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## CANADA

# MEDICAL JOURNAL.

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### ORIGINAL COMMUNICATIONS.

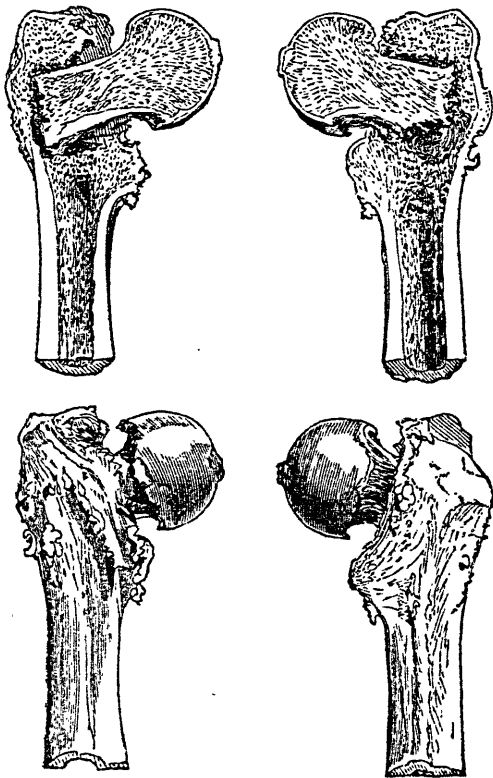
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*Case of Impacted Intracapsular Fracture of the Neck of the Thigh Bone.*

By GEORGE ROSS, A.M., M.D., House Surgeon, Montreal General Hospital, Attending Physician Protestant House of Industry and Refuge.

On the 2nd July, 1868, I was summoned to the Protestant House of Industry and Refuge to see an old man named John H., æt. 79, who had slipped and fallen on the floor, and was said to have been bruised on the hip. I found him lying in bed where he had been lifted, complaining of pain over the region of the left hip: he was unable to stand upright and the attempt to do so gave pain. There was no shortening, and very slight eversion of the foot. I was not satisfied that there was fracture, so prescribed an evaporating lotion and saw him the next day. There was now marked eversion of the foot, some shortening and considerable swelling over the hip-joint, which was painful. I had him removed at once to the Montreal General Hospital, where he was placed under the care of Dr. Wright. Upon proper extension and rotation by an assistant distinct crepitus was now got. This confirmed the diagnosis of intracapsular fracture of the neck of the femur. He was laid upon a hair mattress and moderate extension was made by means of a pulley and weight, the limb being steadied by a light splint placed along the outer side. This was kept up for between three and four weeks when, it having become irksome and a small bed sore having been formed, it was discontinued, but he was still confined to bed. In two weeks more he was allowed to get up—the slight bed sore soon healed, his appetite improved somewhat, but his general health remained very poor. He never could bear any weight whatever on the limb, and there was shortening about  $1\frac{1}{2}$  inch. On the 12th October he was discharged from the hospital, returning to the institution whence he had been brought. From this time he gradually failed, and finally died on the 16th November, 1869, 137 days after the accident.

I removed the upper part of the femur, made a section of the bone, and of it the accompanying plates furnish an accurate representation.



A description of the woodcut is scarcely needed, as it speaks for itself—The neck of the femur has evidently been fractured short off at its junction with the shaft of the bone, and the loose portion has then been forcibly jammed into the substance of the great trochanter. When examined, the head of the bone could without difficulty be moved in its new position, but still it was found that there existed a considerable amount of strong new fibrous tissue between the broken ends. The case is interesting, as showing how an attempt at union was made in this fracture in a man of nearly 80 years of age and in very feeble health, and also I think as showing how, by thorough impaction, such as existed, doubtless, in this case, a condition of things might be established which would render it *possible* for an intracapsular fracture to become united by bone, contrary to the ordinary experience in such cases, and contrary

to the absolute dictam of some high authorities. Of course there was no bony union in this particular instance, but I think we may conceive that in a somewhat younger person and one possessing more vigor, actual osseous union might be looked for under parallel circumstances.

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## HOSPITAL REPORTS.

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SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL, UNDER THE CARE OF G. E. FENWICK, M.D.

*Case No. 6.—Excision of the Knee-Joint.* Reported by Mr. J. H. MATHIESON.

William H., aged 23, fair complexion, red hair, was admitted into the Montreal General Hospital, May 23rd, 1870, with ankylosis of right knee joint.

Previous History.—He was bathing in a stream one afternoon, when eleven years of age, and remained in the water longer than usual. Felt no bad effects that night, but when he awoke the following morning his right leg was flexed nearly at right angles, and he was unable to straighten it, nor could it be straightened by the force employed. There was no pain—no abnormal sensation. A surgeon was consulted the same day, who then ordered a liniment to be applied, and afterwards proposed subcutaneous section of the ham-string tendons, but it was not consented to.

