to their similarity to each other and partly to the different names given by different authors to the same thing. Popularly, ringworm is looked upon with the greatest anxiety and annoyance, as the term is supposed to represent a very obstinate and contagious disease.]

What is popularly meant by ringworm was by some of the older writers on skin diseases expressed by the word tinea; but the technical name being found, as our knowledge advanced, to have no definite signification, gradually fell into disuse.

It has been recently proposed to employ this word tinea again, and to give to it a precise signification. Under the generic name tinea it is proposed to include all diseases of the hairs produced, kept up, or attended, by the development of parasitic plants.

In this genus are included the following species: Tinea favosa; Tinea tonsurans; Tinea decalvans; Tinea sycosa.

It is to this genus tinea, and to these species of that genus, that I desire especially to call your attention; and I am confident that if you remember the names of the species of tinea I have just repeated, if you learn what I am about to tell you of
those species, and observe well the things I shall presently show you, the remaining and more common diseases of the scalp will be mastered in a very few hours spent in the out-patient's room.

Tinea favosa most commonly affects the hairy scalp, but now and then it is found on other parts of the surface. It is characterized by thick, dry, yellow crusts, which, if small, are circular in outline and depressed in the centre, cup-shaped. Passing through the centre of each of these crusts, is a hair.

If the crusts are very large they have an irregular shape, but still they indicate their origin from distinct centres by the semi-circular outline of the masses which project from their margin. These larger, irregularly-shaped crusts, are pitted on the surface, and, from their fancied resemblance to the cut surface of a piece of honey-comb, the disease has received the name of favus.

The margin of the large crusts rises considerably above the level of the cutis; internally, they seem as though half buried in the substance of the cutis. Carefully detach the crusts from the cutis, and a distinct layer of epithelium is found below them; examine the surface of the smaller crusts, and you find a layer of epithelium cover them.

The hair, at an early period of the disease, can be pulled out from the centre of each little crust with great facility; subsequently it falls off from the diseased parts, and permanent baldness results.

The crusts, then, of tinea favosa are remarkable for their thinness, dryness, brittleness, and depressed centre. Tinea favosa is not a pustular disease, but it is said, by those who have seen much of it (it is a rare disease in London), to be often consecutive to eczema, impetigo, chronic lichen, and herpes circinatus; pustules are sometimes formed subsequently to the tinea favosa, in consequence of the inflammation excited by the crusts, and the injury inflicted on the scalp by scratching.

Tinea tonsurans is often mistaken for herpes circinatus of the scalp, with which it is now and then conjoined. It is characterized by pallor, decolorization, and brittleness of the hairs, and the presence of thin white powdery scales around the base of the hairs, and on the skin between them. The diseased hairs have been likened to "tow." "They are," Mr. Wilson says, "remarkable for their bent and twisted shape, and resemblance to the fibres of hemp in colour and apparent texture." Their brittleness is sometimes such that every hair on the affected spot is broken off just above the surface of the skin.

In Tinea decalcans the hair falls out rapidly from one or more circular spots, leaving a smooth bald surface. There is no eruption of any kind,—no crusts, no scales.
Tinea sycosa is characterized by inflammation of the hair follicles. Sometimes the inflammation leads only to the effusion of serosity, and the exudation of lymph around and into the capsule of the hair. At other times, and more commonly, pus is formed, and then, when the pustule breaks, a brownish scab is formed on the surface. The usual seat of tinea sycosa is, the chin, upper lip, and sides of the cheek. I had a case lately under my care in which the pustules occupied the inner surface of the nares,—that part from which the hairs spring that protect the orifice of the nose. Tinea sycosa rarely occurs on the scalp, and it does not spread circularly; so far as I know, the name of ringworm has never been applied to it. I mention it to you to-day, although I have no example of it among my patients to show you, because of its relation to the species of tinea of which we have examples before us.

You will have remarked, then, from the characters of the species of tinea I have mentioned, that—

Tinea favosa is especially characterized by its crusts.

Tinea tonsurans is especially characterized by decolorization and brittleness of the hair.

Tinea decalvans is especially characterized by baldness, not preceded or accompanied by an eruption.

Tinea sycosa is especially characterized by inflammation, tenderness, hardness, and suppuration of the hair follicles.

I told you that these diseases are arranged together in one genus, because in all a parasitic plant is developed in connexion with the hairs. Now, the plant present is different for each species of tinea; and the situation occupied by the parasite is also different in each species of that genus.

In tinea favosa, the parasite is the achorion Schönleinii. This plant has mycelium, sporule-bearing branches and sporules. The sporules are round or oval, and their diameter varies, according to Gruby, from 0.003 mm. to 0.01 mm.

The vegetable growth is first perceptible between the layers of the epithelium, just at the orifice of the hair follicle; from this point it may spread downwards between the hair and its capsule, and upwards around and in the substance even of the hair.

Such of you that visited ward 4 during the time Jacobs was in the hospital, had frequent opportunities of seeing the mycelium, the sporule-bearing branches, and the sporules of the achorion Schönleinii. You will recognise it in these very excellent drawings of Robin.

In tinea tonsurans, the parasite is the trichophyton tonsurans. This plant is composed of spores only; the spores, however, are occasionally somewhat elongated, and arranged in a linear
series. They are round or oval, and their diameter varies from 0.003 mm. to 0.01 mm.

The primary seat of the trichophyton tonsurans is the root of the hair; subsequently, it extends up into the substance of the hair, and even outwards, according to Bazin, on the skin between the hairs. I have under the microscope some hairs removed from the head of one of these children. You will see in one specimen the spores in the hair follicle; and, in another, the hair split up with the spores among the fibres, as figured in this plate by Bazin, and in this more highly magnified drawing by Robin.

In tinea decalvans, the parasitic vegetable is the *microsporon Audouini*. This plant is formed of branch filaments, on which the spores are developed. The spores are very small—from 0.001 mm. to 0.005 mm. The seat of the growth is the outside of the hair; it forms a sort of sheath around the hair, from the surface of the skin upwards, from 1 mm. to 3 mm. Gruby first described this plant, and its relation to tinea decalvans; and Robin says, he can confirm the accuracy of Gruby’s description.

In tinea sycosa, the parasite is the *microsporon mentagrophytes*. It is also composed of filaments and spores; but the spores are larger, and the filaments broader, than those of *microsporon Audouini*.

The seat of the growth is the hair follicle between the hair and the capsule.

I have told you the names I would have you employ to signify the diseases I have described and demonstrated to you; but you ought also to know the names employed by the writers on skin diseases most popular in this country, to signify the same things.

*Tinea favosa*, then, is called *Porrigo favosa* by Willan and Bateman; *Favus* by Dr. A. T. Thomson, Simon and many other writers.

*Tinea tonsurans* is called *Porrigo scutulata* by Willian, Bateman, and Dr. A. T. Thompson; *Herpes tonsurans* by Cazenave; and *Trichinosis furfuracea* by Mr. Wilson.

*Tinea decalvans* is called *Porrigo decalvans* by Willan and Bateman; *Vitiligo of the hairy scalp* by Cazenave.

*Tinea sycosa* is called *Mentagra* by Willan and Bateman; *Sycoxis* by Mr. Wilson.

As to the etiological relation of the parasite to the disease, it appears that the spores of the vegetable growth require for their development a peculiar nidus. I say so, because all persons who mix with children suffering from tinea do not have the disease. But if a soil highly favourable to their growth exists, then a spore having found its way on to that soil develops
and forms other spores, and so the parasite spreads over the surface of the individual more or less rapidly, according to the more or less favorable nature of the soil.

[As tinea commonly appears amongst strumous and dirty children, we must first in the treatment enforce cleanliness, then strengthen and improve the general health of the patient, and then endeavour to destroy the parasite. The two first intentions are to be fulfilled on common principles, the last by a series of remedies termed 'Parasiticides.' Corrosive sublimate and acetate of copper have been much used, but there are many serious objections to their use, one of which is, that the hairs have to be forcibly removed from the affected parts.]

It is highly probable that, if sulphurous acid be employed as a parasiticide, epilation will be found to be altogether unnecessary to its complete action. This agent was first introduced to the notice of the medical officers of the hospital, by Professor Graham, as a possible remedy for cholera, at the time that disease was said to have its origin in the presence of an entophyte in the intestinal canal. It was first employed by myself to check fermentation, and to destroy the torulæ cerevisiæ and sarcinæ Goodsirii.* When lecturing on this subject, some time since, I expressed myself thus:—"Considerable benefit may be anticipated from the employment of sulphurous acid in all diseases attended with the development of parasitic plants. I would especially mention porigo."

The case I am about to read to you, of Hyman Jacobs, proves that in regard of tinea (porrigo) favosa, these anticipations have been fully realized; while the case of the girl now in the room, and who is still under treatment, renders it highly probable that the beneficial effects of this parasiticide will be as manifest in tinea decalvans as they are in tinea favosa.

In some forms of thrush, too, I may mention that it acts most rapidly, one application of a solution of sulphite of soda (a drachm to an ounce of water) sufficing to remove the disease from the mucous membrane of the mouth in twenty-four hours. The secretions of the mouth being acid, the salt is decomposed, and sulphurous acid is set free; in this, as in all other cases, the sulphurous acid is the active agent in the destruction of the parasite.

Hyman Jacobs, aged 27 years, a Jew pedlar, a native of Amsterdam, and resident in London fifteen months, was admitted into the hospital on March 21, 1853.

*Several medical men have lately administered the hyposulphite of soda, instead of the sulphite; but the latter is the preferable salt, and for this reason, that when the hyposulphite is decomposed by the hydrochloric acid of the gastric juice, not only is sulphurous acid generated, but sulphur is precipitated,—a substance it is very undesirable to have in the stomach in some of these cases.
He was as most of you remember, a man of cheerful disposition, dark complexion, rather short, muscular, moderately stout; in fact, he looked generally in robust health. His habits were those of his class; he slept in the low common lodging-houses, fared badly, rarely eating meat, and judging from his appearance, was not very cleanly in his person.

He affirmed, and I believed him, that he was temperate in regard of the use of alcoholic liquor. His general health, he said, had always been good.

