

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

CANADA

MEDICAL & SURGICAL JOURNAL

JULY, 1886.

Original Communications.

ALEXANDER'S OPERATION OF SHORTENING THE ROUND LIGAMENTS.

BY T. JOHNSON ALLOWAY, M.D.,
Gynæcologist to the Montreal Dispensary.

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

Mrs. —, aged 29, married eleven years. She has had four children at full term and three miscarriages, the last miscarriage occurring twelve months before operation. About eighteen months ago she consulted me for uterine trouble. I found a retroflexed, but moveable, uterus. There was no evidence of past pelvic inflammation. The treatment she underwent during the following few months seemed to benefit her a good deal, but her health failed somewhat on the occurrence of pregnancy. The uterus now became gradually incarcerated in the pelvic excavation. The sharply retroflexed fundus could not be forced from its position without using greater force than was thought justifiable. At about the third month of gestation the patient miscarried. The fundus uteri could then be lifted forwards, but on removing digital pressure it would fall back again. All manner of retroflexion pessaries were now tried without benefit. Columning the vagina with the boro-glyceride tampon once a week seemed to be the only procedure which would support the displaced uterus, and then only when placed in a very careful manner. Attended to in this way, however, the patient could walk long distances and feel perfectly well and free from pain, and it was this fact which led me to regard her's as being a suit-

able case for Dr. Alexander's operation. Accordingly on the 19th February the operation of shortening the round ligaments was performed. About two and a half inches of the ligaments were withdrawn and removed. A glass stem and Thomas' cup pessary were introduced, and the wound dressed with iodoform and borated absorbent cotton. The stem had to be removed on the third day, as it caused most severe reflex pain in the hypochondriac regions and shoulders, and also rather profuse metrostaxis. A Hodge pessary was now tried, but had also to be removed in the course of a week. The last examination of the patient took place three months after the operation; the uterus was found in a normal position, the patient free from pain, and completely restored to health.

Patients to be considered suitable cases for this operation should be subjected to treatment such as the boro-glyceride tamponade for several weeks, in order that all inflammatory exudates be removed sufficiently to allow of perfect mobility of the uterus and disappearance of the slightest tenderness in the parametric tissue. This course of treatment includes absolute confinement to bed. To operate under any other circumstances will be liable to jeopardize the life of the patient and bring discredit upon the operation.

It will be necessary here to give a description of the steps in detail of the operation, and I cannot do better than quote from Dr. Alexander's article in the *British Gynæcological Journal*, November, 1885 (pp. 250 *et seq.*) He says:—

“ I will now point out what I think the best way to make sure of finding the ligaments; but I would warn anyone who intends to operate, no matter what their standing, to practise it first a few times on the dead subject if they wish to avoid disappointment. The pubic spine is the first landmark, and can be felt by an intelligent finger under any depth of superincumbent fat. It does not matter very much whether the finger can feel the spine clearly or not, provided the primary incision is made within reasonable distance of it, but there need be no serious difficulty in feeling it. From this an incision is to be made upwards and outwards in the direction of the inguinal canal for one and a half,

two, or three inches, according to the fatness of the subject. A considerable thickness of subcutaneous fat is now met with, which must be cut through by subsequent incisions until the pearly glistening tendon of the external oblique muscle is reached. Midway through the fatty tissue an aponeurosis sometimes appears, so firm and smooth that it may cause the operator to think he is deep enough; and if he begins to poke about here, as I have done and have seen done, it is little wonder no ligaments can there be found. The first stage of the operation consists simply in cutting down upon the tendon of the external oblique muscle until it appears clear and shining at the bottom of the wound. If the operator succeeded in hitting the spine, the external inguinal canal, with the intercolumnar fibres crossing it, can also be seen. If not, the aperture made down to the muscles can be dragged over an extensive area by retractors, so that the region can be searched until the ring is found. The finger, passed to the bottom of the wound, may be used to detect the spine and the ring outside, the former by its hardness, and the latter by its lessened resistance compared with that of the aponeurosis around it. The anatomical knowledge of the operator should always be equal to the recognition of these structures—that is, the spine and the external abdominal ring. There are other apertures, as the aponeurosis, and a depression filled with fat below Poupart's ligament, that sometimes simulate the external ring. Poupart's ligament below, the intercolumnar fascia running across, and the spine at the inner side, are sufficient landmarks. When in doubt, a slow deliberate survey of the position should be taken, and no gropings in the dark made, as these are certain to lead to failure. Having clearly isolated the external abdominal wound, and tied or compressed any little vessels necessary to be attended to, the next step in the operation may be entered upon—viz., to find the end of the ligament. The intercolumnar fascia, which is generally pushed forward by the fat and other structures beneath, is to be cut through over all the extent of the external ring and in the direction of its longest diameter: a nerve, some vessels, fat, some tendinous bands, and the round ligament springs out of the canal immediately.

In fat people the quantity of fat conceals all the other structures. No 'grabbing' at the mass is now to be practised, as some have recommended. By everting all the structures upwards the round ligament can be seen generally at the lowest part, and with the white, easily distinguished genital branch of the genito-crural nerve along its anterior surface, and close to it. The ligament at this stage is more or less rounded in shape, sometimes rather delicate, but an always easily recognized flesh-colored structure that might be easily destroyed by forceps rudely and blindly applied. Should the ligament seem very frail, or the operator be doubtful whether he has found it or not, he should take care not to displace the structures, or to destroy them by searching or pulling. His best plan in such a case is to open up the inguinal canal a little, and then re-examine what he supposes to be the ligament. No difficulty in finding the ligament need thus ever be experienced, provided the operator knows what he is about. When the ligament is clearly identified, the small nerve on its surface is to be cut through without cutting any of the ligament; then gentle traction is to be made either by the fingers or broad blunt-pointed forceps. Care must be taken not to break the ligament by such traction. Bands will now be seen holding it to the neighboring structures. These should be cut through with scissors, the greatest caution being used to avoid notching the ligament itself at the same time. With a little patience and perseverance the structure is so far free that all resistance is at an end, and it comes out as easily as if broken inside, as Dr. Mundé thought it was in his first case. As soon as it begins to peel out, and without drawing it out further, I leave that side after covering the wound with a clean sponge, and operate on the opposite side. To do so, my assistant and I change sides, so that I always stand on the side opposite to that on which I am operating. I can look thus better into the canal, and draw the ligament more conveniently towards me; but, of course, the operation could be performed without this change of position. Having freed the opposite ligament, the difficulties of the operation are at an end, and the second stage is finished. I cannot on paper give with advantage a more detailed description of how

to perform the second stage. It must be seen to be thoroughly understood. The third stage consists in placing the uterus in position, by the sound, and pulling out the ligaments until they are felt to control that position. The replacing of the uterus is first performed, and is held in position by a third assistant. The operator pulls out both ligaments almost simultaneously and gently, until the sound is felt to be slightly moved. He then hands both to the first assistant to hold, while with the curved needle, threaded with moderately fine catgut, he stitches each to both pillars of the ring by two sutures on each side, and thus secures the closure of the external abdominal ring, and the fixation of the ligament without injuriously strangling the latter structure as it lies between. The assistant can now let go, the chafed ends of the ligaments are cut off, and the remainder stitched into the wound by means of the sutures that close the incision. A fine drainage-tube is inserted, and the wound washed out with carbolic or other lotion before these sutures are tied. In hospital I perform the operation under the spray, and use the gauze dressings. In private I dispense with the spray, and sometimes use boracic lint or absorbent cotton wool. I always drain, as I believe it to be much safer, preventing any collection of pus or danger of interfascial suppuration. It may retard in some cases the healing of the wound, but as I never allow my patients out of bed under three weeks, this is not of much importance. Before the dressing is applied, in simple cases of retroversion and prolapse, I insert a Hodge's pessary, and keep it in at least during convalescence. When there is retroflexion as well, I always insert a galvanic stem to keep the uterus straight during the healing of the wound. This I look upon as essential. By keeping the stem in for a month or so, the cure may be with certainty effected. An important question with regard to the third stage of the operation is, how far are the ligaments to be pulled out? My reply is, to put the uterus in position and pull out the slack. The after-treatment of the operation consists in rest. The wound I generally dress on the second day, when I remove the tubes, the small aperture left where they were removed being sufficient to maintain the necessary drainage in

most cases. The ligaments should be allowed time to unite to the wound, to the pillars of the ring, to the canal, and for this purpose three weeks is quite short enough time. Several of my private patients have taken a longer rest, and with benefit, as thus all the pelvic organs have become accustomed to their new position. The rest need not be in bed—a sofa and the sitting posture may vary the monotony of lying in bed, whilst sewing, reading, and other feminine arts may be indulged in after the first few days.”

As regards the future of the operation, one feels inclined to speak carefully ; but judging from the way it has been favorably received and discussed at meetings of eminent societies in Europe and America we must acknowledge that its field of application and usefulness will become largely increased. At a meeting of the Obstetrical Society of New York, April 6th, 1886, Dr. Polk stated that he had operated fifteen times, and that he was satisfied the operation would prove an extremely valuable contribution to surgical gynecology. Views of this nature coming from an authority so highly respected as Dr. Polk must tend to remove the objections usually made by weak-knee'd *pessary-gynecologists*. I am firmly convinced that the day of treatment of retro-displacements and procidentia with pessaries is fast drawing to an end, and the bright sun of operative surgery will be seen shortly looming up over the now dark horizon, dispelling the last streak of inert empiricism.

ADDENDUM TO PAPER ON CEREBRAL ANEURISMS.

By WILLIAM OSLER, M.D., F.R.C.P., LOND.

I accidentally overlooked the records of two of the most interesting cases of aneurism of the cerebral vessels, one of which was shown Nov. 17th, 1882, and the other May 25th, 1883, at the Medico-Chirurgical Society. The case of the boy aged 6 is specially interesting, as it is, so far as I know, the youngest case on record. I append the notes :—

CASE XI—*Aneurism of left middle Cerebral Artery.*—Woman, aged 62. Admitted in a semi-unconscious state, with

right hemiplegia, which came on after a fit three days before. Death occurred on the seventh day after admission. There was extensive hemorrhage in the meninges of left Sylvian fissure, and thin clots also at the base. The inner and anterior part of left temporal lobe was lacerated. A small sacculated aneurism the size of a pea was found on left Sylvian artery, just within the fissure. The walls were extremely thin, and the orifice of rupture large. The vessels of the circle of Willis were atheromatous. No heart disease.

CASE XII—*Aneurism of branch of Anterior Cerebral in Longitudinal fissure.*—Boy, aged 6, brought to hospital unconscious, with feeble pulse, pale face, eyes and head turned to right, and left hemiplegia. Death in six hours. He had fallen from a hay-loft three weeks before, but he recovered rapidly from the effects. There was meningeal hemorrhage at base and in longitudinal fissure. On separating the median surfaces of the hemispheres, and clearing away the blood, a small nodular projection was seen on the right side, about the middle of the gyrus fornicatus. This proved to be an aneurismal sac imbedded in the colosso-marginal fissure just where it turns vertically upwards. The rupture was on the meningeal surface, but there was hemorrhage into and slight laceration of the contiguous portion of the brain substance. The arteries were not atheromatous, and the heart was healthy.

CLINICAL REMARKS ON THE TREATMENT OF COMPOUND FRACTURES.

DELIVERED AT THE MONTREAL GENERAL HOSPITAL, 12TH MAY, 1886.

By FRANCIS J. SHEPHERD, M.D., Surgeon to the Hospital.

GENTLEMEN :—The treatment of compound fractures was, up to the period of the introduction of antiseptics, in a very unsatisfactory state. The surgeon always dreaded the occurrence of such fractures in his practice, knowing how uncertain the results of treatment were, and how often these cases died of blood-poisoning. If the external wound was small, good results frequently resulted by immediately sealing the wound with its own blood, collodion, or the compound tincture of benzoin, but not unfre-

quently the wound failed to close and suppuration ensued, often necessitating an amputation, which frequently ended in death. Occasionally there was not time for amputation, the patient dying rapidly of pyæmia.

If such results not infrequently followed fractures accompanied by slight wounds, in larger wounds, with much laceration of tissues, the leg was rarely saved, and if not amputated immediately, fatal pyæmia generally followed. The idiosyncrasy of the patient and not the surgeon and his methods had to bear the blame of the fatal issue. It was only with the knowledge of the principles of antiseptics and their influence in wound treatment that the cause of failure of success in the treatment of wounds was understood; then it was found that it was from external and not internal sources that danger was to be feared. Lister was the first to insist on the necessity of absolute cleanliness, not only of the wound, but of the surgeon himself and the instruments employed by him. He introduced the method of treating compound fractures by carbolic acid. It was first employed in the form of a paste made with whitening and linseed oil, and gave very fair results, remarkably lessening suppuration. Later, the gauze, spray and McIntosh were employed, and wounds connected with fractures were treated like wounds in other parts with the best results, but with an infinite amount of trouble. Still later, iodoform and bichloride of mercury came into vogue, and dry and infrequent dressing of the wound with some antiseptic absorbent material, such as cotton-wool, jute, peat, wood-wool, etc., surpassed any method that had previously been employed. This method of treatment I shall shortly describe, the results have been most excellent, and, armed with a knowledge of modern antiseptic surgery, no surgeon need now dread treating a compound fracture of the leg, even if the bones be comminuted and the wound large.

Compound fractures being most common in the leg, I shall describe the treatment adapted to such a case. The method is as follows* :—

* In describing this method, it is, of course, understood that before treating the wound the surgeon's hands and instruments should be rendered aseptic by the usual means, a description of which is unnecessary here.

