The importance of Local Treatment in certain Female Diseases,
By Jno. Stainback Wilson, M.D., of Airmount, Alabama.

When very frequent and almost uniform lesions of the mucogenital tissues, in a class of affections considered heretofore as constitutional and functional, have been conclusively demonstrated, by a host of the most intelligent and distinguished pathologists, it would seem to be supererogatory, if not presumptuous, to attempt a further elucidation of the subject,—and, indeed, we disclaim any such design; our object will be to give a summary of the most important evidence in favor of what may be termed the local, organic, uterine pathology of Leucorrhœa, Dysmenorrhœa, Menorrhagia, &c.; and we will then endeavor to inculcate the importance of certain therapeutic measures founded on this pathology: in short, we will strive to show the great advantage, and the indispensable necessity, of local remedies in the management of the interesting, very common, and often intractable diseases above mentioned. With such a bright array of names as those of Recamier, Lisfranc, Dupuytren, Gendrin, Duparcque, Gilbert, Kennedy, Murphy, Locock, Roberts, Bennett, and others scarcely less celebrated, all of whom have ably advocated the "organic pathology," we might safely rest the evidence, had not the equally distinguished Robert Lee, Ashwell, Tyler Smith, Hall, and some others,
denied the correctness of the statements made by the first mentioned writers, and denounced their favorite instrument, the speculum, as immoral, indecent, unnecessary, and destructive in its tendency. But, in addition to these contradictory opinions, there are other very forcible reasons why the pro-organic evidence should be adduced, and they are these:—A mere opinion or name cannot be received in lieu of established facts; again, this "organic pathology" is comparatively new—is yet in its minority, while at the same time it is forced to wage a contest against its hoary rival, the constitutional or functional pathology, fortified, as the latter is, by all the prejudices and prepossessions of early education; and lastly, we think that it is proper and necessary to sum up this evidence, because it tends to confirm, what we believe to be, one of the most important truths, in practical medicine, to which the present century has given birth. We will then, briefly, present the views of Dr. J. H. Bennett, and some others, on the affirmative side of this question, and also advert to those on the negative; and finally, we will attempt to explain and harmonize the difference apparently existing between the contending parties.

The first disease to which we shall direct attention is—

**Dysmenorrhœa.**

Dr. Bennett divides this affection into Constitutional, Accidental, and Inflammatory Dysmenorrhœa. The first form he considers as "evidently functional, the result of the distension produced by over-congestion, or of a peculiar susceptibility of the uterine innervation." And this, he says, "can scarcely be considered a morbid condition, although verging on disease." He informs us that the distinguishing characteristic of this form is its presence during the menstrual function, and the absence of all morbid symptoms during the intervals. Should the symptoms become persistent, he looks upon it as "a suspicious circumstance, as indicating the possible, or even probable existence of some inflammatory condition of the cervix uteri, or of some morbid ovarian condition." The accidental variety is regarded as the result of transient or temporary causes, and, like the first division, not permanent. It will thus be seen, from this brief analysis, that this distinguished writer really recognizes but one morbid condition as the principal and almost
exclusive cause of dysmenorrhea, and that is, inflammation or organic disease of the uterus.* Under the head of inflammatory dysmenorrhea, he says: "When menstruation, naturally easy, becomes permanently painful; or when, naturally but slightly painful, it becomes extremely so, we are warranted in looking for a local disease. Such a change does not take place without a cause, and that cause is, generally speaking, inflammation or organic disease of the uterus; dysmenorrhea being one of the most prominent and most ordinary symptoms of that disease." Dr. Bennett, we think, very properly, embraces under this head, the pseudo-membranous variety of dysmenorrhea. The views of our author on this disease, and other points of uterine pathology, are so well known, that we consider it useless to multiply quotations on this almost inexhaustible subject; we will therefore refer those who wish to consult him further, to Ranking's Abstract, No. 15, 1852, p. 151. Before dismissing the pathology of dysmenorrhea, it may be proper to add that we are not ignorant of the fact, that Dr. Bennett has been charged with exclusiveness and ultraism, even by those who are willing to admit the truth of his positions, in the main; and we confess, candidly, that we belong to that class—still, we are firmly convinced at the same time, that the pathology and treatment of uterine affections advocated by him is founded on the immutable basis of truth; and, consequently, that his doctrines must and will prevail, with such modifications as future and more dispassionate investigations may suggest.

The next subject which will engage our attention, for a short time, is, the Pathology of Menorrhagia, as enunciated by Dr. Bennett. This disorder (op. cit., p. 158) is divided by him into—1st. Accidental Menorrhagia; 2nd. Inflammatory; 3rd. Menorrhagia from Ovaritis; 4th. Menorrhagia at the dawn and close of Menstruation; 5th. Menorrhagia during Pregnancy; 6th. Menorrhagia after Parturition.

To the first, he applies the same mode of reasoning that he does to the accidental variety of dysmenorrhea, viz: that it is

* Of course physical dysmenorrhœa, arising from contraction of the os externum, is admitted as an exception; but even this is declared to be a not unfrequent complication of inflammation, &c.
transient, and generally passes off with the cause that produced it, without treatment. The third he considers very rare. The fourth, like the first, he says, is seldom permanent, "in the absence of tumors or malignant disease, unless there be inflammatory ulceration of the cervix." He admits, however, that the hemorrhage will persist, in some few cases, even after "the removal of the inflammatory and ulcerative disease of the cervix, which had probably, in the first instance, given rise to it."
The fifth variety he regards as a hemorrhage, produced by "inflammatory ulceration of the cervix," when "it is not merely temporary, and not proceeding from separation of the ovum."

The menorrhagia after parturition, (6th.) he says, "is nearly always complicated with, and occasioned by, inflammatory ulceration of the neck of the uterus, with or without disease of the body of the uterus." It should be remembered, that this is intended to apply only to those cases of "continued and obstinate hemorrhage" which sometimes continue for months after delivery. It appears, then, from the evidence of Dr. Bennett, that the vast majority of uterine hemorrhages belong to the second, or inflammatory division; while he at the same time admits that the sanguineous discharge does not always cease with the subduction of the inflammation, or the healing of the ulcer that gave rise to it.

As we do not expect to treat of amenorrhœa separately, we would here mention that Dr. Bennett regards "the development of inflammatory disease in the neck or body of the uterus, or in the ovaries, and of cystic and serofulous tumors in the ovaries, as one of the most frequent causes of amenorrhœa, in those in whom the function has once been fairly established; and especially of partial amenorrhœa."

Having now very briefly adverted to the "organic pathology" of dysmenorrhœa, menorrhagia and amenorrhœa, as promulgated by one of its most distinguished and able champions, we proceed to the last division of our subject—Leucorrhœa: a disease of exceeding interest, and one that can command a stronger array of evidence in support of its organic origin than any other of its class, unless dysmenorrhœa be excepted.

Dr. E. J. Tilt, who has himself directed much attention to the subject of Uterine Pathology, and more especially to Leu-
corrhæa, says: "I scrupulously adhere to the truth in asserting, that in the conviction of the great majority of enlightened practitioners in France, Germany, America, or at home, chronic leucorrhæal discharges generally depend upon organic lesions of the os uteri and its vicinity."

Some of the distinguished physicians who have ably defended the "organic pathology" of the several uterine diseases which we have passed in review, but more particularly of leucorrhæa, have already been mentioned: the views of others, equally entitled to our confidence, will now be adduced.

Dr. C. D. Meigs, in a late work "on Acute and Chronic Diseases of the Neck of the Uterus," uses the following language:—"One of the most common of sexual disorders is leucorrhæa. Most women suffer from this affection at some period of their lives. In general it is not profuse and ceases spontaneously. When the discharge consists only of vaginal products it is of little consequence. It is hurtful only when it comes from the canal of the cervix." In another place, he says: "The excretion from the follicles and glands of the canal of the neck is always gluey or albuminous, and resembles fresh white of eggs; and when the patient, in describing the disorder, informs us that she discovers a slimy mucus, and especially if it appears at intervals of once a day, or oftener, we may take it for granted that she labors under inflammation of the neck of the womb." (Med. Examiner, July, 1854, p. 419.) We may take this occasion to add, that Sir C. M. Clark made a similar observation, long since; but being denied the aid of the speculum, he may have confounded the vaginal and uterine discharges.

Dr. E. Harris, of New-York, in "A comparison of the Statements and Facts advanced by the leading Uterine Pathologists on the Nature and Source of Leucorrhœal Discharges," while he admits, to some extent, the doctrines of the reflex nervous, or constitutional pathology, thus expresses himself:—"But there are physiological alterations, and lesions of structure that are found very constantly in connection with leucorrhæa. 1st. Engorgement of the uterus or its cervix. 2d. Congestion and inflammation of the utero-vaginal mucous membrane. 3d. Excoriation and ulceration of the cervix uteri. 4th. A peculiar
abnormity of the glandular structures of the canal of the cervix, probably depending upon other and more general pathological conditions of the uterine organs, or of the whole body.” We have been thus particular in giving the words of this writer, because it is our design to recur to them again when we come to notice the negative side of this question, and attempt to “harmonize the apparent differences” existing between the opposing parties. But, before doing this, let us advert to the views of those who belong to the nervous or constitutional school of uterine pathologists.

Dysmenorrhœa is divided, by Colombat, into idiopathic and symptomatic: of the former, he says, the causes are but little known; and he does not attempt to give its pathology. With regard to the latter variety, he informs us that it “is much more common than idiopathic dysmenorrhœa;” and that its most frequent cause is engorgement of the neck and body of the uterus.

Dr. Churchill, who may be regarded as the representative of the constitutional school, it is well known, treats of this disease under three heads:—1st. Neuralgic dysmenorrhœa. 2d. Congestive or inflammatory. 3d. Mechanical. The first form, he says, “may last from twenty-four hours to four or five days, after which the patient (unless afflicted with headache) speedily recovers,” &c. He considers it most frequently of a simple neuralgic character, but admits that this explanation will not do for “those cases where the membrane is expelled.” It will thus be seen that Dr. Churchill confirms the statement made by Dr. Bennett, in reference to what he terms “constitutional dysmenorrhœa,” which answers to Dr. Churchill’s “neuralgic” form, viz., that the morbid symptoms exist only during the menstrual function. And this we believe to be the true condition of things in simple neuralgic or constitutional dysmenorrhœa: So long as it retains this simple form the general health is not impaired, unless there be some other co-existent disease; but this periodic nervous excitement, combined with the hyperaæmic congestion of the uterine vessels, which is a concomitant even of physiological menstruation, constitutes a strong predisposition to inflammation or other organic affection. And should this periodic excitation and congestion become habitual, peri-
manent, organic, uterine disease, with grave and complicated symptomatic derangement of the general health, is the result. And this conclusion is formed, not only on the concurrent testimony of the distinguished writers to whom we have referred, but it is in strict accordance with the teachings of our own experience; for we can truly say, that we have never seen a case of continued, obstinate and intractable dysmenorrhœa, where an "examination" did not reveal some organic lesion of the uterus. And we may add, with equal truth, that we have never given permanent relief in a single case of this disease, treated on the plan prescribed by those who found their therapeutics on the nervous, rheumatic, or constitutional pathology; and this is doubtless the experience of most practitioners. When it is remembered, then, that this pathology is only suppositive, speculative, and incapable of positive demonstration, while the practice inculcated by its advocates, has been weighed in the balances of experience, "and found wanting," we think it will be conceded that such an unsatisfactory theory should be but little regarded, if not entirely discarded, even in the absence of the "organic pathology," with its "cloud of witnesses"—its solid, safe and sure anatomico-physical basis, and its consequent capability of mathematical demonstration. This being admitted, then, we would suggest that neuralgic, constitutional and rheumatic dysmenorrhœa, (all of which are different names for the same condition,) be stricken from our nosology; that these terms be no longer coupled with dysmenorrhœa; and that the transient pains to which many females are subject at the catamenial period, be designated as utero-menstrual-neuralgia. By adopting this name, we would at once convey an idea of the nature, seat, and exciting cause of the disorder to which it should be applied, while it would tend strongly to prevent many grave errors of practice which, no doubt, spring as often from an unfortunate and incorrect nomenclature, as from a false pathology. We would then have but one kind of dysmenorrhœa—the organic, with its sub-divisions; for we would exclude (though it might be embraced under this head) physical or mechanical dysmenorrhœa from the division, and define it in accordance with the well-established physical condition of the cervix, or os internum, which causes the symptom of dysmenorrhœa.
In accordance with the programme of our subject, we should next present the teachings of the Constitutional school on Menorrhagia; but for fear of protracting this article too much, we will omit this, and return again to the last disease, in our order of arrangement—Leucorrhœa.

It is well known that all the older, and many modern writers have failed to distinguish vaginal from uterine leucorrhœa; while Drs. Churchill, Hamilton, and some few others, among the English, and almost all of the French writers have insisted on the distinction in the symptoms, pathology, and treatment of the two affections. It is equally well known, also, that most authors consider the leucorrhœal discharge as the result of general debility, accompanied with relaxation of the uterine vessels, as a kind of passive exudation or white hemorrhage from the uterine and vaginal capillaries. Now, while this may be true in some cases, we concur fully in the pathology of uterine leucorrhœa, as expressed by Dr. Churchill, who is, by the way, a very good authority, as he may be considered as belonging to the constitutional school. He uses the following words: "That the general system may be in such a state (debility) is very probable, but it by no means follows that the individual organs are so. On the contrary, we know that in many cases of constitutional weakness, the cause must be sought in the inflammatory condition of certain organs. In the present instance this appears to be the case; for if we consider the local distress, the increased secretion, the course of the disease, and the remedies which are most successful, we can have but little hesitation in attributing all to the effects of inflammatory action, generally sub-acute or chronic, of the mucous membrane lining the uterus." It may not be amiss to add, in this place, that this author takes a similar view of vaginal leucorrhœa. (Diseases of Females, pp. 68 and 147.)

Having now succeeded, as we hope, in establishing the organic or local origin of many, or most cases of amenorrhœa and menorrhagia, and more particularly of dysmenorrhœa and leucorrhœa, it only remains now for us to conclude the pathologic branch of our subject, by a notice of the objections to the views advocated in this article, and by an attempt to reconcile the contradictory opinions expressed by the opponents and friends of the "organic pathology."
Now, it seems that Dr. Bennett, and the other English and French pathologists referred to in the beginning of this article, have insisted on the frequency of ulceration as a cause of leucorrhœa and dysmenorrhœa, (the diseases to which we shall confine our attention); while Drs. Lee, Ashwell and Tyler Smith have denied the correctness of the statements made by the former writers, and pronounced ulceration of the cervix uteri to be a comparatively rare disease; having found, as the result of their experience, “only about one case of ulceration in fifty of uterine disease.” Here, then, is a direct disagreement, between writers of equal authority, each professing to give facts founded on personal experience and observation. But we think that these differences can be reconciled by a proper understanding of the lesions to which the term ulceration has been applied. If a cavity or excavation be a sine qua non of ulceration, then, indeed, in all probability, ulceration of the uterus is not a very common affection. But we will be able to show that there are several other uterine conditions to which the term ulceration has no doubt been applied, by the organic party, and moreover, that the frequency of the organic changes alluded to, has been admitted, by Dr. Smith and others of the constitutional party. The pathological conditions of the uterus in leucorrhœa, as enumerated by Dr. Harris, have already been given; and it has been seen that he embraces in his 3rd division excoriation and ulceration of the cervix uteri. Now, there can be no doubt that the Bennett party have considered many of these cases of “excoriation,” abrasion, &c., as cases of ulceration; for we have the authority of Dr. Harris for saying that the structural alterations, denominated by them as ulcerations and granulations, “do not differ from abrasion, erosions, aphthæ, morbid vascularity, granulations of the conjunctiva,” &c. We may add, that Dr. Harris objects, perhaps with propriety, to calling simple epithelial abrasion ulceration; still he admits the great frequency of this organic change. (Ranking, No. 18, pp. 195–96.) Dr. Smith, while he expresses the opinion that the glandular portion of the cervix uteri is the chief source of the discharge in leucorrhœa—and that this discharge is a secretion—suggests the following divisions, founded on microscopic and minute anatomic investigations: “1st. The mucous variety, secreted
by the follicular canal of the cervix. 2d. The epithelial variety, in which the discharge was vaginal. With respect to the so-called ulcerations of the os and cervix, two kinds of morbid change would be observed—1st, epithelial abrasion, by far the most common, in which the epithelium alone was deficient; 2d, villous abrasion, erosion, or ulceration, in which the villi are affected by superficial ulceration." It is hardly necessary for us to say that we do not agree with Dr. Smith, as to the follicular secretion of the canal of the cervix, as a frequent cause of leucorrhœa; for it strikes us very forcibly that this secretion would never transcend its normal limits, unless some irritation or other morbid condition of the mucous membrane or the glandular structure, existed as a cause of the excessive discharge; and of course it would be proper in that case to regard the cause as the ipse morbus, and to treat it accordingly.

