

CANADA MEDICAL JOURNAL

AND

MONTHLY RECORD

OF

MEDICAL AND SURGICAL SCIENCE.

EDITED BY

E. L. MACDONNELL, M. D.,
Surgeon to St. Patrick's Hospital,
and Lecturer on Surgery, St. Lawrence
School of Medicine, Montreal, &c., &c.

} AND {

A. H. DAVID, M. D.,
Physician to St. Patrick's Hospital,
and Lecturer on Practice of Physic,
St. Lawrence School of Medicine,
Montreal, &c., &c.

MONTREAL :

PRINTED FOR THE PROPRIETORS, BY JOHN LOVELL,
AT HIS STEAM-PRINTING ESTABLISHMENT, ST. NICHOLAS STREET.

1852.

B. DAWSON, No. 2 Place d'Armes, Agent.

Price Three Dollars per Annum—In Advance.

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CANADA

MEDICAL JOURNAL.

VOL. I.

MONTREAL: JULY, 1852.

No. 5.

ORIGINAL COMMUNICATIONS.

ART. XXIV.—*Case of Cerebral Disease accompanied by Anomalous and Fatal Symptoms.* By JAMES SEWELL, M. D., Physician to the Hotel Dieu, Quebec, &c.

THE following case presents many points of pathological interest, and I confess myself much puzzled to explain the symptoms, and therefore send it to the profession without comment.

CASE—A. B., aged 50, of sober habits, complained on Monday, February 3rd, of much pain of head, which she referred principally to the occipital region, and upper and back part of neck. She, however, continued to attend all this day to her household affairs, slept but little that night, and on the morning of the 4th, complaining still of headache, did not rise at her usual hour, but did so at 10 A. M., with the intention of fulfilling her ordinary duties. In about an hour she felt worse, complained of nausea, vomited slightly, and almost immediately became insensible, when the nearest physician (D. J. P. Russell,) was called in, who found her in the following state: insensibility complete, pulse full and slow, beating 45 in the minute; respiration corresponding with the circulation, noisy but not stertorous. Pupils dilated and insensible to light, bowels not moved since previous day, but had passed water freely in the morning. Dr. R. ordered three drops of croton oil, enveloped the head in pounded ice, and returned home for his cupping case. He was absent but for a few minutes, and on coming back, found her much in the same state, but while preparing his instruments, to his surprise, she suddenly became aroused up and remonstrated violently and positively against being cupped, and then requested to see me. This occurred at half-past twelve, and I saw her in consultation with Dr. R. at half-past

one, when I found her with a pulse 80, *very weak and compressible, insensibility perfect*, pupils dilated, capillary circulation very languid, no stertor, but respiration performed with a constant moan; feet and hands cold, bowels not yet acted upon. Croton oil to be repeated, to have the head shaved, sinapism to the legs, and to apply hot bottles to the spine and feet. My impression at this first view of the case was most unfavourable. At half-past three we met again, and found things going from bad to worse. Pulse just perceptible, hands and feet deathly cold and covered with a cold clammy sweat, respiration twelve in the minute, with mucous r le, coma complete, eye fixed, apparently dying, and so we informed the friends, promising that extraordinary recoveries did sometimes take place, but that we could hold out no hope. Being urged by her husband to leave nothing untried which might tend to her recovery, we determined (more with a view to gratify him, than with any well defined hopes of deriving benefit from the remedy) to administer an enema containing about one oz. of turpentine, which was done immediately, and we then sat down to wait the fatal event which we looked for momentarily, the hand being at this time not only icy cold but nearly black, while *no pulse* at the wrist could be felt. The enema was retained, and on examining the wrist in about half an hour, I perceived not only that the skin was not so death-like, but that I could also feel an indistinct thread-like pulsation of the artery; in fact there was an attempt at reaction, excited, no doubt, by the turpentine.

5 P. M. There being at this time a still further improvement both in the skin and pulse, we determined to repeat the enema, deglutition being impossible.

8 P. M. Upon entering the room at this hour, my surprise may be imagined, but cannot be described, at seeing my patient extend her hand to me and to hear her exclaim, "Ah, Dr., I am glad to see you!" Her consciousness is perfect, has no pain in her head, pulse still weak, but quite distinct and regular; breathing natural, bowels moved twice, remembers nothing but her refusal to be cupped. To have some gruel, and to be kept very quiet.

February 5.—Convalescing—to have beef tea; makes no complaint.

February 6.—Much in the same state as yesterday.

February 7.—9 P. M. Complains of nothing but a slight cough, which annoys her.

February 7.—11 P. M. Was called at this hour, and found that an hour previous she had begun to complain of severe headache, which gradually increased. Having requested Dr. Russell's attendance we found her partially insensible, though she could be roused to answer questions; pupils somewhat dilated, pulse very weak. To have pounded

ice to the head and sinapisms to the feet and nape of the neck, with bottles of warm water to spine and epigastrium. To take half an ounce of camphor mixture with thirty drops of nitrous æther every half hour. I remained with her for about an hour and then left, directions to be sent for at any time during the night, should there be any change for the worse, which I suspected would occur. I was accordingly again summoned about 3 A. M., of the 8th, when I found her perfectly insensible, respiration very laboured, bronchial tubes loaded with a thick frothy mucus, which escaped in large quantities from the nose and mouth; pulse almost imperceptible, pupils dilated and insensible to light, skin *warm and moist*. Bearing in mind the effect of the turpentine in the former attack, four ounces of this oil were at once administered as an enema, and a smaller quantity in about an hour, without, however, producing the slightest reaction; deglutition being impossible, three ounces of brandy were thrown up the rectum, and she shortly after, in answer to a question, said faintly "yes," left her in this state at half-past 6 and returned again at half-past 8 A. M.; at this hour I found *reaction quite established, consciousness perfect*; free from pain of head or elsewhere, but complains of a sinking sensation at the scrobiculus cordis, cough very troublesome, can only lie on the left side, experiences a suffocating sensation when on the right, cooing or dove sound in a slight degree on the right side, to have some gruel or a little chicken broth, and to take decoct: senega with carb: ammon: a blister over the chest.

Continued much in the same state during the 9th, 10th and 11th, with the exception that the debility was gradually increasing, as was also the difficulty in the chest, rendering death almost inevitable. During all these three days the intellect remained perfectly clear, and continued so up to 8 o'clock P. M., of the 12th, when she died without a struggle.

Post-mortem examination, 18 hours after death.

Body corpulent and well formed; on opening the chest, old and firm adhesions were discovered on the left side, substance of both lungs considerably engorged. Bronchial tubes red and congested, heart and its valves quite healthy, about 1 ounce of serum in pericardium. Free margin of the liver somewhat harder than usual, otherwise healthy; stomach and bowels perfectly normal, as were also the kidneys.

Some blood flowed out upon dividing the scalp, but nothing extraordinary; external surface of dura mater rather more injected than usual. Arachnoid and Pia Mater membranes perfectly healthy, no fluid at the base. The choroid plexus presented a vesicular appearance, as if œdematous; upon puncturing these small vesicles they collapsed, a small

quantity of serum escaped ; substance of brain perfectly healthy. Great commissure somewhat injected, about 1 oz. of coloured serum was found in each lateral ventricle ; medulla oblongata, and about two inches of the upper portion of the spinal cord, which were removed, were found healthy.

As the *post-mortem* examination had already occupied a considerable time, the spinal column was not further examined.

Quebec, 18th June, 1852.

ART. XXV.—*On Inversion of the Uterus.* By A. VON IFFLAND, M. D., M. R. C. S. L.

THE advantages accruing to the practitioner, or to the student, from bringing before him, in a contracted view, the widely scattered facts belonging to an extensive and advancing science, and which chance, or the labours of individuals, has brought to light, have so often manifested themselves to me, that I cannot but seriously reproach the pertinacity with which several members of the profession—distinguished not only by the extent of their practice, but sometimes also by their learning—withhold from publication those stores of valuable and interesting information, which must unavoidably have been acquired in the course of years of practical observation ; for, as has been justly observed, whatever advances have been really made in the knowledge and cure of diseases, have been more the results of observation and experiment (and not unfrequently indeed, of chance itself), than of any process of reasoning on previous or abstract principles. Of the many extraordinary accidents which may fall under the observation and treatment of the practitioner in obstetrics, none, I am persuaded, will be found of so rare a nature as the very distressing and dangerous one of *inversion of the womb*—so rare indeed, that many may pass a long life in the most active and extensive practice, without, perhaps, having had an opportunity of personally witnessing so alarming a case. The following having occurred some months since in the course of my private practice, may be deemed worthy of record in this highly interesting periodical.

On the 23rd of November last, about 9 A. M., I was called to attend a lady from Montreal, aged about 22, then on a visit to her father, a very respectable inhabitant of Beauport. She had miscalculated, by a fortnight at least, the time of her confinement, for I found her in precisely the state which unfailingly characterises the first stage. It was her first pregnancy. She had, it appears, during the three last months, suffered much from lancinating pains in the back and below the umbilicus,

they were not so severe as to confine her to bed. The labour progressed regularly, although slowly, and at about 8 o'clock in the evening, she gave birth to a large, full-grown child, the placenta following shortly after. Nothing very unusual supervened from that time until the 25th, two days after, about noon, when I was hastily sent for. I found the unfortunate patient lying on her back, deadly pale; the pulse quick, weak; the voice tremulous and almost extinct, and the patient in a state threatening a speedy dissolution.

On removing the clothes, I found her literally floating in blood, with the *uterus* of globular form, with a red, rough, and bleeding surface, completely protruding from the *vagina*; the *os uteri* at its superior extremity, forming a circular thickening at the apex. It was evidently that organ turned inside out. At first sight, says Churchill, it may resemble *prolapse of the womb*, but considering the period of its occurrence—the hæmorrhage—the absence of the smooth vaginal covering of the bladder anteriorly, and of the *os uteri* inferiorly, it is very easily distinguished. It would appear, that, immediately preceding the descent and protrusion of the inverted uterus through the *vagina*, the patient had been sitting on her *pot de chambre*, with the desire of voiding urine; that while on the *pot* she experienced a very violent pain, (uterine contraction), and a dragging sensation from the loins, leading her to expect a second child. The bystanders, the nurse, and other women in attendance, under the impression that she was in labour of another child, removed her to her bed. After visual examination, however, they persuaded themselves that the large tumour protruding, was neither a child nor a monster, but truly a very large *mole*, and after a short consultation they lost no time in attempting to rid the poor patient of the extraneous incumbrance by pulling at the tumour. It is, therefore, not surprising, that, on my arrival, independent of the case itself, I should have found the sufferer in so exhausted and precarious a state.

I lost not a moment in effecting the re-inversion of the uterus by the means recommended by the most experienced writers, but, finding the upper portion of the organ—where it is tightly encircled by the cervix—so strangulated, that, at first, I was apprehensive the reduction would be impeded, and that I should be under the necessity of dividing, with a bistoury, the circular band of the fibres of the *cervix uteri*. It was, however, after fomenting the part for a short time, safely passed through the *vagina*, and having followed it thither with my hand, (previously well greased with melted hog's lard), closed and formed into a cone, and mainly pressing upon the fundus for some time, it receded, and suddenly started from the hand, (likened, by a late author, to a bottle of India-rubber when turned inside out) and the organ was restored to its natural position. It may nevertheless be observed, that until the *vagina* can be

put upon the stretch, no effect whatever will be produced upon the inversion; indeed, it is expressly stated by those practically cognizant with similar cases, that they did not feel the reduction properly commence until the vagina was stretched to its full extent; and, as it is also very judiciously remarked by Dr. Churchill, the hand, while in the cavity of the uterus, should not be withdrawn, but rather expelled by the uterine contraction—this will ensure the patient against the repetition of the accident. We should also assure ourselves, before the removal of the hand, that the restoration has been complete.

It may be remarked, that although the bladder had been emptied (a precaution of the highest importance), I was particularly anxious to prevent any inconvenience, which, from its probable incapacity to void the urine, might follow without the aid of catheterism; but being at the time called to another urgent case, which required all my attendance, I sent, with that view, an intelligent woman of much experience, and for many years in the habit of drawing off the water of female patients, by means of the simple, and easily-introduced, elastic gum catheter. This very reasonable transfer of duty, however, gave offence, and the attendance of another medical gentleman, of long standing and reputation, soon followed, and she perfectly recovered. Having since been consulted by the mother of the patient, I learned that she had not quite recovered her natural strength, but believes that she is again pregnant.

REMARKS.—The above case of *inversion* appears to be one of those which may occur spontaneously, after the labour has been completed in the natural way, and may, as Dr. Radford observes, be attributed to atony of the uterus, or to active contraction of one part, with an atonic condition of another. In the above case no violence or force whatever was employed in the delivery of the placenta; it followed the child at the interval of about four minutes. I have no doubt, however, that violence in extracting the placenta, may produce either of the degrees into which some authors have divided inversions of the womb, viz:—*depression*, *partial*, and *complete* inversion.

The uterus, during pregnancy, is chiefly enlarged towards the *fundus*, so that the broad ligaments are left much below its principal bulk; consequently, from pulling violently at the cord to deliver the *placenta*, the *fundus* may be drawn down through the *os uteri*.*

* Dr. Hamilton says: "of five instances, where this happened from the ignorance of the practitioner in hurrying the extraction of the *placenta*, one lady only survived the dreadful accident. Her recovery is the most extraordinary, as the womb could not be restored to its natural state, and though replaced within the *vagina*, it still continues *inverted*."

The eminent and experienced Denman observes:—There is reason to believe that the uterus has been inverted, when, on account of hæmorrhage, or some other urgent symptom, the hand has been introduced within the cavity of the uterus, while in a collapsed or wholly uncontracted state, and the placenta being withdrawn before it was perfectly loosened, the fundus of the uterus has unexpectedly followed, and a complete inversion has been occasioned. Forcibly pulling the funis, for the purpose of detaching the placenta, may, perhaps, under certain circumstances, give rise to the accident, but it is not a frequent cause.

But inversion, says Churchill, may occur quite unconnected with parturition, contrary to the assertion of Astruc, and some of the older writers.

If a tumour form at the upper part of the fundus uteri, it will first distend the uterus mechanically, and then, by its weight; it may descend through the os uteri, dragging the fundus after it, and so produce complete inversion. Such a case the Doctor mentions having himself seen in Jervis Street Hospital, under the care of Mr. Lynch. Another case, of a similar character, is also published by Dr. Browne, in the Dublin Medical Journal.

Adverting to the three degrees in which the inversion may vary, I would recommend a reference to a valuable monograph on this subject, by Dr. Newnham,* (published in London, 1 vol. 8vo; but very scarce). He divides the inversion into—*depression*, *partial* and *complete*. In the first, the fundus of the uterus is depressed within its cavity, but does not form a tumour in the vagina. This stage can only be known by introducing the finger into the uterus; and by ascertaining the state of that organ by pressure upon the abdomen. By the *former process*, the fundus of the womb will be found to have approached the os internum, and by the latter, a corresponding depression will be observed, instead of that regular contraction, which is so familiar to every prudent practitioner. This state is generally accompanied with an effort to bear down, by which it is often converted into *partial* or *even complete* inversion. When the inversion is *partial*, the fundus of the uterus is brought down into the vagina, forming a tumour of considerable size, presenting a semi-spherical form, and closely invested by the os uteri. In this case, the depression of the fundus, observed through the parietes of the abdomen, will be considerably greater than in the former, and the edge of the cavity thus formed will alone be felt. With regard to the last degree, the *complete* inversion, it is fully explained in the case above related, but I shall give it in his own words:—

“ In the *complete* inversion, the uterus will be found not only filling

* The author of the *Reciprocal Influence of Body and Mind* considered.

the vagina, but protruding beyond it, resembling in its form that of the uterus after recent delivery, only that its mouth is turned towards the abdomen. The os uteri may be felt at the superior extremity of the tumour, forming a circular thickening at its apex, and the uterus is wholly wanting in the hypogastric region. This state is usually accompanied with inversion of the vagina."

It sometimes happens that the *placenta* remains attached to the uterus at the time of inversion, and a question of great practical importance has arisen, as to the propriety of removing it before attempting the reduction. Several French and other continental writers, who have devoted their whole professional life to the practice of midwifery, recommend its removal before reduction; but others, also of great eminence and experience in that branch, and principally practitioners in England, Ireland, and Scotland, are decidedly opposed to it. Newnham observes: "it has been recommended by several respectable authorities, to remove first the placenta, in order to diminish the bulk of the inverted fundus, and thus facilitate the reduction. But it is surely impossible that this proceeding can be attended with any beneficial consequences, whilst the irritation of the uterus would necessarily tend to bring on those bearing down efforts, which would present a material obstacle to its reduction, and would increase the hæmorrhage at a period when every ounce of blood is of infinite importance. Besides, returning the placenta while it remains attached to the uterus, and its subsequent *judicious* treatment as a simply retained placenta, will have a good effect in bringing on that regular and natural uterine contraction, which is the hope of the practitioner and the safety of the patient."