The scalp affection was of nine years' duration at the time he came into the hospital. He had been in many hospitals, but had never derived any marked benefit from treatment. When Jacobs came under observation, his condition was as follows:—

Cerebral, circulatory, respiratory and digestive functions healthy in all particulars.

The whole of the scalp, excepting the margin, was covered with the crusts of tinea favosa. The largest crusts were of a greyish yellow color, of the consistence of dried putty or mortar, and brittle. Their thickness generally was considerable. Where thickest, the surface of the crust was below the level of the cutis; so that it looked at the first glance, as if the latter had been partially destroyed by ulceration. The surface of these crusts was very irregular; it had a pitted, worm-eaten, or eroded appearance. At the edge of the large, irregularly-shaped crusts, were many small circular crusts, depressed in the centre. A hair passed through the centre of each of these small crusts. When the crusts were forcibly detached from the scalp by mechanical means, the exposed surface of the cutis was very red and raw.

The head itched much; and though scratching gave considerable pain, it was evident, from the traces of blood on the surface, that he had been applying his nails to the part.

The odour of the head was very offensive, something like that emitted by mice, only as one of you remarked at the time, sweeter and more nauseous. Scattered over the trunk and extremities were a very large number of circular favus crusts. There were as many as forty on the back alone. The smallest of these appeared, when seen through a lens, to be constituted thus: in the centre was a hair, around and touching that a brownish yellow crust, and around that again a dusky-red halo; the diameter of the whole not exceeding two-thirds of a line. On the back no crust was more than one-fourth of an inch in diameter; on the leg there was one one-third of an inch in diameter. These crusts were circular, raised about a line above the level of the cutis, hard, dry, and appeared as though made up of concentric rings of pale, greyish-yellow, and brown
colours alternating. The surface of these crusts was readily detached, and then a cup-shaped cavity was exposed, filled with a brimstone yellow powder. The base of the crust being removed, the surface of the cutis, from which it had been detached, was raw.

We saw, you may remember, the mycelium, sporule-bearing branches, and sporules of the achorion Schönleinii, when portions of the crusts, or of the yellow powder, were placed under the microscope.

No treatment was adopted for some time after the man's admission. On April 13th his state was exactly the same as when he entered the hospital. Rags, wet with a solution of sulphurous acid, were now ordered to be kept constantly on the scalp; the head to be covered with an oil-silk cap.

On April 18th, large quantities of crust had separated from the scalp, and those that remained attached had entirely lost their yellow hue; they were now of a dirty brown colour. All itching of the scalp ceased shortly after the application of the sulphurous acid. No sulphurous acid had been applied to the crusts on the trunk and extremities, and they had still the characters they presented on the man's admission into the hospital.

A piece of lint, wet with sulphurous acid lotion, was applied to one of the largest crusts on the leg.

On the 22d April a mere trace of the favus crust remained on the scalp; but the surface of the cutis was red, and there was an inflamed papula near the vertex. Thinking this condition might be partly due to the acid, which was a very strong solution, I ordered its use to be discontinued for twenty-four hours. The crust on the leg to which the sulphurous acid was applied on the 19th, had separated; the exposed surface was red, but not raw. Two favus crusts which were seated in the vicinity of that to which the acid was applied on the 19th, were observed to be turning brown; subsequently they dropped off spontaneously. The effect of the sulphurous acid gas on these two patches is of great interest, as illustrating the mode of action of the solution. The crusts on the scalp turned brown shortly after the acid was applied to them, and before they separated from the cutis.

On the 29th April the lotion was discontinued, and zinc ointment applied to the scalp.

On May 2nd the head was free from crusts, but the scalp was still red, and several inflamed papulae were seated on it.

On May 9th the skin of the scalp was here and there more natural in hue, and one or two papulae had suppurated; the pus was healthy in appearance, and there was no trace of the parasitic plant to be detected by the microscope.
On the 18th, the head continued free from favus; the scalp was much less red; the hair was growing. As the crusts on the trunk and extremities were still in the same state as on the patient's admission into the hospital, he was immersed, about nine in the evening, for half an hour, in a full-sized tepid bath, containing sixteen ounces of saturated solution of sulphurous acid; no friction was employed. During the night all the crusts save three fell from the surface.

On the 20th he was again immersed in the acid bath, and the next day no trace of a crust was to be found on the trunk or extremities. My note says:—"No fresh crusts on head; a small pustule occasionally appears, and dries up in two or three days, and then disappears entirely; the skin of the head generally is much paler and more healthy in aspect."

31st. The scalp was still paler than at the previous report. There were only two small pustules on the scalp. By the microscope, no trace of the parasite could be detected. The skin generally appeared healthy; and, on June 2d, Jacobs left the hospital, at his own desire, to return to Holland.

I cannot conclude without expressing my confident belief, that a very great advance was made in pathology when the vegetable nature of the disease I have to-day referred to, as well as of some others, was demonstrated; and my equally confident belief, that the foundation for a very great advance in therapeutics was laid when Professor Graham introduced to notice the power of sulphurous acid to destroy vegetable life, and explained how it could be given internally without injury to the patient.

*Note.*—The solution of sulphurous acid I have used is made by passing a stream of the gas through water till the latter is saturated. Of this saturated solution, two ounces may be added to six ounces of water, to make the lotion.

The saturated solution of sulphurous acid I have employed has been either prepared in the Birkbeck Laboratory of University College; or procured from Button’s, Holborn; Hopkins and Williams, New Cavendish-street; or Burcham’s, Albany-street.—[Medical Times and Gazette.

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**Remedy for Favus.**

From the observation of about a dozen cases of severe favus (diagnosis by the microscope in all) recently treated by Mr. Startin at the Hospital for Skin Diseases, we can speak with great confidence of the efficiency of the following ointment.—It is the Ung. sulph. comp. of the Pharmacopœia of that Institution. *‡. Sulph. sublimati lbss.; hydrarg. ammoniochloride.*
On Epiphytes and Entophytes.

From a Review of Dr. Robin’s “Natural History of the Parasitic Vegetables which grow on Man and on Living Animals;” and of Dr. Bazin’s “Researches into the Nature and Treatment of Tinea;” by Dr. E. A. Parkes.

[It may be observed that all the vegetables which grow on living beings are low forms of Algae. or Fungi.]

Most of these plants are composed of simple cells, or of cells placed side by side; the unicellular algae being distinguished from the unicellular fungi by containing chlorophyll or some analogous substance, and usually one or more colored vesicles. The more highly formed algae are composed of interlaced filaments (Trichomata,) simple or ramified, cylindrical or flattened, and containing colored molecules; and of a reproductive system—viz., vesicles sporangia, conceptacles) and spores
(sporidia.) The fungi are represented by filaments, at first simple, then ramified, and formed by a single elongated cell, or more rarely, by several cells placed end to end (mycelium.) The reproductive system is constituted by spores, which are seated on a receptacle, either at once or by the mediation of certain special structures, or are contained in a distinct vesicle (sporangium)

It would lead us too far to go into the minute anatomy of these plants, nor shall we attempt an account of the various genera and species which are found on the lower animals. We shall content ourselves with enumerating those which are found on the bodies of men.

The conditions of growth of the parasitic plants on human bodies are the same in all other cases. Whenever the normal-chemical processes of nutrition are impaired, and the incessant changes between the solids and the fluids slacken, then if the parts can furnish a proper soil, the fungi will appear.

The soil on which these plants grow is for the most part composed of epithelium or cuticle, acid mucus, or exudation; acidity, although favorable for their growth, is not indispensable, since some of the cryptogamia grow in an alkaline or neutral ground, as on the ulcerations of the trachea. On the skin, and in the buccal and pulmonary cavities, the plants are exposed to atmospheric air, and many of the fungi absorb oxygen, and emit carbonic acid. In the intestines, the nature of the gas is somewhat different; but some species grow here also. Humidity and warmth are important conditions of growth, and these, of course, are always to be found in connection with the animal body.

An useful division of the subject for our purpose is afforded by the anatomical seat of the cryptogamia on the skin, or on the mucous membranes of man.

A. Cryptogamia on the skin.—Ten varieties have been noted in this locality. We shall enumerate them in the order in which they are given by M. Robin.

1. Trichophyton tonsurans (Malmsten).—Syn. Trichomyces tonsurans; Mycoderma of the Plica polonica; fungus of the hairs in Herpes tonsurans; fungus of Porrigo scutulata; Achorion Lebertii; fungus of the Teigne tondante (Bazin); Rhizo-phyte (Gruby).—This fungus was discovered and described in 1844 by Gruby, in the disease called by the brothers Mahon 'Teigne tondante;' by Cazenave 'Herpes tonsurans;' by Erasmus Wilson 'Trichoses furfuracea,' (one of the diseases called ringworm and porrigo scutulata in this country). It exists also, as pointed out by Gusberg, in the plica polonica, although the two plants were formerly described as different.
The trichophyton is formed by oval transparent spores, which give rise to articulated filaments. Its anatomical seat is in the interior of the roots of the hairs. The hair and fungi simultaneously increase; the former seem larger than usual, are paler in color, lose their elasticity, soften and break off when they have risen some one or two lines above the surface of the scalp; in the short cylinder then left the fungus grows still more rapidly, so that the normal structure of the small stump of hair soon becomes indistinguishable. Sometimes the hair breaks off before emerging from the skin, and the fungus, epidermis, and cebaceous matter fill the ends of the piliferous conduits, and form the little prominences which can be seen by the naked eye in this disease, and give the skin a rough, anserine appearance. The sporules and mycelium of the plants can sometimes be seen, in the form of a white powder, on the roots of the broken hairs; sometimes the cutis becomes congested and thickened, and then the plant is mixed up with scales of epidermis, with fatty and albuminoid granules, with pus, &c.; and crusts are formed of greater or less thickness, in which the growth of the fungus can go on.

