doubtful case of the same kind was published by Cornil in the *Gazette Médicale* for 1873 (p. 185); and though, perhaps, it is hardly possible to claim Bayle's twenty-third case as belonging to this class—a case of “tubercular phthisis complicated with melanosis” in a man aged 62, who “had often contracted the venereal disease” (Barrow's trans., p. 249)—it is far less possible to pass over Morton's chapter (lib. ii, vii), “De Phthise à Lue Venereâ orta”. His observation of its clinical symptoms was made with his usual keenness: “Semper enim (quantum ego observavi) est genii Asthmatici, Phlegmate viscoso, et dyspnœa magis, quàm urgenti tussi stipari solita”. (*Op. cit.*, p. 281.)

With reference to that third form of fibroid change which, called roughly by the Germans “Staubinhalationskrankheit”, includes under one name a pathological result due to the inhaling of fine particles of coal, iron, stone-grit, tobacco, or cotton, we in London have, perhaps, but small experience. But since Wepfer (*Observationes Medico-practicae*, etc., Schafhusii, 1727), over a hundred and fifty years ago, noticed its occurrence among millstone-workers at Waldshut on the Rhine, and tried to see for himself its pathological changes, and tried in vain—“quia hactenus nullo cadavere potiri potui, quamvis id precibus et pretio tentarem” (*op. cit.*, Obs. cix, Catarrhi frequentes, p. 444)—experience as to this alteration is becoming large. Without referring further at this moment to a paper written by Dr. Peacock, who begins by quoting Wepfer, in the twenty-fifth volume (p. 214, etc.) of the *Medico-Chirurgical Review* for 1860, the literature on this subject, especially of late years in one periodical, the *Deutsches Archiv für Klin. Med.*, has been multiplied exceedingly. Zenker, Seltmann, and Riegel give full bibliographical references in addition to their own experience. I have to thank my colleague Dr. Andrew for allowing me to lay before the College one of the most marked examples of this affection which it has been my fortune to see. The patient was a French millstone-maker, aged 45, who had worked at his trade since his apprenticeship. He had had a winter-cough for many years; had never suffered from syphilis; “had an attack of congestion of the lungs five years ago”; had worked hard, and had undergone great domestic trouble. And yet with the lung pictured in this drawing—and, with the exception of cavities and dilated tubes, the whole of both lungs was in that condition—he managed to live till he was killed by a pericarditis. The note made by Dr. Bristowe in reference to one of Dr. Peacock's cases (*loc. cit.*, p. 222) has its exact repetition in this patient's lung. “The diseased portions of lung were much indurated, having generally an opaque whitish hue, but being thickly studded with black pigment. Under the microscope, little or no trace of original lung-structure was visible; but the diseased masses appear to be made up of dense closely arranged fibroid tissue, studded here and there with numerous irregular groups of black pigment.” The lung itself, and microscopical sections of it, are here on the table for the examination of those gentlemen who wish to see them when the lecture is over.

Physiological experience points in these cases even more markedly than in other types of phthisis to the part the lymphatics seem to play. I have no need to refer to the calculations, whether as to chemical constitution or to weight, of the foreign particles found in the lung-tissue of these cases. That they do occur in the lung-tissue is a settled fact. By what way they reach it may be still an open question. Knauff (*Das Pigment der Respirations-organe*, *Virch. Arch.*, vol. xxxiv, p. 442), writing in 1867, had sketched to his own satisfaction the following process. In the case of the inhalation of particles of carbon, he held that, while in healthy persons these particles led only to their own expulsion from irritation of the bronchial mucous membrane, in persons continually subjected to their presence, they caused, by repeated and increased catarrh, extensive destruction of the ciliated epithelium, and, by accumulation, further necrotic processes, till a way was opened into the lymphatic vessels. Sikorsky, in 1870 (*Centralbl. für die Med. Wiss.*, 1870, No. 52; and see Slavjansky, *Virch. Arch.*, vol. xlviii, p. 326), showed from his experiments that carmine-particles, injected under the form of carminated ammonia into the lungs of cats and dogs, penetrated between the epithelial cells of the bronchial mucous membrane into the lymphatic system of the bronchi. The further explanation of these facts is furnished by Dr. Klein (*op. cit.*, vol. ii, p. 27, etc.), who has demonstrated the presence of certain interepithelial connective-tissue cells, to which he gives the name pseudo-stomatous tissue. These occupy a system of spaces which, in the normal state, do not form open communications between the surface and the lymphatic system, but in certain circumstances, under which they are distended, may be converted into free passages between the two. The same interepithelial cells are found in the interalveolar septa, and may aid absorption from the alveoli themselves. These cells occur in the positions indicated in these diagrams.