When called to treat a compound fracture of the leg, if there is severe hemorrhage and the wound is small, it would be better to enlarge it and search for the bleeding point. Having arrested all hemorrhage and placed the fragments in proper position, the wound should be thoroughly irrigated with a solution of 1-1500 of mercuric bichloride and then dusted freely with iodoform; over this, some washed gauze wrung out of bichloride solution is placed over the wound, and over this a pad of finely-carded sublimate jute, covered with bichloride gauze, and dusted with iodoform. This pad is kept in place by an antiseptic gauze bandage, and the leg placed in a McIntyre or other splint. The pad, if there be much oozing, should be removed next day and a new one applied, but the gauze over the wound had better not be disturbed. After this the dressings should not be changed unless the temperature and general condition of patient indicate that something has gone wrong in the wound. In my cases, as a rule, the second dressing has been left on a month, with result of finding, on its removal, the wound perfectly healed. If the wound is not of very large size, I have been in the habit of immediately putting up the leg in plaster-of-paris bandages, leaving a window opposite the wound, protecting it with an antiseptic towel whilst the plaster is being applied. The edges of the window I stuff with antiseptic jute to prevent the blood and serum getting under the plaster. After the plaster has been applied, the wound is dressed in the way I have described above. It is a very rare occurrence that the dressing has to be removed after the second day, when oozing generally ceases. In one case treated in ward 23 last summer, where there was a compound fracture of the ankle joint, with rupture of the posterior tibial artery, the wound was enlarged, the artery tied, and the parts dressed with iodoform and a large jute pad, and left undisturbed for a month, with the result of finding, at the end of that time, the wound completely healed. The temperature never rose above 99°F. In another case of compound fracture of the thigh, the same result followed the same course of treatment; and many fractures of the leg have healed in this way without the slightest febrile reaction. When the wound is large, sutures

of catgut are used ; but when not very large, no sutures at all are employed, the wound apparently, with the aid of iodoform, which forms a crust over it, healing as under a scab.

I take this opportunity of presenting to your notice the patient, Ed. N., aged 33, sailor, now before you, who has occupied a bed in ward No. 23 for the last nine months. His history is shortly as follows : On the 11th of August, 1885, he was brought to the hospital with severe compound fracture of both legs, consequent on falling some twenty feet into the hold of a ship. He had lost a considerable amount of blood, and there was a good deal of oozing when he was admitted. My house surgeon, Dr. Eberts, as it was near the visiting hour, merely put on an antiseptic towel and bandage. On my arrival, I found that patient had sustained a compound comminuted fracture of left leg, the wound in soft parts being some two inches long, and a compound fracture of right leg, with considerable riding of bones and a large amount of laceration of soft tissues. Both legs were much swollen. After cleansing the wounds in both legs thoroughly, the left was put up in plaster-of-paris bandages, a window being arranged for opposite the wound. The right leg was so severely lacerated that it was not thought wise to put it up in plaster, so a McIntyre splint was employed. The wounds were dressed in the manner I have already described. The same night, owing to the profuse oozing of blood, the dressings had to be changed. From that time till the 9th of September (nearly a month) the dressings were not removed, and then the wounds were found completely healed, or, rather, scabbed over. After the third day, the temperature, which, on the second day, rose to 100°, was perfectly normal. The fracture of left leg, on removal of dressings, was found to be firmly united, but there was no union in the right, in which, as I said before, there was considerable riding of fragments, the bone being broken about the junction of lower with middle third. The bones were rubbed together and put up in plaster-of-paris. From time to time this was renewed, the man being allowed to go about early in November, and at present you see he has fair union in right leg, but some shortening. He leaves hospital during the present week to return to his occupa-

tion. I have advised him to wear for a time the plaster splint on his right leg. This case is a very good example of the happy results of this method of treating compound fractures when the wound is very extensive. Before the introduction of antiseptics the man would probably have had one leg amputated, and might possibly have lost his life by some form of blood-poisoning in the effort to save the other. As it is, the man is in a fit condition to resume his ordinary work, and the accident will not in the slightest degree interfere with his future prospects.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

By WILLIAM GARDNER, M.D.,

Professor of Gynæcology, McGill University; Gynæcologist to the Montreal General Hospital.

Treatment of Chronic Pelvic Abscess.—Pelvic abscess, after spontaneous rupture into the bowel or vagina, or after vaginal opening by the surgeon, occasionally runs a very chronic course. As is well known, Mr. Lawson Tait of Birmingham, with a view to preventing this, has devised and many times practised the method of opening the abscess by abdominal section and drainage. In certain cases this method is undoubtedly to be commended, but it will not suit in all; moreover, many cases do not reach the surgeon till long after spontaneous rupture, when the conditions of the abscess cavity are such that free drainage and irrigation will not suffice to cure. The walls are in a condition of chronic granulation or contain *trabeculæ*, or present numerous loculi or nooks in which pus and other debris lodge—each or all of these conditions may obtain. The action or condition of the wall must be changed. An interesting example of the disease, with cure, is reported in a paper recently read before the Chicago Gynæcological Society by Dr. Henry T. Byford. The patient, aged 25, contracted cellulitis returning from a dance. At the end of six weeks the resulting abscess burst into the rectum. Palliative treatment was continued for ten weeks without effect. The pulse remained about 120, and the temperature ranged from 99° to 102°F. Pain and septicæmic diarrhœa were fre-

quent. The bacillus of tuberculosis was found in the pus. She became so emaciated as to weigh only 83 pounds. It was then decided to operate. Dr. Wm. H. Byford, after etherization, forcibly dilated the sphincter of the anus, tore open the fistulous tract with the finger, and dilated the abscess cavity, scraping off granulation tissue and bands. All this was scooped away and the cavity thoroughly cleansed with a 2½ per cent. solution of carbolic acid. The highest temperature after the operation was 99°F. Perfect drainage had been secured. The cavity of the abscess was treated by irrigation with antiseptic solutions, insufflation with iodoform, and the introduction of sulphate of copper. At the end of two months she had gained 13 pounds. Three months after the operation she contracted dysentery, which was then prevalent, and died soon after. At the autopsy } no appearance of abscess cavity could be found; it was completely obliterated. Dr. Byford attributes much importance to the use of the sulphate of copper, and, speaking generally of this method of treatment in such cases, believes it to be safe and sure.

It has for some time been apparent to readers of medical journals that there is a coming reaction against the over-frequent performance of abdominal section for the removal of the uterine appendages. There can be no question that the operation has been abused, that women have been needlessly mutilated, and that certain conditions of ovaries and tubes thus removed are not pathological, but really physiological. Dr. H. C. Coe read a paper entitled "Is Disease of the Uterine Appendages as frequent as it has been represented?" before the New York Academy of Medicine on the 1st of April last. Dr. Coe said he did not intend by the title to imply skepticism so much as a mildly negative answer to the question. Our knowledge of the normal ovary is unsettled, but especially, so far as the text-books are concerned, is this true of our knowledge of conditions supposed to be included in such terms as ovaritis, periovaritis, etc. The question, then, naturally arose, What is a normal ovary? So much has been recently said about chronic ovaritis, cystic degeneration, etc., when speaking of specimens

Sp. Copper

*reaction against
abdominal
section*

removed, that, said Dr. Coe, the existence of a normal ovary, except in animals, might be doubted. Besides, the minute structure of the ovary was not constant, histologically. Hence reasons why it is difficult to determine where the physiological condition ended and the pathological began. "Ovaries had been removed because they were regarded as cystic, and yet it had not been decided what was meant by a cyst; that is, when the ovisac ceased to be a vesicle and became a cyst. Ovaries as removed in specimens often seemed to deviate from the types described and illustrated in text-books on histology, but on this account were not to be regarded necessarily as suitable to be plucked out. Then the question arose, To what extent may an ovary deviate from the so-called type without being diseased? In general, the conditions which had been said to justify an operation for the removal of ovaries were included under variations in size and shape, the presence of cysts more or less numerous upon their exterior, changes affecting the thickness of the cortex, and the stroma, adhesions, etc." The author then said that variations in shape could not justly be held to indicate abnormality. Moderate and even considerable increase in size may be due solely to congestion. Variations in position and in color are consistent with health. The ovary may be seamed and scarred. The cortex may be thickened when it is in full functional activity. Cystic degeneration was most frequently given as a condition that justified extirpation, and Dr. Coe had rarely heard the diagnosis of cystic degeneration called in question when three or four vesicles, not larger than small peas, had been found upon the exterior of the organ. If all the so-called cystic ovaries were to be regarded with suspicion, there were few women who were positively out of danger. He admitted, however, as had been demonstrated by Olshausen, a true cystic degeneration, but it is rare. He (Dr. Coe) asserted that an ovary with a half-dozen transparent vesicles as large as peas on its surface, and functionally active, did not justify the diagnosis of cystic degeneration and removal without regard to other and more positive indications. Partial disease, moreover, does not imply loss of function. Schröder recently removes only the

diseased portion of ovaries, with the expectation that what remained would perform the function of the organ. As regards the Fallopian tubes, if they were distended with pus, there was no difference of opinion that they ought to be removed. Such a case was plain, but rarer than generally supposed. He did not believe with Tait that in chronic ovarian disease the tubes are invariably involved. A healthy tube might be increased in size, but he had sought in vain for evidences of disease in the so-called catarrhal salpingitis. Moderate hyperæmia of the mucosa and a thin layer of mucus did not constitute disease. Cilia in active motion was proof against the presence of inflammation. Dr. Coe had examined all the cases within his reach, and they included a large proportion of the cases performed in the city, and he had found that in not more than one-fifth was pyo- or hydrosalpinx present. With reference to symptoms, he believed that they were not due to the condition of the ovaries and tubes so much as to localized peritonitis and neuralgia pure and simple; and that these symptoms were removed by extirpation of the uterine appendages he did not believe. It would not be proven that a cure had been effected, until it could be shown that the patient was well at the end of six years after the operation. The special point he wished to insist on was that the presence of insignificant changes in these organs was insufficient to subject a woman to the risks of abdominal section.—(*N. Y. Med. Record*, April 10, 1886.)

Rapid Dilatation of the Cervix Uteri for Dysmenorrhœa and Sterility.—This was the title of a paper read by Dr. A. H. Goelet before a recent meeting of the section in Obstetrics of the New York Academy of Medicine. In the paper the author set forth his views concerning the indications for the operation and the method of performing it. The indications were—1st. Dysmenorrhœa constant and severe where stenosis, with obstruction, is present; this includes flexion with obstruction. In these cases the pain is relieved by the flow; it sometimes becomes more pronounced after marriage. 2nd. It is indicated in cases of acute flexion, where the probe can be easily passed after the proper direction of the canal has been ascer-

tained ; there is no actual obstruction—the dilatation is done to overcome the flexion. 3rd, It is indicated where little or no flexion exists and there is only slight obstruction, the passage of the sound through the internal os is attended by pain, and there is no other cause of the dysmenorrhœa and sterility. 4th, It is indicated in a class of cases which give a history of no inconvenience, but sterility exists and dysmenorrhœa, at first only slight, gradually increasing in severity ; the sound passes without pain until the fundus is reached, and an albuminous discharge exudes from the os. In these cases endometritis did not exist previous to marriage, but the congestion consequent upon that state has lessened the calibre of the uterine canal and increased the secretion from the uterine cavity. Complete dilatation, if maintained, will alone cure some of these cases. The proper time for performing this operation is a week or ten days after the cessation of the menstrual flow, and much can be done by preparatory treatment to favor a good result. The mode of performing it consists in anæsthetizing the patient, exposing the cervix through a speculum, introducing a sound, first to ascertain the direction of the canal, fixing the cervix, drawing it down slightly, introducing the dilating instrument, which usually goes through the internal os with a jump, making it evident that it has entered the uterine cavity, and then applying gentle pressure to the handles of the instrument until they are brought together and the required amount of dilatation has been effected, usually the full extent of the instrument. If the dilator does not pass the internal os with a moderate amount of pressure, introduce the applicator repeatedly, armed with cotton, which will increase the size of the opening so that the instrument can be introduced without force. When the handles have been brought together they should be held for a few moments, then removed, and a Hank's dilator introduced, to be followed by the applicator. This done, a tampon of boro-glyceride is applied and the patient put to bed. On the following day introduce a stem made of hard rubber, slightly curved, tunnelled, and perforated in the centre, and for a week this is to be removed daily, cleansed, and replaced, when it can be removed permanently, and the patient allowed to get up.

*Time for
operation
next day*

Dr. Goelet regards the operation as perfectly safe and effectual, if done properly, and in eighty cases it has not failed in a single instance to cure dysmenorrhœa. The following conclusions were reached :—

1. Rapid dilatation is a perfectly safe and justifiable procedure.
2. If a stem be used in the after-treatment, recontraction does not follow.
3. The operation is demanded by the following conditions :
1st, Marked stenosis, with or without flexion. 2nd, Acute flexion, without actual stenosis or obstruction. 3rd, Slight stenosis shown by the passage of the sound, and dysmenorrhœa and sterility existing without other cause. 4th, Moderate endometritis, acquired, with narrowing of the canal and lack of free drainage for the discharge.

Circumscribed Peritoneal Dropsy simulating Ovarian Dropsy.

—At the Baltimore Academy of Medicine, on 2nd March, 1886, Dr. H. P. C. Wilson reported the case of a married woman, aged 37, the mother of seven children. On admission to hospital, she had a prominent fluctuating tumor of the lower abdomen; dullness on percussion to two inches above the navel, also in either groin; a clear note in both lumbar regions. The tumor was round and prominent, and was diagnosed to be ovarian. Change of position did not change the area of dullness. No tenderness of the abdomen. Uterus free in pelvis; measured three inches. An incision was made into abdominal wall and through into the peritoneum, when immediately a gush of greenish-yellow fluid escaped. One and a half gallons flowed away. On looking through the opening, a solid body 9×6×3 inches was seen. A large quantity of recent lymph and adhesions everywhere; uterus and ovaries normal, but touch and sight did not reveal the true nature of the tumor till it was lifted out of the cavity, when it was found to be made up of coils of intestine agglutinated with lymph. It was so firm and solid that at first it was hard to believe that it could be made up of coils of intestine. It was not adherent to other viscera, but seemed free in the peritoneal fluid. The mass was returned, and the abdominal wound closed.

and dressed as after ovariectomy. The case did well, and on the 16th day the woman was out of danger.—*Philadelphia Medical News*, March 27, '86.