Dr. Churchill, however, remarks:—"It may be doubted, I think, whether the removal of the placenta is attended with so much danger; for, in many instances, it has been found impossible to reduce the uterus in consequence of the great addition to its bulk, which the adhesion of the placenta occasions, and in such cases there is no hesitation about the propriety of removing the placenta, nor have I met with any evil effects recorded as the result of so doing."

Another very important question may arise, whether, when the inversion is found to be *irreducible*, we should be satisfied with returning the tumour into the vagina to protect it from injury, and of maintaining it there by means of bandage and compress, or by pressary, as recommended by Dr. Hamilton in *prolapsus uteri*, or by extirpation; cases are not wanting in which the uterus has sloughed off, or has been removed, without being followed by loss of life.* It is, moreover, recorded

* On reference to my medical note book, I find the following extract of a letter from a medical friend, dated as far back as 15th June, 1831:—"On the 8th instant,

that the operation has been successfully performed by several eminent practitioners, both of France and Germany, as well as of Great Britain and Ireland, and the United States. And provided the health of the patient is not too much impaired, or the uterus affected with scirrhus or cancer, the operation would appear to be, if not in my humble opinion, perfectly justifiable, at least, no more compromising the patient's life, than in those numerous cases which necessitate the surgeon's agency.

Some women have been known to live many years under the affection of an inverted uterus, and without experiencing any great pain or suffering in their general health. It is also asserted by the most credible authorities, that in some cases the uterus has returned spontaneously, after the lapse of considerable time, to its natural condition, and the individuals have conceived and borne children. Several very interesting cases, of a similar nature, are related by Dr. Meigs, for many years professor of midwifery, &c., in the Jefferson Medical College of Philadelphia, and whose name carries great weight throughout the great confederation.

Beauport, near Quebec,
7th June, 1852.

A Clinical Lecture on the Diagnosis of Cardiac Disease. By R. P. HOWARD, M.D., L. R. C. S. E., Physician to the Montreal General Hospital and Montreal Dispensary,—Lecturer on Chemistry and Medical Jurisprudence, St. Lawrence School of Medicine, Montreal, &c., &c.

GENTLEMEN,—You have lately had an opportunity of observing some of the difficulties that are frequently encountered at the bedside, in ascertaining the exact pathological conditions existing in affections of the heart, and, at the same time, of witnessing how many of these difficulties may be overcome, and how large an amount of positive and accurate information may be obtained by the application of our present knowledge of Cardiac diagnosis, when assisted and corrected by successive examinations.

I will first read to you the notes of the case, suggestive of the preceding remarks, and explain the manner in which the successive steps of the diagnosis were made, and the indications for treatment, and then,

(June) Dr. Painchaud introduced, for the inspection of the members of the *Quebec Medical Society*, (Quebec, renowned for its antiquity, possessed in those days such a society, but where is it now?) a woman of the name of —, from whom he had extirpated one half of the uterus. She appeared to the members in a perfect state of health, and says she continues to menstruate as usual.—A. V. I.

after detailing the post-mortem appearances, will point out the particulars in which the diagnosis was incomplete, and conclude with a few observations :—

—Churchill, a tall negro, aged 58, was admitted into the Montreal General Hospital on the 16th March, 1852, suffering from general anasarca and ascites—states that about 8 weeks ago, after sawing wood in a damp cellar, he had a “cold shivering,” which was followed in two or three days, without pain, by a cough, and in a week by “a swelling,” which gradually extended up his legs and body. The cough having become very distressing and his breathing very short, he soon found it impossible to lie on the left side, where, and under the ensiform cartilage, he has a sense of constriction amounting almost to pain. Linseed tea, &c., failed to relieve him, and about a fortnight ago, bullæ formed on both legs and burst.

He denies ever having had rheumatism, but for many years back has been “short-winded” and subject to palpitations, especially while walking up-hill, and has had occasionally to stand still for breath in the ascent. Not subject to epistaxis—accustomed to hard work.

March 17th.—Present State.—General anasarca, except of face, neck and arms; feet, legs, thighs, prepuce and scrotum enormously distended. Two sores on each leg, caused by the bursting of the bullæ above mentioned. Enlargement of the abdomen, with ascitic fluctuation. Frequent, distressing, paroxysmal cough, with frothy serous expectoration. Dyspnœa with occasional orthopnœa; the former insupportable during decubitus on left side. Complains of great oppression or weight in epigastric and left lateral regions and about the heart. External jugulars somewhat distended—do not pulsate; pulse small, weak, irregular and intermittent, cannot be counted, nor its synchronism with the 1st sound proved.

Heart not displaced into epigastrium, but cardiac dulness extends from right margin of sternum towards left side for 4 inches. Impulse diffused over this region, and perceptible under xiphoid cartilage, and near left nipple; it is feeble and felt irregularly. Heart's rhythm irregular; sounds very quick, not distinct; scarcely distinguishable from one another—the first not being of its usual prolonged soft character, but shorter and more abrupt, unaccompanied by any murmur, and most audible midway between left nipple and left edge of sternum, under centre of lower part of sternum, and at nipple when lying on left side. Dulness of lower third of left side of chest all round, slightly changing with position; with absence of vesicular murmur; bronchial respiration, and nasal bronchophony over the same extent. Exaggerated respiration over rest of lungs, with crepitus of ordema towards base of right lung.

Diagnosis.—No disease of Aortic Valves; possibly disease of Mitral, obstructive rather than regurgitant, or, perhaps, softening or weakness of the Heart. Enlarged heart; Dilatation of right ventricle, with slight tricuspid regurgitation. Left Hydrothorax and pulmonary Congestion.

By Infus. Digital. oj. Potassæ Acetat. ℥ss. Tr. Scillæ et Spt. Ætheris Nit. aa ʒiv. M. Capt. ʒi. ter in die.

18th.—Sleeps uneasily and talks much during it. Considerable anxiety of aspect. Has not micturated since last night.

9 P. M.—Passed only about ʒii. of urine since visit at noon. The catheter drew off about ʒiiss. of clear urine S. G. 1023, containing no albumen. To have Calomel gr. v. Pulv. Jalap. Comp. gr. xxv., immediately.

19th.—Detect a faint crepitus at end of inspiration at base of left lung posteriorly. Passed about Oss urine this morning, which deposited the lithates in small quantity. Blister to back.

20th.—Says breathing is less difficult. Considerable expectoration of serum, covered with froth—no blood. May have 4 oz. beefsteak and a pint of beef tea.

21st.—Heart sounds more distinct, and audible under the clavicles; less of sharp clapping character about the first. Strange to say, also, the rythm is perfect, and the pulse is equal and regular—72 in a minute.

22nd.—Slept but little. Sang during the night, and kept the sitting posture most of the time. Says breathing is more difficult to-day than it has been, and the irregularity of the heart's pulse has returned, though not to the same degree as before. Pulse about 90. External jugulars slightly distended. Head and eyelids droop. Bowels very loose. Legs more swelled. Blister over left back below the last.

23rd.—Pulse again regular, 70; appetite good.

24th.—Semi-erect posture; chin resting on sternum. Jugulars less distended. Langour and indisposition to speak. Pulse regular, 78. Tongue clean; daily liquid stools; about Oss. urine in the 24 hours; and say ʒiii rusty coloured serous expectoration in same period. Cardiac dulness as before, its superior limit on level with the nipple. Sounds normal, heard under clavicles and in epigastrium. Impulse felt more sensibly than before. Cup the right dorsal region to 6 ʒ.

25th.—Add gr. vi. Ammoniaë Carb. to each dose of the mixture.

26th.—Diuretics do not act. To have a pill night and morning, containing gr. ii. Mass. Pil. Hydrarg and gr. i. Pulv. Scillæ.

27th.—Fully 6 pints of urine passed in last 24 hours!

28th.—About 2 pints of urine since last visit. Has been very languid

since the 24th. Complains of great tenderness of right side, which, on examination, presents the red blush and induration of erysipelas over the entire antero-lateral region. (The patient in the next bed is recovering from erysipelas of the head.) Applied nitrate of silver to limit the cutaneous inflammation, and ordered a poultice to the part.

29th.—About 9 A. M., the house-surgeon learned from himself that he felt much better and had had a good night, but he had not left the ward beyond two or three minutes when Churchill died suddenly and without a struggle.

Let me now, gentlemen, explain the manner of, and stages in, the diagnosis. The first question that arose in my mind, on first examining this case, was, *are the valves diseased, and which?* Finding no murmur with the 1st sound either over the semilunar valves or up the aorta, and no visible pulsation of the arteries, and remembering, that, contrary to the opinion of Louis, Bouillaud and others, it is only in extreme aortic obstruction that the pulse is irregular and intermittent, I decided that the *aortic valves* were sound. But the unequal, small, intermitting pulse was just what would exist in disease of the mitral. Now there was no murmur with the 1st sound at the apex of the heart, and extending thence towards the angle of the left scapula, as there ought to have been, had there been sufficient regurgitation through that valve to account for the condition of the pulse; hence I concluded that there was *no regurgitation* through the *mitral* orifice. But bearing in mind that obstructive disease of that orifice is capable of producing the same pulse, and by retarding the circulation through the lungs, of leading to engorgement of the right heart, retardation of the general circulation and general dropsy, and that mitral obstruction is only very rarely declared by a murmur with the 2nd sound, (most audible at the apex) because the left auricle does not propel the blood with sufficient force to cause a bruit, I concluded there might be *possibly obstructive* disease of the *mitral valve*. This is a point worthy of your attention; I repeat, the mitral orifice may be contracted—obstructed—without an abnormal bruit announcing it; indeed the presence of a bruit, under such circumstances, is the exception, its absence the rule.

But, again, other possible conditions of the heart, besides obstruction at the mitral orifice, were capable of accounting for the symptoms present in this case, thus: effusion into the pericardium; softening of the heart, whether from fatty degeneration, inflammation, blood disease or other cause; weakness of heart, from engorgement of its cavities and polypus, all produce many of the signs and symptoms observed in Churchill's case. However, the amount of dulness over the cardiac region scarcely indicated a sufficiently large effusion to so embarrass the heart, as to pro-

duce so small, unequal, intermittent a pulse, so much dyspnœa and pulmonary obstruction; hence there was little probability that the symptoms were due to hydro-pericardium.

As regards polypus of the heart, the diagnosis is confessedly difficult and seldom certain; but according to the best observers, it is chiefly based upon the *sudden* supervention of anomalous, confused, and obscure pulsations and sounds of the heart, with the general signs of an extreme obstruction to the circulation through the organ, (such as sudden and excessive aggravation of the dyspnœa, &c.,) without any other obvious cause than polypus to account for these signs and symptoms. Now, in our patient, the symptoms had been coming on for several weeks, were gradually gravescent in their progress, were not of that extreme severity which the existence of polypus presupposes, and were rationally referrible to the consequence of previous cardiac disease. Besides, probability was greatly in favour of its being either mitral obstruction or weakness of the heart, inasmuch as these affections occur more frequently than true polypi; that is, polypi formed during life. And probability, you will remember, is a very important element in the diagnosis of disease, as well as in the settling of other obscure questions.

Having then excluded extreme aortic obstruction, mitral regurgitation, copious pericardial effusion and polypus, there remained to meet the signs and symptoms, mitral obstruction, softening and weakness of the heart from temporary embarrassment. And here, you may remember, I stated I was at a loss how to decide, and could not confidently say, which condition obtained; for though mitral obstruction is a not uncommon lesion, and well explains the case, and often exists in the absence of valvular murmur, yet softening and weakness of the heart are also tolerably frequent, harmonize with the general signs present, and further seemed indicated by the sharp-clicking character of the first sound, and the weakness of the impulse. Unable then to say which of these conditions was present, I mentioned my doubt to you at the time, and left it for future examination, during the progress of the case, to clear up the difficulty.

Do you now enquire what led me to diagnose enlargement of the heart, dilatation of the right side with tricuspid regurgitation—I will proceed to explain. The increased dulness was due either to effusion into the pericardium or enlargement of the heart; to which of these it was not easy at first to say, for such an effusion was a very likely thing in disease of the heart attended with general anasarca, ascites and hydrothorax: and a copious effusion would account for the increased dulness, the irregular, weak but diffused impulse; the sense of weight in precordia, the dyspnœa and the small, frequent, intermittent pulse. And

a largely dilated heart would be equally compatible with such signs and symptoms on the supposition that its walls were *weak*, or that they were gorged with blood from the obstruction to the pulmonary and general circulations. Both views being thus far tenable, one sign only remained unanalyzed, and this was the sounds of the heart, which, being quite audible, and the first partaking more of a valvular than of a muscular sound, favoured the idea that *dilatation* was the cause of the increased dulness, and not *pericardial effusion*, for then the sounds would in all probability have been more masked. Connecting this view with the following facts—the increased dulness chiefly occupied the lower sternal region, and extended to its right border, the sounds were very audible over the right heart, the general dropsy and enlarged jugular veins pointed to tricuspid regurgitation as established by Dr. Blakiston and corroborated by myself—I ventured to assert, that the heart was *enlarged*, and that there was *dilatation* of the *right* side, with slight tricuspid regurgitation. I said “*slight*,” because, had it been great, the veins would have been more enlarged, and would most likely have pulsed, at each contraction of the ventricle.

I must not detain you with a long statement of the signs by which the condition of the lungs and pleura was ascertained. Dulness on percussion, changing with position and accompanied with ægophony and indistinct vesicular murmur, point conclusively to effusion into the pleura; and the anasarca, ascites and cardiac disease almost necessarily involve the conclusion, that such an effusion must be of the nature of hydrothorax—passive, not inflammatory—the result of pleuritis—but like the general dropsy, the consequence of obstruction of the circulation.

What was to be expected from treatment in this case? Advanced disease of the heart, with extreme anasarca, ascites and hydrothorax, sloughing of the integuments of the legs, and great debility. Plainly very little. The *prognosis* was decidedly unfavourable.

What was the proper course to be pursued? Why to relieve the embarrassed heart by keeping up its tonicity, and at the same time reducing the amount of fluid it was obliged to propel. Nature, in this respect, had set us an example, by pouring out into the loose areolar tissue and large cavities of the frame the watery portion of the blood, and by exuding into the bronchial tubes a copious serous expectoration. With this object in view, active diuretics were given with the hope that, by their instrumentality, the renal organs might be excited to assist in pumping off the now over abundant serum, a brisk hydrogogue cathartic was administered and blisters applied to the back, while at the same time beef tea and beefsteak were allowed to support his strength. On his admission, and for two days subsequently, he passed a very small quantity of urine, not ex-

ceeding 3ii. on the 18th, and this, when examined, was found of the S. G. 1023, (which is about natural,) and free from albumen. This was a point of importance, for a condition of the kidney declared by the secretion of urine of low S. G., and containing albumen, thence called albuminuria—is a common source of general dropsy, and even, it would seem, of disease of the heart.

Four days after the commencement of the treatment, some important changes, you may remember, were recorded in the physical signs, which threw additional light on the case. The heart's sounds had become more distinct, and more extensively audible, and the first had less of its sharp clapping character, while the rhythm was restored and the pulse had regained its regularity. And now you can perceive the value of repeated examinations. The restoration of regularity to the heart's rhythm, and to the pulse, was incompatible with much mitral obstruction; softening of the heart to an extent capable of rendering the pulse so weak and intermitting as it was here, could not have been cured in four days: so that the only supposition upon which the progress of the case could be explained was, that the urgent dyspnœa and pulmonary obstruction so embarrassed the heart as to overpower it—to render it temporarily weak. In harmony with this view, we find that on the 20th, the day before the improvement in the pulse, the dyspnœa is stated to have abated, while on the 22nd, coevally with the aggravation of the dyspnœa, was the return of the irregularity of the heart. The diagnosis of enlargement and dilatation previously made, also, was now corroborated by the greater distinctness of the sounds, and the wider space over which they were heard, and at a still later period by the greater force of the impulse.

A second blister was now applied, and with the view of more effectually relieving the gorged heart, 6 ℥ of blood were abstracted by cupping from the right back. Two days later, the diuretics having failed to fulfil their intended use, blue pill and squill were given, and that evening the kidneys began to act vigorously, so that 6 pints of urine were passed in 24 hours. You will find the combination of blue pill with squill and digitalis, a very excellent and tolerably certain diuretic. The diuresis, however, did not continue long; it was reduced two-thirds the next day, perhaps by the revulsive influence of an attack of erysipelas, which unfortunately seized our patient and seemed to hasten his end for he died the following day.

I will now read for you the appearances discovered in the body four hours post mortem.

Head.—The anterior and external jugulars very visibly gorged; much blood escaped on cutting the scalp. Membranes of brain not much injected; some serous effusion under visceral arachnoid; bubbles of air

in several of the cerebral vessels, brain of healthy appearance and consistence.

Thorax.—Serum oozes through the incisions made in the parietes. Left pleura filled with this straw coloured fluid in which albuminous flocculi float. Left lung invisible, lies pressed against spinal column, except the inferior free edge which is attached to the costal pleura at one spot; lung universally healthy. Right pleural cavity contains about a pint of similar fluid; the opposed surfaces are extensively bound together by old adhesions, both laterally and at the base of the lung. Structure of this organ healthy; more carbonaceous deposit than is common in white men.

