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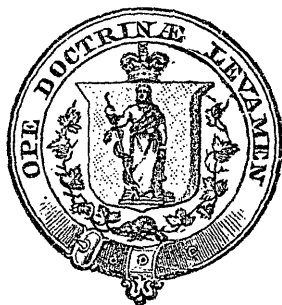
MEDICAL AND SURGICAL SCIENCE

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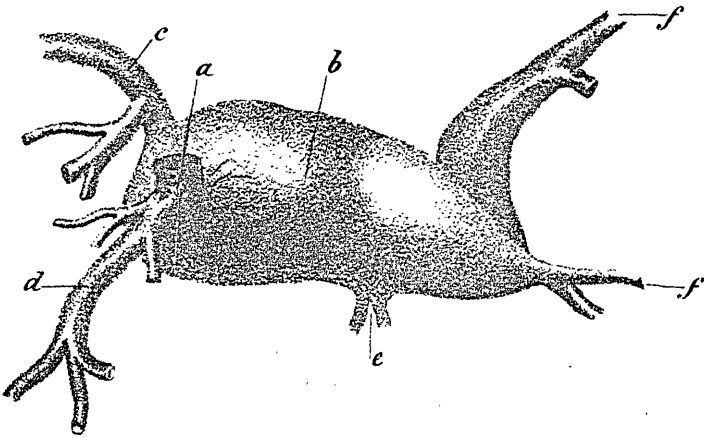
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ANEURISM OF THE HEPATIC ARTERY.

(a) Hepatic artery, (b) right branch mainly involved, (c) left branch, (d) gastro-duodenalis, (e) cystic arteries, (f) occluded branches of right trunk.

# CANADA

# MEDICAL & SURGICAL JOURNAL

Original Communications.

## ANEURISM OF HEPATIC ARTERY; MULTIPLE ABSCESSSES OF THE LIVER.

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—AND—

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(Read before the Medico-Chirurgical Society, Montreal.)

Aneurism of the hepatic artery being of such very rare occurrence and the case which we are about to relate presenting in addition some remarkable pathological features, we are led to believe that it will be found of considerable interest.

For the notes of the case we are indebted to Mr. JOHN BRODIE, ward clerk.

W. H., æt. 21, single; height 5 feet 11½ inches; weight, about 140 lbs,—was admitted into the Montreal General Hospital on the 8th of November, 1876, complaining of pains in the right side and great weakness.

The patient was born in Wisconsin, U. S., and lived there until about two years ago, since which time he has resided in this city. His family history, as far as could be ascertained, is good. Has never been ill with the exception of small-pox, and a mild pneumonia of the left lung. Has never had dysentery nor

piles, nor any abdominal or rectal trouble of any kind. Has always been of extremely temperate habits.

His present illness began, he says, about the 1st of September last, with what he describes as a severe cramping pain in the stomach, which began in the morning and continued all day. At 4.30 p.m. of that day he had a violent rigor, lasting about twenty minutes. This was followed by high fever and perspiration. Similar chills recurred, he says, with great regularity, every second day for five or six times, and then ceased after he had taken some medicine from the Hospital Dispensary. At this time his appetite became poor, he felt weak and was very low-spirited, and observed that his skin assumed a sallow colour. Ever since he has been gradually getting weaker and losing flesh pretty rapidly, and the sallow tint of the skin has been steadily increasing in intensity. There has also been almost constantly present a dull, aching pain in the right side over the region of the liver. Slighter rigors, followed by fever and some perspiration, have also occurred several times at irregular intervals.

*Present Condition.*—Much emaciated, somewhat anæmic, but the whole skin of a dirty, dingy, sallow hue, without any jaundice,—the sclerotic clear, and not yellowish. There is a very peculiar, pungent, somewhat feculent and extremely disagreeable odor exhaled from the surface of the body.

There is slight fullness of the right hypochondriac region which is also somewhat tender upon pressure. *Liver.*—Dulness extends from the 4th interspace to one inch below the margin of the ribs. The belly is full and tumid, and tenderness is also found on pressure over the epigastrium. Splenic dulness not increased. Tongue slightly furred, rather dry, and with red edges. Bowels have been, and still are, considerably relaxed, the motions being light-coloured and especially offensive. Urine, sp. gr. 1019, high-coloured, but containing neither bile pigment, albumen nor sugar.

*Heart*—Situation and sounds normal, pulse 116. *Lungs.* Resonance and breathing normal throughout, except at the base of

the right lung where there is an area of dulness with enfeebled respiration. Temperature 105° F.

Ordered quinine gr. xx each evening.

*Nov. 11th.*—Has not complained much of the pain. Disagreeable odour from the body very marked. Bowels are regular, but motions are ochre-coloured and offensive. Tongue clean. A dull red flush on cheeks especially in afternoon. Has occasional slight epistaxis. Temperature has ranged between 102° F. and 103° F.

*16th.*—Is getting weaker but is quite cheerful, and feels well. Tongue moist and clean. Takes nourishing food very well, and bowels remain regular. Never vomits. Temperature continues equally high, always rising 2° or more in the evening, followed by sweating which is sometimes very profuse. This usually commences at 6 p.m. Urine 43 oz. sp. gr. 1022. No bile pigment, albumen or sugar.

*23rd.*—The volume of the liver has considerably increased, and, owing to the progressive emaciation, bulging of the lower ribs on the right side has become quite apparent. Dulness extends from the top of the 4th rib to two inches below the margin of the ribs. The lower edge of the liver cannot be felt owing to the fulness of the abdomen and its tender condition. Pain on pressure over liver region and epigastrium increased. His strength is failing fast, and the sallow colour has become deepened. The odour from his body has been so offensive in the ward for some time that the House Surgeon has been obliged to employ spongings with carbolized solutions, and disinfectants round the bed. He lies almost continuously on his back, occasionally turning slightly towards the right side, but any attempt at turning on his left side is accompanied by severe pain and a feeling of a dragging and weight in the region of the liver. The superficial veins on the right side of the chest are very large and prominent. Ordered linseed poultices over the liver.

*25th.*—Tenderness less. Hepatic dulness increased in area, measuring 8 inches vertically at the line of the nipple. No localized fulness or redness of the skin or fluctuation to be found

anywhere. The enlargement of the organ is very general and uniform. Pulse 128, very small and feeble. Temperature continues high with evening perspirations. Is remarkably cheerful, saying he feels well but weak, although he suffers a good deal of pain. Ordered acid nitro-mur. dil. Tr. calumb., a a ̄ss ter die.

29th.—Pain and tenderness low down on the right side, Excessive pain is caused by the slightest change of posture. Lies constantly on the right side. Pulse 130. His diet throughout has been of a most nourishing kind. Milk abundantly, beef-tea, eggs, wine, &c.

Dec. 3rd.—This morning there occurred a temporary collapse, marked by a rapid fall of the thermometer to a remarkably low level, 94.8° F., accompanied by great prostration and a cold sweat. In the evening the temperature rose to 102.4° F., and during the night great pain was felt in the left iliac region, which was tender.

Ordered an opiate, and a small blister to this region.

6th.—Is rapidly sinking. The signs of effusion in the right pleura, hitherto stationary, have in the last few days, rapidly extended, and there is now dulness over the lower two-thirds of that side, with absence of breathing, and an amphoric note beneath the right clavicle.

7th.—Died at 6.00 a.m.

#### AUTOPSY, 31 HOURS AFTER DEATH.

Rigor mortis present. Skin of a dirty-brown colour. In the abdomen about 22 oz. of yellow turbid fluid. In the right pleural cavity about 20 oz. of similar fluid. *Right lung* collapsed. The pleura covered with a thin layer of greenish-yellow lymph. On section, the lung is dark, airless and sodden. *Left Lung*. On the visceral layer of the pleura, especially behind, are numerous small ecchymoses. On section, organ contains much blood, is firm, and only slightly crepitant. *Heart* normal. *Kidneys* rather pale, cortex swollen, and malpighian tufts injected. *Spleen*, weight 445 grms. (14 oz), adherent to the stomach. Organ soft. On section dark and congested.

*Intestines* normal. No trace of ulceration in the large intestine. *Bladder* and prostate, normal.

*Liver*, 4879½ grammes, (10¾ lbs). The peritoneum around it in many places showing signs of inflammation. The left lobe intimately adherent to the stomach by a thick layer of firm yellowish-coloured lymph. The right lobe also cemented to parts in its neighbourhood by lymph of a similar character. A small amount is also observed on the descending colon, but the general peritoneal surface is not affected, the serous covering of the intestines being clear and glistening. The liver itself retains its normal shape, the upper surface is smooth and not adherent. Towards the right border a yellowish-coloured swelling is evident which is perceptibly fluctuating. Other less distinct yellowish spots are seen scattered over the organ. To the touch the upper and back part of the right lobe is exceedingly soft and fluctuating. On the under surface many yellowish-white nodules are apparent, some large, others quite small, all distinctly fluctuating. A similar one of large size is apparent on the under surface of the left lobe. A transverse incision through both lobes reveals the fact that we have to deal with a diffuse suppurative hepatitis. An immense quantity of yellowish-white, custard-like pus flowed out. The right lobe is completely honey-combed by a series of small, closely united abscesses, ranging in size from a marble to a walnut. The septa between these abscesses are composed of a dark-red tissue. Most of these small abscesses communicate together; some have merged to form larger ones. They all possess distinct lining membranes which are frequently stained with bile. The left lobe is in a similar condition, and in both the abscesses extend throughout the thickness of the organ. Thus, the only portions of liver-substance which are found comparatively free are the lobus quadratus and that portion of the organ lying immediately above and a little to the left of the gall bladder. These parts on section are of a dark colour, lobules distinct, small bile vessels very evident. The gall bladder is small, contains about three drachms of a clear, somewhat viscid secretion. On pressing it and along its ducts no fluid could be forced out at the papilla biliaria. It was with