Readers of this journal may remember the case reported by myself in the number for June, 1885. In this case the encysted collection was from tuberculous inflammation, and the patient died six weeks after the operation, of general tuberculosis.

Oöphorectomy for the relief of Hystero-Epilepsy, by Dr. T. A. Reamy of Cincinnati.—The great value of this operation in the disease mentioned has been amply demonstrated, although not always successful. On this point Dr. Reamy's case, as reported, is too recent to be of any value, but its history is of importance, as showing the value of chloral enemata in controlling certain symptoms after the operation. On the third day, tympanites and vomiting became marked. These symptoms were more severe on the fourth day, the vomited matters being green. The pulse was 110, very feeble, and the patient very restless. The rectum was now washed out with salt and water, and then fifty grains of chloral thrown in. In less than thirty minutes she was asleep, and slept for five hours. When she awoke, all the symptoms were improved. On the fifth and sixth days the chloral enemata were repeated. The vomiting recurred but once after the first enema of chloral, and recovery was uninterrupted thereafter. In the course of his remarks, Dr. Reamy referred to several cases of obstinate vomiting of pregnancy successfully treated by enemata of chloral.—*Phila. Med. News*, Feb. 27, '86.

*Chloral
Enemas
Feb. 27, '86.*

Correspondence.

DETROIT, June 4th, 1886.

To the Editor of the CANADA MEDICAL & SURGICAL JOURNAL.

DEAR SIR,—Common as are the number of cases of malaria or intermittent fever in this section of country, I think the one I wish to report will prove somewhat interesting for two reasons: First, as being of that division called quotidian; and, secondly, from the fact that two paroxysms occurred within the twenty-four hours, making it double quotidian:—

On November 5th, 1885, I was called to see Mrs. M., four

months pregnant with first child, who was complaining of having severe rigors every day at two o'clock in the afternoon, and after passing through the successive stages characteristic of intermittent fever, and having an intermission of about four hours, there came on another rigor or exacerbation at about eight p.m. Towards midnight she became cool, and would fall into a comfortable sleep, and awaken in the morning feeling fairly well, when the thermometer would register about 99° F. in the mouth. The rigors were so distinctly marked, and occurred with such regularity, that the diagnosis was very easy, and the case most interesting from its being so well marked and rare a form of intermittent fever. Proceeding in my therapeutics as is usually the case in periodic fevers, I gave quinine bisulphate in 5-grain doses, repeated every three hours, and doubled the dose two hours before each exacerbation. After three days under this treatment, I found the evening rigor had disappeared, but the afternoon one persistent, but not so severe. In five days from commencement of treatment all rigors had ceased, and patient felt quite well and able to perform her household duties. I ordered quinia to be continued thrice daily for a week, and my patient fully recovered, to remain quite well until I was called in to attend her in her confinement, five months later, when she was delivered of a fine healthy girl. In connection with the latter, I may add that her confinement was a very quick and easy one, and her recovery would have terminated without a bad symptom had not malarial poisoning interfered and kept her back four or five days. Quinine proved my friend once more and all ended favorably.

Very truly yours,

W. G. HENRY.

NEW YORK, June 21, 1886.

The American medical profession generally has, rightly or not, the reputation of resorting to methods to get "business" which the members of the same profession in other countries think unprofessional and undignified. Such an impression could scarcely prevail if all American medical societies were as jealous of their honor and dignity as the County Medical Society of

New York recently showed itself. It was on the event of a paper to be read by one of its members, entitled "Saccharine, a new Chemical Preparation." The reader of the paper, a well-known and respectable member of the Society, in his opening remarks, made the statement that the preparation had been patented. The remark had scarcely escaped his lips when one of the members rose and called the reader to order for bringing before the Society a drug that had been patented. Chapter XVI of the Society's by-laws was read by the chair as the only guide in such cases, and he ruled that it did not apply in the present instance, as the reader, so far, had not said anything of a laudatory nature, and his object might be to condemn the preparation. The protesting member appealed from the decision of the chair, and asked that the Society be allowed to vote upon the question. This was almost unanimous against the reading of the paper.

The gullibility of members of our profession has almost become a bye-word. The latest illustration of this feature in the disciples of *Æsculapius* was the signing, by several of the most honorable physicians of the city, of a petition to the Health Officer asking him to rigidly disinfect all rags, etc., coming into the port. It would now appear that the petition emanated from the Health Officer himself, and what adds a strong tinge of suspicion to the whole affair is the circumstance that an intimate friend of his has lately invented a new method of disinfecting rags. This method has the advantage over all others in that it is a prolific source of dollars for the pockets of the inventor, while it is not at all of a murderous nature to the poor tiny creatures that find a home in the cast off effects of mankind. That the latter feature should not commend itself highly to the public shows what an unfeeling and selfish mass of humanity the public is.

The hydrophobia scare in New York and surrounding country, to which I referred in past communications, has recently been the subject of an able and forcible paper by Dr. E. C. Spitzka, a profound and original observer, and a well-known neurologist of this city. Through the kind courtesy of Dr. Spitzka, I have in my possession the advance sheets of the paper. The author, while not denying the existence of a disease known as hydro-

phobia, communicable from the dog to man, expresses a very strong doubt that such a case has occurred in this country within the past few months in spite of the many cases reported by the secular press. He has sifted the evidence of all the reported cases, presenting a picture resembling true hydrophobia, with the perspicacity and astuteness of a legal mind, and has arrived at the conclusion that they were spurious, merely of a nervous nature, induced by the sensational and horrifying accounts published in the New York papers. Some of the author's remarks are extremely caustic, and exhibit a vim of sarcasm, reminding one of the English classic authors in the days of Dryden and Pope.

A "Pasteur Institute" has been organized in this city, and is now ready to receive contributions. I believe I am doing that institution no injustice when I say that the more the hydrophobia scare can be created in the community, the better it will flourish. It rests for the present on two foundations: First, on a rabbit brought over from Paris which had been inoculated by Pasteur, and which died on the way over or shortly after its arrival; and secondly, on the allegation that genuine hydrophobia exists in and near New York city. About the defunct rabbit there is very little to be said; about the alleged existence of hydrophobia, a great deal. The following are a few of Dr. Spitzka's conclusions: 1, There is, at present, no proven epidemic of hydrophobia either in New York city or in its vicinity. 2, A number of deaths have occurred from spurious hydrophobia (lyssophobia) in New York city and its vicinity during the past nine months. 3, The agitation of the subject of Pasteur's method of preventive inoculation, for hydrophobia, and other accompanying strained accounts of the sufferings and death from that disease, are responsible for those deaths. 4, The means to be adopted to prevent future outbreaks of spurious hydrophobia is to muzzle the dogs, to dam up the torrents of ink flowing from the pens of hasty investigators within appropriate receptacles, and to exclude sensational publications from the household.

With the approach of the summer months, a very noticeable

decrease in the activity of the medical societies is observed. Many have already closed their doors for the summer, and those that have not display a languor and lassitude more characteristic of periodicity than the hot weather that we, so far, have had. Notwithstanding this malaise of the medical profession, a new society for the "prevention and treatment of venereal diseases" has recently been incorporated, with some of New York's leading medical men and laymen forming the board of directors. The objects and advisability of such a society I must leave over for my next communication.

H. N. V.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE
MONTREAL GENERAL HOSPITAL.

Case of Epithelioma of Tongue—Excision performed by a modification of Nunneley's method—Recovery.—(Under the care of DR. RODDICK.)

(Reported by DR. H. S. BIRKETT, House Surgeon.)

Wm. B., aged 43, laborer, was admitted to the Montreal General Hospital 4th January, 1886, to receive treatment for an ulcer on the tongue. Family history: His father died at the age of 47 years from cancer of the tongue; his mother died of dropsy; one sister and one brother died of phthisis; one brother died at the age of 20 years from some affection of the stomach; has two brothers, aged 30 and 35 years, enjoying good health. The patient has enjoyed the best of health until the present trouble; there is no specific history; habits intemperate; smokes very much, using a short clay pipe, and carries it on the right side of mouth. About ten months ago, patient noticed a small, hard pimple upon under surface and right side of tongue, about three-quarters of an inch from the tip. This subsequently broke, and an open sore remained. Suffered from a darting, stabbing and intermittent pain, extending from the tongue along the right side of face. The pain was severe enough at times to prevent him from swallowing, talking, or even sleeping at night; sense of taste not affected; slight increased salivation. Received

specific treatment at the out-door department of the hospital for five months, but without much relief. For the last month has had no treatment whatever; has lost flesh and become much weaker.

On admission.—Patient is noticed to be a tall man, somewhat emaciated, but not cachectic; no evidences of specific disease; does not suffer in the least from the ulcer on his tongue. The latter is a superficial ulcer, about the size of a split pea, on the under surface of the tongue, three-quarters of an inch from the tip. It is irregular in outline, purplish in color, and a small slough at the bottom is observed. From the posterior part of ulcer, a superficial fissure, one-quarter of an inch in length, is seen, and extends round the border to the dorsum of the tongue. Immediately behind this is a second similar fissure, one-eighth of an inch long, and a third one extending anteriorly from the ulcer. The tissues about the ulcer are hard, and indurated to a considerable extent in all directions; there is little, if any, pain; no carious or broken teeth found in either upper or lower jaw of the right side; submaxillary and sublingual glands slightly enlarged and painless. Microscopic examination of the secretion from the ulcer shows the presence of epithelial nests, and subsequent examination of sections of the ulcer proved its epitheliomatous nature. Heart and lungs give negative results on examination. Urine 1025; no sugar; no albumen. To exclude the possibility of the disease being syphilitic, 20-grain doses of iodide of potash are ordered to be given three times a day.

Jan. 26th.—No material change being produced by the iodide of potash, operation for removal of the tongue was performed to-day. Patient being etherized, a mouth-gag was introduced, and a silk ligature passed through tip of tongue. With a pair of scissors, the tongue was loosened from its attachments to the floor of the mouth and drawn well out. A sub-mental perpendicular incision two inches in length was next made, and through this the chain of the *écraseur* was introduced into the mouth and placed securely around the base of the tongue. The entire organ was in this way removed, leaving the smallest stump possible. After its removal, a spurting vessel on the left side

of the root of the tongue gave some trouble. This was ligated with silk, when all hemorrhage ceased. A silk ligature was next put through the stump of the tongue, and secured outside the mouth; sub-mental incision brought together by two silk sutures and a single drainage-tube of medium size drawn through it. Wound dressed with iodoform and jute, while a mixture of equal parts of iodoform and boracic acid was dusted on the stump. At 6 p.m. the patient was found to have rallied from the operation very well; no pain, and feels comfortable. Complains only of feeling thirsty. Moderate amount of oozing; wound and stump re-dressed; allowed ice only by the mouth. At 8 p.m., temperature 102.5° ; pulse 112. Ordered four ounces beef juice and peptonized milk alternately every four hours per rectum. 27th—Slept well after 4 a.m.; slight pain under jaw; no thirst; submental incision dressed and powder blown in on stump, which was previously irrigated by carbolic lotion 1-120; temperature $98\frac{1}{2}^{\circ}$; pulse 112. 28th—Slept all night; slight pain under lower jaw; slight bloody discharge; dressed as usual; temperature 98° ; pulse 88. 29th—Pain under jaw absent; rests well; sub-mental incision quite united; discharge quite sweet; temperature 98° ; pulse 94. 30th—Patient still in good spirits, and has nothing to complain of; mouth irrigated; discharge sweet; sub-mental sutures removed; boracic acid blown in on stump, which looks very well; patient allowed to sit up.

Feb. 2nd.—Drainage tube removed; stump looks healthy; discharge small in amount and quite sweet; temperature and pulse normal. 3rd—The enemata of peptonized milk and beef juice are discontinued, milk and beef juice by the mouth being substituted, as the patient swallows well; bowels moved to-day; stump granulating well; ligature removed from tongue. 12th—Discharged from hospital, the stump having almost entirely healed; general condition much improved; a gland which was slightly enlarged at time of operation is much smaller. The patient can be readily understood when speaking.

June 24th, '86.—The patient was seen to-day and the parts examined. The stump has a healthy look, and is soft to the feel,

no induration whatever being present. He speaks remarkably well, and is in perfect health, having been engaged at his trade almost ever since his discharge from hospital.

Reviews and Notices of Books.

Lectures on Syphilis. Delivered at the Chicago College of Physicians and Surgeons.—By G. F. LYDSTON, M.D., Lecturer on the Surgical Diseases of the Genito-Urinary Organs, College of Physicians and Surgeons, Chicago, &c. Chicago: A. M. Wood & Co.

This little volume, which, by the way, has been dedicated to our esteemed friend, Dr. Joseph W. Howe of New York, a former preceptor of the author, consists mainly of a course of lectures originally published in the *Western Medical Reporter*. The subject of syphilis is treated in a very plain and practical manner, and the book will be found especially valuable to the student.

How we Treat Wounds To-day. A Treatise on the subject of Antiseptic Surgery which can be understood by Beginners.—By ROBERT T. MORRIS, M.D., late House Surgeon to Bellevue Hospital, &c. New York and London: G. P. Putnam's Sons.