Both layers of pericardium universally adherent, and so closely as to be with difficulty separable by dissection; the membrane is also much thickened; its exterior is covered with a ridge of very dense fat, in which the areolar tissue is abundant and almost fibrous. Heart dilated and hypertrophied, weighs with bronchial glands, and small portion of trachea 2 lbs., without these say over 1½lb. Measures 4 inches in transverse diameter. Both ventricles closed by rigor mortis. Walls of left ventricle 8 lines thick at apex, 14 at base; firm and red; small white coagulum extends from its interior into that of left auricle. The mitral orifice 4 inches in circumference; its valves close it, are healthy, but present thickening of their fibrous structure. Left auricle's walls thickened and cavity large. Right ventricle's walls also are thickened; measures 5 lines at apex, and 8 lines at base; it has not the usual flaccid appearance of the right heart, and its cavity is occupied by a yellow white coagulum, which extends up the pulmonary artery to the valves, and through the auriculo-ventricular ring into the auricle. The tricuspid orifice measures 5 inches; its valves are healthy and might close the orifice when the ventricle is not much distended. The right auricle's walls are much thickened and measures 6 lines, its cavity is enlarged. The thickening is chiefly due to the pericardium and its lining of lymph; aortic and pulmonary valves healthy; aorta much smaller than usual, forming a strong contrast with the large and powerful heart.

The bronchial glands very large, several of them the size of a plum, extremely hard, and either jet black, or mottled with a pink, firm, cheesy looking substance.

Abdomen contains about 4 pints of straw coloured serum. Liver extends across to spleen, to which it is firmly adherent; the convex surface of both lobes is almost universally attached by old adhesions to the diaphragm; it does not reach below the ribs. The lymphatic glands about the cardiac orifice of the stomach, and leading to the longitudinal fissure, are enlarged and hardened like the bronchial. Gall bladder,

stomach, and intestines normal. Kidneys large, apparently healthy within, but studded externally with numerous little clear cysts, filled with transparent fluid, and varying in size from a pin's point to a cherry.

You see then, Gentlemen, the cadaveric examination confirmed the diagnosis very closely ; it proved the valves to be healthy ; the heart to be generally dilated and hypertrophied ; the right cavities so enlarged as to allow of tricuspid regurgitation whenever distended by the blood which would naturally accumulate therein during severe exercise, or the dyspnœa under which the patient laboured ; no softening or fatty degeneration of its walls ; no effusion into the pericardium, but copious effusion into the left pleura, and moderate effusion into the right.

But it also revealed a condition which was not expected—which had not indeed been thought of, viz : universal adhesion of the pericardium to the heart.

The diagnosis of adherent pericardium is admitted by most Auscultators as not yet attainable. Even Hope grants that it "cannot be made with absolute certainty,"* and Dr. Blackiston, one of the most recent writers on the subject, knows of no signs by which this condition can be ascertained. The signs which have been attributed to adhering pericardium are, an abrupt tumbling, jogging motion of the heart, sometimes the jogging having a double character ; the heart occupying its natural situation instead of falling downwards by the increased gravity consequent upon its enlarged condition ; the locality and boundaries of its dulness not altered by deep inspiration or position ; prominence of the paries of the chest in the same situation ; retraction of the intercostal spaces and epigastrium during the heart's systole ; and, lastly, the history of previous pericarditis.

Now if these signs were generally present, or when present, always indicated adherent pericardium, the diagnosis would be easy ; but neither Williams nor Blackiston has ever seen in this affection, the jogging motion mentioned by Hope, and it is not unfrequently met with when no adhesion exists ; it was absent in Churchill, as was also the retraction of the intercostal spaces and of the epigastrium. As regards the last sign, Blackiston observed it but once in 7 cases of the disease. The prominence of the cardiac region also, was not noticed in our case, and had it been, it would have been, perhaps, referred to the enlarged heart or to the œdema of the thoracic walls. Nor had we a history of previous pericarditis to direct our thoughts into the proper channel. In fact, the only one of the above signs noted was the non-displacement of an enlarged heart downwards, though, perhaps, had we tried the effect

* Hope on Diseases of the heart : 5th edition, page 183.

of posture upon the organ's situation and impulse, another valuable sign might have been elicited.

Before concluding this lecture a question suggests itself, of some importance, to the full appreciation of the case under consideration. What was the initiative evil—the starting point—of the Cardiac disease in Churchill. To this I would answer, an inflammation of the pericardium, and for the following reasons:—It is a common affection; there were then the results of an old severe inflammation of an adjacent part, (the adhesions between the pleural surfaces and between the diaphragm and liver); and there was no condition of the aorta, valves or lungs which so well accounted for the hypertrophy of the heart. The sequence of the morbid alterations and consequences was probably as follows: pericarditis, effusion of lymph, adhesion of opposed pericardial surfaces, synchronous hypertrophy and dilatation, (the hypertrophy produced by the increased exertion of the heart to discharge its function in spite of the restraint or opposing force of an adherent pericardium; and the dilatation caused by the engorgement of the cardiac cavities consequent upon the difficulty with which the organ expelled its contents)—increase of dilatation and distension of cavities, retarded pulmonary circulation, aggravated by bronchitis, temporary or occasional tricuspid regurgitation, obstruction of the general circulation, anasarca, ascites and hydrothorax.

Our time will not permit the examination of this interesting case any further, though it affords ample materials for another lecture; but before concluding, let me observe, that the feebleness of the impulse of this very large heart was, doubtless, due chiefly to the temporary debility which it suffered from its great engorgement, but partially also, to the shackling influence of the adherent pericardium; and this same engorgement by preventing the quick and firm contraction of the ventricles necessary to produce an audible muscular sound, was, perhaps, the reason why, at our earlier examinations, the first sound of the heart was so short and sharp, instead of being prolonged, as it generally is in hypertrophy, the sound heard in this case being that produced by the closing of the auriculo-ventricular valves only.

April 3, 1852.

Case of Expulsion of Hydatids from the Uterus. By E. W. C. KINGDOM, M. D., Assistant Surgeon Royal Canadian Rifles.

Mrs. S—, æt 40, bilious temperament, consulted me during the month of January last, as to the cause of severe uterine hæmorrhage, to which she had lately been subject. She was under the impression that she

was pregnant, not having menstruated for 6 months, and, as there was also considerable enlargement of the abdomen. On examination, I found a tumor in the hypogastric region, evidently the uterus, nearly as large as it is at the full period of gestation.

She stated that the enlargement had taken place gradually, and that from the morning sickness and other signs of pregnancy, together with her experience of former pregnancies, she felt convinced that she was again in that condition.

Within the last few days she had been subject to alarming "floodings," and she thought the "*child*" was dead, that indeed she had never "quickened."

Stethoscopic examination of the abdomen, could distinguish neither sounds of fetal circulation nor placental soufflet.

The tumor was smooth, there was no sense of weight, cold, or any other sign of a dead child.

On vaginal examination, I found the cervix uteri elongated and flabby, the os patulous and apparently easily dilatable.

No pyrexia, pulse good, and no indications of anæmia from loss of blood.

I sent her home, and told her to let me know when any return of the hæmorrhage came on, recommending rest, in a horizontal posture, &c.

I was sent for about 24 hours after, and found her in strong labour. Pains frequent, violent, and genuine in their character. Considerable hæmorrhage. On examination per vaginam, I felt a spongy mass protruding through the os uteri, a portion of which came away in my hand. This proved to be a mass of hydatids, varying in size from a small pea to a hazel-nut.

The uterine mouth being now well dilated, I gave the patient a good dose of ergot of rye, being anxious to get rid of the remaining hydatids, as the "flooding" still continued profuse, and I had occasion to leave her for a short time, and on my return found that an enormous mass of hydatids had been expelled, the uterus had contracted precisely as it does in natural labour, and the hæmorrhage was arrested.

She made a rapid recovery, without a single bad symptom. I regret I did not weigh the mass of hydatids, but some idea may be formed of their quantity, when I mention, that they more than filled a large wash-hand basin.

REMARKS.—In this case we have the rather rare instance of a woman, the mother of a family, being deceived for such a length of time as to her actual state. It is rather curious too, that the disease should increase in the same manner, and produce all the changes in the uterus, which the presence of a fœtus would. The expulsion of the mass at the same

period as that of a full grown child, I suppose must be attributed to its mechanical distension of the uterine walls.

TREATMENT.—In the present case, the “vis naturæ” did all that was necessary, otherwise, I should have dilated the os uteri, either by the finger or by the introduction of sponge tents.

St. Johns, Canada East.

REVIEW AND BIBLIOGRAPHICAL NOTICE.

An Analytical Compendium of the various Branches of Medical Science, &c. By JOHN NEIL, M. D., and FRANCIS GURNEY SMITH, M. D., Philadelphia, Lea and Blanchard.

THIS is an able, and at the same time a concise treatise, or rather a series of treatises upon Anatomy, Physiology, Surgery, Obstetrics, Materia Medica, Chemistry, and Practice of Medicine, designed for the use of students, but from a careful perusal of some of the chapters, (for we do not profess to have read all) we can confidently recommend it to the practitioner also, who will there find precisely the kind and amount of information he requires on each subject. We strongly recommend this excellent work to our readers.

SCIENTIFIC INTELLIGENCE.

SURGERY.

Surgical Operations for Retention of Urine. By Mr. COCK.

THE author first dwells upon the difficulties which surround the question of what course should be pursued in those cases where an old chronic indurated stricture, recently closed by inflammation and congestion, defies all attempts to pass a catheter, and upon the failure which frequently attends the attempts of the surgeon to relieve such cases by the introduction of sounds, catheters, or bougies. He points out the three modes to which recourse may be had, when the urgency of the symptoms renders some decided interference necessary. First, that of forced catheterism; second, that of opening the urethra in the perineum behind the stricture; and third, that of puncture of the bladder. There is nothing new in either of these measures for relieving retention. They may each possess certain advantages, and the circumstances of the case, and the condition in which we may be placed, may incline us to the

adoption of either the one or the other. They have all their draw-backs ; but on the whole, the author is disposed to believe that the bladder may be reached with the smallest amount of pain, with the least risk of present or future danger, and with the greatest prospect of ulterior good, by puncture through the rectum. The first of these operations, the author regards as in reality a mode of puncturing the bladder with a blunt instrument, tunnelling through the perineum under cover of the urethra ; and he believes that the stricture is, in the majority of such cases, neither forced nor crushed, but that a new passage is made outside the urethra, which may either reënter the urethra, or continue its course through the prostate into the bladder. The urgent symptoms may be thus relieved, but the after condition of the patient is not bettered, and it may be rendered even worse. The second operation, of section of the perineum, the author thinks, is, when dexterously and successfully performed, preferable to forcible catheterism. The urine may be allowed to flow by the new channel, until the urethra has had time to recover itself from the injuries it may have sustained by previous manipulation, or from the irritation caused by the continual pressure of the contents of the bladder. But unfortunately the difficulties are often so great, in long-standing disease of the perineum, that the urethra cannot be reached, and great mischief, or even death, may result from the protracted operation. The author describes the proposed modification of this practice, called "cure of stricture by division," of which the principle consists in uniting the upper and lower permeable portions of the urethra by the division of the intermediate impermeable portion, and thus restoring the integrity of the canal. This, however, he thinks, is very rarely carried out ; and that very often death is caused unmistakably from the injuries sustained during the operation. So convinced is the author, by experience and observation, of the difficulty which frequently attends the operation of opening the urethra behind the stricture, where the landmarks which should guide us are obliterated, that he has of late years abandoned the operation of incising the perineum, with a fixed determination to reach the bladder. In those cases where retention and extravasation render it necessary that an outlet should be afforded to the contents of the bladder through the perineum, he limits himself to making a free incision down to the region where the urethra may be supposed to be situated ; and if he cannot then gently introduce a catheter through the wound into the bladder, he does not proceed any farther ; and he has generally found that the urine has speedily found its way through the wound. With regard to the third mode of relieving the bladder, by puncture, the author brings forward cases to show puncture by the rectum safe and simple. Forty cases of operation by the rectum are

related. In all of these, the operation was entirely successful, so far as the relief and the absence of any ill consequences from it were concerned. Seven deaths occurred, from various causes, connected with the previous sufferings of the patients, as diseased kidneys, inflamed bladder, &c. In many cases, the author believes the operation to have materially tended to the restoration of the patient, with a less amount of suffering, and at the same time more speedily and effectually, than could have been effected in any other way.

Mr. SOLLY concurred in opinion with Mr. Cock, that the operation described in the paper was a most valuable one in certain cases. He (Mr. Solly) had heard Mr. Cock describe it years ago, and had himself since performed it several times with success. He considered that this operation was one of the least dangerous that could be performed in cases of retention of urine from stricture. Cases of course occurred in which cutting down upon the urethra was advisable—as when the stricture was of traumatic origin; but where the canal had been much damaged, and where false passages existed, the operation of puncturing the rectum was the most advisable.

Mr. ARNOTT said, that although he was unable to speak in the same unqualified terms of approbation as the author of the paper and Mr. Solly had done, of the operation of puncturing the bladder through the rectum, he was yet able to add his testimony generally in its favour from a personal experience of five cases in which he had resorted to it. He considered that the Society was indebted to Mr. Cock for having brought the present collection of cases before it. He (Mr. Arnott) had only performed this operation in cases of retention of urine supervening on permanent stricture, when other means of relief had failed. But having witnessed incidentally its advantages in facilitating the subsequent treatment of the stricture which had rendered the operation necessary, he was prepared to receive with favour the suggestion to resort to it occasionally in the treatment of that disease. Before, however, he proceeded further in his remarks on this operation, he wished to observe that he thought Mr. Cock had expressed himself with too much severity with regard to the operation of what was called forcing the stricture, and also in regard to the operation of opening the urethra behind the stricture. Both of these proceedings, properly performed in suitable cases, were justifiable and safe. The operation of forcing a stricture was not so severe a proceeding as puncturing the bladder from the rectum, and it had some advantages. Indeed, if he had the misfortune to suffer from retention of urine as a consequence of stricture, he should, if in the hands of a competent surgeon, prefer that the stricture should be attempted to be forced before any opening should be

made in the urethra behind the stricture, or the bladder be punctured through the rectum. What he wished to convey by the operation being "properly performed" was this, that if upon trying to urge the catheter through the stricture, the urethra itself should give way, and be perforated, then that the proceeding should be immediately abandoned. So also with respect to opening the urethra behind the stricture; the best mode was not that usually performed, of cutting from the surface or skin inwards, but by putting the forefinger of the left hand into the anus, so as to depress it; then to introduce the point of a bistoury slightly curved just in front of the anus, and carry it directly inwards so as to strike the membranous part of the urethra; and then holding the instrument outwards, to divide all the superjacent parts. He (Mr. Arnott) had first seen this mode of procedure resorted to by the late Sir Charles Bell, twenty years ago, and had frequently since successfully performed it. If in the operation you missed the urethra, then the operation of puncturing the bladder could be resorted to. With reference to the last operation, which had been employed at the Middlesex Hospital, he had not found it so entirely destitute of disadvantage as had Mr. Cock. Of the five cases in which he had employed it, one patient died, and on examination an abscess was found between the bladder and rectum in the track of the canula. Effusion of urine in this situation was a danger to be dreaded, and he had expected that it would have occurred in some of Mr. Cock's cases; and gratified as he was at hearing the short abstracts of some of them read, he should like to look over the details of the whole before he could satisfy himself that the danger was not real. He could, perhaps, illustrate his views with respect to the different operations, by relating a case in which he had performed all of them in the course of a quarter of an hour on the same patient. In 1844, he was called one morning to an officer of Engineers, who had retention of urine from stricture, and who had had a similar attack some years before. The patient was six feet six inches in height, of large frame, and being partially palsied on one side, was very cumbrous to move. An unsuccessful attempt was made to introduce an instrument into the bladder. Large and repeated doses of laudanum, both by the mouth and rectum, were exhibited at short intervals, and a fresh attempt to pass a catheter was made at the end of some hours, but again without success. A small quantity of water had, however, dribbled away. The patient was now purged, cupped in the perineum, &c. On the following day, the quantity of urine passed was not considerable, yet the relief was such as to lead him (Mr. Arnott) to suppose that the difficulty of the case had been got over. On the following morning early, however, he was again summoned to the patient, and found that he had passed no water since the

preceding afternoon ; the bladder reached half way up to the umbilicus, and he was greatly distressed. The case now admitted of no delay, and he accordingly attempted to force the stricture, but the urethra gave way, and the catheter was at once laid aside. He (Mr. Arnott) explained to the patient's brother, a physician, that he would now endeavour to open the urethra behind the stricture; an operation in which, in these cases, he had generally succeeded ; but in the present instance he did not feel so confident, as there had not been much previous suffering from the stricture, or strain upon the parts, so that the urethra, posterior to the stricture, might not be dilated. If he failed in the attempt, he should then puncture the bladder through the rectum. The attempt to lay open the membranous part of the urethra was made in the way already described, but the urethra was not struck. The bladder was then immediately punctured through the rectum. He (Mr. Arnott) saw the patient twice during the day, when the urine was flowing freely through the canula ; but the next day he was called to him again, and learnt that on the previous afternoon the canula had got displaced ; it was, in fact, out of the bladder ; and that no urine had passed either way since. The bladder was now full, and after a short and unsuccessful attempt to pass a catheter by the urethra, the bladder was again punctured through the rectum ; the canula was kept in sixteen days, when an instrument was got through the urethra into the bladder ; the case did well, and the patient was still living. In one instance it appears that Mr. Cock had failed to reach the bladder in the attempt to puncture it through the rectum, but failure to strike the bladder was not confined to puncture in this situation. Mr. Arnott had twice witnessed in the hands of a very able surgeon, the bladder missed in the attempt to puncture it above the pubes ; in one of these cases, the trocar was reintroduced, and with success ; he might add that both cases recovered.