much difficulty that a probe could be passed along the cystic duct, owing to an unusual number of irregular folds of its mucous membrane which were evident when the duct was slit up. The common bile duct itself was patent, the mucous membrane of its upper two-thirds stained with bile. There were no clots in the superior mesenteric, gastric, or splenic veins. On slitting up the portal vein itself, a small abscess was found to project into the calibre of one of its right divisions. The tissue in the neighborhood of these main divisions was infiltrated with pus. A firm nodule was felt at the portal fissure and mistaken at first for a bunch of lymph glands. Section of this, however, showed it to be distinctly laminated, and careful dissection of the part revealed the existence of an *aneurism* just at the bifurcation of the Hepatic Artery, but occupying chiefly the right branch. (see plate.) The dilatation begins immediately beyond the gastro-duodenalis, (*d*) and extends for about 3 inches as a somewhat conical swelling. The left hepatic artery (*e*) arises from the obtuse end of the aneurism and is unaffected. At its thickest part its circumference measures 3 inches. For  $2\frac{1}{2}$  inches it passes to the right and gives off two branches (*f*) which appear occluded, then turns at right angles and passes backward for  $1\frac{1}{4}$  in., towards the posterior border of the liver, terminating by a conical extremity which is continuous with the main branch of the artery. The arteries of the body had been injected, and the red mass is found in the trunk of the hepatic before its bifurcation, in the gastro-duodenalis, and the left hepatic branches, all of which are full and tense. The hepatic artery appears to enter the aneurism about  $\frac{1}{4}$  of an inch from the obtuse end, the gastro-duodenalis and left hepatic being given off apparently from the dilatation itself; and on slitting up the hepatic artery it appears at first sight as if these were its only branches, and that its communication with the aneurismal sac had become obliterated. Careful inspection, however, of the lower and posterior wall reveals a small canal, the calibre of a hypodermic needle, which leads directly into the sac. The aneurism being opened by a longitudinal cut on the upper surface, it is seen that the anterior third, comprising the rounded end, is completely filled with firm



decolourized laminae of fibrin, concentrically arranged. The middle third of the sac contains semi-coagulated blood, and red injection mass, after emptying which there is seen a cavity about the size of a small walnut. This is in communication with the hepatic artery by the small canal already referred to, which passes for rather more than half an inch through the fibrinous laminae of the anterior end. Two small branches, both containing injection pass from the cavity, one the cystic, (*e*) going to the gall-bladder, the other a somewhat larger branch, passing to the central part of the organ. The sac is lined with sheets of fibrin, which, at the under part were thinner than elsewhere, and at this point the blood has infiltrated the proper coats of the aneurism, which, in consequence, look reddish black. The terminal portion of the sac lay chiefly in the substance of the right lobe, surrounded by suppurating hepatic tissue, which had to be dissected away to expose it; and on section the cavity is found almost completely obliterated by fibrinous laminae, which in the centre are softer, and not so colourless as the other end of the sac. No direct passage could be traced through this from the central cavity, and the main branches given off from the aneurism are found empty, and at their commencement plugged with fibrin, which in several extends as a thin sheet along the intima.

The condition appears to be one of simple aneurismal dilatation of the vessel. the walls being thin, slightly roughened on the interior, but not markedly atheromatous. The trunk of the hepatic artery itself looks healthy, and there are no evidences of general vascular degeneration.

*Remarks.*—Aneurismal dilatation of the Hepatic Artery would appear to be of rare occurrence, the chief reason, of course, being that its main cause—atheromatous degeneration—is very seldom met with in this situation. Embolism of this artery Frerichs has never seen—the situation and mode of giving off of the vessel being such as to hinder the entrance therein of foreign substances from the stream of the aorta. One single case of the kind has been recorded by Virchow, where an hepatic abscess followed embolism from a gangrened lung.

The same author (Frerichs) alludes to four, or possibly five,

as the only recorded cases of Aneurism of the Hepatic Artery. They are those of Ledieu, Stokes, Sestier, Wallmann and Lebert. In the case of Ledieu, the patient died of some pulmonary complaint, and had never had any symptoms of hepatic disease. There was found, just before the giving off of the pyloric branch, on the hepatic artery, a small hard tumour the size of a hazel nut. It was entirely composed of firm laminated fibrin, and had completely occluded the main artery. The case of Sestier was also obscure. There had been "symptoms of some chronic painful affection of the stomach." The right branch of the vessel was found occluded by a small aneurism filled with clots, and the gall-bladder was gangrenous.

In Wallmann's patient—a female—there was an account of attacks of violent pain in the upper part of the abdomen, coming on after intervals of several days, gradual loss of strength, and emaciation. There was enlargement of both liver and spleen. No ascites; no fever. Then there supervened obstruction of the ducts with perceptible fulness of the gall-bladder, and very deep jaundice. She was believed to be suffering from gall-stones. Then fever, abdominal tenderness, collapse and death. A large aneurismal tumour was found in the situation of the lesser omentum. It was the size of a child's head, and showed a rent communicating with the cavity of the abdomen.

Lebert's case was accompanied by severe pains in the pit of the stomach, followed after a time by hæmatemesis and melæna. Vomiting was persistent, and the patient soon died. The aneurism involved the main trunk of the vessel, and communicated by a fistulous opening with the gall-bladder, by which means the blood had found its way into the duodenum and stomach.

From a relation of these cases Frerichs sums up as follows the clinical features resulting from this lesion:

"The symptoms to which aneurism of the hepatic artery gives rise are accordingly of a three-fold nature. In the first place there is the tumour, which is sometimes remarkably large and displaces the liver; secondly, there is the neuralgic pain, produced by pressure upon the hepatic plexus of nerves; and lastly there is jaundice caused by compression of the bile ducts. The

fatal termination in most cases takes place under symptoms of internal hæmorrhage.”

We are inclined, therefore, to look at the record of the present case as of considerable importance, inasmuch as it clearly shows that besides, or even without, any of the symptoms mentioned by writers as accompanying aneurism of the hepatic artery, it may actually institute an entirely different series,—those namely of acute suppurative hepatitis of a diffuse character. The case as it came under observation was one presenting the marked characteristics of the latter disease, and every possible source of contamination of the portal system which might have given rise to it was interrogated in vain. Of course, we need hardly say that the real cause was entirely unsuspected, nor do we see but that the diagnosis of the aneurism was truly impossible. In the future, however, we must admit, in cases owning no other evident cause, that hepatic aneurism may be the starting point of acute hepatic abscess.

Among the many interesting points in connection with this case, the causation of the multiple abscesses takes the front rank; not only because in this one alone among the recorded cases was the fatal termination due to a suppurative hepatitis, but also on account of the extreme rarity in the human subject of opportunities of studying upon this organ the effects of disease of the hepatic artery. Taking for granted, as from the careful examination we may justly do, that the portal system did not in this instance furnish the *materies morbi*, we have to consider the consequence of total obliteration of the hepatic artery, or of its main branches, and also the effect of small emboli, in the form of particles of fibrin, plugging its terminal twigs.

It will be necessary first to refer briefly to a few anatomical and pathological points in connection with the blood supply of the liver. This, as in the lungs, is two-fold; the portal vein ministering solely to the functions of the gland, the hepatic artery chiefly to its nutrition. The ultimate branches of the portal vein ramify at the periphery of the lobules, forming the interlobular vessels, from which numerous capillaries pass into the interior, and finally converge to the centres of the lobules, as

the ultimate radicals of the hepatic veins. The hepatic artery furnishes blood to the bile ducts, portal and hepatic veins, and the connective tissue of Glisson's sheath. Its capillaries empty their blood by small venules into the interlobular veins. Hence, remembering this distribution of the hepatic artery, it is easy to understand how that in cases of thrombosis of the portal vein, even where the obstruction is complete, the functions of the organ may be maintained, and both bile and glycogen secreted; for the capillary plexus of the lobules continues to receive through the interlobular veins the blood which has been emptied into the latter from the venules of the hepatic artery. The nutritive blood serves as a substitute, acts vicariously, for the functional. It has been maintained, and the statement passes current in the text-books, that the converse of this is true, viz: that the portal blood can replace the hepatic, the functional act for the nutritive. This view is based on experiments made upon the lower animals. Schiff states that in the cat the functions of the liver are performed just as well after ligature of the hepatic artery as before; and Betz found that in the dog, after tying the trunk of the hepatic and all the collateral branches, no important alteration took place either in the structure of the liver or in its secretion.

Cohnheim and Litten have shown, however, in a very important paper on "Disturbances in the Circulation of the Liver," (Virchow's Archiv. May, 1876), that in experiments on dogs arterial blood still reaches the liver even after ligation of the hepatic, the coronaria ventriculi, and the gastro-duodenalis, owing to the very extensive anastomoses and connections of these vessels. In the guinea-pig, on the other hand, the supply of arterial blood can be completely shut off, either from the whole organ or from individual lobes. In the former case the operation is always fatal within 24 hours, and even in this time important changes are found to have taken place in the organ. These are all the more marked if, instead of ligating all the arteries, only the one going to the extreme right lobe be tied. The result is an entire necrosis of the portion of the liver supplied by the ligatured artery, and in every instance the animal died within two days.

Cohnheim states that pathological proof of the correctness of this view is as yet wanting, but we are inclined to believe that by this case the deficiency is supplied; for we think the suppuration of the organ best explained on the view, that the shutting off the supply of blood, either by the gradual occlusion of the aneurism by clots, or by the quicker process of emboli conveyed away from the interior of the sac, produced numerous areas of necrosis, which subsequently became, by inflammation and a sequestering suppuration, converted into abscesses. It is impossible to determine, in the absence of any positive evidence, whether the process resulted from emboli or simply by the gradual obliteration of an important blood channel; and in any case there are certain difficulties which will occur to the minds of many in the view which we have suggested. There are at least two cases on record of total obliteration of the artery, without consecutive suppuration, one of which was from aneurism. Still, this, if occurring gradually, and not involving the pyloric artery, need not necessarily, as the above-mentioned experiments prove, deprive the liver of arterial blood. There is no reason to suppose that the obliteration in the case before us did not occur slowly, for the fibrinous laminae, especially at the anterior end, were firm and tough. Again, on an embolic theory it might be urged that in this instance the emboli, consisting of fibrinous shreds from an aneurismal sac, should have produced simply mechanical effects, infarctions, and not, as in the case of emboli proceeding from necrotic or suppurating foci, abscesses. Mechanical emboli do, however, sometimes produce suppuration, and in the liver might do so by causing death of the structures supplied by the obstructed arteries, viz: the portal vessels, bile ducts and connective tissue of Glisson. In the present case, supposing the process to depend on emboli, there would be arterial blood enough sent through collateral branches to furnish material for an active suppuration about the necrotic centres. Altogether, we think the embolic theory meets the case better than any other. We must remember, too, that the disease was not rapidly fatal, but came on slowly, lasted five weeks or more, and it is not unlikely that during time that much of

the fibrin was deposited, and the obliteration of the distal end of the aneurism took place. This is rendered still more probable by a consideration of the condition of the left hepatic branch, the commencement of which is involved in the aneurism, but which now, owing to the filling of the proximal end of the sac with fibrin, appears to be almost the direct continuation of the main trunk. In fact, for a short distance from the bifurcation, the upper wall of the left branch is made up of condensed fibrin, which is grooved by the blood channel. This explains, too, the occurrence of the abscesses in the territories supplied by the left branch. The almost entire obliteration of the obtuse end of the sac occurred, most probably after the mischief had been started by the escape of emboli. The appearance of the abscesses adds further support to this view. None of them looked recent or contained shreds of necrotic liver tissue, but all were filled with a creamy pus, and had walls lined by definite pyogenic membranes.