We have now seen that Dr. Smith and Dr. Harris, (and others might be adduced) both admit the frequency of various lesions of the genito-mucous membrane in leucorrhœa; and moreover, that these lesions have been denominated, by Dr. Bennett and others who belong to his party, ulcerations; the contest having originated then only in a misunderstanding as to the proper definition of the term ulceration; while all parties agree as to the great frequency of structural alterations of the genital organs, as a cause of dysmenorrœa and leucorrhœa, the controversy should here end. But whether the latter continue or not; whether ulceration be defined or not; whether the frequent existence of excavated ulcer of the cervix uteri, be proven or not; still the "organic pathology" would stand unshaken, when we have the evidence of daily experience, together with the testimony of the most distinguished observers, to prove to a demonstration, that a vast majority of the cases of leucorrhœa and dysmenorrœa, (to say nothing of amenorrœa and menorrhexia) owe their existence to some of the various local organic conditions to which allusion has been made.

As we will be compelled, by the length of this article, to postpone our remarks on the treatment of the diseases to which we have directed attention; we will briefly recapitulate the evidence adduced in support of the "organic pathology," and we will then conclude by some deductions which, we think, may be
legitimately predicated upon this evidence. We have shown, then. 1st—That Dr. Bennett recognizes really but one morbid condition, as the principal, and almost exclusive cause of dysmenorrhea—viz: inflammation, or organic disease of the uterus. 2d—That the same writer considers the vast majority of uterine hemorrhages as the result of inflammation or organic disease. 3rd—That he attributes a large class of cases of amenorrhea, to similar pathological conditions. 4th—That leucorrhrea is declared to be a symptom or effect of organic disease, in most cases, by Drs. Tilt, Meigs and Harris; while Dr. Tilt appeals confidently to the most “distinguished physicians” at home and abroad, to sustain his position. 5th—That the above opinions are confirmed by Churchill and Colombat. 6th—And by our own observation. 7th.—That Drs. Lee, Ashwell and Tyler Smith, while they deny the frequency of ulceration, still admit that there are many other organic alterations which are acknowledged to be common causes of leucorrhrea. 8th—That many of these organic changes have been denominated ulcerations by Dr. Bennett and his partisans. And lastly—That the “organic pathology” is thus established: 1st, by daily observation; and 2d, by the concurrent testimony of the most distinguished writers of the two contending parties into which the medical world is divided.

Deductions.—1st. That leucorrhrea and dysmenorrhea are very common symptoms of local organic uterine affections; and that the constitutional complications are generally resultant—symptoms alike with the leucorrhrea and dysmenorrhea—and but seldom causative. But, 2d. Whether the constitutional affections be resultant or causative, the local treatment is of essential, if not of primary importance, and should never be neglected. 3rd. That constitutional symptoms should not be disregarded in our therapeutic means, for whether they be the cause or the effect of the uterine affection, they may and will react injuriously upon it. 4th. That many cases of amenorrhea and menorrhagia are produced by ulceration, congestion, tumors, and other organic uterine affections. 5th. That the principles already announced, should govern us in the treatment of such cases.*

*We might with great propriety make a 6th deduction, viz., that our nomenclature of uterine diseases should be changed; for it is as vague and uncertain as the treatment connected with it.
And lastly, that "dioptic instrumental examinations" are all important and absolutely indispensable in the diagnosis and treatment of a great number of cases of amenorrhea, menorrhagia, dysmenorrhea, and leucorrhoea.

**ARTICLE XXXI.**

Additional Remarks upon Vertex Presentations. By C. C. Howard, M. D., of Lowndesboro, Alabama.

Professor L. A. Dugas:

Dear Sir—In the July No. of the Southern Medical and Surgical Journal, are contained some remarks on the cause of the great frequency of the 1st position, Vertex Presentation of Baudelocque. Allow me, now, to offer a few remarks on the other positions of the Vertex Presentation, somewhat in continuation of the article referred to. In that article it is intimated, if not clearly stated, that there is an evident tendency for the foetus to bear the relation to the mother, of the 3d position; but counteracting agencies make it usually the 1st. It is also admitted, that the peculiarities of the pelvis, have much to do in determining the frequency of the 1st, 2d, 4th and 3rd positions, as compared with the 3rd and 6th; but little as compared with each other. The explanation, then, of the cause of the greater frequency of the 2d position, as compared with the 4th and 5th, must involve the facts* mentioned as determining the 1st position, except the peculiarity of the right hypochondriac region. The resistance offered by the liver, to the extension of the uterine globe in that direction, is such, I think as usually to throw the body of the foetus around to the left side; but the variable size of that viscus, the variable length of the abdominal cavity, the relaxations of the abdominal muscles, as well as the lying much on the right side during gestations, are facts sufficiently well known, for us to understand that all the causes of the 1st position may not always be brought to bear on the foetus, and consequently we often have the 2d. Indeed, when the peculiar means by which the child is turned to the left side are wanting, I cannot see why we

*See July No. Southern Medical and Surgical Journal.*
should not have this 2d position as readily and frequently as the 1st. If the foetus be relatively small, or the amniotic fluid relatively great; in a word, if the cavity containing the foetus, be sufficiently commodious, to allow it to be quiet, with the back somewhat to the maternal back, and yet the liver brought to flatten the right side of the uterine globe, then, and then only, it would be probable that the 4th position might occur. I am very far from thinking that this position is owing to an impacted rectum, &c., as some suppose. But by accident, the child may lie on the right side, rather than the left; and then, if the conditions just stated exist, I should expect the 4th position. On the other hand, if the circumstances favorable to the 2d position exist, and still the relative size of the foetus and cavity in which it is contained be such as to give it accommodation in the 5th position, I see no reason, other than the force of gravity, why we might not have this 5th position as readily as the 2d; but under ordinary circumstances, the force of gravity would exert a very controlling influence, and therefore, though absolutely, the 5th position might not be unfrequent, yet, as compared with the 1st or 2d, it ought to be, and I think, is, most decidedly so.

As to the 3d and 6th positions of the vertex presentation, I have already indicated this opinion, viz., that the peculiarities of the pelvis would make them very unusual; and as to the latter, i.e., the 6th, I have never seen a pregnant woman whom I thought in a condition for it, by any possibility.

I am quite aware, that in attempting to account for the greater frequency of the 2d position, as compared with the 4th, I am undertaking to account for a fact most distinctly denied by gentlemen who occupy a position in the profession to which I do not so much as dream of attaining; and surely, I should not have the temerity to express an opinion, if only supported by my experience or the reasonableness of any theory. But how does this question stand? Let us see, In Baudelocque’s practice, in 10322 labors the occiput was to the right and anterior portion of the pelvis 1754 times, and to the right and posterior portion only 25 times. In Madame Boivin’s practice, in 19584 births, vertex presentation, there were of the 2d position 3682, and of the 4th only 109. In Madame Lacha-
pelle's practice, of 20698 vertex presentations, there were of the 2d position 4659 and of the 4th only 164.

Although Dr. Dewees says, "the 4th position is by no means unfrequent," I do not understand at all, that he regards it as occurring near so frequently as the 2d.

Dr. Bedford, in a note to his translation of Chailly, page 183-4, insists on the correctness of Baudelocque's observations, and wishes especially, to direct the attention of the student to the different view of the subject, which he calls an error.

But, here we have something of the other side of the question:—M. Naëgelè, who, I believe, was the first to contend for the greater frequency of the 4th position as compared with the 2d, in 100 presentations of the Vertex, found the occiput 70 times to the left, and in front, and 30 times posteriorly, and to the right. In another series of thirty six labors, there were twenty two of the 1st, and eleven of the 4th position.

M. P. Dubois, in 1913 presentations of the vertex, found that in 491 the occiput corresponded with the right sacro-iliac symphysis, and in 55 only was the occiput turned forward, behind the right cotyloid cavity.

J. F. Moreau (page 149) says, "we have for a long time been of the opinion of M. Baudelocque; but enlightened by experience, we now agree with M. Naëgelè; we think that Baudelocque has mistaken the exception for the rule, &c."

Murphy, in his lectures on Parturition, referring to this subject, says: "Being anxious to determine this question, I availed myself of the opportunities afforded me in the Dublin Lying-in Hospital, of putting it to the test, and found that in nearly an equal number of cases the head entered the brim in the third position as in the second, that of those which descended in the third, the majority passed without any difficulty into the second, and were so expelled, while a very few remained in their original position. The whole evidence, establishes Naëgelè's accuracy of description, and it may be admitted that, as a general rule, the head rotates from the third (that is our 4th,) into the second position, when it is passing through the pelvis." Here is his table of seventy-four cases: First position, 43; fourth (our 5th,) into first, 3; second, 11; third (our 4th) into second, 9; third, 2, &c.
Says Professor Meigs, * "In a conversation I had with this venerable and most honored professor at Heidelberg, in 1845, (referring to M. Nægelè) he gave me convincing proof of the correctness of his opinions of this circumstance. Indeed, I kept a register of presentations a few years since, upon learning through a publication of Dr. N's Mechanism of Labor, made by Dr. Edward Rigby, now of London, that the common view as to the greater frequency of the vertex right position, was erroneous. I am fully convinced, by my registry, and by the course of my clinical experience ever since, that Prof. X is quite correct in his statements, and I venture to assure the medical student, that while he shall surely meet with vertex left positions more frequently than any others, he shall as surely find the forehead left positions next in point of frequency."

"Prof. Simpson agrees with Dr. N's views."

Now, what under the sun does all this mean?—this astonishing exemplification of the adage, that "doctors disagree"?—The forceps have been applied again and again—special rules are given in relation to them—applied when the head is high up in the pelvis, and yet, until within a few years, we were taught that the head was frequently in a position, which indeed, we are now told, is very unusual.

As I have undertaken to account for the frequency of a circumstance which is represented as being very unfrequent, the discussion of this question unavoidably comes up; and if I only shew the awkward position in which it now stands, and induce others of more extended opportunities and riper judgement, to turn their attention more particularly to it, will it not be rendering valuable service to the profession?

I used to think, if we knew any thing about the subject of positions, it was those of the vertex presentation. If Baude-loque and his followers blundered so dreadfully, about the relative frequency of the 2d and 4th positions, how do we know that they are right about any of them? I thought they spoke from observation, and though my experience is very limited, I thought that, as to this question, it coincided with theirs—for the few cases I have had, I have tried to understand, and if I ever saw a 4th or 5th position, of the vertex presentation, I do

* Treatise on Obstetrics, p. 271.
not know it. Very certain it is, I never saw any case in which
the forehead passed under the pubal arch. I have seen the
shoulder presentation. The breach is said to occur only, in
about two cases out of every hundred, and yet I have seen that
presentation several times—and in passing, I may state, no less
than four times in the same woman, viz., her tenth, eleventh,
twelfth and thirteenth labors. And what is farther remarkable
about it, so far as the lady knows, she had never previously,
had such a presentation. Another fact, in this woman’s expe-
rience, allow me to mention, viz., that after two of her confine-
ments she had an "abdominal abscess" (in the anterior wall)
either of which ran a very protracted course—the first, before
I ever saw her, which was probably mistaken for disease of the
left ovary; the second, after the first confinement in which
I saw her. It occupied near six months in running its course,
and was also mistaken for disease of the ovary; but that of the
right side. Under the error in diagnosis, her first physician pre-
dicted a discontinuance of child-bearing; and now, as the other
ovary was believed to be radically diseased, the prediction was
confidently repeated. Long before the termination of the case
however, it was evident, that the diagnosis was wrong—that
the disease was one of Abscess, confined to the wall of the abdo-
men. The prognosis therefore was reversed, as to the liability
to pregnancy, and its correctness, as already stated, has been
demonstrated three times since.

To return: Under this state of the question, let us proceed to
examine the observations of the 4th position advocates, and
this we do with all possible respect; for no man ought to
have a higher respect, for his predecessors, and the aged and
experienced of his own day, than the writer. Far be it from
me to breathe a breath, that would raise one gray lock upon the
head of the time honored, or deepen or lengthen one single fur-
row on his brow. But farther research ought to be made; the
errors of former observations ought to be corrected, or progress
has ceased. And should we wait until we grow old before
commencing, how little may we hope to accomplish!

The following objection, I think, ought to lead us to receive
this new statement with some hesitancy, viz., a want of agree-
ment in the result of observation, and this want of agreement
is very apparent. M. Nægelè, in 100 cases, had 30 fourth positions, and not one second. M. P. Dubois, in 1913 cases, had 461 of the 4th position, and 55 of the 2d: and Dr. Murphy found nearly an equal number of 4th and 2d positions in his series of 74 cases.

But let us notice the observations of some of these gentlemen farther. Now, I hold, that to be very far from right on a part of the positions, is to be so probably, on the whole. If we diagnosticate twenty 2d positions, and twenty 4th, and it turns out that all are 2d positions, in our diagnosis we are twenty wrong in each, therefore, in equal error on the whole. M. Nægelè disagrees with almost all modern observers, on the positions of the Vertex Presentation. I read in J. F. Moreau's work on Midwisery, page 149, subject—"Third Direct Position—Occipito-pubal." "The ancients, and Levret among the moderns, consider this position as the most natural. Baude-locque, on the contrary, says, that it is very rare. He only observed it twice in 10329 labors; Madame Boivin 6 times in 20517, and Madame Lachapelle not once in more than 30000. Nevertheless, Drs. Dewees and Radford have reported authenti cases of it. M. Nægelè even goes so far as to say, that it occurs originally in all the anterior occipito-iliac positions, and that the latter are merely a secondary transformation of it, which is (not?) recognized only because we make our examinations at too advanced a period." How does this observation coincide with the general experience of the profession? and yet, is it not as probable as that stated by this observer in relation to the 4th position?

But again: The reason that the fact is not recognised is "we make our examination at too advanced a period." I cannot say at what period M. Nægelè makes his examinations, for I have never seen any work of his; but we have several pages in Dr. Murphy's Lectures on Parturition, in relation to "making a Vaginal Examination." On page 94, he says:—"The only position that should be ascertained before the waters are discharged, is the shoulder presentation." On page 98, he says:—"The head if presenting, may also be felt; but the position cannot be determined until the dilatation is more increased, and the head fully in the brim. And on page 100, we read:—"In ordinary
cases of labor, such as we are now speaking of, the membranes seldom give way until the second stage has made some progress, and often remain entire until the head of the child is almost expelled." The presumption is that the Doctor observes the rule laid down in his book, and if so, tell me who does not attempt, at least, to note as much, and as soon, in the management of cases, as he advises? Shall we then admit, that Baudelocque and his followers have failed to come to a correct conclusion, because they have made their examinations at too advanced a period? By no means.

Professor Meigs also advises a similar course. On page 259, he says:—"For the most part, we only ascertain, in such an examination, the presentation, and being satisfied with that, we wait until a great dilatation, or the discharge of the waters allow us to discover the position." Farther on he says:—"As soon as practicable after the escape of the liquor amnii, the touching should be repeated, and now there is little difficulty in determining the position of the head, though it may often be ascertained through the unruptured membranes." I again ask, is it possible, that Baudelocque, who was deeply interested in the question of positions especially, failed to attain a correct conclusion, because his examinations were made at too advanced a period?