MM. Robin and Bazin adopt unreservedly the opinion that the trichophyton is the cause of the disease known under the various names above given; and each author relates examples of the contagion of the disease by transmission of the spores. Bazin has made the very important observation that the same disease will attack horses, and can be communicated from them to men. But both Robin and Bazin, however, admit that there is some condition of the hairs (dependent, no doubt, on constitutional causes) which is essential for the growth of the plant, as sometimes the disease disappears—i.e., the fungus dies—without treatment.

The diagnosis of this disease is extremely easy. The usually round bald patches, with the little elevations caused by the swollen roots, and the dryish scales of epidermis covering the skin more or less, and accumulating round the elevations, are very distinctive marks. Occasionally, when the cutis is more congested, and the crusts are thicker from abundant cuticle and exudation, some doubt may exist, but then the trichophyton can be usually found in the crusts.

The treatment of this species of ringworm has been long one of the most difficult points in dermatology. Its principles, however, are now well understood, and few cases resist the proper measures. The essential point is to apply to the roots of the hairs a preparation which may destroy the trichophyton; if this can be done, the disease is cured. It is first of all necessary to remove the hair; this is in part generally accomplished
before the case comes under treatment, by the course of the disease; if it has not been sufficiently done, 'epilation’ can be accomplished by a chemical agent, or by extraction with pincers. M. Bazin recommends the ointment given below,* or the oil of cade, which appears to be the best depilatory known or with these means epilation with the pincers may be combined. The removal of the hair permits a “parasiticide” solution to be applied to the hair-follicles, within which are the prolific spores of the fungus. For this purpose M. Bazin recommends either a solution of bi-chloride of mercury (1 part to 250 of water), or an ointment of the acetate of copper (1 part to 500 of lard). We have used also, with excellent effect, a solution of the permurate of mercury, about 1 part to 30 or 40 of water; this is, however, a very powerful remedy, and is to be cautiously used, as it easily blisters the scalp. We have used also an ointment composed of sulphate of copper (1 part), alum (3 parts), and lard (20 to 30 parts, according to the age of the patient). Probably, however, a better parasiticide agent than any of these is the sulphurous acid, which we have seen Dr. Jenner employ lately in a case of favus, with astonishing results, and which doubtless would be equally successful in tinea tonsdens. Chlorine water might also possibly answer the same purpose.

With respect to the name of the most common disease in which the trichophyton tonsurans appears, the term used by Cazenave (herpes tonsdens) is extremely unfortunate; no doubt vesicles are sometimes seen, and sometimes the cryptogamic disease succeeds to true herpes circinata of the scalp, but in many cases there are no vesicles at all throughout the whole course of the disease. The term used in this country, porrigo scutulata, is inconvenient, as it is applied with greater justice to favus. The old term of tinea is, after all, by far the best, and the specific affix tonsdens expresses well one great feature of the disease, the baldness arising from the brittleness of the hairs.

[The second species, which has been little studied, is the Trichophyton sporuloides. The 3d is the Trichophyton ulcerum. M. Lebert has described a fungus in the crusts covering an atonic ulcer of the leg. The 4th is the Microsporon Audouini, present in the disease termed Porrigo decalvans by Willan. The 5th is the Microsporon mentagrophyta, found in a case of mentagra. This disease is easily cured by epilation, and subsequently using a lotion of bichloride of mercury. The 6th the Microsporon furfur, has been discovered in the

* Lime and carbonate of soda, of each one part; lard 30 parts.
Pityriasis versicolor of Willan. The 7th, the Achorion Schönleini, is the most important, being the fungus of Favus.]

Schönlein was the first to suggest that the honeycomb, or yellow favous crusts in the so-called porrigo lupinosa (Willan) and porrigo scutulata, were constituted by a vegetable growth. This has been repeatedly confirmed, and many excellent descriptions have been given of the disease, now called indifferently favus, tinea favosa, or porrigo scutulata; but none, we think, better than that which is contained in the work before us.

M. Robin believes he has discovered that the primary seat of the achorion is in the depth of the hair follicle, against the hair, and, as we can understand the description, outside the layer of epithelium which covers the root of the hair, and which forms "the inner root-sheath" of Köllicher. In this observation, however, he has been anticipated by Wedl, who has pointed out that by using a concentrated solution of liquor potassae, to make the parts transparent, the fungus is found in the follicle around the hair at the place where it passes through the epidermis. In addition to this, the plant is found in depressions on the surface of the skin, forming the yellow honeycomb-like masses which gave the specific name, favus, to the disease; and which, from their frequent buckler-like shape, suggested the term 'scutulata.' The development of the achorion in this situation is described by Robin after Remak and Lebert. A cuticular elevation is seen, beneath which is a small favus; when the cuticle is raised a drop of pus sometimes issues; hence the error of those who have considered this disease always pustular; generally, however, (Robin, Simon, and Hœffe,) there is no pus or liquid of any kind; the plant grows, and the cuticle over it (supposing it has been forcibly detached) finally separates, leaving the favus exposed to the air.

M. Robin does not notice the important statement of Simon, that at first there is at the point where the favus is about to form only an increased secretion of epidermis; he notices briefly the fact, that sometimes the under surface of the favus is coated by cuticle, which separates it from the compressed and attenuated derma.

The structure of the favus is given at length by both authors, but it is scarcely necessary to do more than notice that Robin, in addition to the mycelium, the spores, and the receptacles of the achorion, describes a finely granular amorphous layer, which forms the external coat of the favus, and is the representative of the amorphous 'stroma' which often accompanies the mycelium of algaé and fungi. In the favus also, as we shall presently see, another and distinct fungus can sometimes be found.
On Epiphytes and Entophytes.

M. Bazin describes the favus under three heads, which are fundamentally identical and different only in respect of form.

1. Favus urceolaria dissemina: this corresponds to the porrigo favosa, Favus dispersus, Teigne alveolaire, of other authors.
2. Favus scutiformis: this is the porrigo scutulata, or favus confertus.
3. Favus squamosa; a form usually called scutulata, but distinguished chiefly by the irregular distribution of the achorion, and by the furrowed masses formed by the fungus, the hairs, epidermis, and exudation.

The treatment of favus recommended by Robin and Bazin is epilation, and the application of the corrosive-sublimate solution, or of acetate of copper ointment (1 part to 500 of lard,) to kill the plant still remaining adherent to the hair follicle. We suspect that the sulphurous acid employed by Dr. Jenner will be found a more effectual application than either of these two.

The remaining species of this division are unimportant.

B. Cryptogamia on the Mucous Membrane.—The plants forming on mucous membranes, or in the contents of cavities lined by mucous membrane, are of less interest than those which grow on the skin, as in most cases they are decidedly only secondary. We shall merely enumerate them.

1. Cryptococcus cerevisiae Kutzing. (Syn. Torula cerevisiae—the yeast-plant,) in the bladder, stomach, intestines, &c.
4. Oscillaria (?) of the intestines. Farre.
5. Leptomitus urophilus. Montague. (An alga, described as forming in the urine. It has as yet been scarcely studied.)
6. Leptomitus (?) Hannoverii. Robin. (Alga found by Hannover in the pharynx and æsophagus.)
7. Leptomitus (?) of the uterus.
8. Leptomitus of the uterine mucus.
9. Leptomitus of the eye.
10. Oidium albicans. Robin. (Syn. Cryptogamia of diphtheritis and aphtha.) Aphtophyte (Gruby.)
On the Transmission of Secondary Syphilis from the Male Parent to the Fetus in Utero, and the subsequent infection of the Mother through the medium of the Fetal Circulation.

By W. Tyler Smith, M. D., Physician Accoucheur to St. Mary's Hospital. (Read before the Harveian Hospital.)

In bringing before the Society a few cases bearing chiefly on the transmissibility of secondary syphilis to the fetus in utero, from the male parent, I cannot pretend to offer anything novel, or to claim any interest beyond that which attaches to a very important subject: but I trust I may elicit the experience of the Fellows of the Society, many of whom have without doubt seen cases similar to those about to be described.

When we consider the length of time during which syphilis remains in the constitution after it has once passed into the secondary form, the Protean shapes it may assume, and the great difficulties which attend any attempt to trace the moral histories of individual cases, it is not surprising that discrepancies of opinion should exist respecting the transmissibility of constitutional syphilis. After John Hunter, the greatest name in syphilis is undoubtedly that of M. Ricord. I believe I may briefly state the doctrines of this indefatigable observer to be as follows:

He believes that when the primary poison is taken, it remains during several days in a state of incubation, during which time the poison may be destroyed, without any danger of the subsequent occurrence of constitutional disease. That after this time chancre takes on certain characters, and infect the whole constitution, giving rise to the train of evils known as constitutional syphilis. He does not believe that a sore or chancre, capable of communicating syphilis by inoculation, can ever arise as a secondary symptom. He believes that for the presence of constitutional symptoms it is absolutely necessary that a primary sore should have pre-existed, except under two conditions—namely, that a man suffering from constitutional syphilis may impregnate a healthy woman, and the germ may, in the first place, have constitutional syphilis, and, in the second, communicate it to the mother, without the existence of any primary disease in either mother or child. Here, I believe, syphilitic contagion stops, in the opinion of Ricord. He does not believe in the communication of syphilis by the secretions, or by the discharges from secondary eruptions or sores. Nor does he believe that a child affected with secondary syphilis can communicate the disease to a healthy nurse, or that a nurse affected with constitutional syphilis can convey the disease to a healthy infant through the medium of the milk.
Other French writers, and authorities upon the subject in this country, assert, on the contrary, that a man or woman having secondary syphilis may communicate it during intercourse in a direct manner; that a child having congenital or secondary syphilis, may infect its nurse in the act of sucking, the nurse having been previously free from the disease; that the nurse, thus diseased, may become a medium of infection to others; that an infected woman, suffering from secondary syphilis only, may infect a healthy child, through the milk. These are the views held by Dr. Whitehead, in his work on "Hereditary Diseases," published in 1851, and by Mr. E. Wilson, in his work on "Syphilis," published in 1852. Mr. Wilson goes so far as to assert the identity of gonorrhœa in which no urethral chancre existed. Cases are given which appear to warrant these views, but the whole question of the transmission of secondary disease is in such an unsettled state that no apology can be needed for introducing it in a Society like the present. The following cases bear upon some of the points in dispute, and it will be impossible for any one who pays attention to this subject not to acknowledge, that it is one whose importance, both as regards medical science and the physical degeneration of mankind, is much underrated or overlooked.