We have no clue to the origin of the aneurism itself. The age of the patient, and the absence of arterial degeneration elsewhere, are almost sufficient to exclude atheromatous degeneration as a cause, and the walls of the sac appear thinned but not evidently diseased. Of other agencies capable of producing aneurism, especially of smaller vessels, embolism is the most important, and, even in the absence of valvular disease, and remembering the unfavorable position of the hepatic artery for emboli, we are inclined to regard it as the most probable cause.

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### PATHOLOGICAL REPORT ;

GENERAL HOSPITAL, MONTREAL,

*For the year ending May 31st, 1877.\**

BY WILLIAM OSLER, M.D.

Records of exactly one hundred autopsies have been entered in the post-mortem book of the General Hospital for the year ending May 1st. A few of special interest occurring in private practice have been included.

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\* Published with the consent of the Medical Board.

I may mention that the post-mortems are performed under my direction by the students attending the hospital, and the system of inspection followed is that of Virchow at the Charité, Berlin, and fully given in his "Sections-Technik." The notes are taken on the spot from dictation.

I propose in the following Report to give brief summaries of the cases of practical and scientific interest. Some of them have already been published in the pages of this journal, to such a mere reference will be made.

When possible a synopsis of the clinical features will be given. I have grouped the cases under the various organs affected, believing this to be a more convenient method than dealing with the individual diseases, and in each case the organs are dealt with in the order of their pathological importance.

#### OSSEOUS SYSTEM.—FRACTURES.

CASE LXXI.—*Fracture of 1st and 2nd ribs from direct violence; deep abscess of the neck; Empyema.* J. L., æt. 20, was struck on the sternum by the shaft of a fire engine; almost immediately after a tumor formed in left clavicular region, the arm on that side became paralysed and on admission was pulseless. Tumour inflamed, was opened, and discharged a milky fluid and blood, subsequently pus. Empyema supervened, and death.

Abscess found to be deep in the neck, immediately above the left pleura cavity, and about as large as a good-sized orange. On putting the fingers into the sac the ends of the fractured ribs can be felt in the posterior wall. The fracture of the 1st rib is straight, just external to the tuberosity; the inner end is embedded in the wall of the sac, the outer lies one and a half inches from it. The 2nd rib is fractured obliquely just external to the angle, and is also comminuted. The inner end projects into the sac, as a rough, sharp process, and lies at a higher level than the outer end which is external to the sac. Between the two is a small separated portion enclosed in the sac wall. The lining membrane of the cavity is stained, and in places covered with flakes of fibrin. Immediately below the anterior part of the floor

of the sack, the apex of the left lung is firmly attached, and separated from the abscess by condensed tissue,  $\frac{1}{4}$  of an inch in thickness. At the posterior part of the floor only a thin membrane separates the latter from the pleural cavity. An orifice, in communication with an external one at the root of the neck, exists at the upper part of the anterior wall. The subclavian artery runs along the inner and upper part of the sac, being apparently lifted somewhat out of its course. It is completely obliterated by a thrombus, which begins an inch from the aorta and extends to the first portion of the axillary. The subclavian vein is also obliterated, though not in such a long part of its course. Above the artery, at the top of the sac, is the brachial plexus, the cords of which appear stretched and compressed.

Between 2-3 pints of pus in the left pleural cavity. Lung compressed.

#### ACUTE NECROSIS—PYÆMIA.

CASE LXXXIII.—*Necrosis of Tibia. Ulcerative Endocarditis. Pyæmic Pneumonia.*—A. B., æt. 12, male. No definite history of an injury; pains of a rheumatic character about the joints, only slightly more marked at the left ankle; symptoms of pyæmia; death within a week.

Acute periosteal abscess found in the lower end of left tibia, with necrosis of the bone, which is denuded and roughened, especially in front. The cancellated part did not appear much affected.

Pericardium is beginning to inflame. In the wall of the conus of the right ventricle, is a purulent depot the size of a bean, and not far from it a superficial loss of substance, half the size of a three-penny-bit. Traces of atheroma in the sinuses of Valsalva. Scattered throughout both lungs were small, firm slightly-elevated spots, ranging in size from a pea to a marble. They are most abundant in the upper lobes. On section some were dark in colour, their firmness alone distinguishing them from the lung tissue; others had a greyish red appearance, while others again had softened in the centre, forming small abscesses. Small supernumerary spleen present.



CASE XCVI. — *Necrosis of Femur. Pyæmic Pneumonia. Abscess in superficial Muscles. Pustular eruption on skin.*—J. C., æt. 30.—The clinical features of the case are well summarized by Mr. Vineberg,\* as follows: The disease attacked a strong and apparently healthy man; no history of injury; the symptoms at the outset simulated those of rheumatism; the rapid setting in of a pyæmia, which ran its course without rigors, or marked fluctuations, and remission of temperature; the presence of a pustular eruption and erysipelatous patches on the skin; which, with the tuberos elevations beneath the skin—not unlike farcy buds—and the general symptoms presented a clinical picture very like that of glanders.

*Left Femur.*—Muscles of anterior region of lower third of thigh infiltrated with pus, the posterior ones not so much, and here there are distinct abscesses in the muscles. The periosteum of the lower end of the femur is raised, and contains beneath it much pus, the bone is bare and roughened in front, behind and on the inner side; on the outer side the periosteum is still adherent. It is covered with a dirty greyish exudation. Scrapings from the bone and roughened surface examined with the microscope show an enormous number of large myeloplques. The marrow where the bone was sawn through looks healthy, that of the end of the bone itself was not examined.

*Skin.*—Numerous flattened pustules, with reddened bases exists over the skin of trunk and upper extremities.

*Muscles.*—In those of the arms and legs, many small and tuberos swelling can be felt which, on section, are found to be abscesses in the substance of the muscles.

Long int. saphenous vein occluded by a thrombus.

*Blood* dark and fluid. During life there was a large number of Schultze's granular masses, and the net-work of fibrin fibrils which separated out on the slide under the microscope was unusually dense and coarse.

Commencing *Pericarditis* over right auricle.

*Lungs.*—Numerous firm, slightly-elevated nodules, ranging in size from a pea to a marble, in all the lobes, but most abun-

\* In a paper read before the McGill Medical Society; May 8th, 1877.

dant in the lower. On section most of them present a white granular surface, interspersed here and there with hæmorrhages, some of the larger ones in the lower lobes have softened at the centre into abscesses. The margins of these pneumonic areas are congested, sometimes hæmorrhagic.

Effect.

### CANCER OF THE VERTEBRÆ AND RIBS.

CASE LXXXII.—*Primary Cancer of bodies of 2nd and 3rd vertebræ and heads of corresponding ribs on right side. Secondary masses in ribs, liver and brain. Chronic Phthisis. Lobar Pneumonia.*

#### HISTOLOGICAL EXAMINATION.

M. C., æt. 52.—Vertebræ, 2nd and 3rd. Bodies not enlarged, but soft and porous. On stripping off the anterior ligament, a soft, greyish-white juice oozed out. The transverse and articular processes also involved. Two soft cancerous outgrowth spring from the junctions of the laminæ and body of the 2nd, and encroach upon the calibre of the canal; at the centre of the back part of the body of the 3rd, is another tuberos outgrowth. The cord did not appear much compressed by these masses, and the membranes are unaffected.

*Ribs, 2nd (right side).* To two inches beyond the angle the bone is enlarged, double the size of the 3rd, the articular surfaces are bare. The compact tissue has disappeared, and the cancerous growth has elevated and infiltrated the periosteum. On section large cancellæ are seen, filled with a reddish-white juice. At the middle of this rib is an irregular swelling, one inch in length, which presents the same appearance as the head.

*3rd Rib (right).* Not nearly so much enlarged, the articular surfaces not affected. Compact tissue gone, but periosteum is free.

*8th Rib (left).* An elongated swelling about the middle,  $1\frac{1}{2}$  inches in length, most marked internally. On section external part soft and cuts readily; the central part is hard and dense.

*9th Rib (left).* A still larger swelling of same character, two inches in length; not hard in the centre, but not so porous as the heads of the affected ribs.

*Liver* not enlarged ; contains a dozen or more white masses, situated superficially, ranging in size from a walnut to a small pea ; surfaces of most on a level with liver—the larger are elevated and with depressed centres. On section many hæmorrhagic centres are seen.

*Brain.* A rounded cancerous mass— $1\frac{1}{2}$ " by  $1\frac{1}{4}$ "—occupied the superior parietal convolution of the right side, extending into the longitudinal fissure for a short distance. On section it is greyish-yellow in colour, except at the centre and margins, where there is more blood. Small masses also in the right corpus striatum and left thalamus opticus, and on the pia mater of lower convolution of the left occipital lobe, and on the pia mater of right crus cerebri. All of these, on examination, are cancerous in character

*Lungs.* Left is emphysematous, several very large blebs existing near the root. Throughout both lobes are numerous firm fibroid tubercles, ranging in size from a pea to a pin's head. Lower lobe is solidified, in a state of red hepatization, the air cells being filled up with fibrinous plugs.

The right lung contains hardly any air. At the lateral part of the upper lobe is a large dense caseous mass, the size of an orange, with a sharp round contour towards the lungs, and much puckered on the pleural surface. It is very firm, and on section beautifully marbled. At the lower and back part of this lobe the lung presents a very peculiar appearance over an area equal in size to an orange ; it is irregular, soft, and spongy, no definite cavity exists, but the tissue at the upper part is soaked with pus, while below there is pus mixed with blood. It looks not unlike the fibrin of blood clot soaked with pus, but on examination proves to be a rapidly breaking down lung tissue, infiltrated with cellular elements. The pleura over it is very thick and fibrous. Nearly the whole of the lower lobe is in a condition of grey induration, being firm, airless, and scattered through it are a few caseous masses.