This is a spicy little book, written in the characteristic free-and-easy style of the true-born American citizen. Elegance is sacrificed to conciseness, the sentences being short and pithy, but the meaning always unmistakable. The author is, of course, an ardent admirer of Lister, and thinks that he has given to the world a better means for preventing suffering than has ever before been given by any one man. All the various antiseptic methods and apparatus are described, and their several plans of application. He makes a clear comparison of past and present surgery. Thus, speaking of Bellevue Hospital, of which he was at one time house surgeon, he says: "The profuse suppuration to which we had been accustomed disappeared as if by magic, and instead of spending several hours daily in changing dress-

ings, we employed only a few minutes in that sort of work, the number of operative cases being at the same time very greatly increased. Patients became enthusiastic, and brought friends for us to operate upon, etc. The wards lost the old-time hospital odor. From a reign of terror we came to a sort of millenium as regards microbe invasion, and the micro-organism and the wound lay down in peace together, with a good antiseptic dressing between them."

The author prefers the bichloride of mercury as an antiseptic to carbolic acid, but speaks of the danger attending the free use of the former, having caused, in one case, alarming toxic symptoms. He applies Lister's protective to all wounds. The directions given for the preparation and application of antiseptic dressings are easily understood, and could be readily carried out even by one who has never witnessed an antiseptic operation.

On the Suprapubic Operation of Opening the Bladder for the Stone and for Tumors.—By SIR HENRY THOMPSON, F.R.C.S., &c. London: J. & A. Churchill.

Anything from the prolific pen of this very distinguished surgeon is ever welcomed by the profession. Fortunately, Sir Henry is anything but a selfish man, his greatest pleasure being, apparently, to disseminate as rapidly as possible any new facts that are born of his vast experience. Hence, for many years he has been in the habit of treating the profession every few weeks to some precious contribution to the literature of his own special subject. There is this to be admired about him also, namely, that he is ever ready to take a hint and to give the methods of others a fair trial. Thus Bigelow's rapid lithotripsy method was, after a time, actually championed by our author. So, now, with the suprapubic operation for stone. Thompson was at one time strongly opposed to it, but having of late become convinced of its efficacy through the writings and experiments of Peterson, Perier, and others, he is now one of its strongest advocates.

The little book before us gives the history of this operation and the reasons for performing it, together with a description

of the author's method of performing it (which, by the way, is to be found in the "Retrospect of Surgery" published in the June number of this journal). The histories of eight cases are also appended, showing one death after operation. The book contains, besides, fourteen woodcuts. To the teacher, and hospital surgeon especially, the work is invaluable.

The Surgical Diseases of Children.—By EDMUND OWEN, M.B., F.R.C.S., Surgeon to the Hospital for Sick Children, Great Ormond Street, London. With 4 chromo-lithographic plates and 85 engravings. Philadelphia: Lea Bros. & Co.

Mr. Owen, in this number of the series of clinical manuals, embodies the results of his experience in a great metropolitan field for the study of infantile disorders. Chapters are devoted to all the common and a great many of the uncommon diseases, deformities and malformations which may call for the surgeon's assistance. These are treated of in a concise and practical manner, and everywhere the matter of treatment receives a full share of attention. Every general practitioner having much to do with family practice will be glad to have this manual for reference in their children's cases, which so often test his diagnostic skill and therapeutic ability.

Diseases of the Spinal Cord.—By BYROM BRAMWELL, M.D., F.R.C.P. (Edin.), Lecturer on the Principles and Practice of Medicine, Extra-Academical School of Medicine, Edinburgh, &c. With 53 colored plates and 102 fine wood engravings. Second edition. New York: William Wood & Co.

Those best able to judge look upon this treatise on the spinal cord as one of the very best extant by a British writer. The complicated problems of the disease-processes in this very complicated organ are very clearly studied out, and the explanations are made with remarkable clearness and lucidity. With the first edition we have long been familiar, and find that it is a decided favorite amongst advanced students. It is characteristic of the enterprise of the publishing house that such an expensive

and valuable book has been added to their cheap series of standard medical authors. This alone is worth half the year's subscription.

A Reference Hand-book of the Medical Sciences, embracing the entire range of Scientific and Practical Medicine and allied Science. By various writers.—Edited by **ALBERT H. BUCK, M.D.** Volume II. New York: Wm. Wood & Co.

We take much pleasure in drawing attention to the appearance of the second volume of this large work, which covers the ground from C A T to E Y E. From the high character of the articles contained in the inaugural volume, we were led to expect much from those which should follow. We may truly say that a careful examination of the merits of the present number shows that the same standard is fully attained. The general excellence of the various contributions is marked, and many of the separate articles are of unusual excellence. It is surprising to find that, in such an ambitious work, covering an immense field, hardly a subject can be looked for without being found in its right place, and carefully and fully treated by some experienced and competent writer. A large number of new contributors are enrolled upon the list, a glance at which would be sufficient to show the quality of those engaged in the work. Amongst these, the following Canadian names are to be found, viz., Drs. Buller, Bryce, Mills, Stewart and Wilkins. We hope that a large number of our readers are, or will become, subscribers to this work. It is by far the most comprehensive, reliable, and useful cyclopedia of reference on all medical subjects with which we are acquainted.

Urinary and Renal Derangements and Calculous Disorders. Hints on Diagnosis and Treatment. By **LIONEL S. BEALE, M.D., F.R.S. and F.R.C.P., &c.** Philadelphia: Presley Blakiston, Son & Co.

The more extensive works of Prof. Beale upon urinary affections and upon the microscope are so well known that this smaller volume will meet a ready acceptance from such a high authority. It deals with all the more modern views concerning the pathology

of the urine, and discusses carefully the subject of dietary and medicinal treatment in these important and common ailments. It is a book which will be of great assistance to those engaged in seriously considering these daily-occurring problems with a view to practically carrying out their solution in the interests of their patients.

Books and Pamphlets Received.

A COMPEND OF PHARMACY. By F. E. Stewart, M.D., Ph.G. Philadelphia, P. Blakiston, Son & Co.

DISEASES OF THE DIGESTIVE ORGANS IN INFANCY AND CHILDHOOD, with Chapters on the Investigation of Disease and on the General Management of Children. By Louis Starr, M.D. Philadelphia, P. Blakiston, Son & Co.

A MANUAL OF DIETETICS. By J. Milner Fothergill, M.D., Edin. New York, Wm. Wood & Co.

MEDICINE OF THE FUTURE. By Austin Flint, Jr., M.D., LL.D. New York, D. Appleton & Co.

A TREATISE ON THE DISEASES OF THE NERVOUS SYSTEM. By William A. Hammond, M.D. Eighth edition. New York, D. Appleton & Co.

DISEASES OF THE STOMACH AND INTESTINES. A Manual of Clinical Therapeutics. By Prof. Dujardin-Beaumez. Translated from the fourth French edition by E. P. Hurd, M.D. New York, Wm. Wood & Co.

A MANUAL OF MIDWIFERY. By Alfred Lewis Galabin, M.A., M.D. Philadelphia, P. Blakiston, Son & Co.

COCA, COCAINE AND ITS SALTS: Their History, Medical and Economic Uses, and Medicinal Preparations. By Wm. Martindale, F.C.S. London, H. K. Lewis.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 2nd, 1886.

GEO. WILKINS, M.D., 2ND VICE-PRESIDENT, IN THE CHAIR.

Primary Cancer of Pancreas, with secondary deposits in other organs.—DR. ROWELL exhibited the specimen, and DR. ARMSTRONG related the clinical history of the case:

Mrs. M., aged 80, widow, enjoyed good health until three years ago. Father and two brothers are said to have died of cancer. Admitted to Western Hospital in December, 1885, suffering from loss of appetite, pain after eating, and vomiting. On examination, a hard, round, circumscribed lump, about the

size of an orange, was found occupying the epigastrium, just over the region of the pyloric end of the stomach. As little was to be gained from medical treatment, a mixture containing bismuth, hydrocyanic acid and mucilage was prescribed, and she was removed by her friends to her home. It was learned at the time of her death that since her removal from the hospital the vomiting had continued persistently, the most bland liquids, even water, being immediately regurgitated. She had also suffered much pain, for which she had taken morphia pills. Nothing passed bowels for two weeks before death, and she became distinctly jaundiced. At the post-mortem examination, 36 hours after death, only the abdominal cavity was examined. On opening the abdomen, the omentum was found adherent to the anterior abdominal wall. Liver very much enlarged, extending down to level of umbilicus, and containing several large cancerous nodules. Gall-bladder much distended, containing eight ounces of bile and a dark-colored gall-stone the size of a cherry. Upon raising the liver, the head of the pancreas was found to be occupied by a cancerous mass, and the surrounding tissues were infiltrated and adherent to it. The walls of the stomach were free from disease. Complete obstruction of the duodenum occurred four inches from the pylorus, caused by pressure of this cancerous mass, together with the adherent and infiltrated tissues about it. A number of the mesenteric glands were also involved. Intestines empty. Spleen slightly enlarged.

New Method for the Relief of Ruptured Perineum.—DR. TRENHOLME read a paper on this subject, exhibiting drawings of the new method, as follows:—This disease must be as old as parturition itself, and yet, beyond the adjustment of the parts, binding the knees together, in recent cases no really successful advance had been made for its cure till the late ever-lamented Dr. Sims introduced his silver suture. The operations of Baker Brown and others were not of any real value, and perhaps the cause or nature of failure was not fully brought out till Emmet's paper upon this subject was given to the world. Now, I do not propose to go over the many points connected with this trouble and the operations attempted for its cure. How much progress

has been made can hardly be conceived of by those who have graduated during the last twenty-five years. One of the best and most esteemed surgeons of this city, and, I might say, of this country, endeavored to dissuade a confrere from attempting the operation, stating that "it was sure to be a failure." Not only did he do this, but used his endeavors to prevent the lady from having the operation performed. Thanks, however, to the silver suture and the courage of the operator, the operation was successfully performed and the patient cured. This, occurring in our good city, speaks volumes. For my own part, I think the evils resulting from severe lacerations are very great, and if anything I may say will direct more attention to the prevention of these evils, I will be satisfied. I feel confident that the sum-total of the sorrow and misery arising from this cause vastly exceeds our conception. It is a recognized factor in the causation of subinvolution of the vagina and uterus, and I am persuaded its results are not limited to these organs, but that the tubes and round ligaments share in the same mischief. It is a fruitful cause of retro-luxations of the uterus and prolapsus of bladder. Of all the marital misery and personal distress I need say nothing; these, of course, vary with the peculiarities of individual cases and the extent of the disease. I will not speak of the well known preparation of the patient required, especially in extensive lacerations; you all know as to this and the after-treatment also. There is one remark I wish to make as to what is known as the perineal body. Some writers have made light of its existence, because its anatomy and relations are not sufficiently definite to merit, as they think, this appellation. That every uninjured perineum has such a body is unquestionable, and the restoration of this body is *the one* object of perineography. An operation is successful or unsuccessful, according as to whether this end of the operation is or is not attained—without it the natural support of the pelvic viscera is impossible. Not only is there apt to be hernia of the anterior rectal wall, but prolapsus of both bladder and uterus—and this in the order I have given them. The best success heretofore has followed Emmet's operation. His conception of the trefoil character of

the surfaces to be brought together is based upon a right conception of the anatomy of the parts. The perineal body being the central, and the lateral surfaces the outside leaves of the trefoil, each sulcus represents the lateral borders of the vagina and rectum. Perfect union of these surfaces leaves but little more to be desired. What remains to be attained is the object of what I now offer. In the first place, the loss of any tissue is to be avoided, and sure union by first intention the desideratum to be attained. My operation is based upon the recognition of the immense value of the perineal body. I denude the surfaces to the fullest extent of the parts injured. This denudation is accomplished by the removal of the covering of the parts to be denuded—*i.e.*, the cicatricial surface in *one* piece. For this purpose the first incision is made at the upper part where the edge of the skin coalesces with the cicatricial surface—(the dotted line in sketch No. 1 shows this); the knife is entered at the highest point on the right side, and the incision brought down to the lowest part of the fourchette, when it is met by a similar incision on the left side. The lowest part of the angle is then seized with the forceps and carefully dissected upward, taking special care to remove the whole surface without incising the flap; this dissection is carried on till the surface represented by the original wound is uncovered. This flap, when raised with the hook, is seen in drawing No. 2. The next step is the introduction of the shield-sutures (and here I would say a word in favor of the catgut suture which I adopt). It is by far the best, as it gives the greatest possible extent of surface to surface—much greater than can be secured by the interrupted or any other suture. Two deep sutures usually suffice, and these—whether silver, silk, or catgut—are passed in and secured by clamp shot upon an ivory shield. The first suture should be inserted low down, and about three-quarters of an inch from the edge of the wound. It must be passed under the denuded surface so as not to appear, and brought out on the opposite side at a point corresponding to that of insertion. The second deep suture is similarly introduced higher up. The last deep suture should catch the flap, and the interrupted suture will do for this.

Operation
in
detail

The edges of the wound are coapted by horse-hair sutures, and the upper part of the flap and around on the right and left side are secured by catgut sutures; this leaves the united surfaces in the shape of the letter T. The vaginal surface is perfectly covered, and in no way can a drop of fluid enter the wound or interfere with union by first intention. There is very little pain, inasmuch as the deep shield-sutures allow of distention. Interrupted sutures should not be used. Where the rupture extends into the rectum, the flaps are carefully brought together by a running catgut suture, and the operation completed as in this case. The objection to all other operations was that it left the vaginal incision open, which sometimes, therefore, interfered with union by first intention. By my method this is now impossible, and when catgut is used the results of the operation leave absolutely nothing more to be desired. The following points are gained: Perfect union, perfect restoration of the perineum, no loss of substance, and no after fever worthy of the name. Sketch 3 shows the condition of the parts at the completion of the operation.

