the absence of their stimulating effect, than their application to a complex organism, where paralysis of *inhibitory* or restraining functions may result in increase of certain actions.

These experiments, the authors declare, demonstrate more definitely than any others that have been instituted the *essential qualitative similarity* of the action of all the alcohols—their *sedative* effects—and a certain general *quantitative* relationship of one to another. It is scientifically interesting to the chemist and the physiologist to know that as the complexity of the molecular combination increases, the physiological activity, or poisonous effect, increases.

There are some small quantities of these heavier alcohols in various liquors, and certain combinations of them are said to constitute the fusil oil. The quantity compared with the 50 per cent., more or less, of common alcohol in spirits, is not often sufficient to modify the effect to any appreciable extent, especially as the qualitative effects of all the alcohols are so similar; but so far as they are present they increase the poisonous qualities of the liquors containing them.

The report of Drs. Ringer and Sainsbury closes with the remark, announcing the most important practical fact which these experiments confirm, viz., “that by their direct action on the cardiac tissue these drugs are clearly *paralyzant*, and that this appears to be the case from the outset, no stage of increased force of contraction preceding” (*Practitioner*, May, 1883, p. 350).

In another part of the report the authors say: “The position alcohol occupies is that of a *narcotic*, and it is probable that its action is very similar to that of ether. * *. The sphygmographic experiments of Parkes and Wollowicz on man showed clearly the accelerating effect [of alcohol], but gave no distinct indication of increased arterial pressure.” The arterial pressure is the evidence of the increased force. Increased frequency of pulsation is often the strongest evidence of diminished force or power, a very rapid, fluttering pulse usually occurring in extreme weakness.

All agree that the ultimate effect of any considerable amount of alcohol is depressing and paralyzing, and that in chronic alcoholism all the conditions indicate the failure of power; but yet many, even medical men, at least by their use of language, seem to think that in moderate quantities and as frequently used it is a stimulant, and some perhaps still regard its depressing and fatal effects as the result of overstimulation.

With the facts now presented before us, and others of a similar character so constantly accumulating, it cannot be long before our ideas and our language respecting alcoholic drinks will more nearly conform with the teachings of science.

A CASE OF TYPHLITIS, WITH AUTOPSY.

BY R. D. BARKER, M.D.

Luella A., American, aged twenty-one years. Was called to see her first at 2 P. M., July 5, 1883. Learned the following history of the case: Had

been for some time of a costive habit—bowels frequently not moving for three or four days. Although not feeling very well, she went on an excursion to Spirit Lake, twenty miles distant by rail July 4. The forenoon of the day was damp and rainy, and upon arriving at the lake she was too ill to join her companions in the grove, but lay on the sofa in the sitting-room of the hotel most of the day. She complained to her friends of pain “across her,” and vomited once or twice during the day.

On returning home in the evening, not having had movement of her bowels for two or three days, and the pain across her continuing, her mother gave her a dose of salts which she vomited. In the evening after her return she attended a dance, but was too ill to stay long; was in pain all night, the night of the 4th; the morning of the fifth, her bowels remaining costive, her mother gave her some senna tea which she vomited. I found her at 2 P. M., the 5th of July lying dressed on a sofa; had been crying, and seemed very low spirited, anxious and dispondent; very little febrile excitement; pulse 92; temperature normal; tongue slightly coated; her menses had appeared two weeks ago, and she was regular in her periods; she complained of severe pain in lower part of abdomen, extending to the pubes; excessively tender over the region of pain; very little tympanites; urine normal in quantity (so she said), but voided with pain; bowels not moved for three days. The pain being so low down and so severe, without the grave constitutional disturbance indicative of peritonitis, I diagnosed neuralgia of womb and appendices, and ordered copious vaginal injections of water as warm as could be borne; to apply hot applications over abdomen, and

R Fluid extract gelsemini.....gtt. ix
Fluid extract belladonnagtt. xvi
Simple Elix..... 3vi
M. Sig. Teaspoonful every two hours.

Was called at 11 p. m.; medicine had given no relief; lies on the sofa, with knees drawn up, face flushed; pulse 140, and depressed; abdominal tenderness very marked, patient crying out in agony.

I question mother, and learn that she had not urinated to-day, and that they had misunderstood my orders, and had given her one quite large warm water enema into the rectum, which had produced two free liquid discharges. I pass catheter, but obtain no water; I introduce $\frac{1}{2}$ grain suppository of sulph morphia into rectum; I ask for counsel, and Dr. J. Croft is called. We wait half an hour for the effects of the suppository, and then find it necessary to give her by hypodermic injection $\frac{1}{8}$ grain sulph. morphia and $\frac{1}{120}$ grain atropia. This in the course of an hour gives her much relief, and we leave her with instructions to introduce the suppositories every two hours if necessary to relieve pain, and to continue hot fomentations.