(To be continued.)

## Correspondence.

EDINBURGH, May 30th, 1877.

MY DEAR EDITOR, — The recent surmises respecting the movements of Prof. Lister have been verified since the date of my last communication. His telegram announcing his final decision to accept the chair at King's came like a thunderbolt among the men here. Mr. Annandale left by the first train for London, and within twenty-four hours the admirers among the students and graduates in the city of Mr. Watson and Mr. Chiene had petitions in circulation for signature. The three men I have mentioned are the only likely candidates for the chair. The appointment lays with the Home Secretary, so that, of course, the man who wields the most influence will win, and here Watson has undoubtedly long odds in his favor. Besides, he has to recommend him a long term of service in the Infirmary, and the fact that he has lectured on surgery in the College of Surgeons for many years. Annandale has lectured on Clinical Surgery for some time in the Extra-mural school, is the author of a couple of works and some valuable papers on surgical subjects, and is a good operator. Mr. John Chiene, by far the younger of the two, being scarcely yet thirty-five years of age, has much to recommend him. The following extract from a testimonial drawn up in his favor by some of the most prominent of the younger Edinburgh graduates in the kingdom, will give you a fair idea of his position as a candidate: "Although you are comparatively young in years, you have shown such decided ability, and given such rich promise for the future, as to convince us that the University of Edinburgh would have in you a Professor of Clinical Surgery worthy of occupying the chair of Mr. Syme and Mr. Lister. Your whole education eminently fits you for the appointment now vacant. In anatomy you were trained as student and Demonstrator by Mr. Goodsir and Mr. Turner. In surgery you have had the great advantage of having been an Hospital Assistant both to Mr. Syme and Mr. Lister. With the late Professor Syme you acted as Resident

Surgeon for a period of twelve months, and many of us remember how well you fulfilled the duties of that position. As one of the Assistant Surgeons to the Royal Infirmary, you have, on many occasions during Mr. Lister's absence, been called upon to discharge the duties of the Professorship, and you have done so, we believe, with the greatest acceptance both to the University authorities and to the students. You are, what in our opinion, is a matter of no slight importance, a thorough believer in the Antiseptic System of treatment, and you are skilful and experienced in its application. Your knowledge of disease, the skill with which you operate, and the marked success which has attended your operations, show that you possess in an eminent degree all the qualities which make a surgeon. Your success as a teacher has been very remarkable. You began as a surgeon should begin, by teaching anatomy as Demonstrator for four years in the University. You then started as teacher on Surgery and your class, from a small beginning, has in the course of six years grown so rapidly, that during the last Winter session you enrolled over 100 pupils for your systematic course, the largest class in Surgery, we believe, that there has been for many years in the Extra Academical School, &c."

Among those who signed this testimonial are Dr. T. Lauder Brunton of St. Bartholomew's Hospital, London, and Dr. J. Wyllie, the talented pathologist to the Edinburgh Infirmary.

My own convictions are that, no matter how this appointment goes, Chiene is "the coming man." He has youth, energy, and ability on his side, and as far as antiseptic surgery is concerned, Lister could not have a more faithful disciple.

The authorities of King's College Hospital have conceded everything to Mr. Lister, and were evidently bound to have him at any price. They give him a House Surgeon of his own, where there was only one for the whole hospital, and he is to have his wards separate and distinct from those of the other surgeons. While the custom has hitherto been, to divide the fees of the school among all the teachers, his are to be independent; and instead of lecturing once a week, as did Sir W. Fergusson, he proposes lecturing twice. Altogether a special

chair has been provided for him, so that now this little school will have two teachers of clinical surgery, Professors Wood & Lister.

As, I think, I hinted in my last letter, I have seen much to impress me with the antiseptic plan of treatment. In fact, I have seen results that could be obtained in no other way. The following case is an illustration :

A boy, aged thirteen years, fell in front of a heavily laden wagon, the wheel of which passed over the right knee, but before doing so pushed it for some distance before it grinding the limb into the hard pavement. On admission into the Infirmary all the soft parts occupying the outer half of the joint were either carried away or fearfully lacerated. The joint was opened, and dirt ground into the bone, and even the cartilage of the outer condyle. To the unexperienced in antiseptic work there seemed to be no alternative but excision or amputation. Mr. Lister, however, went to work under the spray with a pair of curved scissors, clipped away all the soft parts that were likely to die, scraped or pared away any bone or cartilage containing dirt, rubbed the whole roughly with a coarse nail brush, and lastly applied to the entire surface a carbolic and spirit solution of one to five strength, which, by-the-way, he now uses very rarely. The protective and antiseptic dressing were then applied in his usual way. On the following morning, according to my notes, the temperature was  $99\frac{3}{4}^{\circ}$ , and the pulse 103. The boy was free from pain, and spoke cheerfully. The outer dressing was removed as the serous discharge had found its way to the edge of the gauze. The temperature never reached  $100^{\circ}$  till the fourth day, when it was  $101\frac{3}{4}^{\circ}$ , but this rise was thought to be due to the fact that the patient's bowels had not moved for several days, as after an injection the temperature fell to nearly normal. On the fifth day the inner dressing was removed for the first time. The gap, in dimensions about 4-6 inches, was filled to a level with the surrounding skin with a blood clot of a pale colour, looking firm and evidently undergoing organization. The parts around were entirely free from any inflammatory trouble. There was no redness or swelling to be seen anywhere

in the limb, and except when moved the boy complained of no pain in the joint. There were no elements of putrefaction demonstrable either in the wound or on the dressing. Mr. Lister dipped the protective and deeper dressing in salicylic cream, (made by mixing salicylic acid and carbolic lotion) and put up the limb as before. Two days ago, before the class at the clinical lecture, Mr. Lister removed the deep dressing which had been left undisturbed for *twenty days*, and the blood clot was found to be firm and covered by as healthy granulations as I ever saw. There was not a vestige of putrefactive odour on the dressing. The boy never had a bad symptom, and of course is bound to do well, although he may in all probability have a stiff knee, owing to the contraction which is almost inevitable during the organization of blood clot.

Mr. Annandale has been performing a number of excisions lately. In excising the hip he makes first an exploratory incision into the joint, mainly to find out the condition of the acetabulum. Should it be only slightly diseased he removes simply the head and neck of the femur with a narrow saw, taking away the trochanter only when the socket is much implicated or when he wants freer drainage. He prefers the straight incision. In knee-joint resection he uses simply a plaster-of-paris splint, at which I was much surprised, as no doubt you will be. In excisions of the ankle he prefers as a rule to remove the entire astragalus, as he has found that the fragment left often becomes carious.

Mr. Chiene has performed three operations for the cure of knock-knee with marked success. Instead of sawing through the base of the inner condyle and then breaking it, as Ogston of Aberdeen recommends, he cuts down on the bone, peels back the periosteum, removes with the chisel a wedge-shaped piece of the condyle, and then by a gentle pressure throws the latter upwards, taking care to bend simply (not break) the cartilaginous surface of the bone.

More anon from London.

Yours, very truly,

T. G. R.

*The Question of Rest for Women during Menstruation.*—  
By MARY PUTNAM JACOBI, M.D., Professor of Materia  
Medica in the Woman's Medical College, New York.  
The Boylston Prize Essay of Harvard University for 1876.  
New York: G. P. Putnam & Sons; 8vo.; pp. 232.

The members of the Boylston Prize Committee are to be congratulated in having procured such an essay as the one before us in response to their question, "Do women require mental and bodily rest during menstruation?" It seems peculiarly appropriate that one of the sex to whom this question is an all important one should have been the successful competitor, and by the production of such an essay have given additional token—if such was needed—of the fitness of women for the highest kind of mental labour. It is a work which will add greatly to the reputation of its authoress, already well-known as an able and energetic worker in the field of practical medicine.

Passing over the introductory chapter, which is taken up with historical notes and general considerations in regard to the amount of labour performed by women in various countries, the real work of the essay begins with the inquiry as to the proportion of women who suffer pain and inconvenience during menstruation. To obtain the necessary information on this point 1000 circulars were issued, and to these 268 women replied, of whom 35 per cent. declared themselves to have been always completely free from discomfort during menstruation. It was ascertained that the class who never suffered menstrual pain exercised a great deal more than the other class, and also that persons without occupation suffered more than those who were occupied. "As regards "Rest," the data do not suffice to inform us of its influence. We can only assert negatively that in a large proportion of cases it has been quite superfluous."

Menstruation is next considered, and the ovulation theory, "which construes the menstrual hæmorrhage as a subsidiary phenomenon, entirely dependent on the periodical dehiscence of ovules," and the more recent one, as yet without a name, according to which ovulation and the menstrual hæmorrhage



are processes coincident but distinct, the latter being subsidiary, not to changes in the ovary, but in the uterus preparatory to pregnancy, are very fully discussed. Neither are considered quite satisfactory, and the older 'theory of plethora' is adopted; according to which there is "an excess in women of nutritive force and material, which, when not utilized in reproduction, is expended in menstruation." Hence it follows, "on the hypothesis that the menstrual period represents the climax in the development of a surplus of nutritive force and material," that "we should expect to find a rhythmic wave of nutrition gradually rising from a minimum point, just after menstruation, to a maximum just before the flow." This introduces us to the experimental part of the essay in which the attempt is made to demonstrate by experiments upon the secretion of urea, temperature, the force of the muscles, and the tension of the arteries, that such a nutrition wave exists. In six instances the daily quantity of urea excreted was estimated for two or three months, with the general result of showing an increase in its excretion during the four days preceding the menstrual flow, about the average at the intermenstrual periods, and a marked decrease after the cessation of the menses. The temperature was found to rise one to eight tenths of a degree in the pre-menstrual week, falling gradually during the flow. The estimates of the variations in muscular force in relation to menstruation are not so satisfactory, being lessened in some and increased in others in the pre-menstrual period. Perhaps the most important of the experiments relate to the variation in arterial tension. This part of the essay is accompanied by eight plates with sphygmographic tracings: It was found that there is an increase in the arterial tension during the week preceding menstruation. The lowest point of vascular tension is reached immediately after the cessation of the flow, and may continue for several days. This "rhythmic wave of plenitude and tension of the arterial system, . . . which begins at a minimum point, from one to four days after the cessation of menstruation, and gradually rises to a maximum seven or eight days before menstruation," is believed to depend, not on the increased cardiac systole, or on any obstacle

to the free egress of blood from the arteries, but on an increase in the mass of the circulating fluid. Evidence is gathered from these details to show that the menstrual flow is "the simple equivalent of an accumulation effected by a constantly rising wave of nutrition," the circulating fluid increases in quantity, till at length the tension in the system becomes so great that the vessels of the uterine mucous membrane, weakened by fatty degeneration, yield, and hæmorrhage takes place.