It is this form of phthisis—the third of my temporary division—

which has been, as we are reminded, “unfortunately called fibroid, in which death often occurred through the indirect result of tubercles that had terminated their career” (*Path. Soc.*, vol. xxiv, p. 309); it is this form which has carried the upholders of a specific tubercle into theories of the most startling kind, till it almost seems as if, in their allegiance to a Circe of their own creating,

“τοὺς αὐτῇ κάτεθελεν ἐπεὶ κακὰ φάρμακ' ἔδωκεν.”—*Odyssey*, x, 213.

And yet, in obedience to them, we are to believe that histological growth, or, if you will, pathological hyperplasia from already existing tissue, is not the simple thing it seems to some of us to be; but, against our own eyesight and our common sense, are to accept without questioning this *sacramentum* of “Tubercle”. We might as well, it seems to me, on the same grounds give the same name to interstitial keratitis, or to the hyperplasia of irritated cartilage. Virchow, writing on tumours (*Cell-Path.*, p. 487), had laid down a rule which, in the case of this fibroid phthisis, it would be well to follow: “Investigations ought not to be conducted with a view to determine whether they have a physiological” (he might have said here a pathological) “type, or whether they have a specific stamp impressed upon them: our final answer depends upon the question whether they arise at a spot to which they belong”. And the change arises in fibroid phthisis at a spot to which it does belong, and is as clearly due to the local irritation as is the cell-growth in irritated cartilage and cornea. Here once more the words of Addison apply: “I fail to discover what I had always been taught to consider as essentially tubercle: a distinct, separate, or rather separable body, of a particular colour and consistence, embedded in, and, although adhering to, supplanting a portion of the ordinary tissue of the lung. On the contrary.....there is not one of the varied morbid conditions coming under the denomination of tubercle which has not appeared to me to result from changes in or on the natural tissues, rather than from any separate and well-defined deposit displacing these tissues. These morbid changes have appeared to me to be perfectly identical with those of inflammation.” (*Guy's Hosp. Rep.*, ser. ii, vol. i, p. 3383.) And, sir—to close with those words which the consulting physicians of two hundred years ago used to append to the written statement of their opinion—“*Ita censeo*”.*

THE MECHANICAL TREATMENT OF FLEXIONS AND DISPLACEMENTS OF THE UTERUS.†

By J. G. SINCLAIR COGHILL, M.D., F.R.C.P. Edin.,
Late Lecturer in the Edinburgh Medical School; Physician to the Royal National Hospital, Ventnor; etc.

I PURPOSE limiting the scope of the following remarks mainly to a general consideration of the mechanical treatment of the various forms of flexion and displacement of the unimpregnated uterus. The space at my disposal does not permit more than incidental reference to the pathology of the conditions in question. Indeed, there is, it must be observed, much more unanimity among gynaecologists as to the nature and origin of such affections than as to the mode of treating them.

I have purposely chosen this subject, because it is one with which the gynaecological teaching of the Edinburgh Medical School has been very intimately associated. It is one also, many points in connection with which offer several points for elucidation, if not for divergence of opinion. Gynaecologists are far from being agreed even as to the propriety, much less as to the exact nature, of the mechanical treatment to be employed in this large, important, and interesting class of cases.

To the late distinguished occupant of the Midwifery Chair in our University may be justly ascribed the merit of at least reviving, if not of actually for the first time introducing, the use of mechanical appliances to the relief and treatment of certain disturbances of the physical condition of the uterus, and of its relations to the surrounding structures and viscera. That this *cultus* was the revival or rediscovery of a lost gynaecological art, has been placed beyond doubt by ample archaeological evidence of the most interesting character; for an excellent and exhaustive *résumé* of which I must refer you to the introductory chapter of the work of Dr. Gaillard Thomas of New York on *Diseases of Women*. Nevertheless, it must be conceded that to the late Sir James Y. Simpson is due the merit, not only of drawing the attention of the profession to, and placing within its reach, the means of recognising with certainty a large class of affections previously all but unknown, but also of suggesting a variety of mechanical appliances for their

* Wepfer, *op. cit.*, p. 348; “*Ita censeo Raoult*. Lutetiae Parisiorum, die 4. Septembris, 1678.”