The leg is now flexed on the thigh at right angles. The bones of the leg are dislocated backwards; the condyles of the femur projecting and the patella is firmly attached by apparent bony union to the external condyle. The whole limb is very much dwarfed from arrested development; there is shortening of two inches in the thigh, and one inch in the leg. The foot is very much arched; the heel unnaturally long and projecting downwards; the toes, semi-flexed. He says he has never had any pain in the knee.

May 28th.—A consultation was held and excision of the joint deemed advisable; Dr. Fenwick, therefore, proceeded to operate. He carried a semi-circular incision from a point above the inner condyle, downwards and forwards over the lower border of the patella, and up on the outer side to a point opposite the place of starting. He then dissected the flap up, over the patella, divided the lateral ligaments, and turned out the ends of the bones; with butcher's saw he cut through the extremity of the femur, from behind forwards at right angles to the axis of the bone. Similarly he removed a thin slice from the head of the tibia, but finding that some disease remained, a second portion was removed. It was found necessary to divide the ham-string tendons so as to place the bones in position; the wound was then washed with carbolic acid lotion, and the flap secured

by metallic sutures. A roller was then applied to the leg and thigh, and the limb arranged in the splint. The splint, which was made according to Dr. Fenwick's plan, consisted of two iron bars, extending from the groin to the ankle, and bowed at the knee. To these were riveted two tin gutters, in one of which the thigh rested, in the other the leg, having a space of about four inches between them, so that the wound and the rest of the circumference of the limb were free for the application of dressings; to the lower extremity, a foot piece similar to that of a McIntyre splint was attached; carbolic acid dressings were applied; ordered milk diet, and one pint milk and one pint beef juice extra.

On examining the bones it was found that there was caries of the head of the tibia, and extremity of the femur; the inter-articular fibro-cartilages were destroyed; the patella was displaced outwards, and firmly ankylosed to the external condyle of the femur.

May 29th.—Pulse 120. The operation was followed by considerable shock, from which he has completely recovered. There has been very little oozing of blood; he has considerable pain; got a draught of *liquor morphiaë* last night, and slept soundly four hours.

May 30th.—Pulse 114 and fuller; tongue furred and dry; surface hot: not so much pain as yesterday; the wound looks well; two of the stitches were removed.

May 31st.—Pulse 112; slept well; pain same as yesterday; skin moist and hot; appetite improving.

June 1st.—Pulse 116; he is restless and feverish, did not sleep much last night; great pain and considerable spasm of the muscles of the thigh; the remaining stitches were removed; there is now a free discharge of pus.

June 2nd.—Pulse 100; slept well; tongue clean; surface moist; pain much less; a part of the wound about the centre of the flap appears to be healing by primary union.

June 3rd.—Pulse 96; he is much better; there is less pus than there has been the two past days and it is becoming thinner, and less healthy.

June 4th.—Pulse 88; tongue clean; bowels regular; has very little pain; the knee is slightly bent outwards; a narrow slough, about an inch in length, has formed on the margin of the flap at its inner extremity; by slight pressure upon the flap about 3 ij. of sanious pus, containing some bubbles of gas, escaped; ordered to inject *lotio acidi carbolic* (1 x 40). The injection passed freely from one side of the wound to the other, and washed out a large quantity of dark grumous pus.

June 6th.—Pulse 90; a little more irritable to-day, but not more pain. Dr. Fenwick changed the whole of the dressings; while arranging

the splint, a spasmodic twitch of the muscles, causing slight motion in the joint, made it bleed; the bleeding appeared to be from the granulations, and soon stopped, only about  $\frac{3}{4}$  iss. of blood was lost. A large quantity of pus escaped; the slough along the flap is extending; dressings to be applied at ordinary temperature; lemonade, 1 pint porter, mutton chop.

June 7th.—Pulse 86; much more comfortable; passed an easy night, there is a greater amount of discharge and it contains some coagulated blood; the tendency to sloughing in the flap is arrested.

June 9th.—Pulse 88; sleeps well; has very little pain; the discharge is diminishing, and becoming more healthy.

June 11th.—Pulse 88; very restless; slept but little last night on account of the pain; the discharge is about the same in character and amount; an opening has formed in the popliteal space through which the greater part of the pus escapes; tongue lightly furred; bowels opened to-day.

June 14th.—Pulse 88; is much better to day, but complains of shooting pains through the whole limb; the amount of pus is diminishing.

June 18th.—Pulse 96: Is very irritable; says he did not sleep any last night; appetite is gone; shooting pains through the whole limb, from the hip downwards; about the same amount of pus, but it is more ichorous.