Space will not allow of the consideration of the "theory of supplemental nutrition" dealt with in Section V., or of the succeeding one; we can refer only to the chief conclusions, viz., "that there is nothing in the nature of menstruation to imply the necessity, or even the desirability, of rest, for women whose nutrition is really normal." "It remains true, however, that in our existing social conditions, 46 per cent. of women suffer more or less at menstruation; and for a large number of these . . . . humanity dictates that rest from work be afforded whenever practicable."

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*Report on Adulteration of Food*, being Supplement No. III to the Report of Inland Revenue, 1875. Printed by Order of Parliament. Ottawa.

We have received, and read with much pleasure, the above report, the first which has been issued under the new Act. The necessity for such an Act is shown by the fact that of 180 samples submitted to the Public Analysts up to Dec. 31st, 1876, 93, i.e. 51½ per cent., were adulterated. A considerable proportion of the adulterated articles were condiments—mustard, pepper, &c., and the additions, as a rule, harmless. Fifty-four analyses of milk were made, and in 34 adulteration detected. This condition of affairs the authorities of the cities of the Dominion should endeavour to remedy by establishing a thorough system of inspection, as is enforced in many continental cities, where, by properly trained men, all the milk undergoes a preliminary inspection on the streets, and any suspicious samples are sent to the Public Analysts for further investigation.

Weekly returns are published, and the announcement in this way of the dealers who are in the habit of adulterating has of itself been found most beneficial. How much can be done is shown by the Parisian returns. In 1871, 44 per cent. of the milk was adulterated; in 1875, only 16 per cent.

Interesting analyses of the various quinine wines manufactured in Montreal are given, of which Campbell's and Lymans, Clare & Co's appear to be the most reliable. Altogether, the report does credit to the Inland Revenue Department and to our Public Analysts

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### Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

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**Case of Splenotomy by Billroth.**—The fortunate results obtained by Péan in this operation, which has from time to time in the past 300 years been performed, are encouraging. By statistics we learn that of 21 cases 17 recovered; of these, 15 were individuals in whom the spleen had protruded through a wound, and was wholly or in part excised. Of the six persons from whom Quittenbaum, Koberle, Spencer Wells, Kuchler and Péan removed large hypertrophied spleens, two (Péan's) recovered. Bryant's cases are omitted.

These two successful operations, by the fact of the patients continuing in good health for a long time, do away at a stroke with all theoretical doubts as to the propriety of splenotomy, which has for long needed no physiological justification, and by its success has now removed the pathologico-physiological objection. Among clinical physicians there is no longer any doubt that large splenic tumors of themselves, and without leukæmia, cause death.

In leukæmia we know that, in addition to large spleen and lymphatic tumors, hyperplasia of the bone marrow exists; yet it is a well recognized fact that many cases of hypertrophy of the spleen and lymphatic glands occur with leukæmia. The

extension of our knowledge in this region has, for the time, confused rather than enlightened our understanding of the pathology of leukæmia. The things which were believed to be tolerably certain have again become doubtful.

In Péan's cases it is not recorded whether leukæmia was present or not. Whether splenotomy is more dangerous in individuals with leukæmia than in those without, and whether leukæmia would cease after successful extirpation of the spleen, are questions to be determined not by experiments upon animals, nor reflections in the study, but by a further experience of this operation in individuals whose blood before and after the operation has been accurately examined. Thus leukæmia is not, in the meantime, to be regarded as a contra indication to splenotomy in tolerably fair conditions of health.

The method of operation is not yet definitely settled, so that further communications upon it would be useless; and as it is one which is likely to become more common, I feel all the more bound to put on record a case lately operated upon by me, and fatal through an unfortunate accident, which can, probably, be hereafter avoided:

Mrs. C. A., æt. 45, the mother of nine children, admitted January 20, 1877, never had ague, nor does it prevail in her native place. She has noticed for the past two years a hard swelling on the left side, which has slowly increased in spite of remedies. Until the past summer she could do hard work, but since then has got weaker and weaker, thin, and the belly has become very ponderous.

*Present Condition.*—Woman of average size, strongly built but thin, of a quiet disposition, complexion pale, but she does not look ill. Mucous membranes moderately red. Abdomen swollen. The result of repeated examinations gave:—Enormously large hard spleen, slightly enlarged liver, moderate ascites; remaining organs healthy. Great leukæmia, proportion of red corpuscles to the colourless, after numerous countings, 5:1. Appetite good; pulse 60, moderately strong; general condition fair. She soon made up her mind to the operation, being assisted thereby by the fact that in a neighbouring bed a woman

had been operated upon by abdominal section for fibroids of the uterus, and, after years of illness, completely cured. The operation was performed on January 29th, all the usual precautions in such a case having been taken. Chloroform was administered and an incision made, extending to a handsbreadth above and the same distance below the navel. Abdominal walls were thin, and the small vessels, which bled freely, were ligatured with catgut. On opening the peritoneum a moderate quantity of ascitic fluid escaped, and the lower and inner border of the enormous spleen, together with a portion of the liver border, appeared in the wound. The omentum and intestines lay behind the spleen, and these parts were held back with large flat sponges. The spleen, which was nowhere attached, was slowly drawn from above through the wound, and the pancreas, with the lig. gastro-splen., pulled somewhat forward. The ligament was tied in six pieces, and each piece tied twice, so that in their division no blood flowed from the spleen. (From the results of operations upon animals, this practice is much esteemed.) In the division of the last piece, hæmorrhage occurred from an artery which had not been included; it was stopped with the finger, and afterwards tied. The divided surface then presented no bleeding points, and ligatures were cut short. By means of sponges attached to long forceps the rest of the slightly blood-tinged ascitic fluid was removed. Two long drainage tubes were inserted into the lower part of the wound, in order to carry off any exudation which might take place. The wound was closed by thirteen deep and four superficial sutures, and a compress applied. The operation lasted three quarters of an hour, and was conducted without a hitch; all present regarding it as a relatively simple operation—more so than most ovariectomies. The patient came very slowly out of the narcosis, and spoke with me quietly half an hour afterwards, when I left the hospital. On my return in two hours to enquire, I found my assistant busy in compressing the abdomen, out of the partially opened cavity of which the blood gushed with considerable force. The patient was in her last gasp. Shortly before she wished to go to stool, and on the bed-pan had passed, with

considerable straining, a few hard masses (she had had on the previous day, and also an hour before the operation, copious evacuations). Suddenly she became deadly pale, and sank back. The assistants, on coming from the next room, found her pulseless, and on removing the compress blood flowed out from between the stitches of the wound. The aorta was compressed, and the wound opened, in the hope of finding the bleeding spot, but it was found impossible to master the hæmorrhage. There could be no doubt that in the straining a ligature had slipped. At the post-mortem between two and three pounds of blood-clots were found in the abdomen. On injecting water into the splenic artery it flowed out of a small branch situated between the third and fourth ligature, and from several branches at the same point water escaped when injected into the splenic vein. The loosened ligature was not found. The increased blood pressure in the splenic vein during the straining is believed to have caused the central ligature, situated close to the pancreas, to slip. It is advised, in the future, to include a small bit of pancreas with this ligature.

The excised organ weighed between six and seven pounds and was firm.—*Wiener Med. Wochenschrift*, No. 5, 1877.

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**Diagnosis of Ovarian Disease.**—A rtolh, essay lately published by Prof. GUIDO BACCELLI, of Rome, deals with the percussion of the ilium as an aid to the diagnosis (1) of simple ovaritis, (2) of a commencing ovarian tumour, and (3) of the sides of origin (right or left) of large ovarian tumour whose early stages are unknown. Percussion of the diaphysis of the ilium, according to the author, gives rise to acute pain in simple ovaritis unaccompanied by diffuse peritoneal inflammation. An ovarian tumour gives rise to marked dulness on the side on which is situated, while there is clear tympanic resonance on the side of the healthy ovary. Thus, if the left ovary be enlarged, there is dulness over the left ilium, and resonance over the right; and *vice versâ*. The rules to be adopted in percussing are as follows: The patient must lie on her side, with the

legs drawn up, and the thigh which is uppermost adducted and pressed toward the abdomen, so as to place that part of the diaphysis of the ilium which lies below the centre of the insertion of the gluteus medius muscle in the position best adapted for percussion. The exact point of the external surface of the ilium to be percussed is a little below the centre of a straight line drawn from the posterior-superior border of the iliac crest to the upper edge of the acetabulum. Taking the average length of this line as ten centimetres, the point to be percussed lies between five and six centimetres below the posterior edge of the crista ilii. It is necessary to percuss forcibly, and it is better to use a pleximeter and a hammer than the fingers only. The two sides must of course be percussed at identical spots. The practical value of this method is illustrated in the essay before us by two or three striking cases, in which it was most successfully applied to clinch a doubtful diagnosis; and we are assured by Professor Baccelli that these are not the only ones in which it has stood him in good stead.—*Med. Times and Gaz.*, April 14, 1877.

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### **Means of arresting Epileptic Attacks.**

—M. NOTHNAGEL gives (*Berlin. klin. Wochenschrift*, No. 41 and 46, 1876) the case of a workman subject to attacks of epilepsy, in whom each fit was preceded by an aura, occurring usually from a quarter of an hour to half an hour before the fit. The aura was characterized by a peculiar sensation of constriction, the seat and point of departure of which was the epigastrium. The sensation seemed to rise in the throat, and to compel the patient to breathe deeply and rapidly. Then it seemed to descend and after recurring several times, finally affected the head, which was turned to the right, when the patient immediately became insensible. He had discovered for himself that on putting a quantity of salt into his mouth, as soon as the aura commenced, he could ward off the attack; a sensation of burning was experienced in the œsophagus, and the affection re-descended; a teaspoonful was insufficient; a handful was required. Brown-Séguard arrested, it is well known, attacks of epilepsy in

his epileptic Guinea-pigs by turning their heads briskly to the side of the body opposite to that of the medullary lesion; and it would appear that a strong peripheric stimulus will serve the same purpose, as sharp pinching of the skin in the epileptic zone or elsewhere, or the application of a tight ligature to the fingers. In such cases the effect is probably due to simple reflex inhibitory influence. Prof. L. Meyer remarking on these cases, states several years ago, in fact as long ago as 1855, Prof. Nothnagel observed that sulphate of quinine administered a certain time before an epileptic attack was very effective in preventing its occurrence, and in these days, when intravenous or subcutaneous injection can be so readily employed, this means would appear to be worthy to further investigation. The quantity administered by Prof. Nothnagel was from fifteen to forty-five grains.—*Practitioner*, April 1877.