† Read in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association in Edinburgh, August 1875.

treatment unthought of previously. That he, with many of his immediate followers, was led to entertain an exaggerated idea both of the gravity as well as of the relative frequency of such conditions, and their non-amenability to other than mechanical treatment, I am quite prepared to admit; indeed, I readily do so; but I believe this was almost the natural result of the vast number of such cases, previously unrecognised and unrelieved, which for years crowded his *clinique*, and of the extraordinary success which attended his treatment, due, no doubt, to his powers of diagnosis and great manual dexterity, but perhaps also, and to a greater extent than he himself even was aware of, to the great attention he always paid to general as well as to local therapeutic indications.

Just as in religious and political changes, reformation tends to revolution, and repression to reaction, so improvements in medicine obey the same law of tendency to excess. We are all familiar enough with the reception of a new remedy; how its virtues are exaggerated; then how it loses favour after a time, and too often sinks into unmerited neglect. This has also been the history of the mechanical treatment of uterine ailments, and, with the indiscriminate zeal of inexperienced disciples, is probably to be looked upon as the cause of the disfavour, to a certain extent at least undeserved, with which much of this treatment has come to be regarded by many gynaecologists. It is not my intention here, to recall the discussions which have from time to time arisen in connection with this subject, but rather to indicate generally the class of cases of uterine distortion and dislocation, in which recourse may properly be had to mechanical means of relief or cure; and the nature of the appliances to be so employed. That there has been an unnecessarily excessive reaction in professional opinion as regards this mechanical treatment, I myself have no doubt. I have during the last few years had patients under my care in whom no errors in diagnosis had been made, and the nature of the cases was thoroughly understood, and yet where mechanical treatment had been withheld by practitioners well qualified to use it. It must be admitted by the unprejudiced that this excess of reaction in opinion, is as much to be deprecated in the one direction as in the other, and it should be our desire to ascertain the line of safety between the two extremes: *in medio tutissimus ibis*.

The typical and common forms of uterine dislocation or displacement are, in the order of their frequency, Procidentia, Retroversion, and Anteversion. The typical and common forms of uterine distortion or flexion are Retroflexion and Antelexion, the latter being much more unusual in occurrence. It is very seldom that either retroflexion or antelexion is met with, except in connection with more or less of the corresponding version of the organ. The extent to which these several conditions are developed varies very much, and depends on the amount of relaxation of the uterine tissues and ligaments proper, and of the surrounding connecting structures. Nothing in relation to uterine pathology is more remarkable, and often inexplicable, than the different amount of suffering which such conditions involve, in varying degrees, in different patients. A slight disturbance of uterine equilibrium will produce agonies in one patient, while extreme forms will in another be borne with impunity.

With respect to the immediate causation of nearly all forms of flexion and version of the uterus, it must ever be borne in mind that, in addition to stretching or relaxation of the proper uterine ligaments, the supporting power, or rather function, of the vagina and its attachments has been more or less reduced, so that there is always a certain amount at the same time of uterine procidence or displacement downwards. The importance of this pathogenic relation has not always been sufficiently appreciated. There can be no shortening of the vaginal tube, and consequent subsidence of the uterus within the pelvis, without a disturbance of uterine equilibrium, and, therefore, either retroversion or anteversion to a certain and usually corresponding degree. This relation between procidentia and version at once and satisfactorily explains the beneficial action of purely vaginal supports, to some extent, in all such cases, and it may be completely, in the slighter forms of the dislocation of the organ, forwards or backwards.

The uterine sound of Simpson, the instrument by which the various forms of uterine distortion and dislocation can be most certainly diagnosed, affords at the same time the readiest, simplest, and most efficient means of restoring the organ to its normal form and position. Such instruments as the uterine repositor of Dr. Marion Sims are entirely unnecessary.