June 20th.—Pulse 100; tongue clean; appetite better; complains still of the shooting pains; the inner extremity of the wound has ceased to discharge pus; there is still a little from the outer; it seems to form in, and occupy a sac at the outer side of the knee, about an inch and a half above the wound; there is some discharge from the opening beneath, but not so much as before; the slough which had formed on the margin of the flap is entirely removed; the wound there shows a tendency to gape; brought the edges together with a strip of adhesive plaster.

June 21st.—Slept well last night; shooting pains are nearly gone.

June 22nd.—Pulse 100; says he did not sleep last night on account of the intense pain; he got a draught of morphia at 10 p.m. and another at 4 a.m.; Dr. Ross changed the dressings to-day; the union appeared to be tolerably firm; two strips of plaster were applied to bring the wound together.

June 28th.—Appetite good; sleeps well; occasional shooting pains; rather more discharge from the popliteal opening, but scarcely any from the others; the sac is diminishing in size, and the part feels firmer; the swelling in the knee is going down; ordered to dress with red wash.

July 4th.—Pulse 92; pain is rather greater, and more discharge from the external orifice of the wound. It appears to be forming in the sac again; is more creamy and thicker than before.

10th.—Has been very well and in good spirits the last few days; eats heartily; tongue clean; pus is healthy, and only amounts to about 3 ss. in twenty-four hours.

12th.—Another opening has formed in the popliteal space, internal and posterior to the last, and about three quarters of an inch from it. A large quantity of pus escaped from it when it opened.

16th.—Pus continues to form above the wound on the outer aspect of the thigh, and does not escape freely. There is not much discharge from the popliteal space. Dr. Fenwick passed a seton through the outer angle of the wound, and out at the top of the knee, passing through the collection of pus; ordered six ounces of wine; porter to be omitted.

19th.—Dr. Ross removed the metal splint to-day and moulded a pasteboard splint to the inner side of the leg, extending from near the groin to the ankle, replaced in the metallic splint, and secured it as before with a roller. A little pressure was exerted on the knee by a many-tailed bandage, over the dressings. The discharge is about as usual; he is getting more irritable and has less appetite than before.

25th.—There is very little discharge from the inner extremity of the wound, and that from the popliteal space is diminishing; the principal part now comes from the external wound. A large cauliflower-like excrescence has formed at the outer wound just beneath the seton.

27th.—Pulse 102; did not sleep well; has considerable pain; there is an increase in the amount of pus, and it is streaked with blood. Appetite is not so good; tongue furred; bowels regular; ordered to be dressed thrice daily with red wash.

August 3rd.—Improving; appetite returning; pus diminishing. He continues to get morphia each night, and will not sleep without it.

6th.—There is very little change in the general symptoms; the dressings were all removed; the limb put up in a pasteboard splint as before, and a piece of Chassaignac's drainage tube substituted for the seton.

8th.—Is improving in health; was sitting up yesterday on a chair for a few hours; there is rather less pus, and it is very thick; the excrescence is getting smaller; the inner extremity of the wound has opened somewhat, and is now an indolent looking ulcer about an inch long, and half an inch wide: the limb was suspended to-day by cords passed through rings in the splint, which allows him to move around freely in bed and relieves the popliteal region from pressure.

15th.—The original wound has opened at a point about half an inch

anterior to the point of entrance of the drainage tube, and about 3j of pus has been discharged. He goes out on the gallery each day for a few hours.

26th.—All the dressings were removed, and the bones were so firm that the farther use of the splint was considered unnecessary; there is still a good deal of discharge from the outer wound; the one on the popliteal space is healing slowly, and the granulations on the inner one are less pale and soft; the drainage tube was removed.

September 28th.—A collection of pus is forming over the knee; Dr. Fenwick opened it to-day; ordered one pint of porter instead of wine.

October 8th.—His health is very good; the openings are healing very slowly. He has considerable pain in the course of the external popliteal nerve and its branches.

November 14th.—He has been going out for a walk daily for more than a week, and with a crutch and a stick gets along very well; the appearance of the knee is not much altered; the few sinuses still discharge a small quantity of ichorous pus; the one in the popliteal space is healed. The limb is three and three quarters ( $3\frac{3}{4}$ ) inches shorter than the other.

December 14th.—The foot is so much arched, and the toes semi-flexed, that he walks on the tip of the heel and ends of the toes. Dr. Fenwick divided the plantar fascia and short flexor subcutaneously and straightened the foot.

December 23th.—He has had a boot made which keeps the foot straight, so that he can walk on it with comfort. The knee has a number of scars on it and several small openings which are indolent, from the low vitality of the part. His health is improving rapidly.