DR. WM. GARDNER said that, as a rule, extensive lacerations of the perineum were mischievous, and produced symptoms, yet he had seen many exceptions to this. In numbers of cases, even where some fibres of the rectum have been torn, no inconvenience followed, due, no doubt, to the integrity of the vaginal walls and to individual peculiarity. He had also seen procidentia uteri in virgins and in multiparous women, where there was no rupture at all. The principle of the method advocated by Dr. Trenholme was not new. Hart and Barber had described a similar operation, but denuding in two segments; and Tait, five or six years ago, proposed an operation similar to Dr. T.'s, with the exception of introducing the sutures somewhat differently. Dr. Gardner had performed this (Tait's) operation twice, but was not favorably impressed with it. Convalescence was not so satisfactory as when he had performed Emmet's operation.

DR. ARMSTRONG thought that the different degrees of injury resulting from laceration of the perineum in different cases de-

pended upon the character and extent of the tear. He doubted whether a simple tear of the so-called perineal body, which consisted principally of cellular tissue and skin, was followed by much harm. There was good evidence to the contrary. The evil results charged to laceration of the perineum only obtained when either the pelvic fascia was torn or when the muscular floor of the pelvis was injured, either by a separation of the levator ani muscles in the middle line, or when one or both of these muscles were torn away from their origin from the rami of the pubes or from the ischial spine. This fact is pretty clearly established by Emmet, by Dr. Schatz of Rostock, and by Dr. B. E. Hadia of San Antonio, Texas. The best operation is that which the most perfectly restores the parts to the condition in which they were before the injury was sustained. Emmet's new operation has yielded good results in the Western Hospital. He was not aware that, so far, any attempt had been made to unite the divided muscles in the median line or to the pelvic fascia.

Lanolin.—DR. REED made a few remarks on this drug, a new basis for ointments, introduced by O. Liebreich, obtained from the fat of the keratin tissues, and principally from wool. The very strong recommendations of this cholesterine fat in the articles in the *British Medical Journal* for February would cause it to be extensively tried by the profession. The advantages of rapid absorption and ready miscibility with aqueous mixtures were in a measure confirmed. Manufacturers were preparing for a great demand, and an abundant supply at a moderate price would soon be on the market. A specimen was passed round.

Operation for Intra-uterine Fibroid—Accidental Inversion of the Uterus and Rupture of the Perineum.—DR. GARDNER reported the case as follows: Mrs. —, childless, was sent to him from Ontario. She had had severe hemorrhages for the past five years; of late they had been very excessive, and produced great blanching. On examination, a tumor was found about the size of a child's head, and completely filling the vagina and uterus. *Operation*—The tumor was fixed by an assistant and

removed piece by piece by means of scissors, fingers and serrated scoop. Towards the end of the operation, whilst dragging strongly on the remaining portion of the tumor it suddenly gave way, tearing the perineum and inverting the uterus. The uterus was easily replaced, but sutures were not applied to perineum in order to facilitate irrigation and drainage of the uterus. For this purpose Dr. Gardner always employs the double tubes fixed to the cervix. Convalescence proceeded very satisfactorily for five days, when the temperature rose and diarrhoea set in. This condition persists in spite of treatment. It is feared she has amyloid disease of the liver and other organs, the liver being now enlarged and smooth. She is also passing large quantities of urine containing albumen.*

Stated Meeting, May 1st, 1886.

T. G. RODDICK, M.D., PRESIDENT, IN THE CHAIR.

Tuberculosis of the Tongue.—DR. STEWART exhibited a woman, aged 28 years, who has been complaining for over four months of cough, purulent expectoration, night sweats, loss of flesh, etc. She has lost a brother and sister from pulmonary consumption. Her father and mother are still living, and enjoying good health. When she first came under observation, three months ago, there was distinct evidence of consolidation of both apices. This condition still continues. The patient is hoarse, and complains of pain in the larynx and also in the throat when swallowing. Dr. Major, who kindly examined the larynx, found a tuberculous nodule about the size of a grain of wheat in the inter-arytenoid space. The tip of the tongue is superficially ulcerated to the extent of about a five cent piece. From the centre of this ulcerated surface a fissure extends into the substance of the tongue to the depth of about a quarter of an inch. The tissues immediately surrounding this fissure are hard and nodular. There is no pain on pressure, however, neither is there any discharge from the ulcerated surface of the tongue. Shortly after the sore on the tongue was noticed, the patient experienced

* She died a week later from pleuro-pneumonia.

a severe pain in it, which continued to increase in severity up to the time when she first came under treatment, when it had reached such an exquisite degree that she found it almost impossible to eat or even to speak. The local application of iodoform quickly relieved the pain, but otherwise it does not seem to have had any influence over the course of the local trouble. Lately, a half per cent. solution of papayotin in equal parts of glycerine and water has been applied several times daily, the object being to directly influence the tuberculous infiltration, from the well-known properties that this drug has in dissolving albuminous tissues. The case is undoubtedly one of typical tuberculous ulcer of the tongue. Although the secretion from the ulcer has been examined on two occasions, no bacilli have been found.

In reply to a question raised by DR. SHEPHERD as to the influence of iodoform, when used as a local application, in producing pneumonia,

DR. MAJOR stated that he had used the drug extensively in nasal and laryngeal disease for many years, and he had not, thus far, encountered any untoward result.

DR. R. J. B. HOWARD had seen iodoform freely used in Vienna in cases of excision of the tongue, and there it is said to be free from danger.

Eversion of the Laryngeal Ventricles.—DR. MAJOR presented a case of eversion of both laryngeal ventricles in a male aged 27. The case had been under observation and treatment for over two years, and showed decided improvement. A tuberculous condition was present, as evidenced by lung signs and a local development in the post-laryngeal wall. He referred to a case of complete eversion of the right sacculus, which had been demonstrated at the throat clinic of the Montreal General Hospital in April, 1884, occurring in the person of a syphilitic subject, where the ventricle was completely returned under treatment. Reviewing the literature of the subject, allusion was made to the fact that in the majority of the few recorded cases some dyscrasia was prominent, notably accompanying syphilitic, tuberculous or cancerous disease.

Peculiar Skin Disease of the Feet.—DR. R. J. B. HOWARD exhibited a boy, 12 years of age, of healthy family. He has angular curvature, involving the lower dorsal region. First noticed when he was $3\frac{1}{2}$ years old. His feet were first affected in his sixth year. A small "scurfy" spot appeared first on the right foot, and has spread steadily, healing at the centre. When he came to the Dispensary it appeared as a lupiginous patch about 4 inches across, on the right ankle and instep; smaller similar patches existed on the outside of the right little toe and left great toe, at metatarso-phalangeal joint. The patch is covered with a crust or scab of a somewhat papillary appearance. Not tender or painful at any time, and never ulcerated. Dr. Howard brought the case for diagnosis. He thought it was due to some derangement of the spinal cord at the seat of the curvature, as nerves from this region supplied the skin of the feet.

DR. SHEPHERD believed it to be a form of lupus.

The PRESIDENT suggested that the parts be poulticed to remove the crusts, and the boy be again brought to the Society.

Compound Fracture of both Legs.—DR. SHEPHERD presented a case with the following history:—Edward N., aged 33, sailor, on the 11th of September, 1885, whilst working on his ship, fell through the hatchway into the hold, a distance of twenty feet, breaking both his legs. He was immediately admitted to hospital, and on examination, it was found that he had sustained a compound fracture of both legs about their middle third. The wound in left leg was about two inches long, and the fracture was comminuted. The right leg had the soft tissues much lacerated, the wounds being multiple, the largest some 4 inches long. Large pieces of muscle protruded, and there was much riding of bones. After cleansing the wounds with bichloride solution 1-1000, dusting them over freely with iodoform, and covering them with iodoform gauze and sublimate jute, the left leg was immediately put up in plaster, a window being left opposite the wound, some jute being placed over this and kept in place with a gauze bandage. Owing to the size of the wound and amount of the laceration in the right leg, it was

thought wiser to put it up in a McIntyre splint, after placing the bones in as good a position as possible. The same evening, owing to the large amount of oozing, the external dressings were renewed, but were not again touched for one month, at the end of which time the wounds were found perfectly healed; the fracture of the left leg was firmly united, but although the extensive wound in right leg had healed, there was no union, so, after rubbing the bones together, it was put up firmly in a plaster-of-paris bandage. From time to time this bandage was renewed, the patient being allowed to move about with crutches. At the present time, seven months after the accident, the patient could walk about without support, and during the next week intended joining his ship. The right leg was still encased in plaster, and although the union was not quite perfect, it was daily improving. There was one inch and a half shortening of the right leg. After exhibiting the patient, Dr. Shepherd remarked that he had now no fear of compound fractures, and that all the cases did well if the wound was thoroughly cleansed with bichloride, dressed with iodoform and jute dressing, and left undisturbed. Of course, if the temperature rose, it was wise to examine and change the dressing. He considered this a case which a few years ago would have demanded amputation.

DR. R. J. B. HOWARD said that Esmarch reported a case where there were three compound fractures of the leg, thigh, and forearm. The treatment used was similar to Dr. Shepherd's, and a good recovery followed.

DR. JOHNSTON exhibited the following pathological specimens:

1. *The Cord and Brain* from a case of non-tubercular cerebro-spinal meningitis in a child. Patient was suddenly seized with severe pain in the head and vomiting. A few days before death ecchymotic spots appeared over the chest and arms. The illness only lasted a week.

2. *The Uterus and Heart* from a case of malignant endocarditis in a patient suffering from puerperal fever. Patient did well for the first twelve days after confinement, when she was suddenly seized with rigors, her temperature running up to 105°. Nothing local was found to account for this. There was no pain

in the abdomen. The heart showed endocarditis, with vegetations over the valves. The uterus showed signs of septic endometritis. There was also a diphtheritic-looking membrane in the cervix and on the inner sides of the labia. There were infarcts in the kidneys and spleen, but no pyæmic abscesses.

DR. J. C. CAMERON read a paper entitled

Notes on the Determination and Causation of Sex.

By P. W. P. MATHEWS, LL.D., M.R.C.S.E., Etc.,

Dominion Coroner for the North-West Territories and Medical Officer of the Hudson Bay Company, etc.

of which the following is an abstract:—

From earliest times, men have been anxious to learn the sex of the foetus in utero, and for this purpose many quaint methods have been devised. The following aphorisms enunciated by Hippocrates are to this day believed and practised by midwives in the East:

1. If the child be a male, the mother will have a good color; but if a female, a bad color.

2. The male foetus is usually seated on the right side, the female on the left.

The ancient astrologers directed a drop or two of the mother's milk to be squeezed out upon a clean knife or glass, or upon the finger-nail. If the milk spreads about, the child is a female; if it remains still, the child is a male.

M. Venette, the author of a popular treatise in France, directed that if a son is desired the generative act should be performed when the wind is in the north. Others held that the right testicle secretes female sperm and the left male; others that the right ovary discharges male ovules and the left female, and directed the woman to lie on the right side during coitus if a male child is wanted. This belief still lingers among some of the Hudson Bay Indians.

Pythagoras thought that a vapor descended during coitus from the brain and nerves of the embryo, the grosser tissues being derived from the blood and humors found in the uterus.

Empedocles affirmed that a portion of the embryo was contained in the sperm and a portion in the germ, the child being formed by the union of the two.

Hippocrates taught that conception takes place in the uterus by the mixture of due proportions of the male and female elements, sex depending upon which is stronger.

Aristotle held that the material parts of the embryo are formed by the catamenial blood, and that the male semen imparts the principle of life when the body is formed.

In later times, Descartes and his followers affirmed that a sort of fermentation takes place when the male and female seminal fluids are mingled, a foetus being the result; while according to the chemical school, the acid male secretion mixing with the alkaline female secretion causes a sort of double decomposition, a foetus being the precipitate.

In 1667, Ludwig Hamm contended that an immense number of animalcules exist in the semen of all male animals, which contain the perfect rudiments of the future animal, and that the female simply supplies the proper nidus or habitat and suitable nourishment. The discovery of movement in the minute seminal particles seemed to confirm this theory; while some writers went so far as to say that these animalcules are of different sexes and copulate so as to engender male and female offspring.

Thury of Geneva propounded the doctrine that in animals, males are always produced when completely matured ova are fecundated, and females when the ova are less mature. Thus by serving the cow with the bull at the commencement of rut, a female calf is produced; by serving at the middle or end of the rut, a male is ensured. In further proof of his theory, he said that queen-bees always lay female eggs first, and males afterwards. Applying this theory to the human female, it has been argued that if the ovum which is discharged from the ovary at time of menstruation, is impregnated shortly after the conclusion of the menstrual period, a female will be the result; but if impregnation do not take place for ten days or a fortnight, the child will be a male. This rule has been briefly formulated thus: *Female* offspring result from *post-menstrual*, *male* from *pre-menstrual* impregnation.

The relative age of the parents seems to have some influence upon the sex of their offspring. Mr. Sadler, from an investi-

gation of nearly 15,000 cases, concludes that on an average the sex of the child is that of the parent whose age is in excess. In England the husband is usually older than the wife, and the proportion of live-births is 104.7 males to 100 females. Among illegitimate children, the proportion of males is somewhat higher, 106.3 to 100, probably for similar reasons.

Recently, Mr. Starkweather has published a book on the "Determination and Causation of Sex in Man and the Lower Animals," in which he lays down the law that sex is determined by the *superior* parent. In deciding this superiority, numerous factors are to be taken into account, such as temperament, activity, energy, will, intellect, features, color, physique, health and nutrition. This sexual superiority does not necessarily coincide with superiority as generally understood, nor does it necessarily imply superiority in mental and moral qualities. This theory is an expansion and extension of Hippocrates' dictum, that the parent who is physically more vigorous at the time of conception gives his or her sex to the offspring; or, as Cuvier puts it, "To obtain an excess of female offspring, the father should be young and ill-fed, and the mother of mature years and highly fed."

In 1863, Frankenhauser and others propounded the theory that the rapidity of the foetal heart varies according to the sex of the child, being greater in the female than the male. In 50 cases he succeeded in diagnosing the sex correctly, finding

124 = mean male foetal heart-beat.