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**Treatment of Wounds.**—The rapid healing of wounds without any, or but very slight fever, and without any or but little secretion of pus; and how to prevent the occurrence of traumatic diseases—these problems have given rise to much discussion, and yet they cannot be considered as satisfactorily solved.

Lister has accomplished a great deal. Nussbaum, Volkmann, Thiersch and many others, have had very favorable results from Lister's method. They all attempt to prove, from their experiments, the superiority of Lister's antiseptic method over the common open treatment of wounds.

The advantages claimed for Lister's method are:

1st. The protection of wounds from all untoward influences, therefore preventing traumatic diseases.

2nd. The more rapid healing of wounds, either *per primam intentionem*, without fever, or rapid healing, with very slight fever and but little suppuration.

After Volkmann, Thiersch and Nussbaum made their report to the German Congress of Surgeons of the year 1876, recommending Lister's antiseptic treatment, Burrow reported on the



success his father and himself have had in the open treatment of wounds.

The hospital under their supervision contained 16 beds; ventilation imperfect; the patients of the poorest class; several amputations and other operations were performed by students. Under these circumstances, their report shows that out of 123 operations but 7 per cent proved fatal. While Lister's shows a mortality of 17 per cent., Volkmann, 18 per cent., and Thiersch, 23 per cent.

The authors who are in favor of Lister's method differ in their opinions as to its protective power. Nussbaum looks upon it as a prophylactic agent against hospital gangrene rather than against pyæmia. Volkmann does not think that Lister's method will protect the patient entirely from traumatic diseases, particularly not from erysipelas; he, however, believes that these diseases will decrease in frequency and severity under its use. Thiersch believes that Lister's method is a prophylactic against pyæmia.

For the open treatment of wounds, as practised formerly, well-ventilated apartments were required, the greatest cleanliness was necessary, and experienced corps of assistants and nurses was indispensable. The constant supervision of the surgeon was also required. Any of these conditions failing, the treatment was not a success.

In the technic of operative surgery decided progress has been made—improvements that were essential for the open treatment. We have the catgut ligature which causes suppuration, and if the wound is closed, will be absorbed; anaesthetics and Esmarch's bandage allow the surgeon to prepare the wounded surfaces as he pleases.

A close study of Lister's method shows that the largest wounds, if properly attended to, can heal by first intention. Considerable experience is required to properly apply the bandages so as to obtain favorable results. To fully carry out the directions given by Lister would require skilled assistants and costly bandages, and if not carried out strictly according to directions, our labor will be for naught. For a country surgeon, it would be almost impossible to make use of this method.

Prof. D. has his doubts as to whether the antiseptic measures, as laid down by Lister are at all necessary.

We know that in healthy individuals a wound will heal by first intention, if the edges of the wound are brought into close contact and held there; and that if the person is unhealthy, his blood impoverished, a similar wound will not heal by first intention, owing to a want of plasticity of the exudation between the surfaces.

A wound in a healthy person can be healed by first intention if the following conditions are fulfilled:

1st. To give the surfaces of the wound such a form that they can be brought in the closest contact.

This can be easily accomplished in operations of the extremities by using anaesthetics and Esmarch's bandage.

2nd. To use a ligature that will be absorbed and cause no suppuration.

3rd. To cause the wounded surfaces to secrete copious plastic exudation. This can be accomplished by applying a 4 to 8 per cent. solution of chloride of zinc to the surfaces.

When there is no longer any danger from hemorrhage, to bring the opposite surfaces in close contact.

5th. When it is impossible to bring the surfaces in close contact, to allow a free escape to any pus that may be formed. This we can do by using the drainage tube.

6th. To prevent the dressing, after being impregnated with the secretion of the wound, from adhering to the skin, because, in removing them, we may disturb the parts, by partly tearing open the wound. After the wound has been treated as above directed, a piece of waxed paper is placed over it, openings being made in the paper for drainage tubes, if any are used.

To cause the surfaces to come in closest contact, cotton is put over the surfaces of the wounds, and through adhesive plaster and bandages, the necessary compression is made. The cotton being elastic, there is no great danger of making too severe pressure.

This method was tried in cold abscesses, ulcerations in the sheaths of tendons and hydrocele, with the best of results.

The results have been so gratifying as to prove that Lister's good results are not due to the antiseptic measures adopted, but to the close adaptation of the surfaces, to the exciting of inflammatory exudations and to the free escape of pus. Dumreicher, therefore, cannot accept the doctrine of Lister, maintaining that the favorable course of all wounds treated according to his method and the absence of all traumatic diseases are due to his antiseptic measures.

Stich and Panum, by their experiments on animals, proved that pyæmia and septicæmia could only be produced by direct infusion of the poison into the veins. Burrow's statistics show that by cleanliness, poisoning of wounds can be prevented. During the operation, the escape of blood from the veins prevents the introduction of poison; after the operation, the air, which carries the septic germs, is excluded by the close union of the edges, and the drainage tubes are rendered impervious to air by closing the external end.

D. considers it a rather one-side view, which claims that traumatic diseases are produced mostly by external influences, air, etc.; he thinks that the individuality of the person, his state of health, the condition of his blood, etc., etc., are very important factors.—*Prof. Dumreicher, Wien. Med. Wochenschrift, Chicago Med. Journal and Examiner.*

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**Turpentine in Sciatica.**—At a meeting of the Medical Society of Edinburgh, Dr. Jamieson read a paper on the uses of the oil of turpentine in sciatica. He regarded cases of sciatica as referable to three classes, viz., 1. Those cases where it was due to peripheral irritation of the sacral plexus, generally in branches near the genital organs; 2. those cases occurring at the age of tissue degeneration; 3. Those cases dependent on a specific poison, either gouty, syphilitic, etc. In cases due to the cause given under the second head, he had great success with oil of turpentine, viz., in ten out of eleven a cure was effected. The turpentine required to be given in two-drachm doses, with castor oil, mucilage, and cinnamon water, and re-

peated three or four times. Dr. Young had used turpentine in cases like Dr. Jamieson. In half-drachm and drachm doses, he had found it of no effect. But he would again try it in the way recommended in the paper. The best treatment, so far as he knew, was iodide of potassium pushed to iodism. This was often very effectual in relieving pain. He had got good results—the best results indeed—by the use of acupuncture. In every case, of course, it was important to remember that they had to consider the constitutional state of the patient. In the case of a lady, he had found turpentine in drachm doses of no effect. Benefit was obtained from iodide of potassium in doses varying from four to six grains thrice daily; and, after a three months' stay in England, the pain never returned. He could not say whether the iodide of potassium or change of air had been the cause of cure, but probably both had been of advantage. Dr. C. Muirhead, during the last week or two, had in his wards at the Infirmary three cases of sciatica. In the first case, two drachms of turpentine were administered every second night on three occasions, but no castor oil was given along with it. No effect followed. In Glasgow, where the patient had been previously, almost every remedy except turpentine had been tried. He next injected chloroform in five-minim doses, thus relieving the pain almost immediately, but producing a feeling of numbness not yet gone. He had also in this case used iodide of potassium in twenty-grain doses thrice daily, on the ground that there might have been thickening of the nerve-sheath at the sciatic foramen. The use of acupuncture needles gave him most relief; but he believed the case was one where the sciatica would continue during the man's life. In the second case, a blister was applied over the tendo-Achillis. He had found it of most advantage when applied in this situation, as it was nearer the branches of the nerve than when applied over the gluteus maximus. In the third case, he had used the needles and iodide of potassium with considerable benefit. He wished to allude to the first case, where he had used turpentine. Perhaps, the want of success was due to the non-employment of castor oil along with it.—*Med. & Surg. Reporter.*

## **Treatment of Vaso-paralytic Cachectic Diarrhoea by Chlorate of Potash.—**

By C. BONFIGLI (Arch. Ital. per le Malasse Nerv. Milano, 1875).

By vaso-paralytic cachectic diarrhoea is meant the diarrhoea which cachectic patients suffering from nervous disorders are subject to. The motions are frequent and copious, serous in character, and the diarrhoea generally resists the ordinary methods of treatment by astringents, narcotics, &c. There is neither pain on pressure over the bowels, nor is the tongue coated, and after death the only change that is found is a reddening of the mucous membrane of the bowels. It is called vaso-paralytic because the affection is supposed to be due to paralysis of the vaso-motor nerves of the intestinal mucous membrane, due to defective nerve activity through disease of the neighbouring nerve centres, or due to a participation of the whole nervous system in the general cachexia. This diarrhoea has been frequently observed in animals whose cerebellum has been removed. It is also, according to Bonfigli, common in Italian lunatic asylums, and frequently ends in death; in most cases the best known remedies fail. According to Sasse, chlorate of potash causes contraction of the muscular wall of the blood vessels, and it occurred to Bonfigli that it would be useful in this form of diarrhoea. He tried it with the following results:

(1.) Chlorate of potash has, without doubt, a favourable action in vaso-paralytic diarrhoea, as improvement is often noticed from the first day of the employment of this remedy.

(2.) In order that the diarrhoea may be completely removed it is necessary that the remedy should be continued for several days, and given in increasing doses.

(3.) When the remedy is discontinued too soon after improvement, the bad symptoms return; but on re-employing the chlorate of potash, the case proceeds favourably.

(4.) In the more severe cases of this cachexia that are accompanied by great nervous depression, the chlorate of potash acts much more slowly, the frequency and quantity of the stools are diminished, but the diarrhoea does not completely dis-

appear, and easily becomes worse. In such cases, larger doses of the remedy must be given. It is supposed that here the vaso motor paralysis exists in a high degree, or that some organic change in the walls of the blood-vessels has taken place (as fatty or amyloid degeneration): or, again, that changes have taken place in the mucous membrane (as extravasation: ulceration, &c.) which need an energetic and long-continued employment of the chlorate of potash to bring about a return to the normal condition.