Mr. COULSON said it was clear from the facts detailed in the paper that the operation of puncturing the bladder by the rectum was easy and safe of performance, but he was not equally convinced that the operation ought to be performed in cases like those mentioned by the author. Puncturing the bladder by the rectum for retention had never been very generally resorted to, because it left the condition on which the retention depended untouched. The late Mr. Liston, in his *Operative Surgery*, says that he never performed the operation in question, and spoke in no measured terms of those who had recourse to it. In some of Mr. Cock's cases the catheter had been introduced not long prior to the operation, and he could not understand why it had not been retained in the bladder, and the operation of puncturing dispensed with. In one or more cases there was extravasation of urine, and he (Mr. C.) thought that the free and deep incisions in the perineum which were

necessary to give relief to the extravasated urine would also have been a sufficient outlet for the urine from the bladder. Again, the author had recommended the operation on the ground that by the withdrawal of the urine from the urethra the stricture would yield; but it was delusive to expect this to be the result in all cases. He had punctured the bladder by the rectum in an urgent case of retention, dependent on an impermeable stricture of the urethra; at the end of three or four days the canula slipped out, and retention again occurred. The stricture was in the same position as before the operation, and was then successfully divided by the lancetted stilet. The conclusions which he (Mr. Coulson) arrived at were, that if the smallest instrument, like one of Mr. Syme's staffs, could be introduced through the stricture, it would be better to divide the stricture from without, and thus remove the cause of the complaint. If the stricture was so great that nothing could be introduced through it, then he would prefer passing a grooved staff down to the stricture, making an opening into the perineum beyond the contracted part, passing a strong, straight, director with a deep groove in the median line between the urethra and rectum, and passing a straight bistoury some way along the groove, and then cut outwards and upwards towards the staff which had been first introduced. Except, therefore, under the most urgent circumstances, scarcely admitting of the delay requisite for the performance of these operations, he did not think the measure which had been recommended by the author for retention of urine from stricture should be adopted.

Mr. SOLLY observed that Mr. Liston, before his death, altered his opinion as regarded this operation, as he (Mr. Solly) was present when that distinguished surgeon performed it, a few months before he died.

Mr. DE MORGAN said that he had not perused all the cases detailed by Mr. Cock, but they all supported the same views, and showed that the operations did not, as Mr. Coulson had remarked, remove the cause of the retention. In all operations, however, proposed for the relief of stricture, the urine, after a time, passed more or less by the natural passage, similar to what was observed in some cases lately read to the Society of stricture of the colon, in which, some time after an operation had been performed for their relief, the fæces began to pass through the intestine, and take their natural course. The operation, therefore, of puncturing the bladder in cases of stricture, was to some extent a curative agent as regarded the obstruction.

Mr. CURLING had given his best attention to the cases which had been briefly detailed in Mr. Cock's paper. As far as he could judge, he had no objection to make to the puncture of the bladder in the instances cited. In the second case, it did not seem quite clear whether the abscess in the perinæum existed at the time of the operation or had

formed afterwards ; but he did not believe that so excellent and experienced a surgeon as Mr. Cock would venture to puncture the bladder by the rectum in a case of retention of urine with perineal abscess. He would relieve the patients by a free opening at the part. Mr. Curling agreed with the author of the paper, that the operation was more free from risk than was generally supposed ; and in giving it the preference of forced catheterism, he was quite sure that Mr. Cock, in treating of the latter proceeding, did not object to the perforation of a stricture by the skilful use of the catheter, but to the violence inflicted when the instrument was driven out of the passage, the course of which in its progress to the bladder, had been so graphically described in the paper. Still he was surprised to find that Mr. Cock had to puncture the bladder in so many instances at the hospital of which he was surgeon. At the London Hospital, cases of retention of urine were of very common occurrence amongst the dissolute population in the neighbourhood, and no less than 146 cases had been admitted in the past year ; yet this operation was very rarely performed, and he did not believe the bladder had been punctured a dozen times during the past twelve years. He attributed this to the remarkable success attending the general treatment without instruments, by means well known to the fellows of the Society. After the retention had been relieved in this way, and the local irritation had subsided, the cure of the stricture could then be conducted with as much advantage as after the bladder had been punctured by the rectum. In the very few cases in which he had found it necessary to operate, he had punctured the bladder above the pubes, which he believed was as simple and as free from danger as the puncture by the rectum.

Mr. GAY, from the experience he had had of the practice of puncturing the bladder from the rectum, could give it his unqualified support, but in a certain class of cases only—viz., those in which spasm and inflammation suddenly supervened in old stricture, and retention, with all its evils, followed. Amongst the cases detailed in Mr. Cock's interesting paper, he had not been able to detect many of this kind. It was now six years ago that he (Mr. Gay) was called to see an old gentleman labouring under the severest symptoms arising from retention. He had suffered from stricture for years ; and the day before, in consequence of a debauch and exposure to cold, he found himself unable to pass his urine. Many futile attempts had been made to introduce a catheter, by which the urethra had become seriously lacerated. Hot baths, leeches, and opium, had also been employed ; and it was not until the symptoms of constitutional irritation had reached a fearful height that his assistance was called for. Under these circumstances, he thought it unwise to interfere further with the urethra in any part of its course, but to attend

to what was infinitely more urgent—viz, the over-distended state of the bladder. Notwithstanding the bad odour into which the operation of puncturing by the rectum had fallen, he (Mr. G.) determined, though not without much anxiety as to the results, to perform the operation. It was followed by great and immediate relief; and a further employment of palliative remedies to the urethra caused the spasm and inflammation to be so far reduced by the following day, that the old gentleman began again to pass his urine by the natural channel. In a few days more he was convalescent, and nothing was heard whatever of the wound of the bladder made in the operation. Mr. Gay thought the state of the urethra, in such cases, and under such a conjunction of circumstances, to be of all others most unfavourable to catheterism; and from the results of this case, and others which had since fallen under his observation, he did not hesitate to recommend the evacuation of the bladder by these means, whenever that viscus might become so distended as to occasion severe constitutional and local irritation. He had punctured the bladder since in four or five other cases; and so convinced was he of the comparative innocence of the procedure, that he had on one occasion had recourse to it three days following, and this without any bad results. The palliative local treatment of these cases appeared to be more successful after the bladder was emptied, than if employed during its distension, and generally resulted in the patient's being able to void his urine in the course of twenty-four or forty-eight hours. With regard to another class of cases, in which Mr. Cock had been in the habit of puncturing the bladder—viz., those of chronic and permeable stricture—he (Mr. Gay) had had no experience; but, with Mr. Coulson and Mr. Arnott, he could not see its utility. It appeared to him that the result of this practice was to add to an old stricture the undesirable complication of a fistulous passage behind it, which could by no means be of any service towards curing the original disease. He was of opinion that judicious catheterism might in these cases accomplish as much as could be expected. Mr. Gay felt that on so important and interesting a subject, every surgeon who had had any experience was bound to communicate it, for the purpose of arriving at some really practicable conclusion; and it was this consideration that had led him to make these remarks.

Mr. HODGSON deprecated the employment of such violence as had been described in the use of the catheter for the relief of retention of urine in cases of organic stricture, but advocated the employment of that instrument under such circumstance in a cautious manner. By very long continued but moderate pressure, the catheter might often be passed, even through long and obstinate strictures; but great patience and

perseverance were requisite both on the part of the patient and operator, who should also possess the tact and knowledge to enable him to guide, with his fingers in the perineum, the point of the instrument in the track of the urethra. In the course of his experience he had never found it necessary to have recourse to tapping the bladder, either per anum or above the pubes, for the relief of retention of urine. With regard to the former of these operations, he did not regard it as quite of that simple and harmless nature that had been represented. In cases of old stricture the bladder was often very much thickened and contracted in its coats, and incapable of much distension. This state would render the operation difficult, and in some instances unsuccessful. There was also danger of wounding the vesiculæ seminales. He mentioned an instance in which this was believed to have happened, and the inflammation having extended along the vas deferens produced suppuration of the testicles. In another instance the tube slipped out of the opening in the bladder, and could not be replaced; the patient derived only very little relief from the operation. In his opinion, this operation should only be undertaken by experienced and cautious hands.

Mr. PRESCOTT HEWETT would confine himself in his remarks entirely to the question of operating for retention of urine from stricture. He would at once say that the opinion which he had formed was, that few, very few cases of retention of urine from stricture imperatively demanded an operation for their relief, and he was surprised to find that so many cases of this kind had required an operation in one hospital alone during the last few years. Mr. Curling had stated that in the London Hospital, operations for retention of urine had of late years been of very rare occurrence, but he (Mr. P. Hewett) would go a step further, and say confidently that for the eighteen years during which he had been connected with St. George's Hospital, not a single instance had occurred in which it was found necessary to resort to an operation for the relief of retention of urine from stricture: and yet among the large number of cases of this kind yearly admitted into that hospital, were some of a most severe and urgent character. He had necessarily been obliged to operate upon cases of extravasation from rupture of the urethra with retention, which had been brought into the hospital in that condition; but this was altogether a different matter, and one in which the treatment admitted of no doubt. For many years past, at St. George's, long antecedent to his (Mr. Hewett's) going there, cases of retention of urine from stricture had been treated, when catheterism failed, with opium and the warm bath, and for the last eighteen years, to Mr. P. Hewett's knowledge, as already stated, and for some years more, no single instance had arisen where an operation had been required. On

one occasion, and on one alone, had he (Mr. P. Hewett) seen even anything like an approach to an operation. In this case the patient, a man of intemperate habits, had been admitted into St. George's Hospital with retention of urine from stricture, and some false passages which had occurred during the repeated attempts at passing a catheter into the bladder. Another attempt to get an instrument into the bladder was cautiously made by the house-surgeon; but as this failed, a warm bath was ordered, and some laudanum given by the mouth, and under this treatment the patient soon became easier, and then passed a small quantity of water. Shortly afterwards, however, complete retention again recurred; and as no relief appeared to be derived from the treatment, the surgeon of the week was sent for, and another attempt to pass an instrument was again made, but this also proved fruitless. Under these circumstances, as the bladder was getting largely distended, a question arose as to the propriety of tapping this viscus through the rectum; but as the patient, notwithstanding the great distension of the bladder, did not appear to be suffering much, it was ultimately decided that another trial should be made with a full dose of laudanum, two drachms of which were immediately given by the rectum, and within an hour afterwards the patient began once more to pass his water, and gradually emptied the bladder. Let opium be freely given, and from what he had witnessed, Mr. Hewett had no hesitation in stating that an operation in such cases would be very, very rarely indeed required. In conclusion, Mr. Hewett stated that he had never seen any bad effects arise in these cases from the free administration of opium, notwithstanding that he had in some instances given drachm doses every hour for three or four hours consecutively.

Mr. CHARLES HAWKINS thought that there should be further discussion on the important paper before them, for he was not satisfied that it should go forth to the profession that the Society entertained so favourable a view of the operation advocated by Mr. Cock, as the remarks of the preceding speakers would naturally give rise to. He (Mr. Hawkins) was by no means satisfied that cases of stricture generally required the operation to be resorted to, and he must say he had never heard a paper read in that room which had more astonished and surprised him, detailing, as it did, forty cases in which puncture of the bladder had been resorted to, either by the author or his colleagues. Now, he (Mr. Hawkins) had known St. George's Hospital for the last twenty years, and he had never known this operation to be performed there, nor could he learn that it had been resorted to for nearly thirty years. He also knew that surgeons in extensive practice in the west end of London had found it necessary to have recourse to it only about

half a dozen times during the long period of forty years; it was therefore to him most extraordinary that so many cases could be got together from one hospital or from the practice of those connected with it. Indeed, until the remarks of Mr. Curling, he (Mr. Hawkins) imagined that the operation must be peculiar to the other end of London, but it appeared, that though well placed for bad cases of stricture, the London Hospital could produce no such number. He had been surprised to hear of the advantages of this operation in cases of spasm, for these were surely not the cases in which Mr. Cock recommended it, for he appeared to confine its use to those old cases of permanent stricture where from constant attacks of retention of urine and its consequences, the kidneys and bladder became diseased, and the life of the patient placed in jeopardy. In such cases, if an operation were required, then that recommended by Mr. Cock, he (Mr. Hawkins) considered the best. He thought, however, that at the present time, when so many plans of treating stricture were being placed before the public, it was most desirable that the Society should not, without due consideration, give its sanction to any particular plan. He hoped that the older and more experienced fellows of the Society would express their opinions in reference to this operation; with this view he had addressed the Society. It was not that he did not think that, when an operation for the relief of retention of urine became necessary, that recommended by Mr. Cock was perhaps the one attended with least difficulty and followed by fewer bad consequences than any other, but of the results he could say nothing of his own experience. He could call to mind but one case that had come under his own care in which the bladder was punctured for retention of urine. In that instance the operation was successfully performed above the pubis. He had been in the habit of passing an instrument for that patient since, without difficulty. Of course he did not allude to cases in which an operation had been performed for the cure of stricture, where the obstruction was permanent—usually from accident—and performed not for the immediate relief of retention of urine. He had assisted at operations in about half a dozen of such cases, the urethra being cut into through the perineum. He had certainly been surprised to hear of the great amount of bad surgery which Mr. Cock appeared to have met with, for such did not commonly come under his (Mr. Hawkins') observation.

Mr. HOLT remarked that he entirely concurred in the observations made by both Mr. Curling and Mr. Hewett, and expressed his surprise at the large number of cases in which Mr. Cock had found it necessary to have recourse to an operation for the relief of retention of urine. He had been engaged for the last ten years in endeavouring

to procure cases of stricture of the worst possible description, and although a large number of cases of retention of urine in all their varieties had come under his notice, yet he had only recourse to operative procedure in one instance, the operation consisting in opening the membranous portion of the urethra, which formed an elastic tumour behind the stricture, easily detected and easily punctured. If the ordinary palliative treatment were had recourse to, and the first effort failing, no further attempts to pass a catheter were indulged in, in almost every case the urine would in a few hours escape, and in sufficient quantities to obviate all the urgencies of retention, and in a few days (the parts in the intermediate time having become tranquil) a catheter could, in almost every instance, be passed. Were he called upon to perform any operation, he should have no hesitation in preferring, from its simplicity, facility, and the immediate relief it afforded, that recommended by Mr. Cock. He considered the operation of opening the urethra behind the stricture a most hazardous proceeding, and ought only to be had recourse to in cases where the membranous portion of the urethra could be distinctly felt distended by urine. As a proof of this assertion, he might mention a case in which this operation had been attempted by one of the ablest surgeons of the day, a gentleman of vast experience, and who formed one of the heads of the profession. The patient, from continued disease, died the same evening, and the post mortem examination revealed the urethra completely transfixed, the knife having passed between the bladder and symphysis pubis. Respecting the operation of forced catheterism, he was quite assured Mr. Arnott would not sanction that operation in the common acceptation of the term, or, as recommended by some surgeons, that a catheter should be forced into the bladder *vi et armis*, no matter what strictures intervened. Such a course of proceeding could only be attended with hazardous results, and probably the death of the patient. In conclusion, he felt assured that by patience and proper medical treatment the cases in which it might be necessary to perform any operation would be very limited.

Mr. ARNOTT had hoped, in reference to what had fallen from Mr. Holt, that he had sufficiently guarded himself against the supposition that he was in favour of the operation of forcing a catheter into the bladder. He had expressed his opinion, that the attempt to force a stricture was a proper proceeding in certain cases: and he would again state his meaning, which was this—that with a short silver catheter, gentle but steady pressure should be made on the stricture: if it gave, so much the better; but if the urethra was perforated, as the surgeon would at once be aware of by the sensation communicated to the fingers, and by the

bleeding, the catheter should be at once abandoned. He (Mr. Arnott) agreed in the opinions that had been expressed, that the opening of the urethra behind the stricture, in the way in which it was usually performed, by cutting from the skin inwards, was an operation at once difficult, tedious, and uncertain. He had himself experienced these difficulties, and had witnessed them in surgeons of acknowledged eminence. He had also seen the occurrence described by Mr. Holt, of the bladder being opened at the anterior part of its neck. The plan of operating by the curved bistoury was easy of performance and very simple.