144 = " female " "

Steinbach followed with 45 successful cases out of 57, finding

131 = mean male foetal heart-beat.

141 = " female " "

Devilliers in France and Cumming in Edinburgh denied the truth of this theory, and maintained that the frequency of the foetal heart-beat depends upon the size and weight of the child rather than upon its sex. As it is usually slower in large and well-nourished children, and as males are generally larger and heavier than females, a slower pulse-rate in males is usually to be expected. Opinions seem to be contradictory respecting the

truth of this theory; my own experience does not corroborate it. One strong argument against it is, that if the pulse-rate of a considerable number of children be taken within one hour after birth, the difference of rate in the sexes will be too slight to admit of any rule being deduced therefrom.

Remarks by DR. CAMERON :

In 1879-80-81 I made some observations which tend to confirm Frankenhauser's theory. McClintock, in the Sydenham Society's edition of Smellie's Midwifery, quotes some observations made by Dr. Frank C. Wilson of Louisville, which are so similar to my own that I tabulate them together as follows:—

	DR. WILSON'S CASES.			<i>Remarks.</i>	DR. CAMERON'S CASES.		
	No. Cases.	M.	F.		No. Cases	M.	F.
Fœtal heart-beat, 110-125.	37	35	2	Almost certainly male....	15	15	0
“ “ 125-130.	15	13	2	Probably “	14	14	0
“ “ 130-134.	12	8	4	Doubtful-chances of “	7	2	5
“ “ 134-138.	7	2	5	“ “ female.	15	5	10
“ “ 138-143.	9	2	7	Probably “	19	3	16
“ “ 143-170.	26	2	24	Almost certainly “	30	1	29
	106	62	44		100	40	60

The lowest foetal heart-beat in my series was 98, in a very large male child. From this series of observations, it seems tolerably conclusive that a foetal heart-beat under 130 is generally diagnostic of a male; over 140, a female. To secure accuracy, the following precautions should be taken:

1. Observations should be made before or in the very early stages of labor, for as labor advances the foetal heart-beat tends to become more rapid or irregular.

2. Several observations should be made, and their mean calculated, for the painless contractions of the uterus frequently modify the foetal heart-beat 10-20 per minute.

Many failures in diagnosis may be referred to lack of attention to these precautions.

In discussing this question of sex, much confusion has arisen from the want of clear notions respecting menstruation, ovulation and conception. Menstrual flow and the discharge of a mature ovum from a Graafian follicle are supposed to occur about the same time; hence many conclude that these two processes stand in the relation of cause and effect. Although the question is

not yet definitely settled, evidence is rapidly accumulating to prove that their coincidence is accidental rather than necessary, and that one process may go on independently of the other. Indeed they are essentially opposite in character: ovulation is *progressive*, being the preparation and discharge of ova fit for impregnation; menstruation is *retrogressive*, being essentially a retrograde metamorphosis of the soft decidua prepared for a previous ovum. It has therefore been aptly called "the funeral obsequies of defunct and disappointed ova."

Physiologists tell us that after a ripe ovum has been expelled from its Graafian follicle, its germinal vesicle becomes nuclear and approaches the surface. A portion is eventually extruded from the egg in the form of the Polar Bodies, leaving the remainder to form the *female pronucleus*. The ovum then ceases to grow unless speedily fertilized, perishes, and is cast off. But if spermatozoa reach it in time and penetrate its substance, it does not perish; the heads of the spermatozoa detach themselves and become the *male pronucleus*, which fuses with the female pronucleus to form the fertilized nucleus. Conception is said to have taken place, and growth is thenceforth rapid. Morphologically, the male and female pronuclei are closely allied, both being derived from the primitive ova of early embryonic life. In the female, a primitive ovum develops into a permanent ovum, capable of producing a human being; in the male, a primitive ovum breaks up into a number of spermatozoa. That the sex of offspring must be due to the relative properties and powers of these male and female pronuclei is tolerably clear, but to what properties or what powers is not quite evident. The essential points of Starkweather's theory are the following:

1. The male and female elements share equally in the determination of sex.

2. Sex is determined by the superior potentiality of one or the other.

3. The superior parent or element (at the time of fruitful intercourse) determines the opposite sex in the offspring—cross-heritage, as it has been called.

4. In the great majority of cases, it is possible to prognosticate the sex that will result from the union of certain parents.

5. The sex of offspring is or might be generally within the control of parents.

6. This law holds good for the lower animals as well as man.

He cites numerous life histories in support of his theory, such as Milton, Shakespeare and Sir Thomas More, and dwells upon the well known fact that great men have usually great mothers. He holds that his theory accounts for the small excess of male births among western nations, the marked excess of females among mulattoes, and the temporary large excess of males after war, pestilence, etc. In certain families, too, there has been noticed a remarkable succession of sons in one generation, of daughters in the next, and of sons again in the next. These cases are explained as examples of cross-heritage, the sex being determined by the superior opposites. In the controversy aroused by Starkweather's book, frequent appeals have been made to the experience of stock-breeders both for and against his theory. On the whole, the evidence seems to be against the ability of man to control sex among the lower animals. Yorkshire men, the most experienced breeders in England and probably in the whole world, have no confidence in their power of predetermining the sex of horses and cattle, although it would be very much to their pecuniary advantage to be able to do so, but are confident that they can modify, develop, or eliminate any other physical quality to an almost unlimited extent.

Starkweather's theory is ingenious, and contains much truth, but is yet far from proven. As our knowledge and experience increase we may know more of nature's methods; but it is highly improbable that we will ever gain the power to regulate sex, for such power would be prejudicial to the best interests of the race. During countless ages, the diversity of man's environment, the unceasing struggle for existence, the survival of the fittest and the gradual development of the race have continually, through barbarism and civilization alike, determined those laws of reproduction which were from time to time most conducive to man's welfare. Nature's experience is greater than ours; her wisdom,

patience and unselfishness are greater than ours; her balance more justly equipoised than ours. But though we cannot supplant her, we may learn important lessons by observing her methods. The careful study of sex-formation should throw much light upon the mysteries of heredity, and enable us to foresee and possibly forestall many family taints or predispositions. The knowledge that a grandfather's peculiarities are liable to be propagated through his daughters to his grandsons, should help us to grapple with such diseases as dipsomania, hæmophilia, or gout.

If, in any degree, it be true that the superiority of the parent is a powerful factor in determining the sex as well as the strength of the offspring, it must be equally true that the deterioration of the parent will cause deficiency or deterioration of the opposite sex in the succeeding generations. If, then, the modern craze for the "higher education of women" goes on unchecked till their physical powers are sacrificed to so-called mental culture, the prospects for coming generations of *men* will be dark indeed, and Miltons or Shakespeares will be well nigh impossible. But nature's unerring balance eventually rights all things; the enfeebled progeny of weak, neurotic parents inevitably succumb before the vigorous offspring of the healthy and robust, for the fittest must survive.

TORONTO MEDICAL SOCIETY.

Annual Meeting, April 6, 1886.

THE PRESIDENT, DR. CASSIDY, IN THE CHAIR.

(From our own Correspondent.)

After reading the minutes of the last meeting, the retiring president gave his valedictory address, which consisted in a summary of the work done during the past year, and redounded much to the credit of the Society.

The election of officers for the ensuing year was then proceeded with, and resulted as follows:—

President—Dr. A. McPhedran.

1st Vice-President—Dr. B. Nevitt.

2nd Vice-President—Dr. H. Machell.

Corresponding Secretary—Dr. Cochrane.

Recording Secretary—Dr. Peters.

Council—Drs. Reeve, Graham and Atherton.

A hearty vote of thanks was then tendered the retiring President, Dr. Cassidy, to which the latter made a suitable reply, and the Society adjourned.

Stated Meeting, May 20th, 1886.

THE PRESIDENT, DR. MCPHEDRAN, IN THE CHAIR.

DR. SWEETMAN presented a patient, aged 23, who, eighteen days before, had been struck in the centre of the forehead by a piece of wood thrown from a circular saw, causing a compound comminuted depressed fracture of the frontal bone. Dr. Sweetman trephined the frontal bone close to the seat of fracture, and removed a circle of bone about five-eighths of an inch in diameter; several fragments were also removed, the largest having an external surface half as large as a five-cent piece and an inner surface as large as a twenty-five piece. A very slight puncture was made in the dura mater, and a portion of clot was removed from beneath it. The longitudinal sinus was laid bare, but uninjured. The patient recovered without any bad symptoms.

DR. NEVITT related a case of compound depressed fracture of the parietal bone, in which the wound had gone on to profuse suppuration before it was seen by the surgeon. On careful examination, the wound was found to contain a portion of the felt hat which the patient had worn, some hair, and a number of fragments of bone; these were removed, and the patient recovered without the slightest symptom of compression or irritation.

DR. TESKEY exhibited a kidney affected with marked amyloid degeneration. The two kidneys together weighed 23 ounces. The subject from whom they had been removed had suffered from prolonged suppurating abscesses. Sections of the kidney, stained violet with iodine and methyl aniline, were also demonstrated.

In answer to DR. MACHELL, DR. TESKEY expressed it as his

opinion that patients suffering from amyloid degeneration of organs often improve under favorable circumstances, such as the removal of the suppurating part. The lardaceous matter may be absorbed, but there is hypernucleation of the interstitial tissue which eventually undergoes infiltration and contraction.

Extracts from British and Foreign Journals.

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

Germ and Ptomaines.—In concluding his paper before the French Academy of Medicine, Prof. Peter made the following remarks:—"M. Gauthier has shown that in the dead body, and even in the living, ptomaines are found; these alkaloids, ptomaines or leucomaines, are absolutely toxic; an auto-infection, characterized by hyperthermia, is the result. This theory rids us, at least for a time, of the tyranny of the microbes. If urea, which is an alkali, is constantly formed in our organism, why should there not also be formed an alkaloid in it? It is only a question of degree. Life is a contingent phenomenon; it is a series of partial deaths. It may therefore be said that we carry in ourselves, while living, a portion of our own corpse, but we resist the work of auto-infection by two distinct mechanisms—the elimination of the toxic substance and its destruction by oxygen. We should no longer hesitate between the parasitic doctrines, which are shrouded in dark hypotheses, and this new doctrine, which is as luminous as it is precise, which explains the phenomena of normal and abnormal life."—*Lancet*.

Pilocarpin in Pneumonia.—The Paris correspondent of the *British Medical Journal* tells us that Dr. Humbert Mollière has successfully treated double pneumonia with pilocarpin. The patient, exhausted by dysentery and albuminuria, was attacked with pneumonia in both lungs, and the intestinal disturbance was greatly aggravated. A centigramme of pilocarpin was injected; the respiratory movements fell from 48 a minute to 24, and dyspnoea was much relieved. Four hours later, a fresh injection was made, and was repeated the next

morning; each injection was followed by profuse sweats and salivation, and dyspnœa was greatly relieved. The patient rapidly recovered. In administering pilocarpin, M. Mollière was guided by former experience. An elderly man with uræmia, accompanied with dyspnœa and delirium, who seemed dying, was greatly relieved and ultimately cured by a similar treatment. Dr. Mollière describes another case. A young woman with a comatose form of uræmia and renal lesion, following a cardiac affection, was freed from the comatose condition by injections of pilocarpin.—*Med. & Surg. Reporter.*

Bacteriology.—The rapid advances of bacteriology during the last few years, and the important rôle which bacteria play both in health and disease, give great interest to a sketch of the chief facts which have been made out with regard to these minor organisms, and of the methods of investigation employed in their study, which Mr. Watson Cheyne presents in the July number of the *American Journal of the Medical Sciences*. A knowledge of what has been discovered with regard to these minute bodies is essential for the study of pathology, and for the rational treatment of infective diseases. But it is more especially in the department of preventive medicine that the practical value of these researches is as yet evident. So long as the precise cause of a disease is unknown, the views held as to its origin must necessarily be vague, and the measures adopted against it often either inefficient or excessive. But when the cause is known, and more especially when it can be studied apart from the body, its life history, its habitat outside the body, its mode of entrance into the system, and the best methods of destroying it under various conditions are learned, and the measures to be adopted against it can be made precise and effectual. It is not, however, sufficient for the medical officer of health to know the literature of the subject; he must himself be a bacteriologist, ready and able at any moment to carry out an investigation on bacteria. More especially must he be acquainted with the methods of demonstrating, recognizing and studying these organisms in water, food, etc., with the view of determining in many cases whether these substances are hurtful or not, and also with the view of

ascertaining the exact source and commencement of any given epidemic. It is necessary that the practising physician also should be, to a certain extent, versed in some of the methods, more especially in those of staining and examining bacteria, as, for example, the bacillus of tubercle, in order to enable him to make or confirm his diagnosis. In surgical work, again, more especially in the treatment of wounds, a practical acquaintance with the subject is almost essential. Whatever antiseptic substance be employed, or whatever method of treatment be adopted, the principles enunciated years ago by Sir Joseph Lister must be rigidly adhered to: micro-organisms must be completely excluded from wounds or their active development must be prevented. To do this intelligently, the surgeon must know what are the chief facts with regard to bacteria; while to carry out wound treatment comfortably and successfully, a practical knowledge of the methods employed in laboratory researches is almost essential. The importance of these studies will doubtless become more fully recognized as time goes on, and facilities for their study by students will be provided in every good teaching school, as is, indeed, being already rapidly done in the leading universities in Germany.