Case 1.—The following case came under my observation at St. Mary's Hospital, and I was as careful as possible in tracing its history:

R—S—, a healthy young woman, married a cabman in 1842. She had successively three children, all of whom are living and in excellent health. No spot or blemish has ever been observed upon them. For some time she remained without becoming pregnant, but in December, 1850, her fourth child was born. This child, shortly after its birth, had red spots upon its face and neck, and an eruption upon its buttocks. The child also had a profuse secretion from the nose. It died of what was called bronchitis, at the age of seven weeks and some days. She again became pregnant in 1852, and gave birth to a fifth child, which, like the preceding child, appeared healthy at the time of its birth. In April, 1852, this child was brought to me, and certainly presented one of the most wretched spectacles I ever beheld. The child had remained healthy until it was three months and a half old, when it got hooping-cough; a month afterwards it was brought to the hospital. Its eyes and mouth were surrounded by deep rings of coagulated blood, and its ears and nostrils were plugged with coagula; blood had also been lost by the bowels. All these orifices, mouth, nares, ears, eyes, and anus, had bled some days every time the child had had a fit of coughing. It was scarcely liv-
ing when I saw it; the pulse was almost imperceptible; the face and surface of the body were blanched from loss of blood; it appeared insensible. I ordered the child to be put in a milk bath, and to have broth enemata, but I heard that convulsions came on shortly afterwards, and soon ended in death. In signing the certificate of this child’s death, I returned it as dying of convulsions consequent upon hooping-cough, and loss of blood. I had then no suspicion whatever of syphilis, as nothing was said of the death of the former child.

In the month of March, 1853, the same woman brought me a child, born in December, 1852, about whose condition there could be no mistake. Its buttocks were covered by large erythematous patches in a state of ulceration; the scrotum looked as if it had been covered with yellow varnish; the mouth and nostrils were fissured; the eyelids gummy; and the mucous membrane of both eye and nose secreting a profuse gummy matter; the inside of the lips and the surface of the tongue were aphthous; the cheeks were varnished and wrinkled. This condition of the child had come on gradually about a month previously; before this it had appeared healthy. The mother herself had never had any eruption, sore-throat, cutaneous irregularities, leucorrhœa, or any symptom which, on the most minute inquiry, gave evidence of the presence of the syphilitic poison. During the whole of her married life she had not been conscious of any change in her health. I saw the husband of this woman, and he admitted that five years ago he had an outbreak of secondary syphilis, the primary disease having occurred four or five years before. He then became an out-patient at the Lock Hospital, and was mercurialized. During the presence of the secondary disease he avoided intercourse with his wife, and was confident that he did not communicate the disease to her. He had severe sore-throat, and a copper-coloured eruption. When I saw him the only signs of disease were a few acne upon his forehead, and he declared that nothing more than this had appeared upon him for the last two or three years. The wife has, at the present time, a mammary abscess, but she has had abscesses while suckling the last four of her children.

In this case, if the statement of the man can be relied upon, the syphilitic poison remained in abeyance during the first five years of his marriage, and the children born during this were not affected. After this, two children were destroyed, and a third poisoned, with syphilis. This woman, it will be observed, never aborted. Can the mammary abscesses in this woman be referred to syphilis? It certainly appears as though the poison in this case affected the children without influencing the constitution of the mother.
Case 2.—A woman applied during the course of last year at St. Mary's Hospital, with a nurse-child which she was suckling, and she also suckled at the same time a child of her own. The nurse-child was four months old. The skin of its face was like yellow tissue-paper; its nostrils and eyes were secreting an abundance of gummy mucus and pus, and the nates and scrotum were covered with erythematous patches in a state of ulceration. Numerous blotches appeared on other parts of the body. The mouth and anus were deeply fissured, and the child's mouth bled every time it took the breast. The woman applied both children to either breast without reservation. When I first saw the diseased child, she had sucked it about a month. The woman herself, and her own child, were at this time free from any obvious signs of disease. The nipples were healthy, although the discharges from the nurse-child's mouth were so acrid, that on the spots where it sucked its own fingers erythema and ulceration ensued. The nature of the case being evident, the woman was cautioned not to apply her own child to the same breast with the nurse-child, and the case was narrowly watched, during treatment, for upwards of three months. In answer to the first inquiries on the subject, it was stated that the father of the diseased child had last year been an out-patient at the hospital, under the care of Mr. Spencer Smith; and on referring to the hospital registration books, I found he had been treated for an eruption of the leg, which was set down as "probably syphilitic."

The man himself, on being examined, gave me the following account of himself:—He had contracted syphilis in 1849; a chancre appeared on the foreskin, and remained there three weeks. It was followed by an inguinal bubo. For these symptoms mercury was given him, but he was not salivated. He, however, became apparently well under its use. Last year he got his fellow-servant with child, and married her when she was large in the family-way. The child—the diseased nurse-child already referred to—was born in January, 1853. From the time of the chancre up to the time immediately previous to that at which his wife fell pregnant, he had observed no signs of any secondary affection. But just before this he had lost his situation, that of a butler, and, faring worse than usual, he became out of health. His hair now fell off; he had no sore-throat, but the eruption appeared on his legs, for which he was treated by my colleague, Mr. Henry Smith, and he had a scaly, copper-coloured eruption on his forehead, which became very distinct after eating and drinking. He also suffered at intervals from severe rheumatic pains.

The wife remained in apparently good health. She was
confined, I believe, in Queen Charlotte's Lying-in Hospital, and was subsequently recommended by Dr. M. Babington as wet-nurse to a lady living in the country. The husband is in constant communication with his wife, and states that she has given satisfaction as a nurse, and is in perfect health, with the exception that she menstruates somewhat profusely, and often more than natural. It has not been hidden from the lady whose child the woman is suckling that the nurse's own child had fallen into bad health.

It became, of course, a very interesting question to determine, as far as possible, whether the diseased child would communicate secondary syphilis to its foster-nurse, and whether the foster-nurse would communicate the disease to her own child or her husband, and also to ascertain whether the mother of the diseased child could communicate constitutional syphilis to her foster-child. Here was a case in which secondary syphilis might have at once been communicated to at least four persons, besides the parents of the diseased child and the child itself, if we recognize the transmission of constitutional syphilis through the medium of the secretions. In all, six persons were exposed to the danger of syphilis by the intercourse of the father of the diseased child with his fellow-servant. As far as this case goes to the present time, and I have now had it under my observation nearly four months, it tells against the communication of secondary syphilis from one person to another, either by means of the matter from secondary sores, or the secretions of a person suffering from secondary syphilis.

Some time after the child had been under treatment, its foster-nurse had two or three pimples upon her neck, between the breasts; but she stated she had had the same kind of pimples before she began to nurse the foster-child. When she began to confine the diseased child to one nipple, that nipple became sore, and a large serpentine ulcer formed upon. The ulceration had not, however, the yellow base or other appearances of a syphilitic sore, and three times I performed inoculation with matter taken from this sore, without any effect. The woman has had no signs of secondary disease in any other part of the body, and is as well as a woman could be expected to be who was suckling two children. Her own child is perfectly free from all signs of disease, and so is her husband, at the present time. I have purposely limited the treatment to the diseased child itself, so that I might observe the condition of the nurse.

The state of the mother of the diseased child is perhaps suspicious, as menorrhagic losses are among the most common signs of secondary syphilis in the female; but still it is extreme-
ly frequent in wet-nurses who menstruate during lactation. I
have seen Dr. Babington, and cannot learn that the child
shows any signs of disease. It is fat and healthy, and although
the suspicions of the mother have been excited, she appears
perfectly satisfied with the health of the nurse. Thus, as far
as this case goes, the syphilized father begot a diseased child.
The mother suffered slightly, if at all—probably not at all—and
has not communicated disease to her foster-child. The syphi-
lized child has not communicated disease to its foster-mother
and father, or to its foster-brother, though it would be difficult
to conceive a mouth in a more aggravated state of disease than
was the mouth of this child when I first saw it. The eruption
and other signs of disease were relieved by grey powder, a
mercurial girdle, the iodide of potassium, and cod-liver oil.

These cases show the amount of disease which may follow
marriages in which the husband has had syphilis previously,
and in which even slight signs of the disease remains in his
constitution.

I have also arrived at the conclusion, that where the placenta
and membranes become so diseased as to cause abortion, the
child remaining free from disease, the mother is pretty sure to
be affected with the disease; but when the child is born living,
and is apparently healthy at the time of birth, the mother may
in some cases escape contagion. When the children are born
healthy, the eruption generally comes on a few weeks after
birth, and is probably excited by the alternations of tempera-
ture, and the irregularities of nutrition to which the infant is
exposed after birth, as compared with that of the foetus in
utero. Probably in some infants born of healthy mothers and
syphilised fathers, the eruption may not appear until long after
birth; at least, I have seen cases which seemed to warrant
such a conclusion. When the ovum is affected by secondary
syphilitic disease, we can easily understand that the blood of
the foetus should infect the mother through the placenta. By
pregnancy, through the medium of the blood of the ovum, the
blood of the male parent is, as it were, positively transfused
into the blood of the female. There can be no doubt I think,
that in practice, in all cases of repeated abortion, and eruptions
in the early months of infancy, the health of the male parent
before marriage should be strictly inquired into.

With respect to the contagiousness of secondary sores, it
appears to me to be at present an undecided question, but I
have not seen a case in which it could have been pronounced
with certainty that a secondary malady was communicated
from one person to another by intercourse without the pre-
sence of primary sores. I might have added many other cases
but those I have related are two of the most interesting which have come under my own observation, and in which I was able personally to verify most of the facts relating to them. Not the least important of the results, as I have observed them, is the frequency of leucorrhœa as a leading symptom of secondary disease when communicated to the mother by the ovum.

[London Lancet.

General Bloodletting in Insanity.