(5.) Chlorate of potash is of little or no use when the diarrhoea is caused by an active process in the mucous membrane of the intestinal canal, as enteritis catarrhalis, &c.

(6.) It follows, by analogy, that chlorate of potash is useful in the diarrhoea of old age, cholera, and the serous diarrhoea which is common in hot countries.

(7.) The dose of this remedy is 2-10 grm. in 24 hours (30-150 grs.), according to the severity of the case.—(Quoted in *Schmidt's Jahrbücher*, Bd. 173, No. 2, 1877.)

### **On Hydræmia and Hydræmic Œdema.**

—Professor JULIUS COHNHEIM and Herr LUDWIG LICHTHEIM have made (*Virchow's Archiv*, January, 1877) a very interesting series of experiments showing that they were unable to produce œdema of the subcutaneous connective tissue by any quantity of fluid injected into the vessels; the fluids varied from distilled water, salt and water, sugar solution, to blood-serum, albumen solution, and pure blood: they also thinned the blood of some animals without adding to its total quantity of fluid. In the last case the result was quite negative as far as œdema was concerned; in all the other cases the effect were to cause great transudation into the intestines and the cavity of the abdomen, to increase the urine greatly, which was clear and pale; to cause enormous secretion from all glands and from mucous surfaces, the glands and the mucous membranes becoming swollen; the flow from the thoracic duct was greatly increased, but the lymph vessels of the extremities showed scarcely any more than

their normal quantity; but that of the lymphatics of the neck was increased, though not so much as in the thoracic duct. The injection of fluid had only a temporary influence on the blood pressure in both veins and arteries, but caused a quickening of the circulation of longer duration.

They observed that although hydræmia *per se* appeared unable to produce œdema of the subcutaneous connective tissue, the dogs rendered artificially hydræmic were especially prone to œdema from slight causes, such as painting with iodine, or exposure of their shaved skin to the sun's rays; ligature of the femoral vein scarcely ever caused œdema of the foot in healthy dogs, but under these pathological conditions it very frequently ensued.

They infer from this that changes in the vessels are necessary coexisting factors with hydræmia in the production of dropsy of the subcutaneous connective tissue; and they instance scarlatinal dropsy, in which an alteration in the vessels of the skin coincides with a hydræmia produced by the kidney affection, while in some cases the œdema occurs without any kidney-mischief, scarlatinal dropsy albuminuria. They believe that the œdema occurring in phthisis, carcinoma, and other cachectic diseases, supervenes when the walls of the vessels have undergone changes corresponding to the general atrophy of the tissues from the malnutrition of the individual.—*Lond. Med. Record.*

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**Subcutaneous Injection of Ether in collapse.**—The following cases, in which hypodermic injection of ether was employed, occurred in practice of M. VERNEUIL at La Pitié. A young boy, on whom M. Verneuil had operated for naso-pharyngeal polypus, the operation being a long and difficult one, suffered a considerable loss of blood. The child, enfeebled by successive hemorrhages, fell into a state of severe collapse, his temperature being below 95 deg. His state was so critical that M. Verneuil was asked by his pupils to perform transfusion. Not being a great upholder of this operation, however, he determined to try hypodermic injections of ether, fifteen drops at a time. Several injections having been made

in the course of the day, the temperature was seen to rise rapidly; and the following days, the same treatment being continued, the temperature promptly returned to the normal. The patient recovered. Another case was one of strangulated hernia. The temperature had fallen to about 95 deg. and, in order that the operation might not be performed under such unfavourable conditions, M. Verneuil advised subcutaneous injections of ether in a similar manner. Under its influence, the temperature the same day rose to 97 deg., and made the operation possible.

With regard to the method of using ether, and the dose, M. Verneuil advises the surgeon to go about it with the thermometer in one hand and the syringe in the other. He might commence, for instance, with fifteen drops, and repeat it in an hour, taking care to ascertain the temperature. If this be not sufficient, the injection may be made as many times as is necessary, the ether being apparently well borne.—*Monthly Abstract*, June 15, 1877.

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### **Erythema Exudativum Papulatinum.**

A student at 24 was affected with a papular exanthem, which at first resembled the initial (the eruption of small-pox in its initial stage) and afterwards presented the appearance of syphilis maculosa. The eruption has recurred every two months for the last two years; it was present on the face, neck, back, exterior surfaces of the extremities and soles of the feet—in the latter situation it was painful on pressure. The eruption was also very abundant on the prepuce and glans penis. The last attack came on after a severe attack of inflammation of the mucous membrane of the throat, which was believed to be of an erysipelatous character. This circumstance, together with the fact that the patient possessed a highly sensitive skin, would seem to confirm Lewin's theory that erythema exudativum is a vaso-motor neurosis.

Three other cases are recorded as having occurred in young persons whose family history showed a strong tendency to tuber-



culosis, and may be cited in support of Uffelmann's statement that the form of erythema nodosum, which is apt to be followed by tuberculosis, is met with generally in such persons. The eruption was identical with that of erythema nodosum, and faded gradually without other change of color and without exfoliation. The subjective symptoms were very slight, but there was well-marked fever and great depression of the vital powers and pallor of the countenance. The disease occurs in delicate and anæmic young people with soft, fine skins, and is most common in the female sex. It always tends to recovery, but is usually followed by tuberculosis.

Of the three cases described, the first was a girl five years of age. The attack commenced with fever; in 24 hours' time the eruption made its appearance; about the fourth day the fever began to subside, and had wholly disappeared by the end of the ninth day; convalescence lasted two months. The second case was a peasant woman at 20. The third a boy nine years old. In both of these there was prodromal fever, and fever during the first few days of the eruption; convalescence was tedious. In no instance was there any enlargement of the spleen or affection of the organs of the thorax. The real nature of the disease must remain for the present a matter of doubt, there being no anatomical proof of Bohn's theory that it has to do with embolism, though some of the symptoms (repeated attacks of chilliness) seem to favour that view.—*Centralblatt für d. Med. Wissenschaft*, 27 Jan., 1877.

### **Retention of Urine in Old Men.**—

The generally accepted belief that enlargement of the middle lobe of the prostate prevents the voidance of urine by acting as a valve, has been challenged by W. Burch, who seeks to explain the difficulty on purely hydrostatic principles, basing his statements upon the examination of a number of frozen preparations. During childhood the sphincter vesicæ is situated quite close to the point where the force which opens the inner orifice of the urethra takes effect; for this reason very little of the propulsive power is lost, and the urine can be discharged with considerable force.

At puberty the sphincter is situated relatively lower down, and the urethral orifice must be opened more widely before the urine can escape; a part of the propulsive power is thus lost, and the stream is somewhat less forcible. When enlargement of the prostate takes place the internal orifice is found to be situated in the centre of an elevation, at the base of which, especially posteriorly, there are, more or less, deep depressions or sacculi formed. Under these circumstances, when the bladder contracts the pressure is brought to bear not only on the inner orifice but also on the sides of the prominence which surrounds it, thus aiding the sphincter muscle in its resistance. If this lateral pressure predominates, the use of a catheter becomes indispensable.

The same thing may happen without any enlargement of the prostate, if the walls of the bladder yield posteriorly; as soon as symptoms indicative of such a condition appear, the catheter should be used frequently in order to prevent the fossa or depression from increasing.—*W. Busch Arch. fur Klin. Chirurg.* XX., S. 416.

### **Salicylate of Soda as an Antipyretic.**—

M. Jaccoud speaks favourably of salicylate of soda as an antipyretic in typhoid fever. This substance contains 83 per cent. of salicylic acid, and is soluble in water. A few drops of chloroform combined with it will effectually do away with the nausea and vomiting which in some patients it is likely to produce. To produce good effects large doses must be given (as large as eight grammes— $\bar{3}$ ii.) in mucilage, taken in two portions, at an interval of a quarter of an hour, between seven and eight o'clock in the evening. The fall of temperature commences half an hour after the exhibition of the remedy, varying from one degree to a degree and a half (centigrade); it can fall as low as two degrees and a half in five hours. The temperature can be kept down by a repetition of small doses. Salicylate of soda causes considerable changes in the urine: from the first dose its quantity is diminished, it becomes dense and loaded with uric acid and urates—in other words, the solids are materially increased.

Thus, in favouring the elimination of nitrogenous material retained in the system by febrile combustion, it resembles benzoic acid. To avoid this excessive density of the urine and the danger of catarrhal nephritis, the patient should drink two or three pints of fluid in the 24 hours after its administration. Salicylate of soda is slowly eliminated. Traces can be found in the urine 48 hours after its administration. Its presence in the urine can be demonstrated in the following manner:—Dilute the urine with water, then add a few drops of a solution of the perchloride of iron. A precipitate forms, which, seen by transmitted light, is of a deep-black colour. Normal urine gives a whitish precipitate with the same re-agent.

The employment of salicylate of soda is contraindicated in cases of cardiac debility, since it lessens the force and frequency of the pulse.—*Le Mouvement Medical*, March 24. 1877.

**Cold Baths in the Feverish Diseases of Children.**—Dr. Mayer, at the close of a former article, remarked that he did not only employ cold baths for children of seven or eight months of age suffering from typhus and typhoid accompanied by pneumonia, but also for children of two or three months suffering from disordered digestion with high temperature. He used cold baths of a temperature of  $83\frac{3}{4}^{\circ}$  Fh. with success. The baths were commenced at a temperature of  $92\frac{3}{4}^{\circ}$  Fh., which was reduced to  $86^{\circ}$  and  $79\frac{1}{2}$  Fh. Mayer treated a case of erysipelas migrans in a child *three weeks* old by cold baths alone. The baths used were of a temperature of  $90\frac{1}{4}^{\circ}$ — $92\frac{3}{4}^{\circ}$ ; how often, he does not say. In ten days the temperature was normal, and the child had completely recovered. Dr. Mayer especially recommends this form of treatment in the diarrhoea and vomiting of children with high fever. In spite of warm drinks, &c., the hands and feet become cold, and collapse rapidly ensues. Here he gives baths of a temperature of  $92\frac{3}{4}^{\circ}$  Fh., cooled to  $86^{\circ}$  Fh., every three hours, and as often as the temperature reaches  $103^{\circ}$  Fh. In addition, he gives every hour a teaspoonful of Tokay wine.—(Quoted in *Schmidt's Jahrbücher*, Bd. 173, No. 2, 1877.)

CANADA

# Medical and Surgical Journal.

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MONTREAL, JULY. 1877.