Ulcerative Endocarditis.—In an elaborate study of ulcerative endocarditis, in the July number of the *American Journal of the Medical Sciences*, Dr. Byrom Bramwell records fourteen cases in all of which the aortic valve was affected, either alone or in combination, the mitral in six, and the tricuspid in one. In two of the three cases in which well-marked acute croupous pneumonia was present, he detected micrococci in the exudation filling the air-cells of the lung, but he failed to satisfy himself that they were identical with the micrococci in the cardiac vegetations. The frequent association of acute croupous pneumonia with ulcerative endocarditis is a point of great interest, but Dr. Bramwell's observations on this point have not been sufficiently extensive to enable him to form a satisfactory judgment; but his pathological experience clearly shows that during certain seasons acute croupous pneumonia and ulcerative endocarditis are apt to prevail. The detection of micrococci in the

inflamed cerebral meninges, and in the vessels and substance of the cerebral cortex, and the presence of disseminated patches of cerebritis and acute cerebral softening, are very interesting; and afford a satisfactory explanation of the nervous symptoms which are so prominent in some cases of the disease. Mr. A. W. Hare, in response to Dr. Bramwell's request, undertook an experimental investigation to determine the relationship of ulcerative endocarditis to other infective conditions. The results which he obtained, and which are detailed in the paper, are, for the most part, negative.

Temporary Glycosuria.—Dr. Eichberg (*Cincinnati Lancet Clinic*) reports a case of temporary glycosuria, with remarks, from which we make the following abstract: The familiar term of diabetes has come to be surrounded by so many terrors, both to the lay mind and to that of a considerable portion of the profession, that it behooves us to exercise more care in its application, and to limit it to those cases in which the presence of sugar in the urine is a persistent phenomenon. It is difficult, extremely difficult, indeed, to tell exactly what diabetes is; and as long as there is such uncertainty as to its nature and pathology, our treatment must remain purely empirical. It has often been stated that diabetes, like jaundice, is a name, not for a distinctly diseased condition, but for a prominent symptom. The statement may be true, as far as it goes, but the similarity, to be complete, should be restricted to those cases of jaundice which owe their origin to causes other than those occasioning some obstruction to the outflow of bile: to what are known as cases of *haematogenous icterus*. In these, as in the case of diabetes, the unknown causal agency leads to the appearance in the blood and secretions of some abnormal product, about which we cannot say whether or no its appearance is due to deficient elimination or excessive production of a material whose presence in the blood in small quantities is strictly normal. A process of study similar to that which has been adopted in connection with Bright's disease, of sifting and of comparison, has been adopted with regard to the presence in the urine of the other important abnormal ingredient—namely, the sugar. As was to be fore-

seen, the results achieved have not been commensurate, either in a pathological or clinical way, with those obtained with reference to albuminuria,—firstly, because the number of cases in which glycosuria is a symptom is vastly smaller than those in which the urine contains albumin ; and, secondly, because pathological anatomy has failed to find for us any alteration in the tissues of the body to which we could certainly point as the cause of disease. What a decided help would it not be for us were we able, in conducting a post-mortem examination, to point to some one organ of the body, without being at all acquainted with the previous history of the case, and say : “ This patient undoubtedly suffered from diabetes, for we have here the characteristic lesions of this disease ; lesions which, if found in any case, certainly point to an antecedent history of diabetes ; lesions which may really be regarded as the cause of all the symptoms ” ! We are not in position to make any such assertion, not even able to look forward to any realization of such a hope for the near future. Theories in plenty have been advanced to help us, but we absolutely lack the foundation of facts. Sugar may undoubtedly appear in the urine under the most varied conditions ; small quantities may escape observation by the ordinary tests, however carefully made, and there are doubtless many cases which go entirely unrecognized, but it is somewhat mortifying to have to confess that even in cases in which there is sugar present for many months and other symptoms all point to diabetes, we are treating we know not what ; and that when the patient finally leaves our hands, possibly so far improved that sugar is no longer discoverable, even then we cannot give him the assurance that he is positively relieved of his trouble, nor even promise him a short immunity.

For Rhus Poisoning.—℞ Borax, pulv., ʒij ; acid carbolic, ʒj ; morphia sulph., grs. x ; pulv. acacia, ʒiv ; water, q.s. ad., ʒviiij. M. Agitate till solution is formed. Use with camel-hair brush. The carbolic acid and borax doubtless help to kill the poison, while with a few brushings the skin becomes coated with the gum, and the irritation and pruritus are allayed.
—*M. & S. Reporter.*

Delirium Tremens.—Dr. J. T. Whittaker (*Cincinnati Lancet-Clinic*, June 5, 1885) says that signs of delirium tremens rarely appear until derangement of digestion is noticed, and the history of most cases shows a gastric catarrh which prevents the absorption of the remedies. Gastric catarrh produces delirium tremens by impairing nutrition. The secret of success in the treatment is to feed the patient properly. A man may drink and continue to drink, and show no delirium tremens; but as soon as vomiting begins, with the other pronounced symptoms of gastric catarrh, the mind begins to waver and the whole nervous system to flag. But not every drinker suffers delirium tremens. Alcohol is a food in the amount of one gramme to a kilo of weight (fifteen grains to two pounds) in 24 hours. The speaker frequently has had occasion to testify as to the testamentary capacity of individuals addicted to alcohol, and has familiarized himself with the subject. Eight grammes to a kilo will kill, and 100 grammes will produce disease and true delirium tremens in some cases, pretty much always, with the prelude of a gastric catarrh. So the tongue is coated, the breath foul, the bowels constipated, as a rule, throughout the disease. The secret of success is found when food is given in connection with the treatment of the cases. But the question is how to get food into the body. The gastric catarrh produces vomiting and thereby the food is rejected. If this be the case, it is highly important to inject the food into the bowel. Thus the patient is easily nourished by chopped beef and pancreas. To feed the exhausted nervous system is the best way to give it rest. He had seen many cases of delirium tremens, but never one which required the administration of chloroform. He would, however, not hesitate to resort to it if the necessity arose. As a rule, its use is unjustifiable. He would not hesitate to give bromide of potassium in ʒss doses if necessary to secure sleep. He does not consider it more dangerous than common salt. He gives drachm doses every four hours, largely diluted, of course, in hypochondriasis and hysteria. There is no better food by the mouth than milk. If this be rejected, then recourse must be had to rectal alimentation. The vomiting can be controlled by a dose or two

of the officinal morphia solution (U.S.P.) with a drop or two of dilute hydrocyanic acid. The quickest and best results are obtained by abstention from all anodynes, except, perhaps, the bromides. Steer away from anodynes, but secure sleep by feeding the nervous system. In convalescence, nothing is better than hydrochloric acid, five to seven drops, largely diluted, before meals.

On Surgical Operations during Pregnancy. By Dr. Theophilus Parvin, Prof. Obstetrics Jeff. Med. College, Philadelphia.—My resident tells me that this woman is in the seventh month of pregnancy and she has an ununited fracture that invites an operation for its cure, and the chances are that such an operation would be successful. Well, now, should we operate? I would say no, not during the pregnancy. As a rule, I would advise you to defer all surgical operations that can be postponed until after pregnancy, and especially would I emphasize this rule with reference to all operations about the genital zone, and by this expression I do not mean merely the parts about the uterus and vagina, but I include also the mammary region. An operation for hemorrhoids during pregnancy would be very likely to cause abortion. The relation between the rectum and the genital organs is very close and intimate. So I would say that all operations of complaisance, operations that are not essential to the saving of life, should be postponed until after the labor. But let us suppose that instead of this simple fracture there was a sarcoma or a cancer of the arm; well, then, under such urgent circumstances, I would not hesitate to operate during pregnancy. So, also, would I operate on cancer of the breast or a cancer of the cervix itself, if it were progressing. It will sometimes happen that there will be some disease of the sexual organs, and in this term I include the breasts, which is making rapid progress during pregnancy and where you can see that the only hope of saving life, or at least of prolonging existence, is to be found in operative measures, and, in such cases, I would not hesitate to operate. I would not hesitate when there was a cancer of the cervix, if the progress was rapid, for even if it did produce an abortion, this

would be the lesser of the two evils, and it would be very likely to occur anyhow before the termination of pregnancy, with the uterus in this condition. Even though the pregnancy did go on to full term, it is more than likely that the child could not be born naturally with this condition of affairs. To summarize, I would enunciate the general rule, that whenever the question of surgical operation presents itself in connection with a pregnant woman, if it be possible, without jeopardizing the safety of the patient, I would postpone it till after labor, but if the case be of such a nature as to threaten life, or if delay would prejudice the ultimate chances of a woman for recovery, then I would not hesitate to operate.—*Medical Age*, May, 1886.

Gonorrhoeal Rheumatism.—Loeb is of opinion that gonorrhœa is only complicated by rheumatism in those cases in which the gonorrhœal process has attacked the hinder portions of the urethra, and in favor of this view he adduces the two facts, first, that the rheumatic symptoms never occur in the early stages of the gonorrhœa, and, secondly, that in the great majority of cases the rheumatism is never seen at all during the first attack, but only after subsequent attacks, when the posterior parts of the urethra are almost certain to be involved. As to the disputed point whether the rheumatism is to be considered as a disease *sui generis*, or as merely an ordinary rheumatic inflammation of the joints, predisposed by the gonorrhœal infection, he comes to the conclusion that *polyarthrititis rheumatica* and gonorrhœal rheumatism are two perfectly distinct diseases, and he bases his conclusions on the following grounds:—1st, The difference in the relation of the fever to the local changes in the two diseases, in ordinary rheumatism the fever and the joint affection generally running hand in hand, whereas in gonorrhœal rheumatism the fever is always slight and in most cases is almost, if not entirely, absent. 2nd, The difference in duration of the two processes, the gonorrhœal rheumatism running a much longer course. 3rd, Gonorrhœal rheumatism is much less erratic in its character than ordinary rheumatism. 4th, The frequent association of gonorrhœal rheumatism with inflamma-

tion in the eyes, this inflammation, according to him, occurring sometimes without contagion, and being simply another local expression of the gonorrhœal infection. 5th, The less frequent implication of the heart in gonorrhœal rheumatism. 6th, The greater tendency to inflammation of the sheaths of tendons and synovial sacs generally in gonorrhœal rheumatism. 7th, And lastly, the difference in behavior of the two processes towards the salicylates. Loeb thus considers the gonorrhœal rheumatism as an infectious process, the seat of infection being the hinder parts of the urethra; and this view receives apparent support from the recent discovery of a specific organism in the gonorrhœal secretion, the gonococcus. Some doubt, however, still exists as to the specific character of this organism, and hence Loeb is more inclined to think that the cause of the infection will be found in non-specific organisms, examples of whose action in producing inflammation in joints we have, according to him, in the rheumatic affections of the joints which sometimes occur during the puerperium, also along with bronchiectasis, scarlet fever, and dysentery. As to the treatment, it is especially important as quickly as possible to cure the inflammation in the urethra, and especially of the hinder parts.—*D. Arch. f. Klin. Med.*, Dec. 1885; *Practitioner*.

A Peculiar Sputum in Hysteria.—Dr. E. Wagner has called attention to a peculiar sputum often observed by him in hysterical patients, the appearance of which might readily excite the suspicion that a phthisical affection is to be dealt with. But in fact it has been observed invariably as coming from subjects (always hysterical) who show no symptomatology by which tuberculosis of the lungs may be confirmed. The sputum is, of course, free from bacilli, is of a hemorrhagic nature, mostly red, but of a lighter red than ordinary bloody sputum, and not in any way resembling ordinary rusty-colored sputum. When examined in a glass it appears like a reddish or brownish-red pulp, in which numerous small gray particles cover the bottom. This sediment is so characteristic that it is easy to make the diagnosis with the naked eye. In one case

the sputum for several days, in color and consistence, resembled a raspberry jelly, so that he suspected the development of a sarcoma or carcinoma in the bronchial tubes, under which circumstances it is usual to see this character of sputum. Under the microscope, in the sputa described, may be seen considerable quantities of small red blood-corpuscles, and along with them, frequently, numerous white blood-corpuscles, pavement epithelium, and cocci. Alveolar epithelia from the lungs were not discovered. Sometimes mucous pockets are found embracing pus cells. In every case, upon failure to find signs of disease of the lung or larynx, the author believes he has a right to conclude that the bloody coloring proceeds from small bleeding vessels, that the colorless part of the sputum is a pathological secretion of the mucous membrane, and that probably it all originates in the buccal cavity. The writer reports four cases in which he had observed this sputum for a considerable length of time; in one of which, however, bacilli at length appeared. In all cases an investigation for bacilli is of prime importance with a view to differential diagnosis.—*Deutsche Med. Zeitung; American Practitioner.*

Experiments with the Virus of Rabies.

—On March 6th a man in Brooklyn was bitten by a dog; on May 14th he died, with all the symptoms of hydrophobia. Portions of the brain and cord were sent to Dr. Sternberg, at Johns Hopkins University, and this gentleman, on May 17th, inoculated three rabbits with the tissue by Pasteur's method. On June 2nd, one of the rabbits showed symptoms of the hydrophobia of rabbits described by Pasteur; on June 5th the second rabbit showed similar symptoms. Some of the same brain and cord from the Brooklyn victim was taken by Dr. E. C. Spitzka, and rabbits were also inoculated by him. So far as we can learn from published reports, the rabbits showed symptoms like those of rabies, but Dr. Spitzka believes that such symptoms of themselves prove nothing, since he caused the same by inoculating rabbits with inert material and setting up meningitis.—*N. Y. Medical Record.*

CANADA

Medical and Surgical Journal.

MONTREAL, JULY, 1886.

CLIMACTERIC DIABETES IN WOMEN.