The American Journal of Insanity, edited by T. Romeyn Beck, M. D., for April, 1854, contains an elaborate article of 118 pages upon "Bloodletting in Mental Disorders," by Pliny Earle, M. D., of New York city, in which the latter analyzes with much ability, one hundred and thirty-six authorities, illustrative of this proposition, namely, "to what extent, in regard to both frequency and quantity, is the abstraction of blood required in the treatment of insanity?"—from all of which he draws the conclusions which follows:

"A reply to the propositions at the commencement may now be attempted. It is evident, however, from the very nature of the case, that no positive, definite answer, couched in terms as fixed as the figures representing numbers, can be given. It must be merely approximative. I shall endeavor to convey it in a series of facts, truths or inferences, which I hope are fairly deduced from the substance of the foregoing pages.

1.—Insanity, in any form, is not, of itself, an indication for bloodletting.

2.—On the contrary, its existence is, of itself, a contra-indication. Hence, the person who is insane should, other things being equal, be bled less than one who is not insane.

3.—The usual condition of the brain, in mania, is not that of active inflammation, but of a species of excitement, irritability, or irritation, perhaps more frequently resulting from or accompanied by anaemia, debility, or abnormal preponderance of the nervous over the circulatory functions, than in connexion with plethora and enduring vital power.

4.—The excitement, both mental and physical, produced by this irritation, can, in most cases, be permanently subdued, and its radical sources removed by other means, more readily than by bleeding.

5.—Yet insanity may be co-existent with conditions,—such as positive plethora, a tendency to apoplexy or paralysis, and sometimes sthenic congestion or inflammation, which call for the abstraction of blood. Therefore,

6.—Venesection in mental disorders should not be absolutely abandoned, although the cases requiring it are very rare.

7.—As a general rule, topical is preferable to general bleeding.
8.—In many cases where the indication for direct depletion is not urgent, but where bloodletting, particularly if local, might be practiced without injury, it is safer and better to treat by other means, equalizing the circulation and promoting the secretions and excretions.

9.—The physical conditions requiring bloodletting more frequently exist in mania than in any other of the ordinary forms of mental alienation.

10.—Insanity following parturition, other things being equal, is to be treated by bleeding less frequently than that which has its origin in other causes.

11.—If the mental disorder be the direct result of injury to the head, the treatment must be directed to the wound, or its physical effects, not specially to the psychic condition.

12.—In many cases where insanity is accompanied by typhous symptoms, and in some where the aspect is that of acute phrenitis, active stimulants alone can save the patient, and direct depletion from the circulation is almost certainly fatal.

The following extract from the last number of Ranking’s Abstract, exhibits the state of opinion on the continent of Europe with respect to venesection as a remedy for insanity, and corroborates the conclusions of Dr. Earle:

_Prejudicial Effects of General Bleeding._ Dr Webster in his report on French Asylums, says:

"Although it was not originally intended in the present remarks to discuss the medical treatment usually pursued in French Asylums, one point seems, however, of so much importance that it deserves some notice in these pages; particularly, as great unanimity of opinion prevails among the physicians of departmental institutions, with whom I had an opportunity of conversing upon the question. I now refer to the employment of bloodletting as a remedy in cases of insanity. Without an exception, every practitioner was decidedly opposed to the general abstraction of blood in maniacal patients, as they consider it not only unnecessary, but often injurious. In many cases venesection produced so much depression, that attacks of mania, which otherwise might have been of short duration, under a different but more judicious mode of treatment, were thereby prolonged, and even ended in fatuity.

_Exceptions Requiring Bloodletting._

Of course particular cases of insanity presented themselves where inflammatory symptoms appeared so decided, or in which apoplectic congestion existed to such an extent, that local or general abstraction of blood was then absolutely necessary; nevertheless, these examples were exceptional, and only confirmed the observations made by the most experienced officers, medical officers of French asylums, respecting the baneful consequences of bloodletting in most cases of mental disease, which came under their cognizance. Indeed, one gentleman remarked ‘the delirium of insane patients was never modified by frequent and copious bleedings, but often the reverse.’
Being supported in these practical conclusions by the opinions of many English physicians, it cannot be too strongly impressed upon the minds of young practitioners, or of those who may not have had much experience in treating cases of insanity, to be always exceedingly chary of using the lancet.”—[N. O. Med. and Surg. Journal.

To prevent Night-sweats in Phthisis.

Night-perspirations in the course of phthisis are often extremely annoying to the patient; they appear, also, to be simply debilitating, and unattended by any degree of collateral benefit. Some cases which were carefully noted by Mr. Hutchinson, the Clinical Assistant at the City Hospital for Chest Diseases, with a view to the determination of that question, appeared to show that they may be artificially checked, not only with impunity, but with great benefit. The patients who were so treated, and who, in the course of a week or a fortnight, got quite rid of sweatings which for months had been profuse, thought themselves much better, and did not complain of increase, either as regards the expectoration, the feverishness, or the sense of stuffing in the chest. Under the usual treatment of phthisis, (full diet, cod-liver oil, and tonics,) the tendency to night-perspiration often ceases spontaneously. If it becomes desirable to expedite the process, it may be done by the sesquichloride of iron, the mineral acids, or, best of all, by the gallic acid. The following is the prescription for a nightdraught containing the latter:

B. Acidi gallici. gr. vij.; morph. acet. gr. 1/8; alcohol q. s. (a few drops); syr. toluatan. 5 ss.; aquæ 3 j.

The night-pill, as we find in the Pharmacopœia of the Brompton Hospital for Consumption, is—

B. Acid. gallic. gr. v.; morph. hydrochl. gr. 1/8; mist. acac. q. s. Ft. pil. ij.

It is also of advantage to adopt an astringent regimen as far as convenient. The patient should be directed to sleep on a mattress, alone, and not heavily clothed; he should wear no flannel in bed; as dry a diet should be taken as conveniently can be borne, and fluid should be especially avoided in the latter half of the day, none whatever being allowed later than several hours before bed-time.—[London Med. Times.

Ergotine. By E. Donnelly, M. D.

According to Bonjean, Ergot contains two active principles, essentially distinct and constant in their effects, to wit: an active poison and a powerful and useful remedy; the first is an oil, very soluble in cold ether, and insoluble in boiling alcohol, and in which exists the toxicological properties of Ergot; the second he denominates Ergotine, which is a dark red extract, very soluble in cold water, and possessing in the highest degree the precious obstetrical and haemostatic

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properties that it has always been acknowledged Ergot possessed. The very different nature of the two products of Ergot, permits their easy separation, and we are enabled to obtain the remedy entirely free of the poison. Thus, then, does the oil of Ergot and Ergotine contain in themselves all the properties, whether medicinal or toxicological, of Ergot, and it was for this discovery that the Pharmaceutical Society of Paris honored Mr. Joseph Bonjean with a gold medal, at their meeting on the 21st of December, 1842. Ergotine has been generally considered as one of the most useful acquisitions that has for a long time enriched therapeutics. The good results that are obtained in affections against which medicine has frequently been ineffectual, has already spread its use in different regions of the globe, and every day practice confirms the marvelous properties that its author attributed to it from its first discovery. Ergotine is one of the most powerful specifics known against hemorrhages in general; it is equally approved of in metrorrhagia and bloody flux, in epistaxis, and in spitting and vomiting of blood, and hæmaturia, &c. It has also been employed with good results in cases of spermatorrhea, and in troublesome periodicals, vomitings of blood, and in diseases brought on by a deranged state of the nervous system, and that have resisted other remedies. Moreover, it promotes uterine contractions, and causes to cease the hemorrhages that succeed parturition; as well as prevents them when administered some time previous to this event. Ergotine presents an immense advantage over Ergot in the quantity that can be administered at discretion in a dose, without the fear of resulting in any of those accidents that are caused by Ergot taken in its natural state. Dr. Chevallay, professor of medicine in Chambéry, administered five drachms of this extract in the space of five hours to a woman who would infallibly have succumbed to a most terrible attack of metrorrhagia, if it had not been for this auxiliary, which in two days afterwards was completely suppressed, and the woman finally recovered. After this, many celebrated doctors have endeavored to extend the use of this remedy, and to this end Dr. Arne of the Paris asylums, has used it with happy effect in some chronic affections of the uterus. Drs. Saccheri and Teissier, professors of medicine in the University of Turin, Dr. Mosea, and some other practitioners connected with hospitals of the same capital, have used it with happy success in chronic and acute pain, from which we conclude that Ergotine has direct action on the mucous surfaces, when found in a state of superexcitation or active hyperemia; it is also useful in dry and obstinate coughs, with or without spitting of blood, which so often accompanies consumption. Dose from 20 gr. to 1 oz., according to circumstances—given in pills or solution.

Mode of Preparing Ergotine.—Powdered Ergot one pound, and as much water as it will absorb (cold water), and allow it to stand for twelve hours; then place in a porcelain or glass percolator, and pour over it successive portions of cold water, until the menstruum passes through the mass colorless; the liquid thus obtained is to be evaporated by means of a water bath, unto the consistence of an extract. This extract is the Ergotine of Bonjean.—[Philad. Med. and Sur. Jl.
EDITORIAL AND MISCELLANY.

Epidemic Dysentery.

"I would be very much obliged if you will give me your views of the pathology and treatment of Dysentery as it has prevailed in Georgia for some time. It is carrying off hundreds in this District."

The above extract from the letter of a friend who resides in Spartanburg District, S. C., is entitled to serious consideration. We do not know that we can throw any new light upon the subject of epidemic Dysentery, either in relation to its pathology or its treatment; nor are we aware of the mode of treatment under which such a frightful mortality as that alluded to by our correspondent has occurred. We do know, however, that many practitioners both in Georgia and in South Carolina, as well as in the adjacent States, entertain views of the pathology and treatment of the disease in question very widely at variance with our own; and we may add, that we have not found the disease very fatal, nor difficult to manage, when treated in accordance with the principles we approve. We will not hesitate, therefore to state, although we shall do so as briefly as possible, what we consider the true state of the system and the best plan of treatment in the Epidemic Dysentery observed in this region of country for a few years back. We are happy to say that we are not alone, and that among the many who entertain the same views with us may be found some of the most distinguished practitioners in the South and Southwest.