The difficulty of treatment, unfortunately, only begins at this point. No doubt, in cases which have occurred suddenly as the result of some direct violence, such as a fall from a height or on a hard substance, or the lifting of heavy weights, if seen to at once, simple reposition by the sound, or even by judicious manipulation, will suffice. But nearly all the cases which come under our observation have probably existed

for some time, and have been gradual in their incidence and development. In most of these, it is necessary, after restoration to the normal form and situation, to arrange or devise means for its retention there. As I have already said, in slighter forms of version, it will be sufficient to introduce a pessary or support within the vagina, to atone for the relaxation of that canal, which has probably favoured the occurrence of the morbid condition. In still slighter and more recent cases, mere rest in appropriate positions, with local medication in the form of astringents, may even attain the desired result. But in most cases, as I have already said, vaginal supports or pessaries have to be employed in some form or another. Of these, a great variety have been from time to time suggested by members of the profession. The principle of that on which the American pessary of Professor Hodge is constructed seems most to recommend itself, and has deservedly attained great popularity. But it is not only necessary to know the proper instrument for the particular form of displacement; it is also essential that it should be properly applied and fitted. Without this, a pessary may not only do no good, but may do positive harm. I have seen several cases in which Hodge's pessaries had been worn for months without benefit, from not being of the requisite size and correctly adjusted with reference to the particular difficulty they were intended to rectify.

In some cases of retroversion, I have had to use the form of pessary here represented (Fig. 1), the lower bar turned backwards, and resting

Fig. 1.

on the perinæum, and the upper one projecting forward and against the fundus uteri. It is formed out of a simple ring of gutta-percha, and can be readily moulded as regards size and degree of obliquity to each individual case.

Occasionally, cases are encountered, however, in which local medication, and vaginal support merely, entirely fail even to relieve the urgent symptoms that have drawn attention to the lesion. The question then arises: Do these cases warrant or demand such appliances as the intra-uterine stem-pessary? To this I unhesitatingly reply in the affirmative. I am, however, prepared to admit—indeed, it is within my own knowledge—that this treatment has been too often indiscriminately and unnecessarily employed, and often detrimentally in inappropriate cases, or under unfavourable conditions; nevertheless, I maintain that the intra-uterine or stem-pessary can be used with perfect immunity, and with the best effects, in appropriate cases. The uterine tissues, particularly the mucous lining, are in their normal state of low sensibility, and singularly tolerant of manipulation, even of rough usage. It would indeed be strange if they were not, considering how much they are called upon to undergo, in connection with the ordinary discharge of their functions. I have found the uterine cavity, under ordinary conditions, as tolerant of metallic substances as the mouth similarly is to the appliances of the dentist, or as the conjunctiva to the presence of an artificial eye. But, under conditions of irritation or inflammation, it is very different; and, like corresponding structures elsewhere, the uterus becomes highly sensitive, and strongly resents all interference until the morbid state is reduced. One should hesitate to introduce even temporarily the uterine sound, much more to leave a foreign body like the stem of a pessary within the cavity of the uterus, were that organ and its associated structures in an irritable or inflammatory state; such conditions must first be reduced by appropriate means, of which rest, local sedatives, and depletion are the most efficient. In any case where it is possible to anticipate difficulty, it were wise to insist upon a probation of rest after introduction, in order to test tolerance. This, however, is not often necessary; indeed, I have very seldom seen the presence of the instrument resented when used with the ordinary precautions just indicated.

Antelexion, which is a much less frequent form of uterine distortion than retroflexion, but at the same time comparatively more common in the unmarried and those who have not borne children, is, as far as my experience goes, more readily amenable to treatment than

retroflexion. There is rarely so much procidence associated with it, and accordingly vaginal support is less frequently necessary to correct accompanying anteversion. The function of the bladder is usually disturbed both in antelexion and in anteversion; indeed, it is very often the immediate cause of complaint being made to the medical adviser; in retroflexion and retroversion, on the other hand, the rectum plays a corresponding rôle. In ordinary cases both of antelexion and retroflexion, wearing the simple intra-uterine stem-pessary for a few weeks after reposition suffices to relieve the symptoms and effect a cure. The mere weight, however, of the metallic instrument is often objectionable, and frequently also causes it to fall out of the uterus. To obviate this, I have had pessaries made of vulcanite of such a form as to avoid this difficulty, and also to facilitate introduction, to which I shall refer presently. I am sure the baser metals, such as copper and German silver, cause irritation, and I have long since ceased to use them.