But again: Why should one position be so constantly converted into another, as M. Nægelè seems to think? What reason is there, that the very positions which are the most usual eventually, and the safest, should not be original? Nearly all children presenting the Vertex, are born in the 1st or 2d position; and yet according to this obstetrician, those are not the original positions. Let us examine farther, the 4th converted into the 2d. When the occiput is to the right sacro-iliac symptom, the body of the fetus doubtless, corresponds with that position. Now in the 1st, as well as some other positions, one important mutation is rotation of the head, at the expense of the neck. This is true, I think, in the 4th position also, and if so, when the occiput is carried from the sacro-iliac junction, to the pubes, the rotation must be very great at the expense of the neck, or else the body of the child changes its relations to the body of the mother, which, in the 1st position, Professor Dewees, as
well perhaps as some others, is particular to tell us it does not do. If this is not done in the 1st position, why should it be done in the 4th? I cannot see a reason. And if the rotation is at the expense of the neck, who would undertake to say that "coeteris paribus, the 4th position, is as safe for the mother and the child as the 1st." But, it is said, the relation of the body of the foetus to the mother is changed. * How is that? Is there any peculiar action in the uterus changing it? I cannot think of any. I suppose it must be, that the direction given by the modifications of the pelvis, irresistibly carry the occiput under the pubal arch, and the body is twisted forcibly around. If that be so, can the 4th position be "coeteris paribus as safe for the mother and the child as the 1st?" But, even suppose there is none of this twisting, and by some peculiar action of the uterus the body of the child is changed in its relations to the mother. When the occiput is passing under the pubal arch, the shoulders, I suppose are entering the superior strait; now do they (the shoulders) follow the head in their relation to the pelvis? or do they pass the superior strait transversely? or are they carried round to the 2d position? If the first, then the rotation must be at the expense of the neck. If the second, then the greater diameter of the shoulders, would pass a smaller diameter of the pelvis, than the oblique; neither of which can be safe or easy;—or lastly, if the third, why would not the force which carries the body to the 2d position in the latter stage of labor, carry the head there in the commencement?

Again:—In the former article of July, I attempted to show, that under the uterine and abdominal contractions, if the back of the foetus was to the back of the mother, the tendency of the latter contractions was to throw the child around to the 1st or 2nd positions; or else extend it. Trusting that will be granted, I now wish to show that the 4th and 5th positions, though they will, perhaps in most cases, be converted into the 2d or 1st, if the head enters the superior strait, in the Vertex Presentation, yet they are extremely liable to be converted into face or shoulder presentations. If the contractions of the uterus are not sufficiently great to effect the foetal flexion; but the abdominal muscles on the contrary acting with more energy extend the

* Most of the Italics are mine.
child,* since the direction of the explosive force is not exactly in the direction of the pelvic cavity; the forehead now impinging the anterior pelvic border, is it not clear, that instead of flexion of the head on the breast, the extension may increase, and thus the face continue to roll over, until it shall become the presenting part? The facts just mentioned, viz., that the explosive force is not precisely in the direction of the pelvic cavity, and the head impinging the anterior border of that cavity, have no little influence in the 1st or 2d position of effecting the flexion; but here, in the 4th or 5th position, the relation of things is just reversed, and the very occurrences which aid much in flexion, now make their entire contribution to extension, and to bringing the face to present rather than the vertex. I entirely agree with Dr. Meigs, that the face is but an accident of the vertex presentation; and though I never saw a face presentation, I know of no more probable way in which it could occur.

Reverse the forces spoken of, viz., the contractions of the uterus and abdominal muscles—let the first be great, producing the utmost flexion of the foetus; now, instead of the head passing into the superior strait in the vertex presentation, is it not more than possible, that the occiput impinging the anterior border of the pelvic cavity, will glance, and instead of the head entering at all, will retire to make way for the shoulder, or whatever part below the shoulders may chance to be brought down?

Had I time, and did I not fear extending this article beyond a readable length, much more might and would be said; but, permit me to recapitulate and I close.

1st. Seeing no reason to believe, that Baudeloque and his followers have examined this matter of the frequency of the 2d position, as compared with the 4th, with less care than M. Nægelè and those who receive his opinion;

2d. The opinion not according with my own observation; and,

3d. Being wholly out of keeping with what I regard as the most plausible theory on the subject of the positions of the vertex presentation; I prefer to be in the ranks in which this

* It being at an angle of near 30°

(Continued from August No., page 470.)

PART III.

There is a species of rheumatic affection, so-called, which appears as one of the latter consequences of gonorrhoea, among those pseudo-secondary symptoms, if I may use the term, which are sometimes observed to follow the primary complaint. Here the patient complains of undue frequency of micturition, but there are no concomitant symptoms of inflammation, or of simple catarrh. There is no narrowing of the urethra. Inquiry may elicit the fact that there has been some slight eruption of the skin, or a swelling of the knee, or other joint, or wandering pains may have been complained of; conjointed to these, a gradual depreciation of the general health will commonly have been observed; the skin is often dry and harsh, and the digestive functions are impaired. Under such circumstances, the patient will often derive great benefit from a persevering use of the iodide of potassium, and active tonics, such as the cinchona, with small doses of Plummer's pill. Sometimes, however, more benefit seems to result from small doses of colchicum in the form of tincture, or in that of the acetic extract, with an equal quantity of blue pill added occasionally; sometimes from guaiacum, which is advantageously given in powder with calcined magnesia—ten or twelve grains of each, well mixed, may thus be taken in milk, or water, once or twice in the day. Warm baths, especially when of salt water, and the vapour bath also, are often very valuable adjuncts to other treatment. Added to these, the removal to a warm and dry locality, where this has not previously been enjoyed, may confirm or complete the cure of an obstinate case. In most instances, however, it is necessary to persevere continuously for some time in the course of the treatment which is decided upon, whatever it may be, and not hastily or unnecessarily to change it for another.

Frequent micturition is sometimes associated with an affection of the prostate, or more properly speaking, of the urethra as it passes through that gland, when the symptom occurs in youth, or at an early adult age. Thus, after an habitual inor-
dinate indulgence of venereal appetites, sometimes after repeated attacks of gonorrhea, or quite as commonly after one attack only in certain constitutions which manifest undue excitability of the urinary apparatus, and in which catarrhal discharges generally are very obstinate and hard to cure, the patient complains of vesical irritability, attended or not with some gleety discharge. On passing a middle-sized catheter, no organic narrowing is discovered, but there is extreme sensibility of the canal, after the instrument has traversed some five or six inches of the anterior part. Acute cutting pain is then complained of as it is carried onwards to the bladder. The catheter may be tightly grasped, and is not to be removed without some pain. Perhaps it is not possible to say what is the exact condition of the urethra here; probably there is some vascular congestion, or subacute inflammatory action existing in the mucous membrane, analogous to that met with elsewhere. This, however, we know, that in four cases out of five, the passing of a catheter, repeated at two or three days' intervals, for a short time, almost entirely removes the hyper-sensibility. The muscular constituents of the canal are perhaps stimulated to contract by the presence of the foreign body; the enlarged or relaxed capillaries thus emptied of their contents, gradually return to their normal size, and the congestion ceases to exist.

Thus it happens that on the first or second time of using the instrument, some slight bleeding may occur, which appears to have a beneficial effect rather than otherwise, and it rarely takes place afterwards. The actual presence of the pathological state described, is, in most instances, a matter of conjecture only, it must be confessed, but there is a strong probability that it may not unfrequently be affirmed. Now sometimes it seems to happen that this affection, when much neglected, or if marked by more than usual severity, may implicate the neck of the bladder also to a greater or less extent, and set up considerable irritability of this organ. Such a condition, as might naturally be expected, is aggravated by the stimulating diuretics frequently employed, which contain some volatile or acrid principle, such as buchu, copaiba, &c. I have met with several cases notably illustrating these remarks. In this complication, also, if there be no purulent discharge with the urine, which is sometimes the case, I have found the benefit of passing instruments into the bladder, beginning, say with No. 7 or 8, and passing on to 10, 11, or 12. But if these fail, or if there is some little purulent discharge, an application of the nitrate of silver to the prostatic portion of the urethra and neck of the bladder is exceedingly useful as a curative means. Sometimes
the whole bladder is advantageously injected with solutions of the nitrate; it is, I believe, however, generally sufficient to cauterize the parts indicated. Nevertheless, there are conditions of the vesical mucous membrane in which such injection is highly beneficial. When the neck of the bladder has thus become affected, the urine may be decidedly albuminous, and yet no serious renal disease may co-exist. It would then seem to be a result of irritation, secondary to, and depending upon, the condition of the bladder; for on remedying this, the albumen disappears. In such a case, the absence of the constitutional signs of organic disease of the kidney, and the non-appearance of diseased epithelium or casts in the urine, will lead the observer to watch closely for the source of the albuminous product, and perhaps to connect it with some functional, and not with any organic derangement.

We meet with vesical irritability, accompanied by more or less of mucus in the urine, or muco-purulent deposit, in which no evidence of inflammatory action being present, we cannot feel justified in regarding it as a condition of cystitis, although it is often, but not necessarily always a sequel of it. It seems to be due rather to an astatic or relaxed condition of the mucous membrane, in which the phenomena described occur, and in which much distress from frequent calls to pass urine is experienced, but which will not be combated successfully by any antiphlogistic treatment. It is for this class of cases especially that stimulating injections for the bladder are so useful. Among them may be mentioned the nitrate of silver, in the proportion of half a grain to two grains to the ounce of water. The strength, however, may be greatly increased, even to ten or fifteen grains for some cases. Another useful formula is half a grain to a grain of the acetate of lead, with two grains of the extract of opium, to the ounce of water. The nitric acid is particularly indicated when the urine is charged with the earthy phosphates, and may be added to water in the proportion of one or two minims to the fluid ounce. Creosote and copaiba have both been employed by continental surgeons in these circumstances; the former in the proportion of one minim, the latter in that of thirty to sixty minims, to the ounce of fluid; but I have no experience of the effect of these. Plain warm water is often of great service in most cases where much mucus is present, and it may then be advantageously injected once or twice a day. The employment of a continuous stream by means of the double current catheter, with a free opening for the transit of mucus, is best adapted for the purpose. When there is much pain, as well as irritability, the extract of opium may be added to the water; but, generally speaking, a
sedative effect is much more efficiently obtained by the use of a suppository. When the contents of the bladder are extremely offensive, a weak solution of chloride of soda is sometimes of considerable value as an injection. It may be repeated every day. The strength to be employed should range between six and ten minims to the ounce of tepid water. In the operation of injecting the bladder, instead of fixing the nozzle of the syringe directly upon the catheter itself, it conduces greatly to the comfort of the patient to connect the two by means of a pliable or elastic tube, so that no impetus be transferred to the sensitive organ from the hand employed in propelling the fluid. The vulcanized india-rubber bottle, fitted with pipes and valves, like those of the ordinary enema apparatus, is very preferable to the syringe for this purpose, because it can be worked by the operator with one hand only, leaving the other free to adjust the catheter or turn the stop-cock. With regard to internal remedies, the alkalies before alluded to, provided the urine is not already alkaline, as a general but not invariable rule, or the mineral acids if it be strongly so, combined with the infusions of diosma or buchu, or of the uva ursi, with full doses of hyoscyamus or of camphor, and sometimes with copaiba or chios turpentine, appear to be the most efficient in non-inflammatory conditions of the bladder. The tinctures of iron and hyoscyamus together, or of iron and hop, sometimes exercise marked benefit in weak and anaæmated subjects. From decoction of the pareira brava, in doses of the ordinary Pharmacopeia strength, and also when augmented greatly beyond that standard, I have been disappointed in obtaining the good results attributed to its use, and in cases which have been apparently adapted for it. We have the highest authority, however, for its value in some circumstances.

I may appropriately mention here a form of irritability, with sometimes mucous urine, of which I have had three examples. In these cases the patients had experienced a variety of treatment without benefit, until the simple proceeding about to be described was adopted, with complete success in two of them. The occasion was unquestionably an organic narrowing of the urethra close to the external meatus—that is, within half or three-quarters of an inch, but so slight in degree as not at first to be recognised as the cause. In the first case, No. 5 catheter, in the second and third No. 7, were passed with tolerable ease into the bladder, the only obstacle to larger sizes being the slight narrowing described. Having tried all ordinary means in vain,—having dilated the obstruction somewhat, but finding that the irritation so occasioned rather rendered the subsequent contraction, which was certain to take place in a
few days, if anything, rather more obstinate than before, I divided it in each case by carrying a director and tenotomy knife in its groove through the constricting part, and passing a No. 10 and 11 catheter afterwards. The operation is exceedingly simple, and was attended with the best results. In the two former cases, all the vesical symptoms rapidly disappeared; the latter still remains under treatment, the mucous membrane of the bladder having suffered, I fear, some change from chronic disease. The patient has, nevertheless, improved since the operation, which was performed a month ago. It is remarkable how exceedingly resilient these contractions are, how inefficient mere dilatation is to render their disappearance permanent, and how speedily the frequent micturition and supra pubic pains vanish after the simple act of division has been performed.

It might have been considered by some impossible that an obstruction so slight as those which have been described should occasion serious symptoms. I confess I should have thought so some time ago. Not, however, until after meeting with two of these cases, I became acquainted with Civiale’s observations made some years ago in relation to this very subject. They are so pertinent that I may be permitted to quote them here, from the last edition of his work on “Diseases of the Genito-Urinary Organs,” published in 1850, vol. ii., p. 34. He speaks of “the co-existence of very slight strictures of the urinary meatus with neuralgia of the vesical neck, which latter disappears immediately after the meatus has been divided.” He continues, “I have seen many examples of it, and I own that I have not admitted without some hesitation the influence of a cause which appeared to me at first sight not to have any weight, yet I have had but to incise the urinary meatus, and to introduce some bougies, in order to hinder the little wound from immediately re-uniting, and I have seen all the symptoms disappear. In multiplying themselves, these facts have dissipated my doubts, and the result now presents itself so clearly that I am enabled to announce it as certain.

M. Civiale has written at great length upon “Neuralgic Affections of the Neck of the Bladder,” by which phrase he appears to designate any condition in which the patient experiences abnormally frequent desires to micturate, attended with pain about the pubes and perineum, but without throwing much light upon the exact pathology of the complaint so denominated. In respect of the treatment, however, his observations tend to show the value, in a certain proportion of cases, of passing bougies, and thus subduing the abnormal sensibility, as he calls it, of the vesical neck. Entertaining the
utmost consideration for any opinion advanced by that experienced observer, I am nevertheless compelled to believe that an undue sensibility of the prostatic urethra already alluded to, giving rise to all the symptoms which he describes, is a much more frequent affection, at least in this country, than an altered or abnormal innervation of the neck of the bladder. I have been frequently consulted for pains and uneasiness referred to the neck of the bladder, in which the passing of a catheter has shown that the point of extreme tenderness was situated distinctly anterior to the neck and most certainly in the prostatic part itself. I should not feel warranted in expressing an opinion on this subject, had I not possessed the opportunity of observing a very considerable number of such cases amongst patients who have applied for suspected organic stricture of the urethra, or for some other affections of the urinary organs, supposed, but often erroneously, by the sufferer to be present.

PART IV.

Irritability of the bladder is a symptom which frequently occurs in children and young people, and often proves the occasion of much annoyance and even distress when it persists, as it sometimes does, up to the age of puberty. The patient generally exhibits no sign of it during the day; but the act of micturition takes place involuntarily, and may be repeated during the hours of sleep, appearing to overcome the retentive power of the urinary apparatus when volition is suspended. Whether the natural retentive power is weakened, or whether the expulsive function of the urinary organs is unnaturally called into action, it may not always be possible to ascertain. While some cases exhibit more of the former character, the great majority probably depend chiefly upon causes of the latter kind. The sources of excitement which may thus act are extremely numerous and various in their nature and locality. Among them are the irritations occasioned by dentition, intestinal worms, and other foreign matters in the bowels, food of an improper kind, or taken shortly before going to bed, &c. Very commonly there is an abundance of uric acid deposit in the urine, which seems to act as the disturbing cause. The health is sometimes temporarily deranged, and requires only to be set right. The general tone of the body may be deficient, the muscular fibre being lax and debilitated, and an invigoration of the vital powers may be accompanied by a disappearance of the evil. The force of habit alone may sometimes perpetuate it when the originating cause has been removed. But these conditions appear not to include all the causes which occasionally give rise to the complaint in question. We look
in vain for these sources of excitement in some patients, and after employing empirically a long list of approved remedies, are still doomed to be disappointed. In the spring of last year I had an extremely obstinate case, in which the affection had existed from childhood to the age of fifteen years. The youth was brought to me from the country, where he had received treatment of various kinds, including medicines, blisters to the sacrum, &c. He was intended by his family to be articled to some profession of business, but was disqualified by this most disagreeable infirmity. Not being able to detect any cause in the condition of the urine, or in adjacent organs, I decided upon simply passing a catheter every other day for two or three weeks. As only a slight improvement followed this means, I then cauterized the neck of the bladder with a solution of one drachm of the nitrate of silver to the ounce, by means of an instrument which I designed some time ago for the purpose of enabling us to apply to the prostatic urethra and bladder solutions of various strengths in place of the solid caustic. During the subsequent four weeks there was no re-appearance of the incontinence. He then returned home, and six months afterwards I heard from him, stating that he was perfectly free from his annoyance, and had entered upon the business engagements for which he had been intended. I have had no other similar cases of sufficient obstinacy to warrant me in employing this remedy in the manner described. It is nevertheless a safe and efficient one, when the employment is indicated, if properly applied. I have used it between forty and fifty times for cases previously alluded to, and have never observed any ill effects to result.