With regard, then, to the pathology of this form of dysentery, we think it a complication or modification of remittent fever, the complication constituting in some cases the lesser and in others the greater evil. The perturbations of innervation, and consequently of the circulation, which characterize our malarial or ordinary periodic fevers, may continue for some time without the manifestation of decided concentration of morbid action upon any organ in particular. These are, however, exceptional cases; and we find that, unless checked by remedial agents, some organ will, sooner or later, become implicated to such a degree as to mask the original affection and perhaps to mislead the inexperienced. Thus we may find the liver, the spleen, the stomach, the intestines (small or large), the brain, or the lungs taking on disease more or less readily, according to particular seasons, localities, or causes which escape detection or cannot be appreciated.
At one time the stomach and liver will be the organs most frequently the seat of this concentration of morbid action, and the distressing nausea and bilious vomiting be found exceedingly difficult to control. At another time the supervention of coma, or of delirium, reveals but too clearly that the brain is suffering the inroads of disease. Again, the recession of blood from the surface and extremities, and the impairment of the process of calorification, constituting the algid form of our fevers, is more common some years than others. Some eight or nine years ago we began to observe the pneumonic complication, which has continued ever since to show itself at various points throughout the Southern States in the form of epidemic pneumonia, and occasionally with remarkable fatality. During the last three years the tendency has been to the large intestines, and this dysenteric feature has proved exceedingly disastrous in some of our counties.

We are aware that some will, with our learned friend Dr. La Roche, object to this mixing up of diseases, and argue that Dysentery, as well as Pneumonia, is always an idiopathic phlegmasia, and should be treated upon the general principles termed antiphlogistic. Yet the history of medicine, as found in the writings of practical men, such as Sydneyham, for example, does not permit us to doubt that diseases do from time to time change their phases, their type, and their amenableness to particular plans of treatment. While pneumonia, therefore, prior to the time above named, was most successfully treated here by blood letting and antimonial, such is far from being the case at present. So it is with Dysentery, which, when an uncomplicated phlegmasia, may be advantageously met with the lancet, calomel and opiates, under a different state of things proves rebellious to these agents.

The epidemic dysentery which has ravaged so fearfully some of our districts of country for the last few years, shows itself evidently as a complication of periodic fever, in the great majority of cases. It requires but little observation to detect in it the quotidian remissions and exacerbations peculiar to the class of fevers termed malarial, and the aggravation of the local affection by each returning paroxysm. As bloodletting will not cure remittent fever, so is it ineffectual in this form of dysentery, and may induce fatal prostration—while quinine, the great specific in periodic fevers will also prove all important in the epidemic dysentery to which we refer.

In the management of this disease, two objects must be kept in view; the daily paroxysms of fever must be arrested as soon as possible, and the determination to the large intestines subdued. In order
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To accomplish the first purpose, we direct the administration for several successive mornings of 5 grs. quinine at day-break and at intervals of two hours until twenty grains be taken. We generally find that 20 grs. of this remedy during the remission, which usually occurs in the morning, is sufficient, and that the febrile exacerbations will be prevented in a day or two. The quinine should then be continued in smaller quantities a few days longer in order to prevent relapse.

The tormina, tenesmus, and bloody flux will yield more readily to saline cathartics than to anything else with which we are acquainted. Indeed, if a full dose of Sulphate of Magnesia or of Sulphate of Soda be given at the onset of the bloody discharges, or soon after, it will very often cut short the attack. If it does not, the saline should be continued in teaspoonful doses every two, three, or four hours so as to keep up the serous discharges until the fever may be arrested with quinine. The physician is, however, especially in the country, seldom called on to prescribe on the first day of the disease—and often only when the case has assumed a dangerous aspect. The patient is then found more or less prostrated by the fever, by the frequency of the bloody discharges and the distressing tenesmus. It may be then hazardous to administer a full dose of salts; but serous discharges may be induced by teaspoonful doses, given every hour, or less often, until the desired effect be secured. In short, the dysentery must be, by the use of salines, converted into diarrhoea and the serous stools be kept up as long as the dysentery seems disposed to return upon their subsidence.

There are instances, of which we have just seen one, in which the stomach is so irritable as to reject the salines above mentioned. Others, as Cream of Tartar, or Rochelle Salts, may be then substituted. We have used the chloride of sodium or common table salt in some cases with equal advantage, especially in the advanced stages of the disease, and in children who take it with less reluctance than they do Epsom salts.

We sometimes find that even after the fever has been subdued and the serous discharges kept up for one, two or three days, the irritability of the rectum will persist and seriously annoy the patient. It is under such circumstances that we order washing out the lower bowels with a pint of tepid flaxseed tea or tepid water, and throwing into the rectum with a small glass syringe a fourth or a half grain of Sulph. Morphia in a drachm of water, to be retained as long as possible. If this anodyne enema be returned before it has had time to
be beneficial, it should be repeated. Starch and Laudanum may be used for the same purpose. These local anodynes are often productive of the most delightful relief and composure; but as their effect wears off they may have to be repeated.

It is scarcely necessary to add that we allow the patient to drink as freely as may be necessary to relieve his thirst either cold water (without ice) or any bland tea he may desire. When the case is protracted and exhaustion considerable, we order small quantities of good animal broth slightly thickened with flour to be given at regular intervals, even though the patient may have no appetite. This will generally be induced by the influence of a little such food upon the stomach.

The plan of treatment now laid down possesses, besides the advantage of marked efficacy, that also of great simplicity.

In answering the call made upon us for our views, we have done so in as few words as possible—and do not deem it necessary to allude more particularly than we have done to the opinions of those who differ with us, nor to fortify our position by special reference to the authority of those who participate with us in the views expressed.

Epilepsy cured by Trephining.—We find in the Transactions of the Iowa State Medical Society an extraordinary operation, reported by Dr. J. D. Elbert, under the following caption:—"Case of Epilepsy of several years' standing cured by operation."

The cranium had been fractured, and six inches square depressed about one inch at the centre. This injury was soon followed by Epilepsy, which recurred every two or three days, had existed for eight years and impaired very much the mind and physical powers. Dr. Elbert trephined the patient, and "six inches square of the frontal and parietal bones were removed." The lad was eleven years of age, and has completely recovered. We should observe that the operation was performed in the spring of 1852, and the "report" made in January following.

The Virginia Stethoscope contains an able editorial article upon the subject of "Protection of Domestic Interests," in which after remarking upon the duty of every government to protect the various interests of the community, the writer goes on to show that in Virginia much more attention is given to the protection of pecuniary interests than of the health and lives of the citizens; that while the Legislature
is ever awake to the interests of agriculture, commerce, the mechanic, arts, &c., little regard is paid to those of physicians. Thus:

"Now let us see how fully the legislature has applied these well established principles to the practice of medicine—how carefully they have protected the interests of a large and influential class of their constituents, the physicians of Virginia, and the dearest interests of every citizen of the state, their lives and reputations.

"The state is in want of money to support the expenses of government and construct works of internal improvement. She taxes various employments, and in return affords them adequate protection. The doctors, too, must be made to pay something into the treasury. To be sure he pays his poll tax, his horse tax, his carriage tax, his watch tax, &c. &c. &c., but he must pay in addition for the privilege of practising his profession, of obtaining a livelihood out of the community. The carpenter, the shoemaker, the blacksmith, the architect, &c. may derive larger profits from their business, but no professional tax is laid upon them. The doctor, I suppose, according to the ideas of the agrarians, is an aristocrat, and must be fleeced for the privilege. Well, the doctor pays his license tax, and what protection does he enjoy in return for his contribution to the resources of the state? Why, the very first Yankee quack who comes along, an ignoramus and unprincipled swindler, who knows that there is nothing in regard to which the community is so easily duped and defrauded, applies to the same commissioner of the revenue for a license to speculate upon the lives, health and reputation of the community, and the officer is required by law to take the price of blood and put it into the treasury of the state. Aye, and the impudent foreign imposter will find even some of the press sufficiently venal to side with him against their own fellow-citizens. The foreign mercenary wretch who would have been arrested for exposing for sale in the streets a few papers of needles, a package of jack-knives, or a piece of calico, whose mouth would have been shut by the stern voice of the sheriff if he had dared to open it in a court-room, is fully authorized by law to tamper with the lives of unsuspecting and defenceless men, women and children. The foreign state doctor goes his rounds with no eye upon him to watch and expose his wanton sacrifice of life and health. Lucre is his only aim; for that he sacrifices everything most dear to the community. At last, when some of his victims detect and expose his impostures, he decamps, carrying away a rich harvest of ill-gotten gains* to enrich other communities who despise us for our credulity, and laugh at us for our defenceless situation. By these persons the Virginia physician is elbowed out of the way to engage in some other employment, or seek some other place where his talents and learning will be better protected.

"These are not all the evils of the system. If the foreign pedler was a dangerous ally of the abolitionist, who so fit to carry on in the

* One of the most unprincipled quacks who ever infested this community, boasted that he had made upwards of twelve thousand dollars in Richmond in a few months.
dark his secret, nefarious schemes as the foreign quack doctor? He has unrestrained private interviews with our slaves, and what more fit opportunity for whispering the abolition sentiment and supplying the deadly draught? The license to practice includes also the license to peddle any sort of wares if he can only persuade the ignorant into the belief that they are useful in the treatment of disease. Let us examine how the law works in this respect. A fellow who is known only as a pedlar of trusses comes to the state of Virginia, and the law brings him to a stand. But the low cunning of the pedlar is not to be so easily circumvented. He sees a fine rich field, but the gates are closed and well barred and the fence too high to be scaled. He examines the law and finds that it has provided a most convenient stile, as if just for his use, by which he may most easily climb the formidable barrier. He goes to the commissioner of the revenue, pays him five dollars, and receives the state's authority to practice medicine. This is the toll for entering the rich harvest field.

"Every patient who applies to him he discovers to be in need of a truss, and his is one of extraordinary quality. A patient applies with swelled testicles; the state doctor prescribes a truss; another has hydrocele, for which he is induced to buy a truss; another has varicocele, which he is easily convinced can be cured most readily by Dr. Wooden Nutmeg's patent truss, and so on and so on.