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## COLLEGE OF PHYSICIANS & SURGEONS, P. Q.

The triennial meeting of the College of Physicians and Surgeons of the Province of Quebec will be held in the town of Three Rivers, on Wednesday the 11th July, instant, for the purpose of electing a Board of Governors for the ensuing three years. We hope to see a full meeting, and that all the various districts and cities will be well represented. It must be borne in mind that no member of the profession is eligible for election to the Governing Board unless, nor until, he shall have been four years a member of the College. There is no getting over this clause in the act: "The said Board of Governors of the College of Physicians and Surgeons shall have the power—To fix the period of probation which persons must undergo before being eligible for election as Governors of the College, which period shall not be less than four years,"—or, in other words, the Board of Governors have the power of fixing the period, but it must not be less than four years. It has been stated that persons becoming members, who have been licentiates for four years are eligible for election, this is neither in the spirit nor the wording of the act. The College of Physicians and Surgeons of Lower Canada was not a close corporation, all Licentiates of

good character, and of four years' standing, were eligible for election as members of the College on the payment of \$10. In lieu of the \$10 it was deemed advisable to admit all members of the profession by legislative enactment, but as a saving clause in order that the affairs of the College should be properly administered, it was enacted that no member should be eligible for election as a Governor of the new College until after a probationary period of four years. This is in verity the reading of the act, and no other construction can, in our opinion, be put upon it. All the members of the Profession are constituted by the act members of the College, but they do not become members of the College until they have registered under the new act, and have paid their annual contribution. All the old members of the College which was, are required to pay up their back dues, that is their annual contributions for the years that have passed since the last triennial election. This has been done in every instance, and those old members, moreover have paid the registration fee. It would be manifestly unjust to admit all members who have been made so by the act as eligible for election as Governors until they had fulfilled the probationary period constituted under the act.

This we take to be the equitable reading of the act, the members of the old college surrendered vested rights, but in so doing received what they considered an equivalent. If the former state of things is to be entirely obliterated, and that we are all to be placed on the same footing, then indeed must the moneys paid in to the treasury by the old members be refunded and all contributions which have been in equity paid be returned. The cities of Quebec and Montreal are each entitled to eight members on the Governing Board, but the four colleges have the privilege of nominating two delegates from each of their faculties. There are three schools in the City of Montreal, and it therefore follows that two members only can be selected from the profession of our city outside of the schools. In the case of the city of Quebec, six members will have to be elected from the profession, the Laval University having the right to send two delegates from its Medical Faculty.

## REGULAR MEDICINE AND HOMŒOPATHY.

Dr. Richardson publishes in the *Lancet* a letter from Dr. Geo. Wyld, one of the most prominent of the practitioners calling themselves Homœopathists, in London. It insists that it has become the almost universal custom amongst them to treat disease by contraries as well as by similars—that the auxiliaries of direct treatment are also constantly availed of by them—and finally that in the matter of dosage, the infinitesimal proceeding is practically abandoned. On the strength of these representations it requests Dr. R. to bring the matter before influential members of the profession with a view to the possible union of the Homœopathic Schism with the great body of the Profession. Dr. R. considers that these important admissions should command “a candid and just appreciation.” One could almost fancy that if all called Homœopathists would accept the views of Dr. Wyld, a basis of admission for them might be formed, but we fear that he is a very exceptional man in the schism as regards candour and straightforwardness, and that the majority are much too ready to stand by what he (justly) calls “the often extravagant and incorrect” statements of Hahnemann. We happen to have the personal acquaintance of Dr. Wyld, and can fully endorse Dr. Richardson’s opinion of him as “a gentleman of extended knowledge, good taste and truthful nature.” It must be that his now acknowledged views will carry weight with his brethren, and it will be interesting to see how they will take his overtures to the general profession.

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PERSONAL.

Dr. Edouard Robillard of this city has returned home after an absence of several months which he spent in Europe visiting the various hospitals of London, Paris, Vienna and Berlin. We understand that Dr. Robillard devoted much of his time while abroad to the study of diseases peculiar to women. In a recent number of the *Frans Medical* we observed that Dr. Robillard was elected a Corresponding Member of the Clinical Society of Paris.

## MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

MAY 26TH, 1877.

The President, Dr. G. E. Fenwick, occupied the chair. There being a great deal of general business before the meeting, no paper was read.

Dr. Osler exhibited the following interesting pathological specimens: A blood-cast of a ureter which had been passed by the urethra, causing great horror to the man from its resemblance to a worm. It was nine inches in length, dark-reddish-brown in colour, and wrinkled. The passage of it had been preceded by symptoms of renal colic. A specimen of extensive diphtheritic disease of the larynx, from a patient who had died in the Montreal General Hospital under the care of Dr. Ross.

Dr. Ross gave an account of this case, in which there were some interesting circumstances. The patient was an adult, upon whom, a few weeks before, an operation for excision of part of the tarsus had been performed. He was very much run down, and hectic. He lay in a bed opposite to that of a man with a fistula in ano, which had been operated upon at his own house. There was diphtheria in this man's family, for which reason and on account of an unhealthy condition of the wound, supposed to be diphtheritic, he came to hospital. There was a grey slough in the bottom of the wound, which disappeared entirely in two days under an application of a lotion of chloral hydrate. Dr. Ross does not think that this wound was diphtheritic, and looks upon the diphtheria of the other case as a coincidence and not a case of direct contagion. If the wound was diphtheritic, and this was a case of direct contagion, he thinks that diphtheria must be much more contagious than it is generally supposed.

Specimens of coarse and miliary aneurisms of the vessels of the brain, from a patient who had had an apoplectic attack four years ago, and since which time had been epileptic. Latterly, symptoms of softening of the brain had developed. An apoplectic cyst was found external to the left corpus striatum, and

on the small arterioles on its wall and in the neighbouring corpus striatum numerous small miliary aneurisms were found. Two large ones, the size of peas, existed on the vessels of the circle of Willis.

Two specimens of prostatic disease. One, exhibited for Dr. Malloch, of Hamilton, in which the third lobe of the prostate projected from behind the orifice of the urethra, almost completely closing it. The ureters and pelvis of the kidneys were considerably dilated. The other was from a case of stone in the bladder, of Dr. Fenwick's, and presented a number of out-growths from the prostate surrounding and narrowing the urethral orifice. One of them, springing from the left side, was pedunculated, and fitted like a ball-valve into the orifice of the urethra.

A kidney from the same subject as the larynx came, which consisted of a mass of cysts full of caseous pus, evidently tubercular in character.

Dr. Trenholme narrated a case which occurred in his practice. One year ago he had removed the left eyeball for what he thought was malignant disease. Lately the patient returned to him with a growth on the top of the head, situated on the parietal bone of the side on which the diseased eye had been, one inch from the coronal suture. It had no appearance of being malignant. It was painless, and not adherent to the integument. In attempting to enucleate it with a director, he found that the growth was protruding through the bone. He closed the wound and left it. He thought that what appeared to be the cyst was the dura mater. The growth in the eyeball was dark in color.

Dr. Osler spoke of a case, of which this reminded him, reported in Knapp's work on Intraocular Growths. It was a glioma of the eyeball, which was removed and recurred along the dura mater.

J. D. CLINE, B.A., M.D.,

*Secretary.*



## Medical Items and News.

The most recent treatment of diphtheria is one recommended by a writer in the "Deutsch Archiv. f. Klin. Medicin," who advises the application of a galvano-caustic to the patches on the pharynx.

A case of poisoning with salicylate of soda is recorded in the same journal. A patient with phthisis and pleurisy, took by mistake 230. grs. The symptoms were at first loss of consciousness with occasional delirium, vomiting and dyspnoea, the respiration being unusually loud. After twelve hours consciousness returned, and thirst and difficulty of hearing were complained of. He recovered in two days, and the large dose appeared to have a very beneficial effect upon the pleuritic effusion.

Abortive treatment of whooping cough with amyl nitrite is strongly recommended by Dr. Sawarowsky. (St. Petersburg Med. Wochenschr.) A few drops of the amyl nitrite with a drachm of chloroform are placed in a bottle, and inhaled several times a day directly from it. For three days 1-12 gr. of argent. cyanat is given every two hours.

Trendelenburg of Berlin, in a case of hydrocele which had been treated in vain with Iodine injections and compression, made a small incision and put in a drainage tube, by which a complete cure was effected, the surfaces of the sac uniting together. He advises a small incision, and a short drainage tube, through which carbolic acid may be injected if necessary. An antiseptic bandage is also applied.

The method of treating tape-worm by Prof. Mosler of Griefswald is as follows: The day before the cure a dose of castor oil is given and injections in order to thoroughly clear the bowels, and the diet is restricted to salt food, broths, &c. The next morning the following pills are given within two hours: Extract granati spirit. grs. 40. m. f. pill nr. 30. An hour after taking the last 10 pills the patient get a dose of castor oil, and then every hour or two an injection of a couple of pints of warm water until the worm is expelled. It is stated to be a most successful method.

The medical grist mills of the United States have turned out this year 1,442 doctors; of these 198 are from Jefferson Medical College, 157 from the University of New York, and 145 from Bellevue Hospital Medical College.

The personal estate of the late Sir William Fergusson was sworn under £30,000.

### Personal.

C. N. Stevenson, M.D., C.M., ('76.) has commenced practice in L'Orignal.

A. F. Ritchie, B.A., M.D., ('75) has obtained (by exam.) one of the Resident Physicianships at the Brompton Hospital for Consumption.

Alex. Monro, M.L., L.R.C.P., L. ('76), R. Macdonnell, M.D., M.R.C.S., ('76), and G. E. Armstrong, M.D., ('77) have commenced practice in Montreal.

The following gentlemen of the class of '77 have proceeded to the Edinburgh and London Schools to pursue their studies. T. S. T. Smellie, M.A., C. L. Cotton, Alex. C. Fraser, Henry C. Greaves, William K. Law. Messrs. Brodie and Miner intend going over in time for the winter session.

Casey A. Wood, C.M., M.D., ('77, Bishops), has been appointed to the chair of chemistry in the University of Bishop's College.

Thos. G. Hockridge, M.D., C.M., ('74) has passed the examination for the License of the Apothecaries' Society. London.

Dr. G. W. Major has gone to Europe, where he intends to make a prolonged visit.

Ch. Murray, M.D., ('76), has passed the Primary Examinations of the Royal College of Surgeons.

Duncan Fraser, M.B., Toronto, has obtained the diploma of the same corporation.