I may now briefly glance at a different class of cases, comprised beneath the latter term of the last division of the table, viz., those in which irritability of the bladder is due to "certain derangements of the nervous system."

Anomalous affections partaking more of the character of unnatural retention of urine than of vesical irritability, although sometimes assuming the latter form, are met with among many of those remarkable phenomena which are presented in the female economy, and generally termed hysteria. It is not conceived to be within the scope of this paper to enter upon the consideration of these.

Irritability of the bladder in either sex, but especially in the male, may be the result of cerebral or spinal injuries of various kinds. Chronic organic diseases of the organs indicated also play their part in producing the same symptom. Thus, by those who have passed the meridian of life we are sometimes consulted respecting its appearance. Inquiry elicits the fact
that it has occurred in an almost imperceptible manner, and
that of late it has attracted the patient's attention by becoming
a source of inconvenience rather than of discomfort or pain.
The urine presents no character to account for the occurrence,
and there are no signs of obstruction to its flow. In short, no
indications appear for any direct line of treatment; nevertheless,
the evil increases, and almost disqualifies the individual for
society, and for many of the ordinary engagements of life. At
the same time, however, unmistakeable signs of impaired
nervous function are exhibited. Probably there will be some
uncertainty in the gait; perhaps some inequality in the power
of grasp by the hands. The organs of special sense may be
impaired in some degree, apparently without the occurrence
of any organic changes in their structure. The appearance
of such indications, and à fortiori, of any more marked signs
of chronic change in the nervous centres, together with the
absence of any causes hitherto pointed out, will go far to de-
determine the nature of the case. For these, by such a dietetic
management and regimen as shall tend to invigorate the animal
functions generally, by absolutely insuring, if possible, the ne-
cessary amount of relaxation from wearing occupations, both
mental and physical, in the case of those who are too closely
engaged in business habits and pursuits, together with the em-
ployment of well-adapted mechanical contrivances where their
use is indicated, we may conduce materially to mitigate the
evil and afford support to the undermined constitution, but little
or nothing can be done to repair it.

On the other hand, at the outset of life, while the nervous
agencies are extremely mobile, easily excited to undue action,
and erratic muscular movements are prone to occur from slight
disturbing causes, irritability of bladder, when presented, usually
gives way without difficulty, on the discovery of the distur-
bning agent. A like condition occurs at the approach of puberty
in the female sex, and thus we often find the same symptom
severely complained of, ushering in the exercises of the men-
strual functions. Perhaps there is less of what we are accus-
tomed to call hysteria about the affection in such instances than
of ordinary sympathetic action on the part of the bladder with
the neighbouring uterus, through the agency of which, in taking
on a new relation to the rest of the animal economy, the gan-
glionic nerves become the media of disturbing action reflected
to adjacent viscera. Thus, also, the same thing appears to
happen at the critical period of female life, when menstruation
is about to cease. Excited action of the bladder is often asso-
ciated with the uterine derangement then experienced, and
sometimes so early as to offer the first announcement of
the approaching change. The recognition of this fact will point out the appropriate treatment, and may save the patient much that is ill-directed, painful and unnecessary.

But even in matured adult age we frequently meet with an equal susceptibility to the effect of stimuli, displaying itself by that proneness to habitual disturbance in the equanimity of the individual which gains for him the popular epithet of "nervous." Whatever the cause, whether it be a hereditary disposition, or a condition acquired, as not unfrequently, either through severe and long-continued bodily or mental exhaustion or both, one of the most obvious manifestations in a few cases is the symptom under consideration. Under some more than usually exciting circumstances, particularly if of a disagreeable nature, the want becomes perfectly uncontrollable, continuous and distressing, while at most times it amounts to an annoyance. On the other hand, the enjoyment of congenial society, and a moderate indulgence in alcoholic stimulant, (so contrary to its effect in all other cases), for the time improves his condition by giving temporary stability to the weak, inconstant, and purposeless activity of the nervous centres. Such a case it is difficult to mistake, while an observation of the character given renders the diagnosis a matter of almost absolute certainty. With time and perseverance much may be accomplished for such patients. Strict attention to every means for improving the general health and promoting the tone of the body, as by generous diet, exercise, country air, sea and other bathing, cheerful society, regular but congenial employment, tonic medicines, especially quinine and the chalybeates, constitutes the necessary treatment. Local applications of belladonna, opium and camphor combined, in the form of plaster, or otherwise, and occasionally the use of opium, conium, or Indian hemp, internally, are often temporarily very useful to patients of this class. The causes, however, of the constitutional condition must be ascertained, and no longer be permitted to exercise their influence. Now, it is partly with such individuals, or among those who are possessed of a similar constitution, that we find an irritability of bladder, originally induced by some palpable physical cause, as by a gonorrhcea, obstinately persisting despite of all treatment, although the lesion has long ago disappeared. The relationship between the nervous centres and the genito-urinary organs is of that peculiar and intimate character, that the symptom exists through the existence of an erroneous mental impression, while all physical cause is wanting, purely as a matter of habit; the bladder having been during some time accustomed to retain only a few ounces of urine, resents any addition, the individual becomes conscious of the
want, and feels impelled to gratify it. It requires some determination to resist the suggestion, but in such case nothing more is needed in order to conquer the habit. We must only be assured that the cause is that which has been described, or the advice will be calculated rather to increase than to remove the evil complained of.

I have thus endeavoured to present a slight and hasty sketch of a considerable number of diseases, many of them widely differing, but in all of which the disordered function under consideration is a prominent symptom, dwelling chiefly not upon those which appeared to be most important in themselves but upon two or three which appear to me to have received less of notice or elucidation in any work upon the subject with which I am acquainted. The degree of attention which circumstances have led me to give to this class of disorders, arising in part from advantages which I have long enjoyed at the Marylebone Infirmary (unquestionably one of the best existing fields for their study which can be presented to the inquirer,) but convinces me how much remains to be achieved, how much more needs to be known respecting their pathology, and how much they deserve and will repay a laborious and patient study. At the same time there are perhaps no disorders to which humanity is exposed for which well-adapted treatment can afford so much valuable aid, either in the way of removing actual disease, or if this cannot be accomplished by checking the progress of the malady, or at least by materially palliating its most painful and distressing symptoms.

[London Lancet.


On Impotence.—There are one or two points connected with the pathology of impotence which are not quite so clear as one might wish; or rather, to speak more plainly, respecting which considerable confusion seems to prevail.

The function of generation being the most truly remittent of all we are acquainted with, being liable to cease for years or even for life without any injury to the health, may be supplanted by disordered innervation of some other part. By disordered innervation I mean pain, either gouty, neuralgic, &c., in some near part, especially about the neck of the bladder, or else exalted function in some distant part, as indigestion, cerebral excitement; and by supplanted I mean, that when these actions are set up, the function of generation ceases, as if the vital
force necessary for it were absorbed by the diseased action. Thus—

Observation 1. From Neuralgic Pain.—A patient, an elderly man, had suddenly become impotent; it had not occurred, as it mostly does on the advance of old age, with a gradual decay, the emissions becoming less and less frequent; on the contrary, it had come on quite suddenly, and at the same time severe pain had set in at the neck of the bladder. This continued with great irritability of the bladder and pains at the glans penis; sometimes a little blood came after passing urine. He was sounded for stone, but none being found, it was considered ulcer of the neck of the bladder. To relieve this, injections of nitrate of silver were tried; the first produced great pain, but some relief followed, and a second was given; the pain after this grew more severe, and now never left him day or night. While at the height of his sufferings, he was attacked with dysentery. I was in the country at the time, and on my return to town I found him rapidly sinking. He died shortly after, and I examined the body. Great part of the colon, and about eighteen inches of the ileum, were almost gangrenous; but nothing abnormal was discovered in the genito-urinary organs, except that the mucous membrane of the prostatic part of the urethra was of a vivid red; the testes, ducts, &c., seemed quite natural.

When Rousseau, in whom both cerebral excitement and spasmodic pain at the neck of the bladder, with retention of urine, occurred at a very early age, producing temporary impotence, died after a life of suffering, no organic change was found, although the organs were examined with the greatest care, so that the physicians concluded that his sufferings had been occasioned by a spasmodic state of the parts near the neck of the bladder, or of the neck itself.

Obs. 2. From Gouty Pain.—A gentleman, a strong, healthy active man, in the prime of life, consulted me respecting impotence, of which he gave the following account:—After having been long tormented with flying gout, notwithstanding a very temperate life, he had been suddenly relieved from it in the great toe, the last spot it had settled in, and had been attacked with great pain in the urethra, and some difficulty in passing urine. A bougie was passed, and as the obstruction yielded and recurred very suddenly, the disease was pronounced spasmodic stricture; but from the history of the case, and having met with several very analogous instances, I am induced to suspect that gout in the urethra was the disease, and the stricture and impotence (which was not caused here by the stricture) were its effects.
Obs. 3. From Heightened Function in other Parts.—A gentleman applied in extreme terror at having become suddenly impotent. As he appeared young and healthy, I felt surprised at this. It turned out that having neglected his studies until his examination was close at hand, he had become alarmed, and had betaken himself to them in the most irrational manner, going to bed with his book in his hand, ready to begin in the morning, and sitting up in bed to sleep, for fear, if he lay down, he should sleep too long. He had become exceedingly nervous, and found that on thinking of connexion vigorous exertions came on; but that on attempting connexion they immediately subsided, and, while subsiding, emission took place. Quiet, relaxation, and mild aperients, soon restored the balance of the functions.

From Stricture.—When impotence comes on gradually in patients still in the prime of life, as from forty to fifty years of age, the emissions growing gradually more feeble and fewer in number a mere sensation accompanying them, like that of evacuating urine or passing faeces, stricture may often be suspected. It is the more important to attend to this, as many of these patients persist in stating that the stream of urine is as large as ever it was; or never have had gonorrhœa, and having heard that strictures followed upon neglected disease of this kind, they cannot understand how one can occur without the other. When in case of this class the stricture appears to arise from a fold of the mucous membrane growing up, I prefer the application of a film of caustic on a broad bougie, on the principle so ably advocated by Sir Everard Home.

Obs. 4.—In the autumn of 1852, I dissected with great care the genito-urinary organs of a gentleman who had died of irritative fever, consequent on an operation performed by Mr. Gay for the relief of an impermeable stricture. He had become impotent about the time he began to notice a material diminution of the stream in passing urine. On examination, the urethra was found extremely narrowed near the bulb. Close to this part were two passages, one lying behind the other; they were on the lower side of the urethra, and were both larger than the contracted part of the tube; they were about four lines long, and were lined throughout with mucous membrane; the posterior lip of the second almost entirely overlapped and occluded the natural opening. No instrument could have been introduced into the bladder, and the exit of urine could only have taken place by the force of the stream passing down the valve-like fold of the mucous membrane; that of the semen must, I think, have been very imperfect, if not impossible, and I am induced to believe that this case might have been advan-
tagiously treated by caustic, as I have suggested. I have
cured in this way cases which appear to me very similar, for
no two are exactly alike, and at this present moment I have
one under my care. I invariably adopt it when there is a
false passage difficult to steer clear of.

Diagnosis of Spermatorrhœa.—Like many longstanding
functional disorders spermatorrhœa may, in time, induce struc-
tural change either in the genito-urinary or in the vital organs
producing, on the one hand, impotence, on the other paralysis,
phthisis, or marasmus, &c. But, in the first place, it is very
rarely that these serious changes ensue before the patient seeks
for advice. Spermatorrhœa—i. e. imperfect secretion of semen
from masturbation, accompanied by impotence from congenital
imperfect erection—admits of very limited relief. Impotence
consequent on disease of the spinal cord is necessarily incura-
ble. All other cases may, I think, be cured; but it must be
borne in mind that in this, as in every long-standing disease,
no sudden cure by sleight-of-hand, no miraculous restoration to
health can be looked for. Steady perseverance in a rational
eclectic plan of treatment will generally effect all that is neces-
sary—the restoration of the balance. The dark fears which
beset the minds of patients, and even of medical men labouring
under this disease, are as fictitious as the formless shades which
Fingal beheld issuing from the halls of Gurth-Loda.

It will thus be seen that I differ widely from M. Lallemand,
whom I cannot altogether acquit of lending his great authority
to the dissemination of exaggerated views as to the incurability
and serious results of spermatorrhœa. Not only has he attrib-
buted effects to it which it is not proved to have induced, but
he has inferred spermatorrhœa where it appears to me never
to have existed.

Thus in a patient who died of stricture, complicated with
cystitis and abscesses in every part of the prostate, M. Lalle-
mand referred death, not to these causes, but to the "profound
alteration of the spermatic organs,"* this profound alteration
consisting in an abscess of the left testicle; the corresponding
ejaculatory duct and seminal vesicle being full of pus. Now,
how could he believe that such slight disease as this of the tes-
ticle and seminal vesicle could produce death, when he must, I
suppose, have seen much more extensive disease, not merely of
one, but of both testicles, without the health suffering materi-
ally? How could he overlook the fact, that patients very often
die of cystitis and stricture, and that the testicles may be re-
moved without danger? In another case he attributes the
derangement of the patient's health "to the growing influence

* Vol. 1. p. 45.
of the seminal discharges on the whole animal economy," although in the next page he informs us that long before the cerebral symptoms, which he attributes to the seminal discharges, set in, there was most serious derangement of the digestive and nervous system, &c.

Again, I will just ask the reader to look, among others, at M. Lallemand's thirty-eighth case. I cannot find a single proof that spermatorrhœa was present, yet M. Lallemand comes to this conclusion, because the patient had lately become indifferent to connexion, and passed semen on going to stool. But the explanation seems easy enough. Disgust at the idea of passing semen, the ill-health which generally accompanies this state, and the alarm and nervousness, often render these patients temporarily impotent. In many of these cases M. Lallemand tells us that the patients were not aware of their having daily pollutions till he extracted the fact by cross-questioning; these were, I should say, simply cases of vesicular gleet.

But if I were asked whether any given case was likely to become incurable, I should at once answer that there seems an inevitable tendency in spermatorrhœa to get worse if neglected; that I know of no instance of a spontaneous cure when once day pollutions have set in, and few of well-marked remission; that there seems a very limited power in the generative organs of throwing off diseased action, as if from their representing a system quite unconnected with those of the animal and organic life, marked by a highly remittent function, the steady influx of nervous energy necessary to effect a cure was wanting. When a patient therefore, from day to day puts off the trouble and irksomeness of systematic treatment, it is he who is responsible, not his medical adviser. Then indeed, we may see "a degraded nature and a ruined constitution embittering the best days of the existence, and sometimes leading to insanity or suicide."†

Yet it is scarcely to be wondered at that incorrect ideas prevail respecting this disease, when no one has as yet taken the pains to collect and arrange the many valuable but scattered monographs of Curling, Phillips, Acton, Thomson, and others. Most of the great English works on surgery are silent, or contain little that is calculated to give a comprehensive view of the evil and its proper remedies.—Ib.

*I really can scarcely help thinking, that if M. Lallemand had read M. Louis Odier's account of the death and post-mortem examination of Saussure, he would have attributed the death of his illustrious countryman to spermatorrhœa!

† Curling.
On the Condition and Appearance of the Eyes in Diseases of other parts. By Prof. C. G. Th. Ruete.

After some introductory remarks on the value of eye symptoms for diagnosis and prognosis, the author proceeds to the consideration of the condition of the eyes in particular groups of diseases.