The following case of antelexion, which I have had quite recently under my care, possesses so many points of interest, that I shall briefly detail it. Mrs. S., aged 33, eight years ago was delivered of her first child. From that time, she has suffered from irritability of the bladder, bearing down pains, but especially from almost constant nausea and sickness. These symptoms are markedly exaggerated at the menstrual periods, which are painful, but otherwise normal. She had been treated for dyspepsia, ulceration of the stomach, etc., and had taken all the remedies that could be thought of. The idea that she was suffering from some uterine difficulty was suggested to me by the periodical exacerbation of her sufferings, and, on making the usual examination, I found the uterus slightly increased in length (three inches), very much relaxed, the anterior lip elongated, and the fundus flexed forward. There was not much procidence. I introduced an intra-uterine stem-pessary, which gave almost immediate relief. Sickness and intense nausea returned whenever it was withdrawn; but latterly the uterus has so far recovered position and tone, that the instrument is no longer needed. The recovery of flesh and appearance in this case was very remarkable. The extraordinary reflex symptom in this case is very interesting. Dr. Graily Hewitt has already noticed and drawn attention to the frequency of this dependence of gastric irritation on flexions of the uterus. Sympathetic action may occasionally be met with in still more remote viscera. I have seen a case of very severe asthma of several years' standing in which gout was the predisposing, and a displacement of the uterus downwards the exciting cause. A Hodge's pessary gave almost entire relief, and, in connection with constitutional treatment, effected a cure.

There are occasionally met with cases where even still more elaborate appliances than those already referred to are necessary. In extreme cases of version, and especially where flexion and version coexist, and where the organ is low in the pelvis, it may be requisite to combine the intrauterine stem with a vaginal support. At first, this was attempted, by the late Sir James Y. Simpson and others, to be accomplished by a variety of contrivances having their object to obtain a *point d'appui* externally on the pubes or sacrum, of which many varieties exist, now mostly and very properly relegated to gynaecological museums. For a great many years, so far as I am aware, all instruments on this principle have very properly been abandoned as inefficient, uncleanly, and not unattended with danger. Latterly, the late Sir James Y. Simpson maintained the replaced uterus with intra-uterine stem *in situ*, by introducing under it a gutta-percha plane on a depending stem curved in the direction of the vaginal canal, which, although sometimes difficult and painful to introduce, answered very well.

Rather more than three years ago, a case of great difficulty first suggested the combination here shown. Fig. 1 is the pessary or bougie of vulcanite, formed so that the two segments of the split intrauterine stem spring open on the withdrawal of the stilette of the introducing staff, Fig. 2. This stilette passes through an aperture in the bulb of the pessary, and through two small eyelets seen on the proximal surfaces of the segments of the stem, forming, as represented in Fig. 3, an easily managed combination of staff and pessary for introduction, in the hands even of those comparatively unaccustomed to such manipulations. On removing the stilette, leaving the stem *in situ*, the segments separate, and, pressing gently on the uterine wall, prevent the instrument from being extruded from the organ, as very often happens with the simple metallic stem bougie, not only from its weight merely, but also from slight expulsive contractions in previously flaccid and relaxed uteri, which are being stimulated into increased tonicity.

When it is necessary to retain a dislocated uterus in the normal position to which it has been restored, I have employed the vaginal support (Fig. 4), made either of vulcanite or gutta-percha, the latter preferably, in combination with the intra-uterine stem-pessary

above described, as shown in Fig. 5. It is an adaptation of the ordinary ring-pessary, I believe first suggested by Professor Meigs of Philadelphia. It can be made to adjust itself to any form of uterine displacement in connection with the various versions or flexions of the

organ. When of gutta-percha, it can be readily moulded so as to adapt itself to any vaginal calibre. This pessary can be easily introduced by the medical attendant, and, although the patient is unable to do so for herself, yet, from the nature of the material and its form, there is no difficulty in maintaining perfect cleanliness. These instruments have been made for me by Mr. Archibald Young, Queen's cutler, Edinburgh, to whose mechanical skill I have in many instances been indebted.