So many are apt to take a gloomy view of cases of well-marked diabetes, that we are thankful for anything that will tend to dispel such an (often) erroneous idea. That a severe diabetes may be temporary—may be recovered from either spontaneously or under suitable treatment—is quite well known, but no doubt there is still a good deal of uncertainty in the grouping of the cases, so that hesitation is often felt in rendering a sufficiently positive prognosis. The disease is certainly more malignant, less amenable to any treatment, in the young than in the old. Amongst people in advanced life diabetes is frequently met with, lasting through a series of years, without producing any marked symptoms, and perhaps only discovered when, from any reason, an examination of the urine has been made. Such persons may, after a variable time, completely recover. It is in the young and in young adults that the classical diabetes with bad prognosis is to be sought for. The factor of age is therefore always an important one. The connection of eczema of the genitals with diabetes has for many years been well recognized, so that the existence of such a cutaneous disorder is always accepted as an indication to look for sugar in the urine. The subject of diabetes occurring in women at the time of the climacteric has been recently treated of by M. Lecorché in the *Annales de Gynecologie*, and by Mr. Lawson Tait in the *Practitioner*. The observations of the latter are of considerable interest as regards the points above touched upon. He relates a series of cases of vulvar eczema occurring in

was a factor

initial symptoms of Diabetes

such

1886

women at or about the time of the change of life. In all of these the general condition was but little impaired—most of them recovered completely, some spontaneously, others under treatment; the remainder having their eczema cured, whilst sugar persisted in varying amount. The points of value which he brings out are chiefly these:—That, as previously observed by others, “the menstrual life appears to create for women a certain immunity with regard to this peculiar disease.” That “there seems to be a special form of glycosuria in women at the climacteric period, which runs a certain definite course extending over some years and having a natural termination in recovery.” That “it does not seem to be curable by drugs.” That “the great majority of cases of eczema of the vulva at the climacteric period are due to the presence of sugar in the urine.” Sugar was found in every case of the kind which he had met with. Though the case will run its course, yet this may be shortened and much suffering prevented by treatment. Mr. Tait recommends the use of crude opium internally and an ointment of ten grains of sulphuret of potassium to the ounce. These observations seem to have separated a special group of cases of diabetes in which the prognosis is more favorable than in any other.

*Menstrual
life a protective*

Treatment

A CENTRAL EXAMINING BOARD.

There can be no doubt of the existence amongst the profession of this province of a sincere desire to promote a high standard of general excellence. Although, perhaps, the attainments of the average practitioner here may compare favorably with those of the same class in *e.g.* many of the neighboring states, yet it is distinctly felt, and fully admitted, that the time has come when a move towards reaching a higher plane may well be taken—is indeed demanded—if we are to hold our own. The only means by which such an advance can be made is by increasing the severity of the tests for admission to practice. At the present time all holders of diplomas from recognized universities in the province of Quebec are simply licensed therein, without further formality. It is quite possible that the

examination at some of these schools is fully equal to any which might be instituted by a provincial board, but it is not certain that all are equally stringent. The appointment of assessors to be present at the various school examinations and to report to the Board thereon, was effected at the time of the passing of the present Act as a compromise between those then favoring a central examining board and those who strongly opposed it. It is curious to observe that, after the lapse of a few years, the course of events has caused the latter to become the chief advocates of a central examining body, as now proposed to be constituted. The presence of the assessors has doubtless been useful in preventing slackness or abuses, but it cannot be considered that this alone is sufficient to oblige all the teaching bodies to keep up to such thoroughness of instruction as is really desirable. Thus it is that there is now a strong feeling in favor of the establishment of a Central Examining Board. We published last month the report of the Committee which has been engaged in considering this matter. Official notice is now given of a special meeting of the Provincial Medical Board, to be held on the 13th instant, when the subject will receive due consideration—final action to be taken upon it by the whole College at its triennial meeting the following day. It is hardly expected that any serious opposition will be offered to the scheme, although the details, as proposed by the Committee, may of course undergo considerable modification. The expense connected with a board of examiners will be very considerable here, owing to the necessity for a duplicate number of examiners in consequence of the two languages. The adjustment of the finances will, therefore, need to be carefully attended to, so as to avoid either burdening the College with debt or placing very heavy fees upon the students. It must be remembered that, if the Central Board scheme comes into operation, the position of Assessor will lapse, and the very considerable sums spent annually upon these officers will be available for other purposes. It is expected that by the saving effected in this way, and also by having a single annual meeting of the Board in place of the two meetings as heretofore, the amount required

for the examiners may be secured without placing too heavy a tax upon the candidates.

THE ELECTION OF GOVERNORS.

The Provincial Medical Board, as at present constituted, does not form a representative body in the true sense of the word. That is to say, the individual members have not been elected by the voters of a certain constituency to represent them in this assembly. On the contrary, the whole mass of the profession, brought together once in three years, determine upon the names of persons from each district to serve upon the Board for the next three years. The great—the preponderating—majority of members do not attend the meeting, but send proxies to their friends. Each proxy then counts for a vote for every district in the province, without, perhaps, the author of it having any cognizance whatever of even any single candidate's name. A few active men, working for a short time before the election, possess themselves of large bundles of proxies and practically control the election. In this way the most unpopular and unsuitable person may be returned for a given district without the possibility of the members resident in that district having the slightest power to prevent it. It is evident that this mode of election is not calculated to bring out the best and the most progressive, or most useful members, from whom to form the governing board. The practitioners of any locality are the persons best able to judge of the fitness and ability of the candidates in their district, and they should be entrusted with the important duty of sending a real representative to the Provincial Council. The outline of a scheme for carrying this into effect has been prepared, and was published last month. The procedure is mainly based upon that which has been followed for some years in Ontario, and meets with general approval. It is to be hoped that all the members of the College have examined its provisions, which, it seems to us, will be found to meet the necessities of the case in a very satisfactory manner.

CANADIAN MEDICAL ASSOCIATION.

The nineteenth annual meeting of this Association will take place in the city of Quebec, on Wednesday and Thursday, the 18th and 19th of August next, and the prospects are good for a very successful gathering. A number of prominent physicians and surgeons of leading medical centres of the United States have signified their intention of being present. We hope to see the profession well represented, both in attendance and literary contributions.

Owing to the absence of Dr. Stewart in Europe, Dr. James Bell of this city is acting as the general secretary, and will be pleased to hear from intending readers of papers as early as possible, so that a list may be printed. Arrangements are being made with the different railway and steamboat companies to enable those who wish to attend the meeting to do so at reduced rates. Further particulars will be given in our next issue.

THE PROVINCIAL COLLEGE.—We would direct attention to the advertisement calling a meeting of the Provincial Medical Board for the 13th inst, and one of the College of Physicians and Surgeons for the 14th inst. As very important matters will come before the members on both these days, it is hoped that a full attendance will be secured.

THE ASSOCIATION OF AMERICAN PHYSICIANS held their first annual meeting in Washington, D.C., on the 17th and 18th June. The Association has been formed solely with the object of forwarding the interests of scientific medicine in America. The membership has been limited to 100, and is composed of well known representative physicians in various parts of the United States and Canada, and of those who are specially engaged in the medical work of the hospitals and in teaching the branches of medicine and pathology. A large proportion of all the members were present, this country being represented by Drs. J. E. Graham of Toronto and Geo. Wilkins and Geo. Ross of Montreal. Dr. R. P. Howard, who has taken part in

the preliminary meetings for organization, was, we regret, unable to attend owing to illness in his family. The proceedings opened with a short address from the chairman, Dr. Delafield of New York, upon the aims and object of the new association. This was followed by an exposition by Dr. S. Weir Mitchell of a series of recent observations upon knee-jerk and muscle-jerk in disease. Dr. Porcher of Charleston read a paper on Typhoid Fever, with special reference to treatment. Dr. Whittaker of Cincinnati one on Spasm of the Larynx in Rickets. A discussion was then had, introduced by Drs. Tyson of Philadelphia and W. H. Draper of New York, upon the question, Does the present state of knowledge justify a clinical and pathological correlation of Rheumatism, Gout, Diabetes and Chronic Bright's Disease? Dr. Bruen of Philadelphia read a paper on Some Cases of Diaphragmatic Pleurisy. On the second day, a very interesting demonstration was given by Dr. Councilman of Baltimore on Certain Elements found in the Blood of Malarial Fever. Dr. Lyman of Chicago read a paper on Certain Clinical facts connected with Tabes Dorsalis, and Dr. Fitz of Boston another on Diseases of the Appendix Cæci. This was a contribution of marked ability and research, and gave rise to an animated and practical discussion. The remaining papers were by Dr. Polk of New York on Peri-Uterine Inflammation, by Dr. Welch of Johns-Hopkins University on An Experimental Study of Glomerulo-Nephritis, and by Dr. Osler on the Bicuspid Condition of the Semilunar Valves. The meeting was considered a great success, and it is confidently believed that the Association will be the means of bringing out some of the best medical work of many of the best men in America. It will meet annually in Washington. For the coming year, Dr. S. Weir Mitchell will be President; Dr. Minot of Boston, 1st Vice-President; and Dr. R. P. Howard of Montreal, 2nd Vice-President.

Medical Items.

—Dr. Oliver Wendell Holmes is to receive the honorary degree of LL.D. from the University of Cambridge.

—Any village or town physician wishing a vacation to visit New York or London hospitals, and wanting a city graduate in medicine to take his practice, during July and August *only*, may do so by addressing "Doctor," Box 579, Kingston.

—The fifty-five million population of the United States have 89 regular medical colleges, with about 10,000 medical students; 8 of these medical colleges have each from 300 to 600 students; and 7 of these colleges have from 200 to 300 students.

—It is reported that his satanic majesty, while on a recent visit to this planet for a cargo of sulphur, was shown a sample of iodoform. He immediately countermanded the sulphur order, and substituted iodoform, saying, "Not in all my realms below does any perfume so please my senses." In other words, the odor of iodoform beats sheol.

A PECULIAR VERDICT.—A coroner's inquest was held a short time ago on the body of a Mrs. Monette, who, it appeared, had been suffering from heart disease, and this bringing on a fit of dependency, she had taken a dose of Paris green. The coroner's jury found that the woman had died of "heart disease accelerated by partaking of a dose of Paris green."

A VERY BROAD HINT.—A physician in this city is said to have the following inscription on his bill-heads: "A patient's gratitude to his doctor is a part of his disease, and is most declared when the fever is highest, cools off during convalescence, and entirely disappears with the complete return of health. All bills due upon presentation. Office prescriptions and attendance strictly cash."—*Med. Record.*

—"Labor among Primitive Peoples," will be remembered as the interesting contribution to the history of midwifery by

Dr. Engelmann of St. Louis. It is a significant comment on the character of the questions now before the public mind to say that an order having been sent to one of our largest book-stores for the above volume, the entire available force of the establishment was engaged for half a day in an ineffectual search for it throughout the department of political economy. We are reminded in this same connection to mention the remark of a parent whose experience of offspring had been chiefly that of twins, that he considered the double births an improvement over the more general custom, as a "labor-saving institution."—*Boston Med. Journal.*

A NEW METHOD OF TREATING THORACIC ANEURISM.—Under this title Dr. Richard Barwell describes a method which he has recently employed. It consists in puncturing the sac with a hollow ivory needle, and passing through this and into the sac about ten feet of fine steel wire. This latter is connected with a galvanic battery (positive pole), and a current of nine or ten milliamperes is passed through it for an hour. In the case in which this method was tried, a considerable degree of firm coagulation was obtained, but the aneurism had a second sac, and the patient was nearly moribund before the operation. He died a week later.—*Med. Record.*

—Professor Huxley, in a certain debate on smoking among the members of the British Association, told the story of his struggles in a way which utterly put the anti-tobacconists to confusion. "For forty years of my life," said he, "tobacco had been a deadly poison to me. (Loud cheers from the anti-tobacconists.) In my youth, as a medical student, I tried to smoke. In vain! At every fresh attempt my insidious foe stretched me prostrate on the floor. (Repeated cheers.) I entered the navy. Again I tried to smoke, and again met with defeat. I hated tobacco. I could have almost lent my support to any institution that had for its object the putting of tobacco smokers to death. (Vociferous cheering.) A few years ago I was in Brittany with some friends; we went to an inn; they began to smoke and look very happy, and outside it was very wet and dismal. I thought

I would try a cigar. (Murmurs.) I did so. (Great expectations.) I smoked that cigar—it was delicious! (Groans.) From that moment I was a changed man, and now I feel that smoking in moderation is a comfortable and laudable practice, and is productive of good. (Dismay and confusion of the anti-tobacconists. Roars of laughter from the smokers.) There is no more harm in a pipe than there is in a cup of tea. You may poison yourself by drinking too much green tea, and kill yourself by eating too many beefsteaks. For my own part, I consider that tobacco, in moderation, is a sweetener and equalizer of the temper.” (Total rout of the anti-tobacconists, and complete triumph of the smokers.)—*Med. & Surg. Reporter.*

—In the April number of the *Edinburgh Medical Journal*, J. Lindsay Porteous, M.D., F.R.C.S., M.R.C.P., Edin., says: “About eighteen months ago a friend of mine from America told me of the wonderful effects of a medicine, much used in the States, called *Bromidia*. According to the makers, it is composed of chloral hydrate, 15 gr.; potassium bromide, 15 gr.; extract of *cannabis indica*, $\frac{1}{3}$ gr.; and extract of *hyoscyamus*, $\frac{1}{3}$ gr. I obtained some, and have ordered it regularly for over a year; and have found it excellent in the pain of rheumatism, pneumonia and cancer, also in the sleeplessness of scarlatina and alcoholism. It has never failed me in procuring sleep, without the disagreeable dreams and after-effects of opium. The dose is ʒss to ʒj every hour till sleep is procured. I have also found it of much service in cases of tonsillitis, used as a gargle with glycerine and carbolic acid.”

—Dr. Reginald G. Alexander, honorary senior physician to the Bradford Infirmary, England, says: “I have prescribed LACTOPEPTINE for many years, and carefully noted its admirable qualities. In some cases of atonic dyspepsia, especially in connection with anæmia, I have found most excellent results to follow from the use of this *digestion-compelling medicine*, if I may make use of such a term as expressive of its powerful action. As it restores the digestive function and improves the condition of the blood, it is a *curative agent*, and not merely palliative and temporary.”