1. Dyscrasiae.—In these are especially noticeable, alterations of color in the eyelids, the conjunctiva, the aqueous humor and the crystalline lens, which, nevertheless, rarely indicate a mere abnormal composition of blood, but rather defects of nutrition, circulation and innervation. In chlorosis, anæmia, hydæmia, and similar conditions of the blood, we find bluish or whitish rings about the inferior eyelids, paleness of the conjunctiva and lachrymal caruncle, isolated bluish vessels of the conjunctiva, dull look, and frequently swollen eyelids. Venosity in its higher degrees produces blue rings about the eyes, and reddish-blue coloration of the sclerotica; the latter proceeds from the delicacy of the sclerotica, which permits the deep part of the eye to shine through. This is also found in some diseases of nutrition; in children it is not a morbid symptom. In typhus petechialis and putridus, besides the reddish-blue color of the eyelids, often appear, also, as in scorbutus and morbus Werlhoffi [purpura hemorrhagica], bluish spots (ecchymoses) upon the upper eyelids, and reddish spots and lines beneath the discolored, dirty conjunctiva, first at the border of the cornea, and extend thence over the whole conjunctiva bulbi. When the coloring matter of the bile passes into the blood in icterus, yellow fever, &c., the sclerotica, and in higher degree also the aqueous humor, are the first to appear yellow, and corresponding with this an alteration of the color of the iris; e.g. a previously blue iris appears greenish. Moreover, a pale yellow color of the conjunctiva is found in old persons, and even in young individuals, when many and somewhat varicose veins, or at times little masses of fat, penetrate this membrane. This latter coloration appears especially in a direct transverse line, whilst the icteric is first observed at the periphery of the globe. The melanotic cacæmia changes the extravasations of blood existing at the time beneath the conjunctiva sometimes into yellow, dark brown, even black, often somewhat marked, melanotic spots, which almost always indicate the existence of similar alterations in other organs. The alteration of the eyes in other dyscrasic diseases, as diabetes, uræmia, lead colic, menostasia, hemorrhoids, scrofulosis, scirrhus, &c., are only derived from the relaxation of the tissues in consequence of disturbances of nutrition, circulation, secretion, and innervation.
2. Disturbances of the circulation, are expressed in the eye by hyperæmia, stasis, or anæmia. Active hyperæmia of the eye, by which the vessels of the eyelids and conjunctiva become turgescent, and thus determine a red coloration with increased secretion of tears and increased lustre of the eye, indicates increased action of the heart, or irritation of the nerves of the head and eye. The former is induced by psychical disturbances, inflammations, fever, cardiac hypertrophy; the latter by inflammations of the brain, of the throat, of the eyes, and neuralgia of the trigeminus. Special signs for special diseases in reference to color and vascular distribution are not found, except that in bilious fevers a yellowish coloration is observed. Hyperæmia indicates merely determination of blood to the head; and the special form and distribution of the vessels in particular inflammations of the eye do not depend upon the exciting causes, but upon the anatomical structure of the parts concerned. Passive hyperæmia of the eyes and their neighboring parts arises in consequence of obstructed reflux of the blood, or of relaxation of the vascular walls on account of debility of the whole body or of the nerves concerned. We see, then, the vessels of the temporal region, of the eyelids, and of the conjunctiva, in different parts thickened, varicose, livid, often with extravasations of blood beneath the conjunctiva, oedematous swelling of the tissues, aversion to light, and other disturbances of vision. The abnormalities of the lesser circulation, induced by diseases of the trachea, the bronchii, the lungs and their envelopes, of the heart, of the abdomen, by swellings in the proximity of the great veins of the neck, obstruct the reflux of blood from the head. Typhus fever, and all chronic diseases which impair nutrition, scrofula, gout, tuberculosis, rachitis, chlorosis, scirrhus, retard the peripheric circulation, and induce an over-fullness of the small vessels, which lie, like those of the conjunctiva and lids, in easily distensible tissues. In typhous diseases, and in central and peripheric torpor of the nerves of the eye, hyperæmia is induced by weakened innervation. Nevertheless, the causes of hyperæmia must also be inferred from other signs, and this alone affords no pathognomonic sign. Anæmia of the eyes owes its origin to obliteration of the vessels in consequence of chronic inflammations, or of constriction of the same from debility of the cerebral nerves, with simultaneous increased power of resistance of the vasomotorv nerves. If the anæmia of the eyes is accompanied by anæmia of the brain, with obscurity of vision, giddiness, fainting, paleness of the face, especially when the long-confined patient gets up again, we must infer a general anæmia, or debility of the muscular power of the heart, which either becomes
diminished by wasting of the body in chronic diseases, or suddenly from psychical and other depressing influences.

3. Anomalies of secretion and resorption in the eye, are the result either of abnormal composition of blood, or disturbed circulation and innervation. The qualitative alterations of the fluids of the eye; the presence of bile, sugar, urine, calcareous salts in the tears, in icterus, diabetes, uræmia, gout; the want of alkalescence of the aqueous humor, in rheumatism, scrofulosis, &c.,—are not yet sufficiently determined to become considered as diagnostic signs. We can, nevertheless, conclude upon a perverse composition of blood, from the progressing development of soft cataract, since the nutritive fluid of the lens, of the aqueous and vitreous humors, are secreted without the intervention of glands directly from the blood, the composition of which is thus indirectly manifested in the crystalline lens. The quantitative alterations afford more definite signs, the causes of which are circulatory disturbances. Hyperæmia produces an increased, mostly watery secretion, therefore, in nervous excitation from psychical or other influences, profuse secretion of tears and mucus, even œdema of the lids. Removal of the moderating nervous influence either prevents the secretion, or in consequence of relaxation of the vascular walls, permits the blood-plasma, or even the blood itself to exude; the eye assumes a venous coloration, and is covered with tears, and tough, often blood-colored mucus. Hence comes a wild or vacant expression of countenance, slight dilatation of the pupil, œdema of the half-closed dependent lids. In the highest degree of the disease, even colliquation of the eye follows. These phenomena are found in debilitated states of the trigeminus which do not affect simultaneously the sympathetic, in typhous, putrid fevers, cerebral inflammations, &c., in the last stages of chronic diseases, with long-continuing agony. OŒdema of the eyelids, especially observable in the morning, and yielding at evening to swelling of the feet, shows itself often in chlorosis, hydæmia, and in all the conditions which determine cutaneous dropsy. Delicate blondines not seldom have œdema of the lids without inflammation of the circumjacent parts after agitation of mind, colds, and similar affections. Dryness of the eye without previous ophthalmia, in consequence of obstructed secretion of the lachrymal and conjunctival glands, proceeds from a debilitated condition of the cerebral nerves. We find it, e. g. in debility of the trigeminus, after fatigues of mind, as a precursor of insanity.

4. Disturbances of nutrition are not without influence upon the habitus of the eye; but they cannot by this be recognized according to their specific nature, whilst their consequences,
general plethora, anaemia, fatty disease, emaciation, collapse, laxness of the tissues, are accompanied by very different signs in the eye. The effects of the first have been already mentioned: immoderate general deposition of fat becomes observable, also, in the orbit of the eye and the lids; the globe becomes somewhat prominent, nevertheless, being more than usually covered by the relaxed eyelids, the space between the latter appears diminished. On the other hand, if the orbit becomes narrowed by local swellings, when the anterior lobes of the brain are enlarged, or chronic hydrocephalus occurs, the ocular globes become more prominent, without being covered by the thin, somewhat livid lids. Moreover, the wild or expressionless appearance in cerebral diseases, the intelligent look in rachitis and pediatrophy, the projection of the frontal bone, &c., furnish here sufficient evidences for diagnosis. In gradual emaciation, the fat of the orbit, also, disappears in due time; the globes of the eye retreat, but appear larger on account of simultaneous emaciation of the eyelids, the expression is lax, but cheerful and intelligent when there is no cerebral lesion; the lids, pale at first, become somewhat livid, and when closed permit the iris to shine through as a ring. The condition of the conjunctiva is the same as in anaemia; through it and the attenuated sclerotica we can see the dark background of the eye, presenting a blue appearance. The circumference of the eye shows, especially upon the lower lid, the living ring which proceeds from the thinness and collapse of the tissues, through which hyperaemic veins become visible. If the eyes fall quickly back into their orbits, if they are surrounded with a reddish-brown, violet, or livid ring, the color of which extends, also, to the upper eyelids, this indicates, especially when the features are stiff and immovable, an important sinking of the nervous power and collapse of the tissues, in consequence of loss of fluids, internal hemorrhage, and decomposition of the fluids. We observe this alteration in typhus and putrid fevers, poisonings with acrid poisons, cholera asphyxia, and in the agony after most chronic diseases; it is a sign of approaching death.

5. The innervation of the eyes yields to the most frequent disturbances, and furnishes the most important signs, especially in reference to prognosis. Uniform, fair, yellowish-red coloration; moderate turgor, and neither too slow nor too swift movement of the eyelids; soft redness of the conjunctiva palpebrarum, and caruncula lachrymalis; moderate tension, and mild lustre of the globe; single, delicate red vessels playing in the white of the sclerotic conjunctiva; in adults a white, in young subjects a uniform bluish white, in the old a yellowish
sclerotica; a certain neither too slow nor too quick changing of the convergence of the axes of vision, which correspond to the object seen; and a dilatation and contraction of the pupil conformable to the degree of light,—these are the signs of an undisturbed innervation. Abnormities are manifested in lesions of the motory nerves by spasm and paralysis, in those of the sensitive nerves and of nutrition, by hyperæsthesiæ and anaesthæsiæ.

a. Spastic phenomena in the eye, which do not depend upon idiopathic affections of its different parts, point to an idiopathic or consensual lesion of the brain, without, however, designating more exactly its nature. Trembling and blinking of the eyelids, with a wandering, unsteady look, are found in cerebral irritation, therefore, in disquiet of mind, anxiety, shame, perplexity; also in erethistic, inflammatory fevers, at the commencement of cerebral inflammation, of acute hydrocephalus, delirium tremens, chorea, eclampsia, and epilepsy. A wild look, with quick motions, and parallel direction of the axes of vision, without fixidity upon objects of vision, is a higher degree of the wandering look. It is sometimes connected with fiery redness, sometimes with paleness of the face and is often a precursor of cerebral inflammation and mania, often an indication of sinking of the forces, loss of consciousness and approach of death.

A staring look, immobility of the parallel axes of vision, wide openness of the eyelids, and dilatation of the pupils are found when the thoughts of the patient are directed to one point, in psychical diseases, in corporeal lesions in which the brain is affected, as in violent pains, typhus fever, gastro-malacia, &c. A sad, earnest look, a slight degree of the staring, indicates a mental or corporeal affection with consciousness, and is especially observed in diseases which seriously affect the organism without weakening the mental powers, e. g. in scirrhus ventriculi, diseases of the liver and spleen, secondary syphilis, chronic diseases of the lungs and throat. In these the corrugators are contracted, the eyelids half closed, the axes of vision move slowly from one object to another and fall easily into the staring look. Another form of the staring look is observed in severe affections of the brain, with loss of consciousness; the eyelids are wide open, and the globe prominent or sunken, the first from tension of the oblique, the latter from contraction of the recti muscles. This phenomenon is not to be considered an index to the nature of the disease. The same cause occasions the eyes to become distorted. Although in encephalitis, acute hydrocephalus, epilepsy, eclampsia, hysteria, apoplexy, &c., they are mostly turned upwards; yet in the same diseases they also take other directions. In psychical diseases, also, the
direction of the eyes shows only in general a cerebral affection. The searching look of the insane has not at all its apparent significance; it merely reaches the surface, and does not penetrate the thought of the person seen, and very soon loses this appearance itself. Herein are the insane very different from an angry man of sound mind. Many let their eyes fall upon objects without perceiving them, often even the axes of vision intersect each other before they reach these objects; others direct their eyes where nothing is to be seen, mostly because they see spectra. At times the eyes are continually moved and distorted. Most patients cannot bear our glance, they cast down their eyes or turn them away. The eyes have often a peculiar, glassy appearance, and are then more or less staring, which indicates the beginning of a severe attack. Finally, in the more violent attacks the eyes stand with extinguished look, and are then a sign of beginning idiocy.

b. As to the diagnostic importance of the eyes in *pareisis* and *paralysis*, we can often draw a conclusion, in reference to the seat of the difficulty, from the paralysed muscles themselves. Upon this point the author lays down the following propositions: 1. The nearer the torpor to the ends of the particular nervous filaments, the more ground have we for considering the cause peripheric. 2. When the paralysis affects all branches of a nervous trunk, the cause lies in that trunk before its division into the peripheric branches. 3. When, besides all the branches of our nerve, neighboring nerves are also paralysed, the cause is to be sought in the central organ itself, or near the place where the first nerve leaves the central organ. 4. When nerves corresponding to one another are disturbed in their function upon both sides of the body, it is supposed that the seat of the evil may be in the central organ; since, however, the distribution of the nervous roots in their central organ, and their connection with the cerebral fibres is yet little known, we must be cautious in adopting this opinion.

A dull look only indicates diminished innervation, and is found when the eyelids are somewhat dependent, or even somewhat oedematous, and move but slowly; when the axes of vision fall, indeed, upon the fixed object, but soon deviate from it and move sluggishly and without energy; and when the globe itself takes on a dull lustre. If an inattentive mien is accompanied by signs of sadness or pain, in the first case the axes of vision are turned downwards, in the latter downwards and laterally. We find this in the beginning of typhus and putrid fevers of chronic cerebral diseases, of hydrocephalus, of cerebral softening, in profuse fluid losses, in strong, especially depressing emotions of mind, in the latter stages of severe inflammatory diseases, chronic diseases of
the liver and spleen, lungs and kidneys. It is not, however a key to any definite disease. The extinguished look, which is only a higher degree of the dull look, is a sign of very great cerebral torpor, and of great danger. The eyelids are then, even in sleep, half closed, the upper one depends loosely, especially towards the outer angle, and moves but seldom and slowly. The eye is dirty, and when the resorptive power of the lachrymal puncta is paralyzed, dirty tears run from the outer corner of the eye, the conjunctiva is traversed by dark veins, the pupil is somewhat dilated and almost insensible to the irritation of light, the axes of vision are parallel, and the movements of the eyes, which are never fixed on one object, are slow. If these phenomena are more perceptible in one eye than the other, the same side of the brain is the special seat of lesion. A dull look during waking, which approaches the extinguished look, and is connected in sleep with distortion of the eyes upwards, even with divergence of the axes of vision, indicates always a severe cerebral lesion, which either proceeds from exudation in the sinus of the brain, or from great weakness in putrid and typhus fevers, cholera, asphyxia, or narcotic poisonings. Squinting dependent on torpor, oblique vision, and anæsthesia of particular parts of one or both eyes, are to be judged according to the above-stated propositions, and indicate, when a peripheric lesion of the nerves is not to be detected, that the difficulty is limited to a small part of the brain, which can often be exactly determined. Generally, the cause is a circumscribed exudation or extravasation. If, however, the symptoms are intermittent, the difficulty is of a spasmodic character, and arises from a temporary irritation. 

c. In hyperæsthesia of the optic nerves we observe sometimes aversion to light, with or without dark or colored or shining appearances before the eyes; with reflex or spasmodic contractions of the muscles of the forehead, of the eyebrows, of the eyelids, of the globe, of the iris, with profuse secretion of tears; sometimes pressing pains in the supra-orbital region and in the globe with aversion to light and nausea; sometimes neuralgic pains in the course of the twigs of the optic branch of the trigeminus, upon which follow secondary lesions of the muscles, of the blood-vessels, and of the secretory organs of the eye. Hyperæsthesia indicates a cerebral lesion, the cause of which, frequently, as in epilepsy, hysteria, and other diseases of the brain, remains fully concealed, but which is not seldom connected with other abnormalities, as in gout, hemorrhoid, fluid losses, &c., finally, also, with congestions and inflammations, e. g. hydrophobia, encephalitis, acute hydrocephalus, synochal, erethistic, and typhus fevers. Since the hyperæsthesia fre-
quently arise from cerebral lesions, the expression of the old physicians is not wholly to be reproached, who declared it a precursor of a new attack of delirium.