These are some of the abominations, the iniquities, the absurdities of the laws of Virginia in regard to the practice of medicine.

"Why, let me ask, has the state invested some thirty thousand dollars in a medical school in Richmond, besides making annual appropriations for medical education in other schools? Why does she appoint trustees to select well qualified teachers of medicine and to guard the title of M. D. against degradation by being conferred upon unworthy men, if it is her policy to confer every legal privilege of the diploma upon every foreign quack, ignoramus and imposter who may pay five dollars into the treasury? Do medical men intend always to submit tamely to this legalized outrage upon them? Let them at least make some well arranged, organized effort, and they will obtain some redress of their grievances."

An extraordinary case of Pin-Swallowing.—In September last, a girl at Vienna, who labored under an aberration of intellect, attempted to destroy her life by swallowing a quantity of pins. The first dose consisted of seventy, which she took one after the other, each pin being enveloped in a wafer; but in consequence of their smallness they passed away without doing any mischief. Subsequently she again took to swallowing pins of a larger size, some of them two inches long. She was then seized with such severe illness, that she was taken to the hospital of the town, when it was instantly detected what she was suffering from, and she was placed under a course of treatment, which had the effect of dislodging the whole of the pins in succession from the bowels. There were no less than 242 pins passed, all of them of a black colour. The girl is now in a fair way of recovery.—[London Lancet.]
Medical College of Atlanta.—The newspapers announce the appointment of the following gentlemen as Professors in the contemplated Medical College of Atlanta.

Horace Nelson, M. D., of New York, Professor of Anatomy.
John W. Jones, M. D., of Auburn, Alabama, Professor of Theory and Practice of Medicine.
Willis F. Westmoreland, formerly of this State, but for some time past resident at Paris, France, Professor of Surgery.
James M. Gordon, M. D., of Savannah, Georgia, Prof. of Surgery.
John S. Duval, M. D., of Texas, Professor of Chemistry.
R. A. T. Ridley, M. D., of Lagrange, Georgia, Professor of Physiology and Pathological Anatomy.
John G. Westmoreland, M. D., of Atlanta, Georgia, Professor of Materia Medica.
J. B. Calhoun, M. D., of Newnan, Georgia, Professor of Surgical Anatomy and Medical Jurisprudence.

Death of Dr. Waldo J. Burnett.—We perceive by the Boston papers, that our learned friend, Dr. Burnett, has finally yielded, in the 26th year of his age, to the pulmonary affection under which he was laboring when he visited this city. As a microscopist, Dr. B. had few if any superiors. Quite enthusiastic in the pursuit of knowledge, he would have reached very soon the highest professional eminence had his life been spared. The death of such a man cannot be too much deplored.

Deaths by Chloroform.—Mrs. A. W. Richardson, of North Adams, Mass., died from the inhalation of chloroform, administered by Dr. C. E. Streeter, for the extraction of a tooth.

Also, Mrs. Jane Morgan, in the British Royal Infirmary, 21st Feb., 1854, died from the effects of inhaling chloroform for the reduction of a dislocation of the arm; death was sudden.

Dr. Beverly R. Wellford has been appointed Professor of Materia Medica, and Dr. B. Sequard Professor of Institutes and Medical Jurisprudence in the Medical College of Virginia.

Prof. N. S. Davis has become associated (in place of Prof. Herrick) with Dr. H. A. Johnson in the editorial management of the Northwestern Medical and Surgical Journal; and Dr. A. B. Palmer with Dr. Andrews, in that of the Peninsular Medical Journal.
To the Editor Southern Med. and Surg. Journal:

Dear Sir—Having seen it intimated that facts ought to be collected in order to expose the absurdities of the Thompsonian system of practice—I have thought that the following, which came under my own observation, was perhaps too good to be lost:

In riding in the country, sometime since, I fell in company with a great, big club-fisted fellow, who had lately emerged from the plough handles, and looked as if he would make a noble axeman or blacksmith. He was called "Doctor"—was mounted, with his saddle-bags pregnant with roots, and was going to see his patients. This "Doctor" had for a time quite a run of practice, and was considered dear at the business. The "Doctor," after a while, began to enquire of me, what could be the matter with his wife?—stating, in apparent surprise, that "she had been delivered of a child some weeks ago—had been very badly off ever since, and continued to get worse—was very low indeed, and had now become so offensive it was hardly possible to stay in the room where she was." After enquiring a little into her condition, the lamentable ignorance of this "Doctor" manifested itself in the fact, that his wife had never been fully delivered, and had for some weeks been suffering from a retained placenta, without his knowledge! Quere: Wonder if our late Legislature would not have licensed this "Doctor," too? "O tempora, O mores!"

Very respectfully, yours,

H. N****.

WORKS RECEIVED.

The Transactions of the Iowa State Medical and Chirurgical Society, 3d and 4th sessions, held at Fairfield, May, 1852, and Davenport, June, 1853. This production indicates the onward tendency of the people of the far West, and is highly creditable to our pioneer professional brethren.

Indiana Medical Journal, a quarterly record of the Medical sciences of the South and West. Edited by W. H. Byford, M. D., Prof. of Practice in Evansville Medical College, and H. Ronald, M. D., Prof. of Anatomy in the same College. Published at Evansville.


Annual Report of the City Inspector of the City of New York for the year 1853.

A large number of Pamphlets, College Circulars, &c.
On the new method of preserving Anatomical and Pathological Specimens. By John H. Brinton, M. D.—The preservation of the animal tissues, in such manner as to present unchanged, their normal and abnormal relations, has ever been an object of study and interest to the practical Anatomist, the Pathologist and the Surgeon. But as yet, all attempts to retain, in an unaltered state, the size, shape and color of parts, have to a certain degree been unsuccessful.

Anatomical objects have hitherto been preserved in one of two states, either wet or dried. Both of these methods are, however, inadequate; for if fresh animal tissues be immersed in alcohol, or any other antiseptic fluid, they become blanched in color, condensed in structure, and consequently modified in size and shape. At the same time, they present inconveniences for demonstration. The method of preparation by drying is open to even more serious objections, since the parts are so shrivelled and displaced as to convey but an imperfect idea of their primitive relations.

Now, since this shrinking of the tissues and their decomposition, depend most probably upon atmospheric influence, it recently occurred to me, that should I be able so to exclude the air as to cause all evaporation to cease, I would effectually prevent, not only the desiccation of the part, but also its decomposition. Acting upon this idea, I commenced a series of investigations; the success attendant upon which, up to the present time, has led me to submit the results to the profession.

My object being to encase hermetically every portion of the specimens, I selected for my earlier experiments a solution of gun cotton in ether, the ordinary collodion. By means of a brush, I applied this carefully upon every portion of the external surface of the object to be preserved. The ether quickly evaporating, a thin pellicle of the cotton was left, coating the entire preparation. This process was then repeated, and the preparation finished by the application of successive layers of damarra, copal and shellac varnishes.

But it early became evident to me, that collodion was entirely unfitted for the preservation of the generality of specimens, especially for those of any size and bulk. It possesses too slight a degree of tenacity, and is liable to become fissured, and to chip off; at the same time its tendency to form white opaque layers, when moisture is presented, renders it unsuitable as a transparent coating. I was, therefore, obliged to make use of some other protective material, and for this purpose I selected gutta percha. This I dissolved in benzole, adding at the same time to the solution a few grains of caoutchouc in order to increase the elasticity of the pellicle. By filtering the viscid dark-colored result through animal charcoal a perfectly colorless solution may be obtained, which upon application deposits a tenacious film.

This film, unlike that left by the evaporation of the ethereal portion of the collodion, evinces but little tendency to opacity; and, indeed, for all practical purposes, may be said to be perfectly transparent. The tenacity of the thinnest pellicle is very great; it possesses sufficient elasticity, is not liable to crack, and thus far has proven
amply sufficient to prevent the occurrence of evaporation, shrinking and decomposition. At the same time, by repeated applications of the solution, the coating of gutta percha can be increased to any desirable thickness.

To prepare a muscular specimen, as, for example, one exhibiting the relations of the arm and forearm, a limb should be selected which has been previously injected with the chloride of zinc, arsenic or other antiseptic solution. When the parts have been sufficiently exposed by dissection, the whole limb should be coated with the colorless solution of gutta percha: a transparent pellicle will then be left by the evaporation of the benzoie. This process should be repeated until a layer of considerable thickness is obtained. Upon the muscular mass, the gutta percha may be applied in much greater quantity. Should opacity here result it matters little, as in consequence of the blanching of the muscle, dependent upon the previous antiseptic injection, an artificial coloring process will be necessitated. In preparations, however, of perfectly fresh muscles, or of those which have been injected with Horner's solution, this will not be the case. The layers of gutta percha having been obtained of sufficient thickness, it will be found desirable to apply next a coating of collodion, which has been filtered, and then mixed with Venice turpentine. This preparation possesses no contractile powers whatever, but is of great body and consistency. It splints, as it were, the specimen securely, and ensures stability and firmness.

In order to impart a proper hue to those muscles, whose color may have been affected by the preceding processes, I make use of colloidion stained with the wood of the Pterocarpus santalinus, (the ordinary red saunders.) The resulting color, when varnished, simulates closely that of fresh muscles. The specimen should then be completed by the application of damarra and copal varnishes. The adipose tissues, the tendons, fasciæ, nervous and cutaneous surfaces will present almost the appearance of a recent dissection; the muscle alone will possess an artificial color, and even this can be avoided.

Each specimen should be mounted on a board separately, and I have found the most convenient method for doing so, to consist in the preparation first of its dorsal surface. The object should then be placed upon the board; when the anterior surface, that intended for inspection and exhibition, can be finished in situ. I have also found it advisable to keep them covered by glass cases. The period required for the preparation and mounting of an object by the above process does not exceed five days.

I have now in my possession specimens of meat which have been preserved by the preceding method sixty days, without having been previously saturated by any antiseptic fluid. In one preparation which I examined, after removing the gutta percha coat at the expiration of forty-five days from its completion, no decomposition whatever had taken place. The fibres of the muscle were, however, somewhat blanched, and afforded a slight odor of the benzoie used in the
preparation. Exposed to the air, decomposition ensued at the expiration of four or five days.