Mr. CURLING rose to explain that in the cases in which the bladder had been punctured at the London Hospital, he included cases of retention of urine from enlargement of the prostate gland, which had been injured by instruments, and attended with hæmorrhage into the bladder. He would also mention a remedy for retention from stricture, which was not applicable to persons of debauched habits and broken-down constitutions, but succeeded remarkably well in robust sailors and others. He alluded to the administration of croton oil; as soon as the remedy began to act on the bowels, the patient was able to urinate.

Mr. SOLLY explained that he recommended the operation in cases of permanent stricture, with enlarged prostate, and where great injury had been committed on the urethra. He supposed, from the remarks of the numerous speakers, that more bad cases of stricture were admitted into the hospitals at the east than at the west end of town.

Mr. N. WARD contended, that the operation was admissible in cases of retention with great distention of the bladder, and if it were done simply for the relief of the intense agony and suffering attendant on that complaint, and for the prevention of paralysis of the organ, on account of its simplicity and safety, as shown by the experience of several hospital surgeons, it might be resorted to.

Mr. CHARLES HAWKINS expressed his surprise that Mr. Cock should have met with so many cases of stricture requiring the performance of such an operation, when so many surgeons longer in practice than himself had not done it once.

Mr. WARD had understood that Mr. C. Hawkins was opposed to the operation altogether in the cases alluded to.

Dr. J. A. WILSON remarked, that if he understood the debate correctly, the operation under discussion was sometimes followed by a fistula, and yet it had been described as simple and safe. He would leave that question for surgeons to settle—how could an operation be either simple or safe if it had such a result?

Mr. Cock, in reply, said that the operation in question was recommended by him and others as a means to rescue patients from the effects

of retention when all other measures had failed. Some misapprehension appeared to have arisen from the number of cases he had brought forward. If his paper had been read in full, it would have been found that only twenty-four cases were his own, and that the others had been furnished by his friends. It might be supposed that he had resorted to this operation rashly. He had not done so, however, and had employed it only as a last resort, except in cases of old, impervious, hard strictures. The cases detailed had extended over many years, having been selected from an immense number of cases of retention of urine. He did not think such severe cases of impermeable stricture were met with at the west end of the town. He had endeavoured to show that this operation was only to be had recourse to in the severest cases, when every other palliative measure had failed; indeed, he was of opinion that he had used palliatives too long. He had mentioned three modes of proceeding for the relief of retention of urine; the first, by forcible dilatation; the second, by cutting into the urethra between the stricture and prostate, respecting which he explained its deficiencies and dangers, all of which were great, and frequently led to failure; the third, which he had mentioned, without detracting from the utility of the others, as being more simple, less painful, and more likely to succeed. Fistula had been spoken of as a drawback; but he (Mr. Cock) had never known of an instance of this, when the permeability of the urethra had been restored. One of the virtues of the operation was obtaining this persistency as a sort of safety-valve, until a free passage per urethram had been secured; there was often some difficulty in securing its patency until the canal of the urethra allowed the urine to flow through it. Some of the cases which had been read would illustrate this point. There is not a fistula through which urine distils; but when the bladder is distended, the impulse to evacuate its contents ensues, and then the urine is discharged in a gush by the rectum, instead of by the urethra; and it is a great comfort to the patient, after enduring the suffering from such a condition of the urinary organs, to be able to discharge the contents of the bladder in a gush. There is one other point which he (Mr. Cock) wished to allude to; it seemed to be denied by Mr. Coulson and by Mr. Gay, that relieving this state of those parts places the strictured portion of the urethra in a better condition for a cure to be effected than previously existed. This denial did not accord with the results of his own experience: every operation by means of which the contents of the bladder can be more freely discharged than was previously the case, must sooner or later place the urinary organs in a better condition; the urethra being relieved from the distress and strain upon it, and consequently the induration and other signs of disease gradually lessen and disappear.—*Lancet*.

Laryngotomy Successfully Performed in a Case of Foreign Body in the Larynx. By G. R. MOREHOUSE, M. D., of Philadelphia.

THE little patient, a girl of 10 years, daughter of Mrs. Saunders, on Wednesday morning, February 26th, while laughing and romping with her school-fellows, drew into the larynx a piece of almond shell which she had been holding in her mouth. She was immediately seized with a prolonged paroxysm of coughing, followed by dyspnœa and loss of voice. As soon as aid could be obtained, she was carried home, and Drs. Scoffin and Gegan successively sent for. Under their hands every medical means for disengaging the shell was tried, the œsophagus also was explored, and instruments used to force anything contained therein into the stomach, but every effort seemed in vain. The dyspnœa increased, and the paroxysms of cough became more incessant and more fatiguing. The only remaining mode of relief was the removal of the foreign body through an opening in the windpipe. Accordingly, on Thursday afternoon, I was called to see the child and operate if advisable. At that time the condition of the little sufferer proclaimed the necessity for immediate relief. The face was turgid and of a purplish hue, the eyes protruding, and slightly divergent, the mouth circled with a white zone, and the nostrils distended and pale, forming a countenance expressive of mingled anxiety and despair, the head was inclined forward, and the muscles of forced inspiration strongly contracted, giving to the neck the appearance of great emaciation. Deglutition seemed unimpaired, and she was able, with apparent ease, to gratify her craving thirst. Respiration was with difficulty maintained, and was accompanied with a wheezing sound similar to that heard in asthma, although much more feeble. She complained of no pain except when lateral pressure was made on the larynx. She seemed disinclined to exertion, except at intervals, when her motions were hurried and restless. She seemed fully to appreciate what was passing around her, and spoke to her friends in whispers, repeatedly expressing a wish to die.

Upon auscultation, the respiratory murmur, although barely discernible, was found alike free in either lung; there was no rattling sound to indicate the presence of a loose body in the trachea. Over the larynx, however, a whistling sound, as of a person blowing through a quill, was distinctly heard. These facts, therefore, the incessant cough, the dyspnœa, the pain of pressure, the whispering voice, and the whistling sound of constriction, all pointed to the ventricles of the larynx as the position occupied by the foreign body. By the time that these necessary examinations were made, and the mother's consent to

the operation obtained, it had become too dark to operate without the aid of artificial light. The extreme condition of the patient, however, rendered it necessary that an opening at least should be made in the windpipe to prevent death from opnœa. The operation of laryngo-tracheotomy, as originally suggested by Boyer, was selected as most appropriate. The patient was placed upon the table, and an attempt made to commence the operation. The violent convulsive struggles of the child, and the forced forward flexion of the head, rendered it impossible to proceed. Ether was therefore administered, sufficient to quiet, without producing its full anæsthetic effect. The superficial tissues were then divided in the middle line by a cut nearly three inches in length, the isthmus of the thyroid body was separated from its attachment, and the plexus of thyroid veins pushed aside with the handle of the scalpel. The windpipe thus being laid bare, and the hæmorrhage slight, as soon as the effect of the ether had passed away, the knife was entered just below the crico thyroidean artery, dividing, as it was withdrawn, the cricoid cartilage and three upper rings of the trachea. The air rushed from the wound as soon as the knife was removed, blowing before it the blood which flowed from the cut. The patient was raised and placed in a position favourable for the outward flow of the blood.

The relief experienced by the child was immediate and most gratifying, the black blood sunk from the face, the asthmatic breathing ceased, the labouring muscles were at rest, and the countenance, a moment since livid, swollen, and impressive, was now lit up with a smile of gratitude. As soon as oozing had ceased, examination was made for the foreign body, and it was found effusion had taken place in the submucous tissue, almost obliterating the cavity of the trachea at its upper portion. So great was the swelling that it was impossible to introduce an instrument through the rima glottidis, with the hope of extricating the shell; it was therefore proposed to continue the incision upward and divide the thyroid cartilage. On account of the prostrate condition of the child, however, and in hope that the œdema would subside and render the extension of the operation unnecessary, it was concluded to defer the division of the cartilage until the morning. In the meantime a conical curved tube, flattened laterally, was introduced through the opening, and secured by means of tapes passed round the neck. An anodyne was administered, and the patient left for the night.

On the following morning, the appearance of the child was propitious, she had rested well during the night, being troubled but little with cough; the tube had occasionally clogged with mucus, but was readily

cleared with a feather. The œdema in the trachea had greatly subsided; the chords were, however, in apparently as close proximity as ever. It was decided therefore to open the thyroid cartilage, and for this purpose a probe-pointed bistoury was prepared in the following manner: A coating of wax was applied to the sides of the blade, thus converting it into an edgeless instrument, which, having passed between the lips of the *rima*, would glide along without injuring them to their junction with the thyroid cartilage. The bistoury thus prepared was entered at the previous opening, passed between the chords, and with it the cartilage divided. The crico-thyroidean artery was cut, but was readily sealed by the application of a point of caustic. The cartilage was pressed asunder, and the piece of shell removed from the left ventricle by means of a pair of polypus forceps. The tube was permitted to remain in the wound until the swelling of the glottis had subsided, which could readily be judged of by the facility of breathing when the tube was closed. On the second day the tube was removed, and the wound closed with stitches and adhesive plaster. In order that the sides of the wound might be brought in apposition throughout their whole depth, a compress of a double headed roller was employed, the roller (half an inch in diameter) pressing parallel to the cut on either side, and bound to the neck by means of a bandage. The cut has healed kindly and rapidly; the water dressing was used, and parts of the surface occasionally touched with nitrate of silver. The wound was entirely healed on the 12th of March, fifteen days after the operation, the child's voice is as clear as ever in the morning, but towards evening is somewhat husky, especially if she is disobedient and talks much during the day.—*Phil. Med. Examiner.*

Dislocation of the Clavicle Backwards.

DISLOCATION of the clavicle backwards is comparatively a rare accident, a case or two from time to time being placed on record. One such is published by M. Foucard, (*Revue Medico-Chirurgicale*, Feb., 1851,) which occurred in a woman who, while endeavouring to move a cart by pushing against the wheel, got jambed between the wheel and the wall. She was bled next day, but her symptoms becoming severe, she was subsequently minutely examined. It was then found that in the place of the natural projection of the head of the right clavicle, there was a distinct hollow, and it was evident that a luxation backwards had taken place. The author made many attempts to restore the bone to its place,

but without avail, and therefore contented himself with subduing the inflammation by leeches. The patient recovered and now is only conscious of the accident when she is called upon to make unusually great exertion.

MIDWIFERY.

Complete Inversion of the Uterus, and Successful Reduction under Ether. By JAMES AYER, M.D., Boston.

A FEW weeks since I was called to Mrs. C., No. 2 W. Place, about 2 o'clock in the morning; and before I could leave my house, a second messenger came to urge the greatest haste. On my arrival I found the labour pains strong, and the patient walking around the room, and at times leaning on a chair. Supposing there was no time to lose, I immediately had her placed in a proper position on the bed; and, on examination, found the head presenting naturally, and pressing on the perinæum. With a few strong pains delivery was effected in fifteen minutes. The feet, however, were delivered with difficulty on account of the tension of the umbilical cord. After its birth the child was supported with its abdomen in close contact with the vulva. The cord was tied and divided. In five minutes after the division, uterine contractions came on, and the placenta and membranes were expelled. I am not aware that the slightest force was applied to the cord; as I usually wait a longer period before employing traction. Neither was the hand introduced within the uterus, before the expulsion of the placenta. The cord was not above eight inches in length. The placenta was of medium size. The waters had broken before my arrival. On the completion of delivery, the finger was passed within the uterus, and nothing abnormal was detected. The patient had been troubled with cough for a week or two previous to confinement; and it was noticed as particularly hard and dry at this period. Hæmorrhage after delivery was moderate. The patient was raised from the bed, her clothes changed in part, then placed in bed and a broad swathe applied to the abdomen, over the hips. As I was about taking my leave, the patient complained of "a painful swelling in the privates." On examination I found a hard tumour, larger than a hen's egg, pressing on the perinæum, and feeling like the internal surface of the uterus. Moderate pressure was employed, but the patient made such great complaint, the uterine contractions were so strong, and the resistance of the tumour so firm, I concluded to defer further attempts for the present. Prescribed syr.

morphiæ, to allay pain and procure sleep; the hips to be elevated, and to have perfect rest.

The same morning, six hours from delivery, I found the swelling increased and protruding beyond the vulva; it was as large as the fist. On inspection it was found to be of a deep purple colour, covered with mucous membrane, with moderate secretion, and tender to the touch. Taxis, though productive of great pain, was freely employed, but without success—and was repeated at each succeeding visit. In the intervals the patient was kept quiet on the back, with a pillow under the hips, and cloths saturated with iced water applied to the vulva.

Next morning, thirty hours from delivery, the protruding mass was larger than the double fist, dark coloured, strangulated and very tender. I had been able, at every visit, to circumscribe the tumour, feel the neck distinctly, and pass the finger up between the neck and the os tinæ, and thus pass it around the entire circumference. At this visit I could not circumscribe it, on account of its size, but could pass the point of the finger up as far as the cervix—but could press it no further. A hard ring or cord appeared to prevent any further progress. The whole body of the organ had evidently become inverted. The hæmorrhage on delivery had been moderate, but had constantly increased up to this time. The pulse, also, had been constantly increasing in frequency, and had taken on an inflammatory character; it now numbered 105 per minute. There was a white fur on the tongue, skin dry and hot, and considerable thirst. Some degree of tenderness over the bladder was noticed, and a swollen and tender condition of the labia pudendi. Since delivery, urine had been voided only once, and then pretty freely. An expectorant mixture had been prescribed, also spt. æther nitras. occasionally, and linseed tea as a common drink.

Here there was a train of symptoms presented far from agreeable. Reduction evidently was the only remedy; and thus far my efforts had proved abortive. Whilst reflecting on the probabilities of the case, and on the character of the obstacle, namely, the contraction of the os tinæ operating as a sphincter on the neck of the uterus—it occurred to me that the difficulty of hernia was similar to this. If, then, I thought the stricture of the abdominal rings can be so far relaxed by the exhibition of ether as to admit of the speedy restoration of the strangulated intestine, why might not the resistance in this case be overcome by the same agency? If the uterus could be once restored to its position, the application of cold and other adjuvants might retain it *in situ*, still sufficient contractions would come on to keep it permanently in its proper place.

Stepping out for an adviser, I accidentally met near the door Dr.

Clark, of Iowa, temporarily residing in my neighbourhood, and invited him in. He examined the patient, at my request, and fully coincided in the opinion that there was complete inversion. I mentioned the plan of treatment which had suggested itself to me. He admitted its reasonableness, and was kind enough to approve it. We knew of no precedent—but could see no risk in the trial. Indeed, it appeared to be the only method that offered any prospect of success. The case was urgent, and demanded an immediate remedy. Sulph. ether was employed, and the inhalation conducted by Dr. C. very gradually, whilst I grasped the fundus uteri and made gentle pressure. As the system became relaxed the tumour gradually diminished. In thirty minutes the vulva became perfectly flabby, and the tumour soft and compressible. I made firmer pressure, and it was reduced to the size of a hen's egg. The finger could circumscribe it. It remained twenty to thirty minutes of this size—uncertain whether further ground could be gained—and then, to my great joy, disappeared *per saltum*, with the peculiar feel of a receding hernial tumour.

The next indication was to retain the restored organ *in situ*, till the contractions should come on. The uterus was kept up by the point of the finger until a large bag of pounded ice was provided, and placed against the vulva; the hips were elevated and the legs slightly flexed on the thighs. Perfect rest, and syr. morphiæ to quiet the cough, were ordered.

The patient was under the influence of ether one hour and a quarter, and nothing unpleasant occurred during the process. Three hours after, I found there had been considerable hæmorrhage and cough; no urine had been passed. On examination, a tumour the size of an egg, was found protruding in the upper strait; made no effort to restore it, but continued the ice. At 7 o'clock in the evening the tumour had entirely disappeared; hæmorrhage moderate, with some coagula—no urine passed—pulse 90 and soft, and moderate thirst.

The next morning, twenty-four hours after the operation, pulse 80 and soft, less thirst, slept several hours in the night, discharged a pint of urine, and felt very comfortable. The uterus had become firmly contracted, and in the proper place. The external organs were yet swollen. Liquor plumbi subacet., ℥ij. to four ounces of iced water was applied on a napkin to the swollen parts, and the ice bag omitted. Afterwards a pint of urine or more was passed every twenty-four hours. The patient convalesced, without further accident, steadily and rapidly; and on the twenty-third day from the confinement was able to sit up two hours during the day, and to take light broth. The babe, a fine girl, weighed about seven pounds at birth, and is now eight weeks old.

The mother has attended to her usual duties for three weeks past, and says her health is as good as usual. She is of cachectic diathesis, and of lax muscular fibre; she is 23 years old.

The nursing, I would observe, was very imperfect, and increased the hazard of the case.