*d.* Anaesthesia of the optic nerves, that is, total or partial abolition, either of the power of sense alone or of all the influences which are reflected upon the other parts from irritation of the nerves of sensation, produces in the eye the most various symptoms, according as it is complete or incomplete, and according as the seat of its cause is central or peripheric. The central anæsthesiæ, e. g. the amauroses, are either constant or intermittent. How the latter arise is not yet sufficiently known. The transient amauroses and amblyopiæ, which we often observe in anaemia and congestions, in fevers before the crisis, in intermittent fevers, in nervous or hysteric subjects, indicate, indeed, a cerebral lesion, but they afford no very unfavorable prognosis; if however, they occur at the end of severe diseases, e. g. in phthisis, they always announce death. Anaesthesia, especially amauroses, which are developed in a short time, without having their foundation in alterations of the eye itself, are connected through chronic and acute diseases, often with disorganisation of that portion of the brain which is in connection with the organ of vision, and are, at times, the first symptoms of this disorganization. Amauroses, without diseases of the eye or brain, except those arising in diseases of remote parts through consensus, do not occur.—*Schmidt's Jahrbücher.* American Medical Monthly.

The following interesting cases reported by Dr. J. F. Sanford of Keokuk, are found in the Transactions of the Iowa State Medical Society:

Two cases of false joint have occurred in my practice—one within the last 13 months—both successfully treated by subcutaneous scarification of the ends of the bones. The last was a case of ununited fracture of the humerus in a boy 17 years of age, from Missouri, in which there was free motion between the ends of the bones after the removal of the primary dressings, and which continued, notwithstanding the re-application of a fracture apparatus, 5 months subsequent to the reception of the accident, at which time I saw him. By passing a strong tenotomy needle down the ends of the bones, free scarifications of the surfaces was effected, after which the application of a retentive apparatus secured firm union. The object of this procedure is to break up the cartilaginous investment, which after a time cover the rounded ends of the fragments, and to excite effusions of plastic material to serve as the medium of union.

This operation, which I believe originated with me, is not urged as
a substitute for the treatment recommended by Dr. Physick in cases of Pseudarthrosis; nor do I think it will supercede other analagous operations for the same disease. Each proceeding has its appropriate adaptation to particular cases, and should be held in reserve by the surgeon. An important principle in Surgical Ethics is, to adopt the simplest and least painful or dangerous operation in the treatment of cases that will be efficient; and it is upon this principle that we rest the claims of the subcutaneous section in cases of false joint. It is in recent cases, before that entire transformation in the tissues is completed, which ultimately happens, that we would recommend this operation. We are thoroughly convinced that at this period, besides being the simplest, it is the best treatment that can be adopted. The seton, ablation, boring, &c., although perhaps in a majority of cases successful, are more painful and dangerous.

Restoration of Lips destroyed by Calomel without a distant transplantation.—This was the case of a boy 18 years old, who at the age of 5, suffered destruction of both lips from mercurial ulceration. The chasm in the lips was of a triangular shape, the apices upward and downward and the base of the triangle extending nearly from one angle of the mouth to the other. To restore the lower lip, an incision was commenced after extensive separation of the alveolar adhesions, six lines below each angle of the mouth, and carried downward in a semi-circular direction and terminating within four lines of each other. The direction was then changed, and they were carried obliquely upward until they met at the commissure of the opening in the lip. The included flaps were then brought upward and united in the median line by the harelip suture. The upper lip was treated in the same way, and both lips were to a great extent restored. The patient did well. Before the operation, there was a hideous deformity—the patient could not pronounce the labial words—and the saliva constantly escaped from the mouth. After recovery these evils were all remedied. I am not aware that this method of labial restitution has before been executed. We shall hereafter practice it in all cases to which it is applicable.

Immobility of the lower Jaw of 14 years standing, cured by extensive section of the Muscles.—I need not enter into a full description of the history of this case. My principal object is to give a brief detail of the operation, which it will be perceived presents some novel points.

Miss B. was submitted to my attention about the middle of March, 1852. She had been profusely salivated in 1837, during an attack of bilious fever. The mercurial ulceration which extended rapidly, destroyed the alveolar processes of the upper and lower jaws, and these processes, together with the contained teeth separated by the ulcerative action, were taken away. A large portion of the cheek was also destroyed. After recovery, the lower jaw was firmly fixed against the upper. The lost teeth had been replaced by others which had grown irregularly—some inwards and some outwards.
The undestroyed portion of the cheek was firm and hard like cartilage and the posterior angle of the open space was bound together by a band of similar substance. The patient had taken no solid food for 14 years; she subsisted on fluids and alimentary substances reduced to a pultaceous mass and forced between the teeth.

1st Case.—On the 18th day of March, 1852, I performed the following operation in the presence of several medical gentlemen, assisted particularly by Professors Hughes, Armor and Hudson:

The patient was placed in a recumbent position, lying upon the right side. The incisions to separate the adherent lips and cheek were carried upward to the lower margin of the malar bone, backward and downward to the parotid gland and angle of the jaw; everywhere the parts were tightly adherent, and so dense as to oppose considerable obstacle to the progress of the scalpel. To avoid branches of the facial nerve these incisions were made close to the bone. All the tense and attached parts being free, an attempt was made to insinuate a wooden wedge between the teeth, but without success, as the jaw did not seem to be affected in the least by what had been done. A broad bladed tenotomy knife was then passed into the mouth, and carried to the posterior margin of the masseter muscle, (which was dense and rigid,) and the whole of this muscle freely divided. A further attempt was made to open the mouth, but in vain, and the knife was again introduced, and carried backward and slightly upward into the Temporo-Maxillary region and turned against the Temporalis. After the division of this muscle, the point of the knife was depressed, and carried still deeper into the Pterygo-Maxillary region, and again turned against the Internal Pterygoid, the complete division of which seemed to remove all the obstacles on that side of the face. It was found that the jaw would now yield a little, and the wedge was with difficulty insinuated sufficiently to allow the application of a lever, which I had previously prepared to open the mouth. But with all the force that could be safely applied, the mouth opened only to the extent of one-fourth of an inch. Passing my finger into the mouth to ascertain, if possible, the cause, I found that the Masseter muscle of the sound side was extremely tense and forming quite a prominent ridge in the cheek. The knife was therefore passed beneath the mucous membrane a little anterior to the muscle, passed backwards, and a submucous division of it effected. The fibres gave way with a cracking noise, the ends retracted some distance, and upon the application of comparatively gentle force with the instrument, the mouth was opened to the extent of an inch and a quarter. The instrument was suffered to remain in its position for an hour, and lint passed into the cut parts to stay the hemorrhage. The margins of the open space in the cheek, where now found to be so far separated, that no attempt to bring them together was deemed proper, and this part of the operation was postponed till a future day.

During the whole of this operation the patient was entirely insen-
sible. She readily came under the influence of Chloroform, and no disagreeable symptoms occurred during the operative process.

The instrument being removed, and some wedge-like blocks placed between the teeth, on either side, to prevent closure of the jaw, the water dressing was ordered to the face, and the patient requested to remain quiet.

We need not detail the course of the treatment during the subsequent six weeks. There was considerable swelling of the face during the week following the operation, but inflammatory action was not excessive. Pledgets of lint were kept between the gums and cheek to prevent adhesion, and after two weeks, she was directed to move the jaw frequently, the blocks being left out during the day, and replaced at night. The Dens Sapienstæ, above and below, on the left side, which were cut after the mouth became closed, were found, as the swelling subsided, to interfere with the closure of the jaw, and the lower one was removed. This permitted the approximation of the teeth, and mastication was performed with facility. In six weeks all the parts were healed and on the 20th of April we proceeded to close the opening in the cheek.

The extent of this opening, when the case was first presented, was so great as to demand, in our opinion, a transplantation for its closure, but the separation of the soft parts, which had been firmly bound to the bone, the stretching and lubrication which was constantly maintained during the healing, had almost brought together the margins of the opening in the cheek, so that it was now obvious, that a very simple operation would complete the cure.

Accordingly, on the day above mentioned, the patient having been placed under the influence of Chloroform, the margins of the open space having been pared, and a slight band—which in spite of our efforts had bound the lower lip to the gum—separated, the edges were accurately brought together, and maintained in contact by the harelip Suture. The principal care in these incisions, was to secure a proper symmetry of the mouth, and this was effected by previously marking in ink the course of the knife. Upon bringing the parts together, the deformity immediately disappeared. It was now thought proper, in order to prevent undue stretching of the parts, to keep the jaw closed and to remand the patient again the fluid diet.

Nothing unusual occurred during the subsequent progress of the case. The wounds healed rapidly, and on the 15th of May the patient having entirely recovered, prepared to go home.

Remarks.—The extensive destruction caused by the mercurial ulceration, left room for the formation of those extensive cartilaginous bands, and for the extreme contraction of parts which occurred in this case, and which rendered the extensive division of the soft parts above described essential to a cure. The change of structure in the muscles and ligamentous apparatus of the jaw, and formation of new tissue, precluded the possibility of opening the mouth without the incisions, as has been practiced by some surgeons. We are con-
vinced that a more speedy and less painful cure was accomplished by cutting as we did, than could have been secured by any other process. Even the masseter of the sound side was so changed in structure, and so firmly contracted, that no force which could be judiciously applied could overcome it.

Result.—Perfect cure. The muscles regained their power, and the jaw was separated and brought together with great facility so that mastication was entirely satisfactory. The space in the cheek was closed with accuracy, and the healing was so satisfactory as to remove every vestige of deformity. The speech became clear and perfect and the disagreeable escape of saliva was at once arrested.

The following case presents some new features, and may bear upon the question of similar operations at a very early age:

2d Case.—Deformity of the Face.—Gordon, infant, aged 7 days.—Presented early in January, before the medical class, at the college. This was a most extensive deformity of the mouth, there being entire absence of the upper lip, of the hard and soft palate and of the middle portion of the superior Maxillary bone. The Septum Narium projected beyond the level of the face, and the portion of the maxillary bone whose absence at the proper place seemed to allow this unusual development, was firmly fixed directly upon the point of the nose; passing over this bone, and projecting somewhat beyond, like a kind of proboscis, was the Columna Nasi, the whole presenting at first view a horrid resemblance to a miniature elephant. Four teeth, fully developed, were loosely fixed in the upper jaw, on each side of the fissures above described.

The great extent of this deformity, and the horrible appearance which it presented, induced the parents to seek immediate relief. The child in other respects healthy and vigorous, was accordingly presented, when only seven days old for this purpose. After consultation with Prof's McGugin, Armor, Hudson and Hughes, who coincided in the propriety of an operation, the infant was brought into the amphitheatre, and delivered to an assistant, with its hands securely fixed. The process was commenced by dissecting up the integuments including the displaced columna nasi from the protuberance on the nose. Carefully preserving the columna to be used in a subsequent step of the operation. The bony growth upon the nose was then removed, when it was found to be firmly connected by cartilage, with the septum and alae nasi. The projecting portion of the septum was also removed to the extent of half an inch, and was found quite ossified. A question now arose as to the proper manner of closing the large fissure of the upper lip, the margins being separated to the extent of an inch. The plastic and yielding condition of the parts, finally induced me to bring the margins together, previously pared, with the common hair lip suture. A needle was therefore passed deeply through the lip at the prolabial margin, and approximation effected by a few turns of the thread. A second needle, was then passed through the lips at the base of the nose the pendent portion of the Columna, cut off and
pared at the lower end, being pulled down placed in proper position and included in the course of the needle. When the parts were all brought together by this means the deformity immediately disappeared. It was feared the degree of tension in bringing the parts together, and the feeble powers of nutrition in so young a subject would prevent a kindly union, and this fear was ultimately realized. The child seemed to suffer but little from this severe operation, but when the dressings were removed, on the third day, it was found that union had not taken place. The parts composing this portion of the face, had yielded and the chasm was reduced at least one half. Adhesive plasters were drawn across the upper lip, with the view of still further approximating the bones and soft parts, and the parents were requested to return with the child in the following April or May.

April 27th. Child was present at the hospital. The constant traction upon the parts with the plaster had brought the labial margins sufficiently close to justify the ordinary operation for hare-lip, which was accordingly performed. The needles were removed on the second day, but the coating of Collodion previously applied prevented an accurate inspection of the part at that time. On the tenth day, the lip was fully exposed and found to be united in such a way as to perfectly remove the great deformity at first existing, and relieve the unhappy and anxious parents. The child has remained well and vigorous thro’ these operations, and grown as rapidly as do children under ordinary circumstances.

Remarks.—The extraordinary extent of the deformity in this case, seemed to call for an operation at an early age; also the progress of development in the parts would have increased the difficulties, had it been deferred. The yielding condition of the osseous structures at the age of 6 days, facilitated the closure and accurate apposition of the parts. The space to be traversed, rendered so much stretching necessary, that adhesion was prevented, yet the amount of necessary cutting was so great that the lateral parallel incisions through the lips, were not deemed advisable, especially as it was known that remunerating benefit would be obtained, whether there was adhesion or not. I never had a patient who seemed to suffer so little after an extensive operation about the mouth, and although the case proves the propriety and safety of the operation at a period, when the age has been generally thought to contra-indicate it.

On an improved plan of removing Hæmorrhoidal Tumours.

Mr. Henry Lee read a paper upon this subject before the Medical Society of London.

* * * The instances to which the application of nitric acid was adapted were those where haemorrhage constituted the prominent symptoms, and those in which a protrusion of
unaltered mucous membrane had taken place. The cases in which the application of the strong nitric acid was not sufficient were those in which the submucous tissue had become thickened by inflammatory deposit, or in which the mucous membrane had become hardened and altered in structure from long exposure. In the latter class of cases, when any operation was called for, the plan recommended was as follows:—

The patient was first directed to protrude the affected parts. The haemorrhoid, or a portion of the relaxed mucous membrane, was then embraced by a kind of broad forceps, called a "clamp," and the part which projected beyond the blades of the clamp were cut off with a sharp knife curved upon the flat. When this was done, the clamp still embracing the base of the tumour prevented the cut surface from either retracting or bleeding. The operation was then completed by touching the cut surface either with the nitric acid or with the actual cautery. The clamp is then removed, and the parts returned to their natural position. In the cases operated upon no trouble from bleeding had ever been experienced after the application of the cautery, which gave little pain and was for this operation to be preferred to the use of the nitric acid. In cases where the parts to be removed could not be sufficiently protruded, the operation was very satisfactorily performed by means of a rectum speculum. The instrument has a slide upon one side, which may be removed. This is made to fit accurately into grooves, so that by being withdrawn to a greater or less extent, a corresponding aperture is left in the side of the instrument. When the speculum is introduced the slide is partially withdrawn, and the instrument is moved about until the tumour or portion of mucous membrane requisite projects through the aperture. The slide is then closed upon the point to be removed, which is thus firmly held between the sides and the rest of the instrument; the portion of tumour or of mucous membrane which projects into the speculum is then removed with a long narrow knife, and the cut surface is touched with the actual cautery as in the first instance. It is not requisite or even desirable to destroy any depth of surface with the cautery. The object in applying it is simply to prevent haemorrhage, which it effectually does. The advantages of this plan of operating in cases where the application of the strong nitric acid was not sufficient, were:—1. That it is less powerful than any other plan equally efficacious. 2. That it is safer than the common operation now in use. 3. That it requires less confinement, and the patient is sooner convalescent than after the application of the ligature in the ordinary way.

[London Lancet.]
Elkoplasty, (ἐλκοπλάστης Ulcer and ἀλάσσω) ; or Old Ulcers treated by Anaplasty. (Read before the Buffalo City Medical Association, June 27th, 1854.) By Frank H. Hamilton, A. M., M. D., Professor of Surgery in the University of Buffalo, and Surgeon to the Buffalo Hospital of the Sisters of Charity.

Some writer has said, "old ulcers in 1830 will be old ulcers in 1860," which not to be understood always in a literal sense, was intended only to express, in a brief and pertinent form the proverbial obstinacy of this class of sores.

In most cases, the integument has been broken and destroyed by ulceration, and then, usually, bad health, or, perhaps, enlarged veins, have helped to perpetuate the lesion. In other cases, however, the ulcers are directly in consequence of severe lacerating injuries, which have at once torn away the skin beyond the power of nature to repair; and that although the health of the body and of the limb may be perfect. In such cases, the refusal of the ulcers to heal is entirely owing to the extensive loss of integument.