Saw her again at 9 a. m.; now thoroughly under the influence of the morphia, but hardly free from pain; has had nausea since early morning, and has vomited several times, greenish, bilious fluid, containing no fecal matter; pulse 150, and weak; body bathed in cold, clammy sweat; complains of intense

dryness and burning sensation in her throat and stomach; introduce catheter and withdraw 8 ounces urine; is to continue suppositories as may be necessary to keep her comfortable; continue hot fomentations, and to have ice water freely and to swallow little pieces of ice frequently.

6 P. M. Not quite so tender over abdomen; increased tympanites; still vomiting, not fecal; seems to retain what is given while the stomach fills, and then ejects it; bowels not moved; perfectly rational; distress at stomach and throat continues; pass catheter and obtain 6 or 7 ounces of urine; ordered mustard over pit of stomach, otherwise continue treatment.

Called at 1 A. M. July 7; again in agony; pain and area of tenderness increased, now extending from pubes to navel; vomiting continues; prostration extreme; cold, clammy perspiration; pulse hardly numerable; I introduce catheter and obtain 8 ounces of urine, and introduce suppository, and again call Dr. Croft. When he comes she seems much easier, and we conclude the alarming symptoms to be the result of the distension of the bladder. Dr. Croft, who has from the first visit been inclined to the belief that the disease was intussusception of the bowels, suggested the introduction of a long flexible rectal tube, and the flooding of the bowels with tepid water. Going to his office for his tube, when he returned she was so much easier we postponed the operation.

9 A. M. Has slept some since previous visit; is more comfortable; vomits, but less often; not as much abdominal tenderness, and less tympanites; pulse 120, fuller; withdraw 4 ounces urine. As she now seems almost free from pain, and believing the discomfort of the throat and stomach is caused by the morphine, I discontinue the suppositories.

6 P. M. Vomiting ceased; free from pain; pulse 120; temperature 98°; catheter passed, and 6 ounces urine obtained; is now taking no medicine; beef tea, wine and milk, as much as stomach will tolerate; called at midnight and passed catheter—6 ounces urine.

July 8—9 A. M. Has slept considerable during the night; more comfortable, perfectly rational, and much more hopeful; pulse 128, temperature 98½; has passed her urine once since midnight unassisted.

6 P. M. Seems to be slowly improving; stomach retains considerable liquid food; is now taking no anodynes; tenderness and tympanites disappearing; as she has had no movement of the bowels since the first day of the attack, and she complains of desire for the stool, I direct the nurse to inject into the bowels slowly and carefully one half pint of warm water, discontinuing the injection the moment it gives her pain; half an hour after was called in great haste, and found patient suffering greatly; her mother informed me that they commenced to give the enema as ordered, but had passed up not more than two or three tablespoonfuls before she commenced to complain of its giving her pain.

I now called Dr. L. W. Warren in council, and expressed to him my positive conviction that there

was a perforation of the bowels somewhere in the region of the descending colon, and that the injected liquid passed directly into the peritoneal cavity. In no other way could I account for the sudden increase of all inflammatory symptoms every time the syringe was used. Dr. Warren advised the resumption of the hot fomentations and the morphia suppositories, and also the application of pure chloroform upon flannel to the region of abdominal pain and tenderness.

From this relapse she never recovered. All the inflammatory symptoms returned in an aggravated form, she became delirious and rapidly sank, and died July 11th, at 11 A. M.

Autopsy five hours after death.

Upon opening into the abdominal cavity I find it filled with a yellowish milky fluid, evidently the liquid food she had been taking for several days.

There was diffused inflammation of the peritonæum and bowels, much more marked on right side in the vicinity of the descending colon and appendix vermiformis, and a creamy, tenacious deposit on the coat of the bowels, evidently of inflammatory origin, and a slight deposit of pus in the immediate vicinity of the appendix.

Examining carefully the appendix vermiformis, I find a perforation, and just at point of perforation, but within the part, a hard substance about twice the size and of the shape of a kernel of wheat, which proves to be hardened fecal matter. Upon pressure upon the bowels, its contents would be expelled through the rupture.

The remarkable features of this case are, the length of time she survived the perforation, and entrance of the fecal matter into the abdominal cavity (as I am confident, from a careful study of the case, that the first injection given into bowel, when ordered for the vagina, passed into the abdominal cavity), and the seeming improvement of the patient after perforation.

WORTHINGTON, Minn., Aug. 31, 1883.

At the last meeting of the New Brunswick Medical Society at St. Johns, the following members were elected: Dr. Vail, President; Dr. Walker, 1st Vice-President; Dr. Patterson, 2nd Vice-President; Dr. G. M. Duncan, General Secretary; Dr. Coleman, Corresponding Secretary; Dr. Nevers, Treasurer; Drs. Daniel, Allison and Berryman, Trustees. The meeting then adjourned to meet in St. Johns, on the 3rd Tuesday in July, 1884.

PROFESSOR WALDEYER, of Strasburg, succeeds Professor Reichert in the chair of Anatomy in the University of Berlin. Dr. H. Chian has been made Professor of Pathological Anatomy in the University of Prague.

Gaillard's Medical Journal has returned to its old monthly form. The change was made at the request of many subscribers. It is now the only monthly medical journal published in New York.