I have taken the liberty to give the history of the case in detail, as it is the first that has occurred under my observation. So rare is the accident, fortunately, that I have been able to learn but little in regard to it from the experience of practitioners around me. Obstetrical authors either deal with the subject briefly, or pass it over in silence. Denman, Dewees, Burns, Mad. Boivin, Gooch and Ashwell discuss the subject at some length. In Braithwaite, Part XIII., a very interesting case of inversion and successful reduction, arising from a short cord six to eight inches long, is given by Robert Smith, of Aberdeen. Part XIV. of the same Journal contains interesting remarks on the same subject, by T. R. Mitchell, M.D., of spontaneous inversion without hæmorrhage — also a case cited by Dr. Lever.

After the history given of my case, it is unnecessary for me to add that the accident was attributed primarily to the shortness of the umbilical cord; and, secondly, the powerful labour pains and the general laxity of the patient's system were considered as auxiliaries.

June 16, 1852.

On a Stethoscopic Indication of the Separation of the Placenta.

M. CAILLANT (*Thèse Inaugurale Paris*, 1852) informs us, that while engaged assiduously in the practice of obstetrical auscultation, it occurred to him to investigate the relations between the cessation of the placental bruit, and the disruption of the placenta from the uterine surface. While thus occupied, he accidentally made the discovery of a peculiar and characteristic sound, heard immediately after the expulsion of the child, and which he at once attributed to the peeling off of the placenta. In order to ascertain with certainty that this sound was so produced, he has been in the habit of auscultating the uterus during the whole process of labour, and thus made out that the sound in question was only audible immediately before the placenta was felt in the vagina. This sound consists in a repetition of cracklings, of considerable intensity, beginning and subsiding with each uterine contraction. It is said to be very different from the muscular bruit attending the contractions of the organ, as well as from the placental bruit itself, and more nearly resembles the dry crepitus of emphysema than any other known sound.

A case of Hæmorrhage from Inversion of the Uterus, in which the Operation of Transfusion was successfully performed: with remarks on the Employment of Transfusion generally. By JOHN SODEN, Surgeon to the Bath General Hospital.

THE author begins by expressing his belief that the evidence in favour of transfusion is not generally known, and that false notions prevail with respect to its dangerous character. Having had an opportunity three years ago of proving its power, he was induced to examine into the results of all the recorded cases, and has presented a table of thirty-six in which the operation was performed in connexion with the puerperal state. The thirty-sixth case was that in which transfusion was performed by the author. A lady was delivered of her third child rapidly, and the latter pains were so severe that the uterus was violently emptied of its contents, and became inverted, a gush of blood ensued, and the patient fainted. The placenta was detached, and the uterus returned; no further hæmorrhage took place. In half an hour the patient had not rallied, and was insensible, cold, pulseless, and exsanguine in appearance; the breathing was at long intervals, stertorous, and jerking. She could just swallow stimulants by teaspoonfuls at a time, and every other means were used to restore her. After about an hour she became, however, worse; was no longer able to swallow, and the respirations became more rare and stertorous. Transfusion was now had recourse to. The opening was made in the external cephalic vein, and blood drawn from the husband was injected by means of an ordinary syringe of German silver, with a detached stop-cock, previously well warmed. At first the blood would not pass, but returned through the opening in the vein; presently the opposition, from the contact of the coats of the vein, seemed to give way, and the blood, though impelled by a steady and moderate pressure, rushed rapidly up the vein. The effect was instantaneous; a convulsion seized the whole frame, and the muscles of the face were frightfully distorted: not more than an ounce was injected. The convulsion soon passed off, and the patient gradually recovered; it was full an hour before any pulse could be felt at the wrist, and she did not recover consciousness till the following morning. During this time stimulants were continually given; she remained for some time in a weak condition, but has since had another child, and is now doing well. The author then proceeds to analyse the table of cases, which shows that out of thirty-six cases, twenty-nine were recovered from imminent danger, and it does not appear that in the fatal cases death was due to or hastened by the operation. In two, it may be presumed that death had occurred before the operation was performed; in a third, only a small quantity of blood could be procured; in a

fourth, no effect; in the fifth, there were marked but not permanent effects; in the sixth and seventh, the women were too much reduced to be restored. The author considers the influence of the blood injected not to arise from the mere mechanical effect on the heart, but from a direct stimulation of the nervous system, and that the rapidity of the effect is modified greatly by the circumstances of the case, as regards previous duration and cause of exhaustion, and by the character of the means used, as regards quantity, quality, and the mode of operating. With regard to quantity, it appears that a lesser amount was needed in proportion as the exhaustion arose from the suddenness rather than the amount of the bleeding. The author thinks that some cases have been lost from a fear of introducing too much blood, the dangers of which, he thinks, have been over-estimated. The quality of the fluid he regards of great importance, and he alludes to the impropriety of using the blood of the lower animals. The blood need not be drawn from one individual only; that drawn from many may be taken, but it should be the blood of healthy persons. The want of success attending Dr. Simpson's cases of saline injection in uterine hæmorrhage he attributes to the nature of the fluid used, while the same fluid might be serviceable in cholera, the quality as well as quantity of the blood is interfered with. With regard to the mode of performing the operation, the author believes that a simple syringe, with a detached stop-cock, plated or tinned on the inside, and capable of holding about three ounces, is the best instrument. The more complicated instruments constructed to guard against the admission of air, he considers needless, as the danger is an imaginary one. In one case the operation was successfully performed with a common toy syringe. The operation should, however, be performed at the arm or in some distant vein, in preference to the neck, where there might be some risk from the entrance of air. The convulsions which arose in author's own case, he attributes, not to any irritating quality in the blood injected, but to the transition of the patient from a state of coma to that of syncope; the same thing was noticed in one case three times on the exhibition of stimulants only, and before transfusion was performed. The author then proceeds to notice the opinions of writers on the subject of the treatment of uterine hæmorrhage, and concludes by making few remarks on the general application of transfusion, which has been equally beneficial in cases of hæmorrhage from other causes, and in exhaustion from inanition. It has been, too, of temporary service in phthisis in cancer of the stomach. Its use is suggested in the collapse of typhus and in the diarrhœa of children, where exhaustion is threatened.

In reply to a question put to him by the President, Dr. Lee said that

he had never seen transfusion of blood employed in any case of uterine hæmorrhage. Having so often of late intruded on the time and attention of the Society, he said he would forbear at present making any further observations on the subject, and now sit down. The Society having expressed a desire that Dr. Lee should state his views on transfusion as a resource in uterine hæmorrhage, he proceeded to observe that in none of the varieties of flooding could he place much dependence on transfusion, and he did not believe that in the case now related to the Society the recovery of the patient could be referred to the introduction of an ounce of blood into the venous system. In accidental uterine hæmorrhage, if the membranes be early ruptured, and where this fails, delivery is completed speedily by turning, the forceps, or craniotomy, and all the means in our power employed to secure uterine contraction, comparatively few women perish; and he (Dr. Lee.) had seen some recover where the symptoms were of the most alarming character, and recovery appeared absolutely impossible. In such cases, had transfusion been employed, the recovery would have been referred to it, and not to the real cause, the persevering and vigorous use of the ordinary remedies—pressure over the uterus, the external application of cold, and the internal administration of brandy, wine, and ammonia. In the hæmorrhage which takes place after the uterus has been wholly emptied of its contents, the same remedies, if actively employed, are successful in a large proportion of cases. In most of the fatal cases of this description which he (Dr. Lee) had seen, the common practice of introducing the hand into the uterus to excite it to contraction by rubbing the inner surface, had been employed, and he had likewise seen cases where fatal uterine phlebitis could be referred to the same plan of treatment, which is not efficacious in exciting uterine contraction where great exhaustion exists from previous profuse loss of blood. This practice of rubbing the inner surface of the uterus with the closed fist, is not merely inefficacious in the worst case of atony of the uterus, but it actually displaces those coagula from the exposed vessels which form one of the principal means which Nature employs for the permanent suppression of uterine hæmorrhage. If proper compression be employed over the hypogastrium, coagula can never form to distend the uterus, and like a foreign body, prevent its contractions. Hæmorrhage to a dangerous extent can never, he believed, take place where the uterus is contracted in the ordinary degree. The danger of uterine hæmorrhage from placental presentation is much greater than in the accidental variety; but the mortality has been very considerably diminished in my practice since I observed the fact, that in rigid conditions of the os uteri it is possible to seize the lower extremities of the child with two fingers, and deliver by turning,

without introducing the whole hand through the os uteri. It is deeply to be regretted that an attempt, founded upon a grave anatomical blunder, should have been made to alter the practice established during the last century and a half in unavoidable uterine hæmorrhage. The blood does not proceed from the placenta, as has been asserted, and it is therefore irrational and absurd to recommend tearing it away, or detaching it from the uterus with an iron instrument, and leaving the child within the cavity after being imprudently deprived of life. Some inexperienced practitioners have actually tried this unscientific mode of proceedings. He (Dr. Lee,) had great faith in the established rules of practice in all the varieties of uterine hæmorrhage.

Large Ovarian Cyst treated successfully by operation. By Mr GABB, of Hastings.

THE following case presents many points of interest. At the time the operation was performed, it was considered impossible the woman could long have survived, if the plan of repeated tapplings had been adopted. The operation performed was a modification of that proposed by Mr. Bainbrigge and Mr. Brown, but the external opening was made lower down than has hitherto been attempted, to facilitate the exit of the discharge, and to prevent the bagging of the cyst below the external aperture:—Mrs. L., aged 32, tall and slight, has been married seven years, has had three children and aborted twice; has never been strong though enjoying tolerable health; she suffered occasionally, about ten years ago, from much pain in the left side, over the region of the descending colon, but does not remember if it was worse during the catamenia; menstruation natural up to her marriage. Had a lingering labour with her first child five years ago, and since then has been more weakly, but had nothing particular to complain of. Was confined again in 1849, and had a good time; she remarked, however, that she did not regain her natural size; health much as usual. Her last child was born in January, 1851; labour natural; after which she so rapidly increased in size that it was necessary to tap her in March, and twelve quarts of clear and highly albuminous fluid were removed; recovered quickly. She again consulted me in October, being much distressed by the reaccumulation of the fluid. Dr. Tyler Smith saw her on the 27th of that month, and it was agreed, if, on a careful examination, all the other internal organs were found to be normal, to perform the operation recorded.

Present State.—Extreme emaciation; the nipple was apparently the

only portion of the mammæ remaining ; thoracic viscera healthy ; urine slightly albuminous, probably from the pressure the kidneys were subject to ; externally and per vaginam, the tumour (in which fluctuation was peculiarly distinct) occupied the left side. The catamenial discharge (which had just occurred) has been regular since February when she weaned her infant ; she has always remarked that after each period she has got more rapidly larger.

On November 3, at eleven A. M., the following operation was performed under the influence of chloroform, and with the assistance of Dr. Tyler Smith, Dr. Stevenson, and Mr. Ranking :—A vertical incision, about three inches long, was made over the lowest portion of the tumour on the left side, a little external to midway between the anterior superior spinous process of the ilium and pubes, and extending nearly as low as Poupart's ligament. The integuments and fascia were cut through and the muscle carefully divided, until the cavity of the peritoneum was opened. The sac (the walls of which were very thin) then came into view, six ligatures were passed through it and the rectus, attaching it closely to that muscle, the fluid was then removed by puncturing the sac with a large trocar, and the operation was concluded by passing a piece of oiled lint into the sac to prevent union and to allow any secretion to escape, and then bringing the edges of the external wound together with sutures, excepting the part left for the plug just mentioned. She bore the operation well. Nine P. M. : very comfortable and cheerful ; pulse quiet. Gave an anodyne draught. 4th. Passed a good night ; very comfortable ; no febrile excitement. 5th. Going on well. 6th. So comfortable that I did not think it necessary to remove the dressing. 7th. Wound healing by first intention ; no discharge. 8th. Passed a bad night ; pulse 120 ; skin hot ; troubled much by flatulence and sickness, which she generally suffers from after her confinements ; no tenderness of the abdomen on pressure, but a little distended ; bowels open ; no discharge from the wound. 9th. Removed the plug out of the sac, and about a pint of clear but offensive serum ran out ; wound, excepting the part kept open by the plug, nearly well. The only thing she complains of is the distress from the flatulence, which was removed by compound galbanum pill. 10th. Slight tenderness on pressure from peritonitis ; sickness ; pulse 120 ; ordered mercury and opium frictions ; no discharge from the wound. 11th. Much the same : abdomen tympanitic ; sickness still troublesome ; no discharge ; from the flaccidity of the abdominal parietes the wound is valvular ; on removing the dressing an immense quantity of highly offensive gas escaped, and about a pint of serum with flakes of pus ; the silver probe was turned black by the secretion ; felt much

relieved. 12th. Comfortable. 14th. Feels much better; wound discharging freely; fluid of the same character, though less offensive. 16th. Going on well; tenderness gone; about a teacupful and a half of healthy pus comes away in the twenty-four hours. From this date she has progressed satisfactorily, the secretion varying from half to a teacupful in the twenty-four hours. She has lost flesh considerably since the operation. December 31st. Down stairs; is gaining flesh; weighed eighty-five pounds and a half; discharge about two table-spoonfuls daily. February 5th. Has been out for a walk in the garden; weight eighty-nine pounds and a quarter; about a teaspoonful of discharge. March 11th. Sutures not come away; discharge the same; the probe will only pass downwards, backwards, and inwards; the sore is contracted seemingly to a very small size. The catamenia had not appeared since the operation. On examination per vaginam nothing abnormal can be detected. The urine shows no trace of albumen. 22nd. Weighed ninety-one pounds three-quarters. Since this date she has steadily continued to improve, and can now take a good walk.

At the request of Dr. Tyler Smith a microscopical examination of the blood, of the fluid which came away when the sac was first opened, and of the fluid which came away at the close of the examination, was made by Dr. H. Jones. The following is the microscopical report made by Dr. H. Jones:—1. "The serum was deeply red tinged, contained fewer blood globules than healthy blood, and they were also apparently feebly formed and less coloured than natural; there were many white or lymph globules, and some granular films of fibrin. 2. The first drawn fluid contained multitudes of small vesicles, bearing on their walls opaque refracting granules, in number from six to one. I think these were altered blood globules, they were about that size, and had much the appearance that blood globules, when roughly treated, sometimes put on; their membrane was often distinct, enclosing a pale fluid. Along with these there were a very few imperfect granule cells and many tablets of cholesterine; the fluid itself was decidedly coagulated by nitric acid, but did not form a very bulky coagulum. 3. The last-drawn fluid contained a few small flakes of whitish aspect; it was similar to the above, containing altered blood globules. I suppose them to be in abundance, and also cholesterine. The flakes consisted of largish granules opposed together like the bricks in a mosaic pavement; they were perhaps the remains of an altered epithelium. Fat vesicles and cholesterine were mingled with them. All this seems to indicate a low condition of vital power."

April 16, 1852. Upwards of five months have now elapsed since

the operation described above was performed, and the subject of it has steadily improved during that time. She was not weighed until she began to improve, but though a tall woman, her weight was only, when it was first taken, eighty-five pounds and a half. She had in three months increased five pounds and a quarter. The comparison between the operation described and tapping, appears favourable to the former. Between the first tapping in March, 1851, and the time when she would have required tapping, a second time,—viz., in November of the same year, eight months elapsed. Upward of five months have elapsed since the operation, and her disease has received a most decided check. The probability is, that had she been tapped in November, the sac would ere this have refilled. The loss from suppuration through the opening into the ovarium is evidently less than the loss from the flowing of albumen and other elements of the blood into the sac. Under the one the patient steadily proceeded in emaciation; under the other, she has gained flesh and strength. But the future progress of the case will require to be recorded.

PATHOLOGY AND PRACTICE OF MEDICINE.

On Fibrinous Deposits on the lining membrane of veins. By HENRY LEE, Esq.