Actual loss of skin is repaired by one or both of two processes. By the development of new, from or upon the free margin of the old skin, or by the contraction of the granulations and of the cicatrix, in consequence of which, the adjacent skin is drawn towards the chasm, and made, as it were, to slide over and cover it in.

This rule admits of but few exceptions. Occasionally, after a very long delay, the granulations acquire the power of forming new skin at various and isolated points of the sore. This process may now and then be observed in the healing of extensive burns, or, perhaps, in the closing up of an ulcer whose surface is excluded from the air. New skin may even find a matrix in the periosteum, as I have witnessed, and maintained several years since. (Buffalo Medical Journal, vol. vii. p. 203.) But the conditions are very rare under which these exceptions can occur. The rule remains as we have stated, and if ulcers are not closed by either the projection of new skin from the margins of the old, or by the contraction of the granulations and cicatrix, then usually, they must remain open. To the action of both of these processes there is, however a limit. The formative power of the old skin does not extend beyond a few lines. The new vessels, becoming more and more attenuated as they stretch inward from the periphery, lose at length the power of generating epithelial cells, or, if formed, they are too imperfectly organized to sustain an existence, and they crumble away from the slightest provocation. Slowly, but perceptibly, the opaque diaphragm proceeds to
shut in the granulations, and for a long time encourages a hope that a cure is to be accomplished. But just when the work is almost consummated, a rapid disintegration sweeps away in a few hours the patient labor of many months. Again and again the reluctant labor is renewed, and as often suddenly, and without provocation, is it arrested and broken up. At the same time the granulations have ceased to condense, and the cicatrix to contract, either because these actions have attained their natural limits, or because the adjacent skin has reached its utmost tension, and affords effectual resistance to further stretching. Here the process of closure forever ends, and the "old ulcers of 1830 will be old ulcers in 1860."

Nature has done its utmost, and hitherto art has failed to complete the work.

I beg to suggest a procedure, which, hereafter, in some unfortunate cases of this class, may deserve a trial.

I propose to close the ulcer by an operation of anaplasty. In short to imitate one of the processes of nature, by sliding in old skin to repair a waste, where the process of forming new skin has ceased, and been finally given up.

If we seek to obtain this supply from the neighborhood of the ulcer, around which the skin has already reached its utmost tension, we shall only substitute one ulcer for another. We must, therefore, generally look to the opposite limb, or to the limb of some other person, for the material with which the transplantation or engrafting is to be made.

The mode of accomplishing this, will not differ materially from that which has been generally adopted in anaplasty from remote parts, except that the ulcerated surface ought to be excised freely before the new skin is laid upon it.

By this means, I hope, gentlemen, not only to supply an amount of skin equal to the size of the piece transferred, but to furnish, also, a nucleus from which additional skin shall be formed. I hope to establish a new centre of life—an oasis—from whose outer verge a true and healthy vegetation shall advance in every direction over the exhausted soil.

It is not improbable, also, that the graft will itself expand, or be drawn centrifugally by the contraction of the surrounding granulations and cicatrix, conversely, as the skin about the ulcer had before been stretched and drawn centripetally, by a similar action of the granulations and cicatrix situated within its free margin, so that, after a time, it will cover more space, independent of any actual growth, than it did originally. The opposite of this happens usually in anaplasty, and would occur here, did the flap equal or exceed in size the wants of the parts to be supplied. The flap would contract, thicken, and pro-
ject itself above the surface. But in old ulcers, it will generally be found impossible to furnish a direct supply of integument equal to the loss. A deficiency must probably still exist, and sufficient, it is believed, to determine in the transplanted skin a necessity of expansion.

The value and practicability of these views are, I trust, in a measure established by the results, in the case which I shall now take the liberty of bringing before you. You will excuse me, however, if I detain you a moment longer to explain to you that, so long as eight years since, I proposed the same operation, and had anticipated most of the results which I have now actually obtained.

In the report of my surgical clinic, for 1846, at Geneva Medical College, published in the Buffalo Medical Journal, vol. ii, p. 508, occurs the following passage:

"Indolent Ulcer. M——, of Geneva.—This lad, now about fifteen years old, had the right leg and part of the thigh terribly lacerated, and almost deprived of its integument, by a threshing-machine, eight years ago. The wound has never closed entirely, but an indolent ulcer of great extent exists, surrounded by a broad margin of hard integument, from which sometimes new skin will form, and then it will rapidly crumble away, and the ulceration will extend, perhaps, beyond its original bounds. Thus it has continued to partially close and again open, during all this time; meanwhile, the health and strength of the lad have remained excellent, but the leg has become bent at the knee, and he walks with a halt. Two years ago Dr. Hamilton took a cast of the ulcer, which is now seen to correspond almost precisely with its present extent.

"Dr. Hamilton and others having tried almost every plan of treatment which would offer a prospect of success, and having so completely failed, as Dr. Hamilton believes, because the indurated margin near two inches in breath—all around the sore, is incapable of projecting from itself sound skin, the Dr. has proposed to the boy a plastic operation, with the view of planting upon the centre of the ulcer a piece of new and perfectly healthy skin. He proposes to take this from the calf of the other leg (having secured the two together,) not intending to cover the whole sore, but perhaps two or three square inches, which he believes will be enough to secure the closure of the whole wound in a short time."

Two years before the date of this clinic, when I took the cast alluded to in the above report, I had made the same proposition to the lad, and when he declined submitting to it, I appealed to his father, who was a worthless inebriate, to allow me to secure one of his legs to his son's, that I might make the transplantation from him. In no other way, I assured him, could he so much benefit his family.
I need scarcely say that permission was never obtained, and that I have never found an opportunity of determining the practicability of my suggestions until during the last year, and in the person of the man who is now before you.

The following is the report of the case, copied, in part, from the Hospital Records:

Horace Driscoll, aged 30 years; Irish laborer; had the skin and flesh extensively torn from the right leg by a dirt cart, on the 3rd of November, 1852. He has been in the hospital most of the time since then until now. The wound has nearly healed several times, but never entirely; after exercise the whole would give way, and the ulcer again extend itself completely around the leg.

Jan. 21, 1854, I made the following operation:

The patient was laid upon his belly, upon the operating table before the class. A flap of skin measuring seven inches by four was then raised carefully from the calf of the opposite leg, extending in depth through the cutaneous and cellulo-adipose textures, until the fascia was in sight. Its remaining attachment to the body was by a broad and thick base. The haemorrhage was slight; no vessels were tied. Lint, spread on both surfaces with simple cerate, was laid between the flap and the surface from which it had been detached, other pledgets of lint similarly covered were placed on the outer surface, while over all and around the entire limb was wrapt a large mass of cotton batting, secured in place by a lightly turned roller.

He was then laid in bed and perfect quietude enjoined.

Jan. 22. During the night the wound has bled until the patient looks pale from the loss. The bleeding has now ceased.

Feb. 4th. Two weeks since the flap was raised. The patient has had to be sustained with beer, his appetite having failed very much since the operation. The flap has been dressed in the same manner as at first, nearly every day. It looks healthy. No part of it has sloughed.

To-day the operation was recommenced before the class, by dissecting out the granulations and part of the cicatrix from the diseased leg, and thus forming a deep bed of the size and shape of the flap as it now appeared, both contracted and thickened. The flap was then made raw again on its margins, and its lower surface was shaved off, with the double purpose of removing the granulations, and of diminishing its excessive thickness. When the bleeding had ceased, the left leg was carried across the right, so that the tendon-Achilles and heel of the left leg rested upon the instep and ankle of the right—a thick cotton pad being interposed to prevent painful pressure. The flap was now brought snugly into its new bed, on the right
leg, and well secured with interrupted sutures, a moderate compress, and roller. The two limbs were further secured immovably to each other by bands, and protected at various points by well made compresses, and the wounds carefully covered with lint spread with cerate.

Feb. 5th. The wound has bled again, as after the first operation, although ice was applied diligently from the moment the dressings were completed. Much pressure was regarded as inadmissible. Bleeding ceased when he became faint, about three hours after the operation.

Feb. 18th. Two weeks since the last operation, and four weeks from the first. Patient has required to be sustained constantly with beer and nourishing diet. His appetite still remains bad. Bowels have not been moved in two weeks. He has not suffered much pain, only fatigue. To-day the base was separated from the left leg, the flap having united through most of its edges and under surface, to the opposite leg. No bleeding of consequence followed. The parts were thoroughly washed and dressed with ung. basil. and a snug roller applied. Ordered sulph. mag. ʒj.


Feb. 20th. One corner of the extreme end of the flap is beginning to slough.

Feb. 21st. Bowels have moved. Sloughing of flap continues. Ordered yeast poultice.

Feb. 25th. Line of demarcation formed, insulating about one inch and a half of the flap, at the corner where the sloughing commenced.

Beyond this the sloughing never extended. The surfaces continued to close, and about one hundred days after the flap was laid down the healing was finally consummated, and now after a lapse of nearly three months, during which he has been acting as a subordinate dresser at the hospital, the ulcer has not re-opened or shown any tendency that way.

The wound made by the removal of skin from the left leg was completely healed over in about the same length of time as the ulcer on the right, and the whole left limb is now as sound and as perfect as before the operation.

Driscoll is, however, at present, by no means a well man. His health has suffered considerably from his long illness, and from his prolonged confinement in bed, which dates from the time of the accident, through most of the period, up to the time of the closing of the wounds since the operation. The cicatrix around the new skin is tender, and especially at one point where several pieces of bone exfoliated soon after the accident and precisely over which, unfortunately, the sloughing of the
flap took place. The ankle is also somewhat stiffened by the contraction of the skin, and of the gastrocnemii and tendo-Achilles, which latter were seriously involved in the original injury. These, however, are conditions which the operation did not propose to remedy, at least only in a small degree, or they are temporary accidents, and will certainly yield to time and careful use. If they were to continue, however, it will not be denied that, in the permanent sealing up of a sore, which, but for this operation, must probably have remained open during life, he is amply repaid for all that he has suffered at my hands. I venture to predict that, within one year from this time, he will be able to labor nearly or quite as well as before the accident.

On the 12th of March, five weeks after the flap had been transplanted, it had united by adhesion to the adjacent skin, through about one half of its circumference. The other half was surrounded by a border of granulations and of new skin, varying in breadth from one to ten or fifteen lines; but only at a few points was the bridge of new skin complete. It was especially noticed that nearly all, probably nine-tenths, of this new skin had sprung from the margins of the flap, and only the remaining fraction from the adjacent cicatrix; demonstrating that after transplantation and complete separation from the parent limb, its vitality was unimpaired, and that its reproductive power, if I may so speak, was vastly superior to the reproductive power of the old cicatrix.

You may notice to-day also, that since the cicatrization was completed, the cicatrix formed by growth from the flap, has contracted; and, that, in consequence of this contraction, the flap has become expanded, or been stretched outward, and its surface has become flattened and firm, whereas, it was, at first and for a long time, elevated above the surrounding skin, and flabby.

Summary: 1st. Ulcers, accompanied with extensive loss of integument, do generally refuse to heal, whatever may be the health of the body or of the limb.

2d. Anaplasty will sometimes succeed in accomplishing a permanent cure, and especially where the health of the body and of the limb are perfect, and where, by inference, the refusal to health is alone attributable to the extent of the tegumentary loss.

3d. The graft must be brought from a part quite remote; generally from an opposite limb, or from another person.

4th. If smaller than the chasm which it is intended to fill, the graft will grow, or project from itself new skin to supply the deficiency.
Simaba Cedron, a Substitute for Quinine.

Dr. Samuel S. Purple publishes in the New York Journal of Medicine, practical observations of interest in relation to the medicinal properties of this new agent. The author used the cotyledons or seeds, reduced to a powder by grating, in doses of 10 grs. The following are his conclusions:

Finally:—From the declared experience of various observers of the medicinal effects of the Simaba cedron, we are warranted in drawing the following conclusions regarding its therapeutic action:

That it possesses decided anti-periodic, properties and is therefore applicable in the treatment of periodic diseases.

That it is less likely than quinine to produce the aggregate of encephalic or neuropathic phenomena, induced by overdoses.

That it may, in large doses, repeated often, produce griping of the bowels, and even diarrhoea; but that these conditions are easily controlled by appropriate medicaments.

That, as a remedy in intermittent fever, it possesses properties, in many respects, equal to quinine, and in most cases is equally adapted to the cure of this disease.

That in the treatment of yellow fever, it does not appear to possess any particular advantages over quinine, but nevertheless is equally well adapted to fulfill the indications which call for the use of this latter remedy.

That it possesses marked tonic properties, and deserves a prominent place in this classification of the Materia Medica.

That in chronic dysentery, diarrhoea, dyspepsia, and all states of the stomach, accompanied with impaired or difficult digestion its use will be found to be attended with benefit.

That, should a demand arise for its use in medicine, it is believed that it will be found not difficult to obtain a supply, in quantities sufficient to afford it at a much less price than quinine.

Treatment of Cancers.

Prof. M. L. Knapp, of Cincinnati, advocates strongly (New York Journal of Medicine) the treatment of schirrous affections by systematic compression and low diet. In lieu of Recamier's
bandages for compressing the mamma he suggests the use of a modification of Hull's truss, one of the pads resting upon the back of the chest, and the other upon the tumor. The idea is a good one, but the author is reminded by the Editors that a somewhat analogous instrument was invented by Dr. Arnott, which is thus described in Dr. Walsh's work upon Cancers:

"His apparatus consists of a spring, an air-cushion supported by a flat resisting frame or shield, a pad, and two belts. The spring, which is of steel, is the compressing agent, its strength being varied with the amount of pressure it may be desirable to obtain. The shield, varying in shape, somewhat, with the circumstances of particular cases, is generally slightly convex on the external surface, of circular or oval outline, and formed of a rim of strong wire, connected at two opposite points by a flat piece of iron, which serves for the support of the spring, screws, etc., the whole being covered with jean. To the rim of this shield is sown a sort of conical cap of soft linen, designed to receive the air-cushion, to keep it constantly slack, and prevent it from slipping about when applied. The air-cushion thus kept slack, fashioned into a sort of double nightcap, lying in apposition with the inner surface of the shield, and sufficiently filled with air to prevent the latter from pressing directly on the part which receives within it the tumor to be compressed. One end of the spring is attached by screws to the external surface of the frame, and the other end to a solid, but soft pad placed wherever the contre-pressure is to be made. The straps are used to keep the apparatus steadily fixed."

### On the Differential Diagnosis of Hydrocele, and the Diseases with which it may be confounded. By R.G.H. Butcher, Esq.

<table>
<thead>
<tr>
<th>Hernia</th>
<th>Hydrocele</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begins above.</td>
<td>Begins below.</td>
</tr>
<tr>
<td>Changeable in bulk.</td>
<td>Unchangeable.</td>
</tr>
<tr>
<td>Engages ring.</td>
<td>Ring free.</td>
</tr>
<tr>
<td>Can often feel intestines, or omen-</td>
<td>Can feel nothing.</td>
</tr>
<tr>
<td>tum.</td>
<td></td>
</tr>
<tr>
<td>Testicle at the bottom.</td>
<td>Testicle at back part.</td>
</tr>
<tr>
<td>Opaque: in child sometimes trans-</td>
<td>Often transparent.</td>
</tr>
<tr>
<td>parent.</td>
<td></td>
</tr>
<tr>
<td>Base of tumor above.</td>
<td>Base of tumor below.</td>
</tr>
<tr>
<td>Flatulence, dyspepsia.</td>
<td>Bowels not deranged.</td>
</tr>
</tbody>
</table>
VARICOCELE.
Soft, like earth-worms.
Changeable, like hernia.
Ring dilated often.
Testicle distinct.
Testicle wasted.
Tumor whole length of cord.
Tumor light.

VENEREAL TESTICLE.
Both engaged generally.
Tumor very heavy.
Hard all over.
Size moderate.
No fluctuation; sometimes small quantity of fluid.
Tumor slanting.
Painful to handling.
Solid contents.
Eruption or sore throat.

SCROFULOUS TESTICLE.
Round in form.
Never very large.
Solid.
Heavy.
Lies at the bottom of the scrotum.
Inflames in spots
Suppurates, fungates.
Scrofula in other glands.

FUNGUS HEMATODES.
Tumor irregularly hard and soft, hardness predominating in early stages.
Shape, globular generally.
Rapid in growth.
Painful.
Opaque.
Elastic.
Chord becomes hard and knobby.
Pains up loins.
Health impaired.
Fungates.

