

"I feel mighty queer, and can hardly see." He then looked in the mirror and exclaimed, "What is the matter with my face? I am going to a doctor!" He walked nearly two blocks to my office, and in attempting to walk up to the door (just three steps up from the pavement) fell, and then had to be assisted into my office. He hurried in without waiting to knock, and in a voice which indicated great distress, exclaimed, "Doctor, some one has poisoned me." This was probably about half-past one, and about an hour and a half after taking the first tablet. The mucous membranes of his eyes, nose and mouth were very edematous. The eyelids and lips were everted and swollen to twice the normal size, the conjunctivæ very much congested; the patient could hardly breathe through his nose at all. Tonsils and uvula were in a state of congestion, the articulation was very indistinct, and when the patient attempted to raise his voice to a higher pitch, it had a peculiar metallic sound, which would end with a muffled tone. The veins in his temples and throat were knotted, and in places were standing out like hard cords. I found his circulation 136, respiration 24, afterward going down to 12, temperature normal. His face was greatly flushed, and this, with the eversion and swelling of eyelids and lips, made him a ghastly-looking object.

I made him lie down on a cot, and as he seemed to have considerable trouble in breathing, removed his collar and opened his shirt. I had the nurse give him a hypodermic injection of digitalin, bathe his face, neck and head with hot water, and apply continuous hot towels, and keep him quiet. Later, as he complained of great pain in the shoulders and neck, I also applied continuous hot pack to those parts, and, as the circulation remained weak, ordered hypodermic of strychnin. At half-past two he suddenly fell into a profound sleep; his circulation slowed down and became stronger, but respiration continued very slow, and seemed almost to stop at times. His slumber was so profound that the removal and the replacing of the hot towels did not seem to disturb him at all. I allowed him to sleep until nearly four o'clock, when I awakened him and had him conveyed to his home, which was about three miles in the country. He stood the trip all right, and after getting into bed he almost immediately fell asleep again. In about three days the edema had disappeared from face, nose, eyelids and mouth, but the throat remained irritated for at least ten days longer, and the patient was slow in regaining his strength.

The report of H. E. W. and this case show that some have a decided idiosyncrasy to this drug, and that it should be listed as one of the dangerous drugs, which should not be retailed indiscriminately to the laity.

THE USE OF CYLINDRICAL GAUZE AND COTTON DRAINS IN DISCHARGING EARS

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Aural surgeons must have witnessed the efficiency of gauze drainage in the ear following mastoid operations. The pus is constantly carried by the moist gauze packing in the external auditory meatus to the preferably wet gauze protective dressing. The solution with which this dressing is moistened should not be strongly antiseptic or irritating. Normal saline is excellent, although to encourage osmosis I sometimes employ a heavy sterile solution of magnesium sulphate. The packing in the auditory canal should be carried down to the tympanic membrane. There should not be any space left to serve as a reservoir for pus. This obliteration of space may be readily accomplished by placing over the outer end of the auditory canal a few folds of the end of a narrow 1 inch or 2 inch strip of gauze packing which has no

loose threads on its margin, and then with a rough or screw-ended probe pressing the gauze directly in, until it touches the drum head. If a smooth probe is used or no fold made in the gauze the probe is likely to slip through the single layer of gauze, irritating the canal or injuring the ear-drum instead of carrying the gauze before it.

In acute or chronic otorrhea, a gauze drain is also very useful, but requires changing once or twice a day, which must be done by the surgeon, since such a drain cannot be inserted safely by untrained attendants. A few aurists, in certain cases, advocate gauze drainage but the patient must be in a convenient hospital or make frequent visits to the aurist's office which in practice is likely to be either too inconvenient or too expensive, or both. To overcome these objections I employed for some time a drain which my office assistants made by rolling a narrow strip of gauze doubled on itself on the end of a sterile toothpick, giving it stability by wrapping its central part with thin gutta-percha gummed together by any unirritating sterile ointment. It presented the appearance of a diminutive cigarette, $\frac{3}{4}$ to $1\frac{1}{4}$ inches long, about $\frac{1}{8}$ inch in diameter, with the gauze projecting about $\frac{1}{8}$ inch beyond the surrounding gutta-percha and with a toothpick sticking in the unravelled end of the gauze. The drain was made loose on the toothpick before being introduced. After its partial introduction the toothpick was withdrawn and its opposite dull end was used to press the gauze drain well into the ear. The outer end of the canal was then packed with gauze to help retain the drain in place and to absorb any excess of discharge when there was more than the drain could contain. Gauze is much more serviceable than cotton for this purpose.

Similar drains are now being manufactured. At first drains made altogether of gauze tightly wrapped by machinery were tried, but they were too stiff, hurting the patient on introduction. Drains made wholly of cotton were not stiff enough to be introduced. The cylindrical gauze and cotton drains which I recommend consist of cylinders of cotton wrapped in gauze, which is both soft and pliable, so as not to injure the delicate tissues of the ear, although sufficiently firm so that they can be readily introduced. They are supplied sterile, ten in an envelope, each six inches long. They may be cut by sterile scissors to any desired length, depending on the depth of the external auditory canal, and are supplied, of proper length, to the patient, in dry sterile two-dram vials or wrapped in sterile gauze. These drains are also very useful in draining small abscesses or cavities anywhere, and are easily introduced. They may be used any desired length. Several, side by side, may also be employed for drainage, as in some mastoid wounds.

They are easily introduced into and removed from the external auditory meatus by any simple forceps. They may also be introduced by first impaling them on the end of a sterile toothpick, using the latter as a handle. When there is much discharge I have the patient keep one in the ear day and night, putting a fresh one in every morning and evening; but after the discharge is much lessened it is employed only at night. After its removal, if there is any excess of discharge, it should be wiped away with cotton on the end of a sterile toothpick. Any drops which the aurist may wish to employ, e.g., 5 or 10 per cent. phenol in glycerin, compound tincture of benzoin, boroglycerid solution, or boric acid and alcohol solutions in different strengths, may be warmed and poured into the upturned