SIMPLE inflammation of the veins—that is to say, inflammation commencing in the coats of the veins—is regarded by the author as a very rare disease. The internal lining of veins especially would appear to be as little susceptible of inflammation as any structure in the body. The large number of instances of phlebitis met with in surgical works, and occurring in daily practice, are regarded by the author as depending upon, and being excited by, a vitiated condition of the blood. This opinion is principally supported by the two following facts: first, that in every case of so called inflammation of the veins, the blood will be found to have coagulated in the vessels; and secondly, that where such coagulation does not take place, no inflammation will be produced. Continental writers of the highest reputation have indeed mentioned the eccentric layers of lymph which are secreted as the result of inflammation in the interior of veins; and English writers, whose names carry with them the greatest authority, have described the adhesion of the opposed sides of veins by lymph secreted from the capillaries under a state of inflammation. The advocates of this view have particularly referred to an experiment of M. Gendrin, in which he mentions, that by introducing ir-

ritating substances into the arteries and veins, he obtained large deposits of lymph upon their interior. The author, on the contrary, having found that inflammation of the coats of the veins only occurred in cases where the blood had previously coagulated in them, was induced to believe that the deposit found in the veins might be derived directly from the blood. M. Generin's experiment was therefore repeated, precautions being taken to exclude all blood from the vessel; and it was found that under these circumstances no lymph was effused in the vein. The lining membrane of the veins does not contain any blood vessels of its own, nor does it require any, being in direct contact with the blood. It appears reasonable to suppose, that under such circumstances it would not secrete lymph, and the experiments and observation of the author lead him to this conclusion. The lining membrane of a vein, the outer coats of which are inflamed, may undergo various changes, or may be disintegrated, and cast off into the cavity of the vessel. Lymph and pus may then be secreted into the interior of the canal; but this can only occur in the latter stages of the disease. The readiness with which some morbid poisons produce the coagulation of the blood, and the constancy with which such coagulation (indicated by the cord like induration of the vessel) is found to precede the other symptoms of inflammation, lead to the conclusion that a vitiated condition of the blood is the common cause of phlebitis. Under such circumstances, although the irritation produced is caused by the morbid matter detained in the vein, yet the inflammation is at first manifest in the surrounding parts. The cellular tissue becomes distended with serum; the cellular coat of the vein then becomes thickened, red, and inflamed; and finally, the changes which have been noticed extend to the lining membrane. The effects of inflammation thus are shown to extend *to* and not *from*, the internal surface of veins. M. Cruveilhier, indeed, regards the coagulation of blood in a vessel as the effect of inflammation previously existing. But the author has satisfied himself, that if blood be prevented from stagnating in a vein, no change will there be produced in its lining membrane.—The inflammation is not therefore propagated by continuity of surface, as has been generally supposed, but by the stagnation in different parts of vitiated blood. Coagulation of the blood would therefore appear to be the cause, and not supported by the effect, of inflammation of veins. This view is further supported by the fact, that simple adhesive inflammation of a vein will not produce coagulation of its contents. A preparation was exhibited, showing the effects of a ligature upon a vein twenty-four hours before death. No coagulation of the blood, nor deposit of fibrin on the lining membrane, had in this case taken place. The coats

of the vein were thrown into folds, and a white band marked the situation of the ligature ; but the projecting folds of the lining membrane presented their natural smooth, polished, and lubricated appearance. Healthy venous blood will remain fluid for days, when confined in a vein by a ligature. In this respect there is a contrast between a vein and an artery. In the latter case, the internal coats are divided, and the blood, coming in contact with the divided edges, immediately coagulates. In the vein, on the contrary, the lining membrane is not divided, and therefore the blood remains in contact only with the natural lining of the vessel. Cases in which a small quantity of pus has been introduced into a vein, afford the strongest contrast to those in which the coats have been mechanically irritated. In the latter case, no coagulum will form, or one only sufficient to unite any lesion there may be of the lining membrane. In the former, on the contrary, extensive fibrinous plugs will occupy the vessel. These will sometimes occupy the whole diameter of the vein, and become firmly attached to its sides ; at other times, the outer layers only will become firmly coagulated, and the central ones will remain in a semi-fluid condition. It will sometimes happen that the central portions will be removed, leaving the outer layers attached to the walls of the vessel. The circulation may then be continued through an adventitious cylinder of fibrin. Cases occasionally occur, in which a delicate velvety layer only is deposited on the lining membrane, which remains unaltered in appearance in other parts. The coagula which form in veins will, under such circumstances, lose, in different situations, much of their colouring matter ; and it will be observed that the lining membrane of the vein is coloured (from imbibition) in exact proportion to the amount of colouring matter contained in the different parts of coagula. It will occasionally happen that portions of the decolourized fibrin will become organized and intimately connected with the sides of the veins, as illustrated in a preparation exhibited to the Society. Such layers of fibrin appear constantly to have been mistaken for lymph, the product of inflammation. The extreme readiness with which the blood coagulates from the contact of purulent matter, affords a most important provision for the security of the general system. It appears to depend upon a faculty with which the blood is endowed for its self-preservation. This faculty, although hitherto unacknowledged by physiologists, doubtless exists, and is comparable to the preservative sensibility with which every other part of a living being is endowed. When purulent fluid is introduced into a vein, if the coagula are firmly formed, a local inflammation will alone ensue ; but if the morbid matter extends along the vessel, a high degree of constitutional irritation will follow, and the symptoms will occasionally bear a striking

resemblance to those of typhus fever. In cases as they present themselves in practice, these two sets of symptoms are constantly present at the same time, but they may be produced separately by a very simple experiment: if, for instance, purulent fluid be introduced into a vein, and allowed to remain undisturbed, a local inflammation only will be set up, which will terminate in the formation of an abscess around the vein. The contents of the vein will then become softened, and expelled externally, together with the contents of the abscess. But if the morbid matter be forced forward, in the course of the circulation, no local inflammation will occur, but the symptoms will indicate either the presence of secondary inflammation in some internal part, or of a general contamination of the blood. If the view taken of the origin of inflammation of the veins be correct, it will be evident that any treatment, to be effectual, must have reference to the first periods of the disease; and that those remedies will most effectually guard the system against the contamination (so much dreaded in this class of cases) which will favour the sequestration of vitiated blood, and tend to localize the disease. The remedies which have been employed to subdue the local inflammation, appear but too often to have done so at the expense of the general system; for although the local symptoms have become less prominent, fatal mischief has appeared in other parts. In severe cases, those remedies only can be safely employed which tend to preserve the power of blood, and especially those which increase its coagulating power, so as to enable it to separate that portion which, as become infected from the general circulation. Bark and opium, together with a nutritious diet, are the means which appear to favour these actions, upon the due performance of which the safety of the patient depends; while bleeding and calomel, however useful they might be in a case of simple inflammation of the coats of a vein, appear inadmissible when the disease, as generally happens, originates in its contents.—*Lancet*.

On the Pathology of Lepra and other Scaly Diseases of the Skin. By
R. B. TODD, M. D.

THE views of the author on the pathology of the squamous diseases are thus expressed:—In discussing this subject, the problem we have to solve is this—What can give rise to these remarkable patches on the skin? why do they assume their peculiar form and other characters? and why do they prefer particular situations of the body? Now we gain an important clue to the decision of this question by our knowledge of the clinical history of syphilitic lepra. That knowledge amounts to this: by the con-

tact of a certain diseased secretion a primary sore is generated ; this is followed by more or less of febrile disturbance, sore throat, articular and periosteal affections, and a peculiar eruption of the skin. It may be taken as quite certain that the cause of all these morbid phenomena is to be found in the introduction into the system of a particular poison. That poison need not be introduced into the system through a mucous membrane ; if it be brought in contact with an open surface on the skin, this is quite sufficient to procure its introduction into the system. In this way medical men sometimes become infected, as in a case which lately came before me :—A highly respectable practitioner attended in her labour a woman in whom it never occurred to him to suspect any syphilitic disease. It so happened that at the time he had an abraded surface on one of his fingers. An obstinate ulcer formed here, and secondary symptoms ensued, extending even to disease of the bones. He was at first quite at a loss to explain the cause of his symptoms, when the woman whom he attended applied to him to be cured of secondary symptoms, having an eruption exactly similar to his own ; he at once saw the source of his affection. It is through the blood that such a poison must be introduced ; there is no other channel through which it can be so conveyed through the system and to such various parts. We learn, then, that a particular poison generated in the body of another may, by its introduction into the blood, create an eruption on the skin which presents characters very much resembling those of common lepra ; and the person in whom the poison is first generated may poison several others, giving rise to the same morbid phenomena in each. Thus a particular modification of the syphilitic poison may produce, by its introduction into the blood, a leprous eruption on the skin. So, also, other poisonous matters will cause cutaneous eruptions ; iodide of potassium will cause an eruption of urticaria or of herpes, or even an eruption of somewhat of the scaly character ; mercury will cause a particular form of eczema. The poison of the exanthemata generates each its peculiar form of eruption ; and the typhoid poison also occasions a very characteristic rash on the skin. Surely, then, nothing can be more reasonable than to assume that the eruption of lepra vulgaris, so similar to the syphilitic form and affecting similar parts, is due to an analogous cause—namely, to the presence in the blood of a poisonous agent. But the questions arise, how and where is this generated ? can it be isolated ? can it be communicated from one to another ? To the first question we may answer, that it is generated in the primary and multiplied in the secondary assimilating process. But as to what gives rise to its generation we can form no definite idea : why it should be generated in one who is fed well and had plenty of work ; and why it should also be generated in another who wanted work, and fared wretchedly, are not

to be so easily explained. This, however, must not be forgotten as bearing upon these questions,—that an excess of food, or supply of a kind of food which is not readily digested by the stomach of the patient in question, may derange the assimilating processes just as much as an insufficient supply of poor food. To the second question we must answer, that the poison of lepra cannot be isolated, no more than we can isolate the syphilitic poison. But in reply to the third question, it may be affirmed that, although the lepra vulgaris is not communicable from one to another, as syphilis is, yet in another sense, it may be propagated from one to another; I mean that, while it is not contagious, it may be propagated by hereditary descent. And this latter fact, which I suppose the clinical history of lepra establishes to the satisfaction of even the most scrupulous, is favourable to the view of its pathology which I am endeavouring to advocate. For most—if not all—diseases which seem to arise from a *materies morbi* in the blood, are apt to be propagated by hereditary descent. Another feature of these scaly diseases which favours this humoral view of their pathology in the disposition which the eruptions manifest to affect the skin symmetrically. Many diseases referrible to the *materies morbi* exhibit this tendency to symmetry; as has been shown by Dr. W. Budd, is a most valuable paper in the *Medico-Chirurgical Transactions*, in which he discusses with great ability the pathology of lepra and psoriasis. To conclude, then, this part of my subject, which time forbids me to treat of at greater length, I would sum up thus: that as the syphilitic lepra is due to the introduction into the blood of a poison generated in the body of another as the result of impure and promiscuous sexual intercourse, so the lepra vulgaris is produced by a poison generated in the body of the patient—an effect of some disturbance of the primary and secondary assimilating processes; or of which the germs, as it were, were transmitted from either parent, and were multiplied in the secondary assimilating processes of the patient.—*Med. Gaz.*

OPHTHALMIC AND AURAL SURGERY.

Dislocation of the Lens, preceded by spontaneous giving way of its Suspensory Ligament; Extraction. Under the care of Mr. DIXON.

DISLOCATION of the crystalline lens is an accident which must be familiar to those who are in the habit of seeing large number of patients in ophthalmic hospitals; but the following cases present certain points sufficiently interesting to allow of their being brought under the notice of

practitioners whose opportunities for observing eye diseases are more limited.

John L——, aged fifty-three, applied at the hospital October 30th, 1851. Three weeks previously, he was chopping a piece of wood, when a fragment, the size of the little finger, flew off, and struck him on the left eye, the sight of which immediately became almost lost. He felt no particular uneasiness at the time, but, within a few days, considerable pain came on, and increased so much, that, for several nights before seeking relief, he had been unable to sleep.

On looking at the eye, Mr. Dixon found the lens opaque and brownish, lying at the bottom of the anterior chamber, and no change as yet appeared to have taken place in the texture of the iris. The upper part of the pupil was not hidden by the lens, and, as the cornea was quite transparent, the patient saw large objects placed a little above the level of the eye. The conjunctiva and sclerotic were much injected, and there was a considerable vascular zone around the edge of the cornea.

In the right eye the iris was slightly tremulous, and on examining more closely, Mr. Dixon found the lens opaque, and attached at only its inner margin to the suspensory ligament, on which, as on a hinge, and with its outer edge directed backwards, the lens was swaying to and fro, with every lateral movement of the globe, leaving the outer part of the pupil unobstructed.

The patient declared the sight of this eye to be quite as good as ever, but it proved (as might have been expected) that he could not read without a convex glass.

No doubt a similar partial detachment of the lens from its suspensory ligament had, for some time, been going on in the left eye, and the effect of the blow had been to break the slight attachment which still remained, and, at the same time, propel the lens through the pupil into the anterior chamber.

The only treatment likely to relieve the patient from the pain he was suffering, was to extract at once the dislocated lens, before the cornea and iris, which as yet appeared perfectly healthy, should undergo inflammatory changes. The patient, however, could not make up his mind to any operation until the following day, by which time another night, passed in sleeplessness and pain, had made him ready to submit.

On Nov. 1st, Mr. Dixon having made a downward section in the cornea, the lens followed the knife, together with a very small quantity of vitreous humour: the eyes were closed with a roller, as after an ordinary operation for extraction, and within half an hour the patient was fast asleep.

The patient remained in bed for six days, and took good nourishment. After this time the eye was examined. The section was united sufficiently to retain the aqueous humour, but there was a slight prolapse of the iris; the patient had good perception of large objects.

He continued to do well: the prolapsed iris gradually smoothed down; and seven weeks after the removal of the lens, the union of the lower margin of the pupil with the corneal wound, was the only noticeable consequence of the operation. The sight of the eye was good for large objects, but he could not see to read with it.

The result of this case is more satisfactory than could have been foreseen. The lens, lying in the anterior chamber, could be regarded merely as a foreign body, which was to be removed for the purpose of relieving the patient from the constant pain he was suffering, and also of preventing the destructive inflammation of the eye, which otherwise must have inevitably ensued. The partially-detached condition of the lens in the right eye rendered it additionally important to secure, if possible, some sight in the left, since, in the event of the suspensory ligament of the right lens giving way totally (as will probably one day be the case), the lens would either fall down to the bottom of the posterior chamber, where it might set up chronic disease of the retina, or, in the event of a blow on the eyeball, might be dislocated into the anterior chamber, in the same way as the left lens had been.

Mr. Dixon has favoured us with another very interesting case of dislocated lens, recorded in his case-book. We transcribe it verbatim, with Mr. Dixon's introductory remarks:—

“The partial or complete detachment of the lens from its suspensory ligament seems to be the result of a slow process of softening, accompanied by a corresponding change in the adjacent, anterior portion of the vitreous body, both of which changes may go on without any symptoms directing the patient's attention to the part. Several such cases have come under my notice at the Ophthalmic Hospital, and others must have been observed at similar institutions. Commonly, such partially detached lenses are found opaque; they probably all eventually become so; but I witnessed a remarkable instance of an extensively detached lens retaining its transparency in a young man of twenty-six, whose case is reported in the Appendix to Mr. Bowman's Lectures on the Anatomy of the Eye, (p. 134, R.)

“The reason why, in some instances, the falling down of a lens is not followed by impaired function of the retina, while in others amaurosis gradually ensues, may perhaps depend on the extent to which the dissolution of the vitreous body proceeds. If only a small portion of this body becomes diffuent, the lens may sway to and fro in this perfectly

fluid portion, while the rest of the vitreous body, retaining its natural consistence, may buoy up the lens sufficiently to prevent it touching the retina. If, on the other hand, the whole of the vitreous body be changed as to differ but little in density from water, the lens will sink as it would in common water, and so come into actual contact with the retina, setting up in that same structure the kind of slow change which so commonly ensues within a year or two after those operations of depression, in which the entire lens, in its unbroken capsule, is thrust down to the bottom of the posterior chamber.

The following case illustrates most of the foregoing remarks:—

“Elizabeth G——, aged sixty-three, had had cataract in the left eye for nearly forty years, the right eye remaining in all respects healthy. In the beginning of January, 1848, she found the sight of the left eye suddenly restored, the lens having become dislodged and fallen down into the posterior chamber. This occurred without any blow or violence to the eye. She applied at the London Ophthalmic Hospital on the 4th of May; the lens had then sunk below the level of the pupil, but came into view whenever the eye was briskly moved, being slightly attached by its lower margin to the suspensory ligament. She complained of a cloud passing to and fro before her, which quite prevented her from working. There was also frequent pain in the eye, but no redness. Whenever the lens sank out of the axis of vision she saw well, and with a convex glass almost as well as with the sound eye.

“By May 5th the lens had become completely detached from the suspensory ligament, and might be seen rolling over and over, as the globe was briskly moved. The pain had increased. Atropine was applied, and the patient ordered to lie for several hours on her face, in hopes the lens might pass into the anterior chamber; but this plan failed.

“I explained to the woman that, if left to itself, the lens would continue to annoy her; that she might be subject for years to pain in the eye, and that, in all probability, total blindness would eventually ensue; that, at the same time, any attempt to extract the lens from the posterior chamber might cost her the sight of the eye, but that, if successful, it would secure her against future pain and inflammation. She readily agreed to an operation on these conditions, as the constant oscillations of the opaque lens altogether incapacitated her from gaining a livelihood.

“June 10th.—The patient being seated, I made an upward section of the cornea; an escape of perfectly fluid, vitreous humour took place as the knife was withdrawn. I quickly passed a fine, sharp hook through the pupil into the posterior chamber, and, getting a glimpse of the lens, caught it by a lucky plunge, and withdrew it through the cor-

neal wound. As it was being withdrawn, the capsule burst, and a creamy fluid escaped; a flattened amber nucleus, about a line and a half in diameter, hung in the section, and was lifted out with the cuvette. The corneal flap having been adjusted, the common bandages were applied, and the patient sent to bed.

“Examined with the microscope, the disk-shaped nucleus presented the ordinary fibrous appearance of lens. It was enveloped by the collapsed capsule, which was transparent, or nearly so, among the folds of which were entangled some oil-globules, granular matter, and broken fragments of lens-fibres.