The first case in which I used this combination of intra-uterine stem and vaginal support was one of very great interest. The patient, a young unmarried lady, aged 28, had suffered for some years from congestive dysmenorrhœa, accompanied by excessive constipation. This had probably been the cause of the extreme retroversion, associated with slight corresponding flexion of the uterus. The fundus could be felt deep in the fossa between the vagina and rectum. Her symptoms were of the most urgent description. She was unable almost to walk or hold herself upright. She had previously been sent two consecutive seasons to Kissingen, without avail, as the Spa doctor there, most indiscreetly and improperly, though truthfully remarked, "She might as well have come expecting the waters to cure an unreduced dislocation of the hip-joint." When she came under my care, I began by enjoining absolute rest in the prone position, reducing the local hyperæsthesia by medicated pessaries of bromide of potassium and atropine, occasionally endeavouring to replace the organ by pushing up the fundus uteri through the rectum. I also applied leeches to the cervix uteri for one or two terms, a day or two previously to the

appearance of the menses. The general conditions were in this way, after a time, much improved; but all attempts at walking or effort again displaced the uterus; so at last I adapted the combination of the instruments Nos. 1 and 4, as represented in Fig. 5. It was worn for about six months, and then the uterus had so far recovered its fixed normal position, that wearing the gutta-percha vaginal support, figured in the first illustration to this paper, was sufficient to effect a satisfactory cure.

In concluding this paper, which I have endeavoured to compress into the smallest possible limits, let me say that I deprecate, in the strongest manner, the *nimia diligētia* in the mechanical treatment of uterine disease generally. I am strongly of opinion that an endeavour to correct the local trouble should always be made in the first place, by treatment directed to correct the general state of health, and only when this, unaided, has failed, should local treatment, involving manual or operative interference with the parts, be attempted. Generally speaking, the speculum should never be used, unless local medication, first by the patient herself, has failed to arrest the abnormal discharges; the sound should never be introduced unless there be presumptive evidence of uterine displacement or subinvolution; and, finally, let me say, mechanical treatment of every kind should certainly be withheld in all cases, until relief by rest, position, and local medication has failed to be afforded. The diagnosis in all cases should be strictly inductive; under no circumstances either speculative or experimental.

THE TREATMENT OF RHEUMATISM BY SALICIN AND SALICYLIC ACID.

By T. MACLAGAN, M.D., Dundee.

As I am probably the only person who has experience of both salicin and salicylic acid in the treatment of acute rheumatism, perhaps (in connection with the article on their employment in that disease which appeared in the JOURNAL of May 6th), I may be allowed space for a few remarks on the respective merits of these two remedies.

The impression left by the article is, that salicylic acid is preferable to salicin, and that the beneficial action of the latter is due to its being converted into the former in the blood. That is, perhaps, a natural conclusion for those who have been using salicylic acid; but it is almost certainly erroneous. More probable it is that both are split up into some other substance which is the true remedial agency. A more accurate view of Senator's position would have been conveyed if it had been stated that he expresses a preference for salicin, though he does lean to the view that it is converted into salicylic acid in the blood.

But all this is mere hypothesis, and is of little importance, as compared with the question, Which is the better remedy, salicin or salicylic acid? That each exercises a marvellous influence in cutting short an attack of acute rheumatism there can be no doubt. I have used salicin or salicylic acid in every case of acute rheumatism which has come under my care since November 1874 (a year and a half), and invariably with the same result—a rapid cure of the disease. Seeing a patient suffering from acute rheumatism, I have no hesitation in assuring him that within forty-eight hours, possibly within twenty-four, he will be free from pain. That is a very different tale from any that can be told in connection with any other remedy.

Salicin is the remedy which I used first, but I have not confined myself to it. When salicylic acid was first recommended as a febrifuge, I determined to give it a trial in acute rheumatism. In the first case in which I used it, ten grains were ordered every two hours. On seeing the patient after four doses had been taken, the general condition was a little better, but she complained much of the medicine "burning her throat". I urged her to continue it. This she did, and on the following morning the pain was less, and the temperature had fallen from 102.3 to 101.1; but to the burning sensation in the throat was now added sickness. I omitted the salicylic acid, and gave the same dose of salicin, ten grains every two hours. The sickness ceased; the burning sensation in the throat disappeared; and by the following day the pain was entirely gone from the joints, and the temperature had fallen to 98.8. She made a good recovery.