I have prepared, in a similar manner, a number of specimens, not only of muscular, but also of nervous tissues, as the brain and spinal marrow. In these no shrinking has occurred, and no evidence of decomposition exists. On the contrary, the preparations now present a harder, firmer and more natural appearance, than at the date of their completion. In the nervous preparations the natural color is retained, and is visible through the transparent coatings. I am at present engaged in making application of the process to the preservation of pathological tissues, and with every prospect of success. I believe also that botanical specimens may be preserved in a similar manner, and, indeed, it seems to me not impossible, that, at some future day an extension of this method may be rendered subservient to the preservation of meats, and all fresh animal tissues.

A longer period than has as yet elapsed, is required of course, to test fully the value of the above proceeding; at the same time the results already obtained seem to me so satisfactory, as to warrant me in laying them before the profession.—[Medical Examiner.

On the Venom of Serpents. By J. Gilman, A. M., M. D., LL. D.

There is much in the history and habits of the reptile tribes, however repulsive they may be in appearance, that is very interesting. During a sojourn of two or three months in the interior of Arkansas, which appears to me to be the paradise of reptiles, I paid some attention to that branch of natural history called ophiology: I found four distinct varieties of rattlesnakes (Crotalus), of which the Crotalus Horridus and Crotalus Kirtlandii are by far the most numerous. The former is the largest serpent in North America. The family of moccasin snakes (Colluber) is also quite numerous, there being not less than ten varieties, most of which are quite as venomous as the rattlesnake. By dissecting great numbers of different species I learned that the anatomical structure of the poisoning apparatus is similar in all the different varieties of venomous serpents. It consists of a strong frame work of bone, with its appropriate muscles in the upper part of the head, resembling and being in fact a pair of jaws, but externally to the jaws proper, and much stronger. To these is attached by a ginglymoid articulation, one or more moveable fangs on each side, just at the verge of the mouth, capable of being erected at pleasure. These fangs are very hard and sharp and crooked, like the claws of a cat, and hooking backwards, with a hollow from the base to near the point. I have occasionally seen a thin slit of bone divide this hollow, making two. At their base is found a small sac, containing two or three drops of venom which resembles thin honey. The sac is so connected with the cavity of the fang during its erection, that a slight upward pressure forces the venom into the fang at its base, and it makes its exit at a small slit or opening near the point, with considerable force; thus it is carried to the bottom of any wound made by the fang. Unless the fangs are erected for battle they lie concealed in the upper part of
the mouth, sunk between the external and internal jaw bones, somewhat like a pen-knife blade shut up in its handle, where they are covered by a fold of membrane which encloses them like a sheath; this is the vagina dentis. There can be no doubt but these fangs are frequently broken off or shed, as the head grows broader, to make room for new ones nearer the verge of the mouth; for, within the vagina dentis of a very large crotalus horridus, I found no less than five fangs on each side—in all stages of formation—the smallest in a half pulpy or cartilaginous state, the next something harder, the third still more perfect, and so on to the main, well-set, perfect fang. Each of these teeth had a well defined cavity like the main one. Three fangs on each side were frequently found in copper-heads, vipers, and others.

The process of robbing serpents of their venom is easily accomplished by the aid of chloroform, a few drops of which stupefies them. If, while they are under its influence, they are carefully seized by the neck, and the vagina dentis held out of the way by an assistant, with a pair of forceps, and the fang be erected and gently pressed upwards, the venom will be seen issuing from the fang and dropping from its point. It may then be absorbed by a bit of sponge, or caught in a vial, or on the point of a lancet. After robbing several serpents in this manner, they were found after two days to be as highly charged as ever with venom of equal intensity with that first taken.

During the process of robbing several species of serpents, I inoculated several small but vigorous and perfectly healthy vegetables, with the point of a lancet well charged with venom. The next day they were withered and dead, looking as though they had been scathed with lightning. In attempting to preserve a few drops of venom, for future experiments, in a small vial with two or three parts of alcohol, it was found in a short time to have lost its venomous properties. But after mixing the venom with aqua ammonia, or spirits turpentine, or oil of peppermint, or of cinnamon, or of cloves, or with nitric or sulphuric acid, it still seemed to act with undiminished energy. It is best preserved, however, for future use by trituration with refined sugar or sugar of milk.

A very fine large cotton-mouth snake, being captured by putting a shoe-string around him, became excessively ferocious, striking at even the crack of a small riding-whip. Finding himself a prisoner, without hope of escape, he turned his deadly weapons on his own body, striking repeatedly his well charged fangs deeply into his flesh. Notwithstanding this, he was put in a small basket and carried forward. In one hour after he was found dead, and no amount of irritation could excite the least indication of life. Four hours after, while removing the skin for preservation, the blood oozed slowly from the vessels in a dissolved state. No violence was done to his snakeship, except what he did to himself.

Another mocasin, shot by a pistol about two inches back of the head, and skinned immediately, gave decided evidence of vitality four hours after being flayed, by writhing the body whenever it was irritated by a scalpel.
A large rattle-snake beheaded instantly with a hoe, would, an hour and a half after, strike at any thing that pinched its tail. Of several persons who were testing their firmness of nerve, by trying to hold the hand steady while the serpent struck at it, not one could be found whose hand would not recoil in spite of his resolution, and one man, a great bully, by-the-by, was struck on the naked throat with considerable violence by the headless trunk of the serpent, and staggered back, fainted and fell from terror. Mr. Stewart, of Miss., tells me he witnessed a similar scene once. An old hunter shot a rattle-snake’s head off, and after reloading his gun and standing sometime, he stooped to pull off the rattles, and the bloody but headless trunk of the snake struck him in the temple and he fainted and fell down with terror.

Seven venomous serpents belonging to five different species were made to fraternize and dwell amicably in one den. A beautiful pair of long bodied speckled snakes, known as kingsnakes, and found to be fangless, and consequently without venom, were duly installed as members of the family. Some uneasiness was perceivable among the older members, but no attempt was made to destroy the intruders, though they might have been killed instanter. The next morning four of the venomous serpents were found to have been destroyed by the kingsnakes, and one was still within their coil, and the two remaining ones would make no effort at self defence. A large rattlesnake seemed stupid and indifferent to his fate. He could not be made to threaten or give warning even with his rattles. The smallest kingsnake was afterwards inoculated with the poison of one of the serpents he had destroyed, and died immediately after—thus evincing that they must have exercised some power besides physical force to overcome their fellow-creatures.

In short, the results of a great number of experiments performed with the venom of a great variety of serpents, seem to lead to the following conclusions:

1st. That the venom of all serpents acts as a poison in a similar manner.

2d. That the venom of some varieties is far more active than that of others.

3d. That a variety of the colluber, known as the cottonmouth, is the most venomous serpents in Arkansas.

4th. That the venom of serpents destroys all forms of organized life, vegetable as well as animal.

5th. That alcohol, if brought in contact with the venom is, to a certain extent, an antidote.

6th. That serpents do possess the power of fascinating small animals and that this power is identical with mesmerism.

7th. That the blood of small animals, destroyed by the venom of serpents, bears a close resemblance to that of animals destroyed by lightning or hydrocyanic acid; it loses its power of coagulation and cannot be long kept from putrefaction.—[St. Louis Medical and Surgical Journal.}
Puerperal Convulsions and Albuminuria. By MM. Depaul and Mascaret.—M. Depaul has read an able report upon a very instructive memoir by M. Mascaret, to the Académie de Médecine, upon this important subject. The author divides the cause of eclampsia into predisposing and occasional. He regards as special predisposing causes, first labours, the sanguineous and lymphatico-sanguineous temperaments, infiltration of the legs; but he does not consider albuminuria, and in this M. Depaul confirms the views of the author, as an essential cause of the disease. M. Depaul cited three cases of puerperal convulsion, in which no trace of albumen could be discovered in the urine; one which had occurred in his own practice, one recorded by Dr. Leuer, and a third by Professor Dubois. Two additional cases are recorded in M. Mascaret’s memoir. M. Depaul again refers to the frequency of albumen in the urine of pregnant women, and the comparative and absolute rarity of convulsions. Out of 41 women in whom the urine was found albuminous, observed by Dr. Blot at the Maternity, only 7 were seized with eclampsia. In order to collect these 41 cases, he examined the urine of 205 women, taken indiscriminately from the wards of the hospital. Further, M. Depaul cites two cases, in which, having examined the urine before labour without finding any albumen present, convulsions broke out, and the urine was found to contain albumen after the second fit in the first case, and after the fourth fit in the other case. M. Depaul also observed that the albumen disappears with remarkable rapidity after delivery, whilst not seldom convulsions only appear some hours or even some days after parturition. The reporters, however, admitted that albuminuria was too frequently observed in the course of gestation, and coincided too frequently with puerperal convulsions, not to render the investigation, of the relation of these conditions necessary. M. Depaul observed that the common explanation of albuminuria in pregnant women was not to be found in inflammation of the kidney. In the autopsies he had made, the kidneys were found either perfectly healthy, or simply congested. The true point of departure he believes to be, the modifications that gestation caused in the blood.—L’Union Méd. British and Foreign Medico-Chirurgical Review.

Fever, Intermittent.—Dr. Harting (Schmidt’s Jahrb., 1853, ix.) has employed quinoidine with alcohol and sulphuric ether in ague, and, from twelve year’s experience, states that it is superior to common quinine. He considers the quinoidine to be an amorphous quinine, (an opinion which has been strongly opposed by Muller.) Dr. Castiglioni (Schmidt’s Jahrb., 1853, ix.) has used the tannate of cinchona; it requires to be given in larger doses than quinine, but is much less expensive.—[Ib.

Cataract.—M. Lopez (Bull. Gén. de Thérap., 1854, ii. p. 89) has employed with advantage iodide of potassium taken internally, and vesication on the temples, in cataract. The treatment was persevered in for five or six months, and in 3 cases out of 4 was productive of great benefit.—[Ib.