“14th.—The eye being inspected, the cornea was found clear, and the section united. The pupil was very large, and its margin had dropped backwards, as always happens after a large escape of vitreous humour. The patient had scarcely any perception of light, and this may have arisen from rapture of some vessels of the choroid or retina, consequent upon the sudden escape of so large a portion of the contents of the globe. The patient remained quite free from pain, and left the hospital on the 8th of July, with the eye in the following state:—The cornea clear; the pupil large and immovable; the sclerotic and conjunctiva free from unnatural vascularity; vision limited to mere perception of light. The woman was, however, quite satisfied at having been freed from pain, and restored to the free use of her right eye at the expense of the other, which, as I have stated, had been useless during the greater part of her life.”

Canada Medical Journal.

MONTREAL: JULY, 1852.

MEDICAL CONVENTION TO BE HELD AT TORONTO.

It will be perceived from the letter of Dr. Widmer, published in another part of this Journal, that a General Meeting of the Profession is to be held in Toronto, and we hope that some plan will be decided upon, to place the Profession on a footing of greater respectability. In Lower Canada we had to contend, in some parts, with uneducated and unlicensed practitioners, but the worst of them were superior to the horde of root doctors, steamers, and quacks, that are flocking into every village in Upper Canada, and dividing with the regularly qualified physician, the scanty subsistence the practice of the neighbourhood is capable of affording. These impostors ingratiate themselves into the good opinions of the farmers and country shop-keepers, and descend to familiarities with the lower classes, to which the educated gentleman cannot stoop, and soon the latter finds, that his ignorant and low competitor is preferred to himself, or at least, divides, pretty equally, public confidence. These fellows have hitherto been allowed to go on unmolested, and have been fostered and encouraged in their proceedings, even by those, who should be the protectors of the lawful practitioner, and who, from the position they have been elevated to by the suffrages of the people, should have taken advantage of that position to protect them from fraud and deception. But no! the quacks are numerous, and exercise a baneful influence at all elections; the well educated practitioner must be sacrificed to elevate the village attorney to a place in Parliament, and he whose reputation has never extended beyond the walls of a small country court, and whose attainments are barely sufficient to place him in the respectable company of the Dodsons and Foggs of his neighbourhood, now discourses learnedly upon medical science, and can adduce the persecution of Harvey, and the old story of Gallileo, as apt illustrations of the intollerant spirit of the medical profession, and of philosophers generally; and with a pointedness, more striking from its novelty, endeavours to class under the same form of persecution and

opposition to the advance of science, and the diffusion of real knowledge, the well-meant and loudly-called-for interference of the government, to prevent ignorant impostors from tampering with human life. That the public are not fit to judge in such a difficult matter, is quite evident from the fact, that in the more simple one, of electing a representative, they have actually chosen some of those advocates of quackery, and invested them with enough uncontrolled power to be injurious. We know full well, that as soon as any measure is laid before Parliament, our brethren in Upper Canada will meet with strenuous opposition, and will have a hard battle to fight, and we trust that the respectable practitioner, who calls the meeting, will not limit his exertions to that one act, but carry out his plans, in that house, in which his high attainments as a member of a learned profession, and his standing in society so justly entitled him to sit, and that there, where he will be listened to with attention and respect, he will claim for his profession, the protection granted to all other professions in this country, and to our own in this part of the Province.

But, are there no abuses to correct except those arising from the spread of quackery? Is that the only object which should occupy the attention of the profession at the approaching meeting? There are many others, and amongst them—medical education. We have now three Universities of British character, and no doubt, an effort will soon be made to establish a French one. These three Universities have the power of granting Medical Degrees, and we have also a Board of Medical Examiners in Upper Canada, and a College of Physicians and Surgeon in Lower Canada, who also grant licenses to practise. It is true that the law recognises these two latter as alone capable of granting licenses, but in point of fact, the Universities give the license, for their Degrees, being put on the same level with those from the Mother Country, exempt their holders from a second examination before the College or the Board.

These Colonial Degrees do more, they carry greater protection than degrees from Oxford, Cambridge, Dublin, Edinburgh, Glasgow or London, for the latter Universities give Degrees in *Medicine* only, and the candidate presenting one of them, is examined in Surgery and Midwifery. They afford greater protection than the Colleges of Surgeons of London, Dublin, Edinburgh or Glasgow, for these grant diplomas in *Surgery* only, and practitioners of several years' standing, have to pass an examination here in *Medicine* and *Midwifery* before getting permission to practise in this Province. The Degrees given by these Colonial Universities actually entitle their holders to greater privileges than can be conferred by any one University or College in Great Britain or Ireland. We will not

stop here to inquire if the attainments of the Students, and the line of study they have followed, entitle them to exemption from further examination, because we can with confidence assert that, the graduate of M'Gill College can bear comparison with the graduate of any University we are acquainted with, and has as little to fear from a second examination as he of Oxford, Dublin or Edinburgh, and much less to apprehend than licentiates of other institutions we could name. We speak of M'Gill College students from personal experience of the intelligence, industry, zeal and gentlemanly deportment that have ever distinguished them, as well as from our knowledge of the estimation in which they are every where held by the communities amongst whom they practise, and we dare say, that in all these qualities they are equalled, but we are sure they are not surpassed, by the graduates of Toronto. It is therefore, because we are satisfied they have nothing to fear from a second examination, that we recommended that all graduates of Colleges and Universities in this Province, as well as those presenting degrees and diplomas from British Universities and Colleges, be obliged to pass an examination before the Licensing Boards of this Province, then, and then only, will practitioners be considered as possessing equal qualifications; and as we foresee, from the rivalry of the schools and universities already so numerous in this country, that no uniform curriculum of study and standard of examination will be maintained, but every method will be adopted to shorten the former, and render the latter more lenient, for the purpose of swelling the class list, we can devise no other check to these abuses, than the establishment of a general licensing body, where candidates from all quarters will be examined, and impartiality displayed, and inasmuch as we believe our own graduates to be as capable of practising, as those from Europe, we insist, that if the former be obliged to submit to the ordeal, that the latter be also subjected to it. Of course, discretionary power ought to be vested in the authorities of this Board to dispense with examination whenever a practitioner of standing and acquirements comes to settle amongst us, who brings testimonials of his qualifications, and affords ample proof that he has practised with benefit to the public. The young surgeon or physician from Europe must not, however, expect greater favour from the Boards, than our own pupils and graduates. But as these views may appear novel to some, it may be necessary to state, that in Germany, where so many excellent universities exist, as well as others of low reputation, and, consequently, where degrees present every variety, from the highest to the lowest standard, each country has established, what is termed the STATE EXAMINATION, which the graduate must pass before he can obtain a license to practise. This examination is consi-

dered a more severe test of the candidate's attainments, than that by which he has procured his degree, and acts as a salutary check upon the universities. When graduates of Bonn, Heidelberg, Goettingen, and Vienna submit to a second trial, our graduates cannot complain if we exact the same. We trust, therefore, that this important question will meet with attention from our Upper Canada brethren, and that some decision will be arrived at.

ST. PATRICK'S HOSPITAL.

Since our last notice of this Institution, the splendid building, known as the Baptist College, with the ground attached to it, have been purchased for the uses of the Hospital, and at this moment, the necessary alterations are going on with great rapidity. The building is one of the most beautiful and capacious in the city, and when the internal arrangements are completed, will be capable of containing from 300 to 400 patients, though, at present, it is not intended to admit more than 160. The nuns of the Hotel-Dieu will act as nurses. One peculiarity of this hospital is, the large accommodation for *pay patients*: being originally intended for a College, 32 bed rooms were situated on the second flat, the greater portion of these will be retained unaltered, and will be neatly and comfortably furnished, for private patients, who will be charged from \$2 to \$7 per week, for board, lodging, &c., the medical attendant's fees being, of course, a separate charge. This will be a great accommodation to patients resorting to Montreal for advice, for here they can retire from the bustle and confusion of an hotel, and being under the constant surveillance of the sisters of the hospital, their every want will be attended to, not by those who expect pecuniary reward for the smallest act of civility, but by those who have devoted their lives to the care of the sick. How often has the merchant's clerk, or the young student, been obliged to leave his boarding house or hotel, when attacked with sickness, to seek admission to the residence of some friend or relative, because his illness might be injurious to the interests of the house or hotel in which he resided?—now, he can apply for a private ward in St. Patrick's Hospital, he can make his selection of a physician from the medical staff, and is sure of being watched and tended throughout his illness with more than a mother's care, he can command a visit from his medical man as often as he pleases, and when necessary to take exercise, he can do so on the grounds connected with the establishment. It may be supposed by some, and, no doubt, will be urged by others, that protestants will not be admitted to these advantages, but such is

not the case; *patients of all denominations and origin will be admitted without distinction*, and no effort will be made to tamper with the religious faith of the inmates. At this moment, there are private patients, members of the Churches of England and Scotland, under treatment, and since its commencement upwards of 30 protestants have been admitted. The benefits of the Hospital are not confined to residents of the city, as is the case in the Montreal General Hospital, but are open to patients from all parts of the Province, and at present, persons from nearly every town in Upper and Lower Canada, are to be found in it. Poor patients from the country are obliged to bring with them a certificate from a Clergyman or Physician of their being in a state of destitution, otherwise, they will be charged a small sum weekly for board whilst in hospital.

As before stated, the existence of such an establishment will be very convenient to our brethren in the country districts, who can now send in such cases as they find it impossible to attend, whether this arise from distance of residence, poverty, or want of nursing, on the part of the patient. All such will be admitted to St. Patrick's Hospital.

In a future number, we will lay before our readers more minute information concerning this Institution, which is now the largest, handsomest and best situated Hospital in British America, and from the arrangements that are about being made to receive patients labouring under all forms of disease, as well as Midwifery cases, it must become the *Provincial Hospital for Canada—and the CLINICAL SCHOOL for the entire Province*, no matter how many Universities and Incorporated Schools we may have scattered throughout the country, for in no other, will the student see every variety of disease, and be able to study all branches of his profession, under the same roof.

Notice to Correspondents.—We have again to inform our correspondents that we do not intend publishing any communications which are not authenticated with the real signatures of the writers, and whenever allusions are made to individuals, these latter must be named. We do not insist on publishing the names of the writers, or those of the persons to whom they allude, but will suppress them if required; but we must have them confided to us, or we can take no notice of the communication. These remarks have been suggested by the receipt, amongst others, of some letters complaining of the nature of the examinations, held at the recent meeting of the College of Physicians and Surgeons,

one of the candidates being asked to describe the "*method of passing a ligature round the ophthalmic artery,*" and that the same candidate was asked to describe the "*prostate gland in the female.*" We know nothing of the matter, and advise our correspondent to apply to the officers of the College for redress, if he think himself ill-used. The second writer complains that—

"In several instances within a short period past, have some of the older members of our profession prevented their younger colleagues from being joined with them in the examination and treatment of difficult cases. This injustice, in some instances, has been perpetrated indirectly, covertly; the patient's preference for a young man has been so nicely hinted, that a sensitive mind has yielded its judgment and wishes to its feelings, the name of an older colleague has been suggested as that of a man of "experience," when his qualifications to discriminate in the case in question were well known, as inferior to those of the slighted person; in others, the injustice has been more openly, more directly committed; the "attending" physician has refused to meet another with whom he was professedly on good terms, but whose only fault was, the "atrocious crime of being a young man," or, conscious of his influence over his patient's affections and esteem, not only has he injured a 'brother,' but even more, his patient's feelings, by the indulgence of unbecoming anger and annoyance at the mention of a junior practitioner's name. Surely this is unfair treatment. Is this doing to others as they would have others do to them? Or appealing to a lower, yet admitted standard of morals, is it in accordance with the teachings of Medical Ethics."

We recommend to this young physician the *lex talionis*, whenever these *ancients*, from whom he has received such bad, usage are proposed in consultation, let him refuse to meet *them*.

Dr. Carter's letter has been answered by Mail.

NEW MEDICAL JOURNAL.—*The East Tennessee Recorder of Medicine and Surgery,*" edited by Frank A. Ramsay, A. M., M.D.—This is a very excellent Journal, containing a great deal of original and selected matter, and we feel confident it will have a long and prosperous career.

DR. WIDMER'S CIRCULAR.

To the Medical Profession of Canada West.

GENTLEMEN,—

Many circumstances connected with the progress of this country, have hitherto conspired to keep the Profession to which we belong, and by which we live, in a comparatively subordinate place in the social scale. It appears to me that the only obstacle to our attaining the position to which we are entitled from every consideration, is the absence of unanimity among ourselves—an evil engendered by the ignorance in which we live, not only of each other personally, but of our mutual wants, opinions, and acquirements.

To remove this barrier must be the desire, I am sanguine enough to believe, of every conscientious and enlightened practitioner,—I, therefore, invite you, as many as can conveniently attend, to meet in this city, on Thursday, the 1st day of July, for the purpose of taking such counsel together as may lead to a course of action calculated to place the Profession on a proper footing.

I make this appeal to you, because I feel deeply interested in the welfare of a Profession of which I have been for many years an active member in this country and elsewhere, and because I believe I am one among the oldest of the practitioners in this Province. I invite you to meet here, because it is the capital of this Province, easily accessible at that season from all parts of the country, and because a point of centralization is necessary in every undertaking of this nature.

Should it be considered a more convenient mode of proceeding, I suggest that each county should assemble, and elect a number of delegates who would represent the views of their constituents. Permit me to make one request in connection with this point, should such a plan be adopted: banish from your minds every other consideration but the interests of your Profession, and select men of experience, education, and enlightened views.

I am, Gentlemen,

Your most obedient servant

And sincere well-wisher,

C. WIDMER.

TORONTO, *May 14*, 1852.

FRENCH MEASURES AND WEIGHTS.

As it is our intention to publish, from time to time, interesting articles selected from the French Medical Journals, we have great pleasure in acceding to the request of one of our esteemed confrères, in inserting the following Tables, extracted from the last edition of *Malgaigne's Surgery*. From it, the Practitioner in this Country will be enabled to appreciate the quantities of the different remedies mentioned in the French Prescriptions.

MEASURES OF LENGTH.*

| New Measures. | Approximate Value. | Exact Value. | | |
|------------------------|-------------------------|--------------|---------|--------|
| | | Feet. | Inches. | Lines. |
| 1 Millimètre. | 1 Half-Line. | 0 | 0 | 0.443 |
| 1 Centimètre. | 4½ Lines. | 0 | 0 | 4.433 |
| 1 Décimètre. | 3 Inches 8 Lines. | 0 | 3 | 8.330 |
| 1 Mètre. | 3 Feet 1 Inch. | 3 | 0 | 11.296 |
| Old Measures. | Approximate Value. | Exact value. | | |
| 1 Line. | 2 Millimètres. | 2 Millim. | 256 | |
| 1 Inch. | 3 Centimètres. | 27 | 072 | |
| 1 Foot. | 32 Centimètres. | 324 | 864 | |
| 1 Ell (<i>aune</i>). | 1 Mètre 18 Centimètres. | 1188 | | |
| The English Inch. | 2½ Centimètres. | 25 Millim. | 399 | |
| The English Foot. | 30 Centimètres. | 304 | 794 | |
| The Yard. (3 Feet.) | 91 Centimètres. | 914 | 383 | |

MEASURES OF WEIGHT.

| New Measures. | Approximate Value. | Exact Value. | | | |
|----------------|--------------------|--------------|-----|-------|-------|
| | | lbs. | oz. | gros. | grs. |
| 1 Centigramme. | ½ Grain. | 0 | 0 | 0 | 0.19 |
| 1 Décigramme. | 2 Grains. | 0 | 0 | 0 | 1.88 |
| 1 Gramme. | 20 Grains. | 0 | 0 | 0 | 18.82 |
| 10 Grammes. | 2½ Gros. | 0 | 0 | 2 | 44.28 |
| 100 Grammes. | 3 Ounces 2 Gros. | 0 | 3 | 2 | 10.80 |
| 1 Kilogramme. | 2 Pounds. | 2 | 0 | 5 | 35.15 |
| Old Measures. | Approximate Value. | Exact Value. | | | |
| 1 Grain. | 5 Centigrammes | 6 Grammes | | 033 | |
| 1 Gros. | 4 Grammes. | 3 | | 82 | |
| 1 Ounce. | 30 Grammes. | 30 | | 59 | |
| 1 Pound. | 500 Grammes. | 489 | | 50 | |

* The following table shows the exact relation between the new French and the English Measures of Length and Weight.

| Measures of Length. | |
|--|---|
| Mètre, the 1-10,000,000th part of the arc of the Meridian from the pole to the equator. | { 39.370788 inches. 3 280899 feet. 1.093633 yard. |
| Décimètre, 1-10th of a mètre | { 3.937079 inches. |
| centimètre, 1-100th of a mètre. | { 0.393708 inch, |
| millimètre, 1000th of a mètre. | { 0.03937 inch. |
| Measures of Weight. | |
| Kilogramme, weight of one cubic decimètre of water of the temperature of 39° 12' Fahr. | { 2.6803 lb. troy. 2.2055 lb. avoirdupois |
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