This case well exemplifies what is the chief objection to salicylic acid—its tendency to produce irritation of the throat and stomach. I may have been unfortunate in my experience, but in every case in which I have given it this irritation has been complained of. All writers on the subject agree in referring to this irritation as one of its unpleasant effects. The salicylate of soda seems to give rise to the same disagreeable symptom. Salicin, on the other hand, never gives rise to any unpleasant effects. I have prescribed it within the last year

and a half in many different ailments, in doses ranging from five to thirty grains. I am probably within the mark when I say that I have thus given it to at least a hundred different people; and I cannot recall a single instance in which any disagreeable effect was produced.

I have myself taken (by way of experiment) three doses of sixty grains—one in the forenoon, one in the afternoon, and one at night—without experiencing the least discomfort; but the smallest pinch of salicylic acid produces in me a feeling of heat and irritation in the throat, while a dose of ten grains gives rise to gastric irritation and a most unpleasant burning sensation in the fauces.

Salicin is a pleasant bitter, and is best given mixed with a little water, flavoured with syrup of orange if desired. In adequate dose—say fifteen grains every two hours—it cuts short an attack of rheumatic fever, without producing disagreeable effects. It should be continued in smaller doses during the first fortnight of convalescence.

As remedial agencies in acute rheumatism, salicin and salicylic acid seem to be equally efficacious; but the former has the advantage of producing no unpleasant effects. In time, too, it is sure to be much cheaper: a matter of some importance with a large class of sufferers from rheumatism.

SKETCHES OF COLONIAL PRACTICE.

By W. PEEL NESBITT, M.B., M.R.C.P.E.
Government Medical Officer for the Burra, South Australia.

IN the spring of 1875, I heard rumours of a disease having broken out at Paratoo, ninety miles north of the associated townships known as the Burra. It had been known slightly before, but this attack disabled half the station-hands and shearers. It was vulgarly designated "Paratoo whooping-cough". I could glean no further particulars.

A little later, I was attending some children for scarlatina simplex. My attendance ceased when they were in a fair way of recovery. Four days later, I was hastily summoned to the father, a strong healthy man, who had been ailing the previous day, but had gone to work, when he suddenly fell down and was carried home. I found him sensible, but complaining of frontal headache. He had vomited, and his tongue was furred. The pulse was rather rapid. There was no rash; no sore-throat. I reserved my diagnosis. Next day, I found all the symptoms of pneumonia, with, by the wife's account, delirium at night superadded. Headache was intense. Then pleurisy was added. His throat was slightly red, but there was no rash. I was then asked to see the children, one of whom had pleuropneumonia; the others had pyrexia, cough, anorexia, and pains in the head and chest. Nothing relieved the headache, and on the sixth day life terminated in a convulsion. I then formed a diagnosis—suppressed scarlatina, superadded to pneumonia; and I filled up a certificate accordingly. The children made very slow recoveries.

Such was my first experience of the Paratoo disease. From that time I had cases every day, not as severe as the first, for they recovered; and thus it was that I soon came to recognise a disease the symptoms of which are generally as follows:—Onset mostly sudden, the patient sometimes falling down; intense frontal headache; pain in the chest, with rapid breathing; sometimes pneumonia, sometimes pleurisy, sometimes bronchitis, being present; furred tongue, cleaning in a day or two; rapid pulse and high temperature (in one case, temperature 103), falling to nearly normal standard after a few days; delirium always present; bowels sometimes very loose, or natural, or obstinately costive; great prostration.

Such was the disease; but as to the treatment I was completely at sea. Anodynes failed to relieve the headache, and expectorants the cough. I heard of patients treated with blisters, and that they died. Then, having in view the last symptom I have put down, I gave quinine and large quantities of stimulants from the beginning with much more success. Still the treatment was unsatisfactory till I came across an account of "sulpho-carbolate of soda". Since then, all my cases have done well. I give ten grains every four hours; and, though the first dose frequently aggravates the symptoms, three or four relieve immensely.

Dr. Gosse, the President of the Board of Health at Adelaide, has given it as his opinion that this is a form of influenza. It may be, though there is no coryza occurring from the nose. The frontal sinuses are probably inflamed, causing the headache; but this is surely a small cause to produce violent delirium.

I hope practitioners will try the effect of sulpho-carbolate of soda in influenza as it occurs at home, and am of opinion that it will prove an useful remedy in the treatment of chronic cough.