CANCER OF THE TESTICLE.
Hard, knobbled.
Small.
Round.
Painful on handling.
No fluctuation.
Chord knobby.
Adheres to scrotum.

HYDROCELE.
Tense, elastic.
Unchangeable.
Ring closed.
Testicle indistinct.
Enlarged, if distinguishable.
Tumor at bottom.
Tumor heavy.

HYDROCELE.
One tunica vaginalis generally.
Tumor not so heavy.
Hard only at back part.
Often very large.
Fluctuation.
Tumor perpendicular.
Not painful.
Fluid contents.
None such necessarily.

HYDROCELE.
Oval in form.
Often very large.
Fluctuating.
Light.
Grows upwards.
Never so.
Never suppurates.
Not so.

HYDROCELE.
Uniformly smooth.
Oval generally.
Slow in formation.
Free from pain.
Transparent.
Fluctuating.
Chord sound.
No such pains.
Not so.
Never.

HYDROCELE.
Soft, smooth.
Large.
Oval.
Not so.
Fluctuation.
Chord soft.
Never.
CANCER OF THE TESTICLE.

Glands in groin enlarged. Never engaged.
Shooting pains. Never (in loins).
Fever peculiar. No fever.
Fungates. Never.
Death. Never.

In hydro-sarcocele the testicle will be found hard, painful, irregular, large at the back part, with some fluctuation in front. Testicle distinguished in hydro-sarcocele, not so in hydrocele generally. Shooting pains on handling the former, not so in the latter. If obscure, the tumor may be tapped, and then the enlargement of the testis will be discovered, and the water small in proportion to the size of the tumor.—[Dublin Jour. of Med. Science.

EDITORIAL AND MISCELLANY.

BIBLIOGRAPHICAL.

The Modern Treatment of Syphilitic Diseases, both primary and secondary; comprising the treatment of constitutional and confirmed Syphilis by a safe and successful method; with numerous cases, formula, and clinical observations. By Langston Parker, Surgeon to the Queen's Hospital, Birmingham. From the third and entirely re-written London edition. Philadelphia: Blanchard & Lea. 1854. pp. 316. (For sale by McKinne & Hall.—Price $1.75.)

However much may have been already written upon the subject of Syphilis, the field is yet fruitful, and the results of twenty years' practical observation, comprehending the treatment of upwards of eight thousand cases by a judicious man cannot be without value. We have had occasion, heretofore, to direct the attention of our readers to some of Mr. Parker's views, and are now happy to see that they can obtain his matured work in full. It is so eminently practical, and in some respects original, that we would advise its attentive perusal.

Auscultation and Percussion. By Dr. Joseph Skoda. Translated from the 4th edition, by W. O. Markham, M. D., Assistant Physician to St. Mary's Hospital. Philadelphia: Lindsay & Blakiston. 1854. pp. 350. (For sale by McKinne & Hall.—Price $1.00.)

A Clinical introduction to the Practice of Auscultation and other modes of Physical Diagnosis, in Diseases of the lungs and heart. By H. M. Hughes, M.D., F.R.C.P., Assistant Physician to Guy's Hospital, &c. 2d American from the 2d and revised English edi-
tion. Philadelphia : Blanchard & Lea. 1854. pp. 304. (For sale by McKinne & Hall.—Price $1.00.)

The advances that are being continually made in diagnosis by means of auscultation and percussion, demand the frequent issue of new works upon the subject. Whilst beginners will generally prefer the "clinical introduction" of Dr. Hughes, the more advanced will find the production of the German author exceedingly valuable, and full of practical details as well as original views. We have repeatedly expressed our surprise that so many physicians are willing to practice medicine without a knowledge of auscultation and percussion; we need scarcely say anything more at present than that the opportunity is now furnished of supplying the deficiency at a small cost.

The Pathology and Treatment of Pulmonary Tuberculosis; and on the local medication of Pharyngeal and Laryngeal diseases frequently mistaken for, or associated with Phthisis. By J. H. Bennett, M.D., F.R.S.E., Professor of the Institutes of Medicine, &c., in the University of Edinburgh, &c., &c. Philadelphia : Blanchard & Lea. 1854. pp. 130. (For sale by T. Richards & Son.)

This is essentially a practical book, and is therefore intrinsically valuable. Prof. Bennett has had ample opportunities for observation and has made good use of them. The main object of this work is to show that tubercular diseases will heal of themselves, if the faulty nutrition of the system can be removed; and that our efforts should be directed to the digestive rather than the respiratory system. His experience in the use of cod-liver oil is especially valuable, now that this remedy is so much resorted to.


The able author of the treatise on Diseases of the Skin has furnished us in the above-mentioned little volume, an interesting and useful hygienic guide. It is proper that such a work be written in a popular style, and it ought to be extensively patronized by the non-professional public, as well as by their medical advisers.

We have upon our table a large number of pamphlets, circulars, &c., some of which will be noticed hereafter.
Yellow Fever.—The prevalence of yellow fever in Charleston and Savannah, its importation and tendency to evolution in this city, and its probable occurrence in various parts of the country in the persons of those who leave the infected districts, makes it desirable to know the views of those who have tried new remedies in its treatment. We therefore willingly depart from our usual course in giving place to the following publications found in the Savannah newspapers. We are not disposed to find fault with the writers for having, under the circumstances, made non-professional papers the medium of their communications.

"Messrs. Editors—Gentlemen: I notice in your papers of this morning an allusion to the 'Muriated Tincture of Iron,' as a remedy in cases of 'Yellow Fever.'

Several reasons, which I cannot now enumerate, have prevented me from hitherto giving this remedy publicity through the columns of the city papers. Feeling, however, that it is my 'duty to place this new mode of treatment before the public,' I beg to publish the following facts in connection with it:

1. I have treated over one hundred and fifty cases of Yellow Fever since 21st ult., and of that number not one has died who commenced this remedy prior to 'Black Vomit.' And,

2. Since 21st ult., I have not administered five doses of any other medicine.

I give the Tincture in doses varying from 20 to 60 drops every two (2) hours in a tablespoonful of water for adults; and smaller doses for children. The cure is generally perfected in three days. This preparation of Iron acts by medicating the blood and exerting its styptic qualities upon the coats of the stomach.

I would respectfully call the attention of the medical profession to this preparation of Iron, as an invaluable remedy in Yellow Fever.

In conclusion, I would suggest that 10 drops of this medicine in a little water be taken by every citizen remaining in Savannah three times daily, as a preventive of the Yellow Fever.

I am yours respectfully,

Sept. 2, 1854. P. H. WILDMAN."

"Messrs. Editors:—Having read the remarks of my friend Dr. Wildman, I take pleasure in adding my testimony to the truth of what he has stated in reference to the general efficacy of the Muriated Tincture of Iron in the epidemic now prevalent in our city.

It has been observed by some of my medical brethren that its use was at variance with all our preconceived ideas of the pathology of Yellow Fever, and I confess myself to have entertained similar views when it was first suggested to me in consultation with another practitioner, as a remedy for the fatal black vomit. But I am sure that
many of the articles of our Materia Medica have been from time to
time improperly classified, and from the experience, during the last
two or three years, of Tincture of Iron in Erysipelas, it cannot rea-
sonably be considered as contra-indicated by the existence of inflam-
mation. I am confident, from close observation of its effects in a large
number of cases of Yellow Fever, that its action is that of a refrigera-
tant diaphoretic—that it allays pain, and produces sleep, and by pres-
serving the integrity of the blood, enables the system to resist the
depression so universally attendant upon the second stage of the
disease. It presents, in fact, a very happy combination of Hydro-
chloric acid, in excess, with iron, the former of which, it is well
known, has been given with great success by the celebrated Dr.
Paris in malignant forms of fever, while the latter, Iron, has been
universally acknowledged as an incomparable tonic from time im-
memorial.

I concur entirely with Dr. Wildman, that it should be exhibited at
the earliest possible stage of the fever, and, when possible, without
awaiting the preliminary action of any other medicine. It is well
known that the revulsive influence of a salivation has always been
regarded as the great desideratum of the Mercurial treatment in Yel-
low Fever; and I am convinced that it will be no small recommenda-
tion of the Muriated Tincture of Iron to the profession when it is
understood, as I am now prepared to assert, that it will produce sali-
vation in a much greater number of Yellow Fever cases, than Calomel
will. This effect, due to the free Hydrochloric acid, is very far from
being attended by the pain and discomfort of Mercurial ptyalism, and
is moreover, not at all indispensable to a cure.

With respect to the dose, it must necessarily be discretionary with
the practitioner, and it cannot be necessary to remind the profession
that even the U. S. Dispensatory allows a maximum of two fluid
drachms. There cannot, I think, be any question of its decided
utility; and in conjunction with sinapisms and blisters will be found
to diminish the mortality to a very inconsiderable proportion when
brought into action before the supervision of black vomit.

In conclusion, I beg to remark that the presence of a terrible pes-
tilence amongst us, and the necessity for immediate action, must
constitute my apology for departing from strict medical ethics in
addressing the profession through the daily press.

Savannah, Sept. 3d, 1854.  
S. N. HARRIS, M. D.

Muriated Tincture of Iron.

To the Editor of the Morning News:

I feel very little inclination to obtrude my opinions, and especially
my medical opinions, on the community, through the secular press; yet,
as many of my personal friends and patrons have desired an ex-
pression from me in regard to the use of the Muriated Tincture of
Iron in the existing epidemic, I cannot do otherwise than frankly
state, through the medium of your paper, that under certain circum-
stances it is a remedy of much value; while in the great majority of
the cases of yellow fever—such as have fallen under my observation—it was not only not beneficial, but absolutely injurious. I have given considerable attention to the use of this remedy, as it was recommend-
ed to the attention of the profession by the able and accomplished Dr. John Bell, of Philadelphia, in erysipelas, two years ago. Acting
upon his suggestion, I tried the remedy in that disease, and had rea-
son to be pleased with its use when appropriately administered.
When scarlatina prevailed in this city during the past year, I used it
in that disease with much success, and published the more important
cases in the Charleston Medical Journal, conceiving the analogy, in
a pathological point of view, quite as striking between the present
epidemic and scarlet fever, as between the latter disease and erysip-
elas. I suggested the remedy to some of my medical friends before
the present epidemic made its appearance, and used it in three cases
prior to the 15th August last. In some cases it proved a valuable
remedy, but, unless I am very much mistaken, it is not the particular
preparation of iron that should be used universally.

Iron I believe to be the very best remedy that the Materia Medica
offers us in yellow fever, but it must be borne in mind that it has se-
veral preparations, and these preparations may be used in conjunction
with other remedies, so, as when judiciously combined, to meet all
the indications for iron. I do not believe in specifics in medicine, nor
in the indiscriminate use of any one remedy or combination of reme-
dies, in any particular form of disease.

Every practitioner must have met with cases in which a remedy of
known efficacy in a particular form of disease—quinine for example
in intermittent fever—was wholly inadmissible, yet quinine is perhaps
the very best anti-periodic known. How then is it possible that the
Muriated Tincture of Iron is the remedy when in yellow fever the
liver in one case, and the kidneys in another, refuse to eliminate or
secrete the bile or urine. Would it not be more in accordance with
reason and therapeutics to select some preparation of medicine. Iron,
if you please, in the first place, calculated to relieve the one or other
of these conditions, and not apply the same remedy, regardless of these
or other functional derangements. I have kept such notes as the
pressure of business would allow, of several of the more important
cases of yellow fever, which have fallen under my observation, with
the treatment, &c., with a view of publishing them through a Medi-
cal Journal.

H. L. Byrd, M. D.

Mortality among the Physicians of Savannah.—We regret to find
among the victims of the epidemic prevailing in Savannah, the names
of Drs. P. H. Wildman, F. W. Schley, S. N. Harris, T. M. Ellis,
and C. H. Welles.

Professors Bartlett and Sweet, of New York.—We regret to learn that the ill health of this distinguished teacher (Prof. Bartlett)
will prevent his lecturing next week. It is also intimated that Prof. Sweet will not be able to discharge his duties in the University.

**Gastrotomy.**—Dr. John T. Gilman, of Maine, reports in the Amer. Journ. of Med. Science, an interesting case in which Gastrotomy was performed twenty-one hours after rupture of the uterus, and a dead child removed from the abdominal cavity, with successful result.

**Removal of the Astragalus.**—Dr. F. M. Robertson, of Charleston, S. C., has successfully removed the astragalus, in a case of irreducible dislocation. (Am. Journ. Med. Sc.)

“The People’s Gazette,” edited by Dr. Davis, of Abbeville, S. C., has been discontinued.

**Circular.**—The undersigned, having been appointed by the American Medical Association, to report upon “the physiological peculiarities and diseases of negroes,” invites communications upon the subject from the physicians of the Southern States. A. P. Merrill, of Memphis, Tenn.


**Tooth-ache.**—An American practitioner recommends a solution of copal in chloroform, as a specific in tooth-ache, dependent on caries. The cavity of the tooth is washed, and filled with a bit of cotton dipped in this solution; the pain disappears as by enchantment.—Cosmos. [Va. Med. & Surg. Journal.

**Haemorrhage from Leech Bites.**—Lastelle, in the Repertorie de Pharmacie, suggests the use of the carbonate of iron in obstinate haemorrhages from leech bites, and states that it is very effective.—[Ib.

**Leucorrhæa.**—M. Arendt, a German physician, states that he has generally been able to cure ordinary cases of leucorrhæa in three or four days by weak injections of creosote. He uses two drops to the ounce of water, repeating twice or thrice a day. Some mucilage, we think, ought to be added, to make this a proper mixture.—[Ib.

**Transparent Cement.**—According to Leuher’s Belgique Industrielle, this may be prepared by dissolving 75 parts of caoutchouc in 60 parts of chloroform, and adding to the solution 15 parts of mastic.—[Ib.
Anasarca.—In the dropsy which supervenes upon scarlatina, Prof. Mauthner, of Vienna, (Journal für Kinderkrankheiten,) employs with success urea, or else the nitrate of urea, as a powerful diuretic. The dose of this remedy is the third of a grain, given in powder with sugar, every two hours.—[Ib.

Cure of Itch.—Take finely powdered brick dust and rub the body well with it, so as to expose the acari to the sulphur ointment, which is then to be applied; the friction to be carefully kept up for half an hour. After this the patient is subjected to a good ablution of soap and water. The whole time occupied by this proceeding is less than an hour and a half. A perfect cure will be the result.—[Ib.

Hiccough.—After sugar and water have failed, Rayer advises that the pharynx should be touched with a pencil dipped in liquor ammonia. On the continent it is common to administer syrup of currants, or the vinegar of beer; different ethereal preparations, and Hoffmann’s anodyne liquor especially, are relied on by many physicians; some authors advise chloroform in potion and even in inhalations. Dr. Ossieur states, in the Ann. Med. de Roulers, that having treated a case of hiccough, which had lasted for eight days, with the remedies we have enumerated, without success, he finally checked it by administering fifteen drops of aromatic sulphuric acid, with forty-five drops of currant syrup in three table-spoonsful of water, every half hour.—[Ib.

Purpura Hæmorrhagica.—Dr. George Willis (Edinburgh Monthly Journal) reports a case of purpura which was promptly cured by the administration of oil of turpentine. This case corroborates the opinion of Nelligan in respect to the efficacy of terebinthinate preparations in this disease, which has been advocated by Dr. Patterson, in the March No. of this Journal. (See vol. ii., p. 483, et seq.)—[Ib.

Chloroform Vapor in Tenesmus.—Ehrenreich relieves the tenesmus of dysentery by the vapor of chloroform passed into the bowel through a syringe and common canula.—[N. Y. Journ. of Med.

Belladonna in Salivation.—Erpenbeck used the extract of bella donna, grs. iij ss. in an emulsion in 24 hours with perfect relief.—[Ib.

Ulcer from Irritation of Nails.—Mr. Ure applies a hot saturated solution of alum continuously to the part. This induces rapid absorption of the thickened cuticle and prompt cicatrization of the ulcerated surface.—[Ib.

The Hahneman Hospital.—This institution has ceased to exist: furniture and effects were sold by auction, on the 14th inst. by Messrs. Debenham and Storr. It has scarcely carried on its miserable existence even for the time which we allotted it.—[London Lancet.