*Case 7.—Comminuted Fracture of the Tibia and Fibula.* Reported by Mr. J. H. MATHIESON.

G. H., æt. 29, a carter, was admitted into the Montreal General Hospital on the 15th November, 1870, suffering from a comminuted fracture of the right leg. He is a healthy man, dark complexion, medium size, strong and muscular. While sitting on the front of his cart, his horse became restive and kicked; the cork of the horse's shoe caught him on the inner side of the right leg between the middle and lower third; both bones were broken—the tibia into several pieces; and an abrasion of the soft parts occurred, which, however, did not communicate with the bone. There was very free motion at the point of fracture and crepitus was quite distinct; the limb was shortened and deformed in appearance. The soft parts were very much bruised, and a large subcutaneous ecchymosis existed. The house surgeon, Dr. Ross, reduced the fracture and placed the limb in a fracture box, packing it with bran; the abrasion was



dressed with a mixture of one part of carbolic acid, to forty of linseed oil; this was applied with lint and covered with oil silk.

Nov. 16th.—The leg is very much swollen; there is some pain, redness and heat, but altogether he was tolerably comfortable; had rested indifferently during the night. The dressings to the leg of carbolic oil were directed to be continued, and as the limb appeared to be in good position, no change was made. From this date he progressed favourably; he was ordered good nourishment, and as the secretions were active, no medicine was deemed necessary.

Nov. 28th.—He complained to-day of slight uneasiness, and pain over the malleoli, so that the form of splint was ordered to be changed. The leg was taken out of the box splint, and put up with an external and internal moulded wooden splint. The malleoli were uninjured, but the wound looked rather indolent; large flabby granulations existed around, which were touched with nitrate of silver, and red wash ordered.

December 5th.—The cellular tissue beneath the skin and corresponding to the seat of injury has sloughed and has come away, subcutaneous sinuses are left both above and below the position of the wound. Dr. Fenwick ordered them to be injected with a watery solution of carbolic acid, one to forty. This was regularly attended to, and the sinuses appeared to gradually heal up.

Dec. 19th.—The discharge from the wound is very slight; the sinuses no longer exist; the fracture is united and tolerably firm; the limb was put up on a starch bandage with paste-board, moulded splint to the outer side of the leg; after the bandage had dried, a square opening was made over the site of injury to the soft parts, to permit dressing of the wound which is not quite healed.

On the 31st December, it is stated the wound is quite healed; the union of the bones is firm, and there is no shortening; the patient hopes to leave the Hospital at an early date; he can bear good pressure on the leg, but still walks with a crutch and stick.

*Case 8. — Compound Comminuted Fracture of Tibia and Fibula. Delirium Tremens, Death. Reported by MR. J. R. HAMILTON.*

Mary H., æt. 35, a spare, ill-nourished woman of intemperate appearance was admitted into the Montreal General Hospital on the 10th December, 1870, suffering from a compound comminuted fracture of the lower end of the tibia; the fibula was broken about the middle third. The upper fragment of the tibia, which was sharp and angular, was projecting through the soft parts at the inner side of the leg about two inches above the ankle joint—the wound in the soft parts was angular and jagged; it was found impossible to reduce the fractured extremity of the bone.

so that Dr. Fenwick, the attending surgeon, removed about a third of an inch of the shaft, and also several small spiculæ which were lying detached from the periosteum and sticking in the soft parts. The wound was then freely injected with a solution of carbolic acid, one to forty of water; the edges of the tear brought together with wire sutures and dressed with carbolic acid lotion and oil silk; the leg placed on a McIntyre splint, and the patient put comfortably in bed; as she was still suffering from the effects of liquor, nothing was ordered except beef tea, and if necessary a morphia draught at night.

The patient had been brought to the Hospital by the police, and upon inquiry it was found that she had been picked up in a state of intoxication. Her leg had been broken by a fall, and it was supposed that it had been converted into a compound fracture through attempts at walking.

Dec. 11th.—Passed a restless night; had not slept. The limb is very much swollen and considerable oozing of blood from the wound had occurred. The bandages were re-adjusted, as in her delirium they had become displaced. Pulse 108; tongue dry, and covered with a brownish fur. The skin was hot and dry; the eye presented that peculiar wildness of delirium tremens. The pulse was rapid but had considerable volume, and there was much delirium, so that she had to be constantly watched. The delirium was of a low muttering character, with an occasional outbreak of violence. The following was ordered:

℞ Chr. Pot. ʒ i; Ant Tart. gr. ii; Tr opii ʒ ii; Aqua. ad ʒ viii.

.....M. Ft. Mistr.

A tablespoonful to be taken every three hours. The bowels had acted freely in the morning; beef juice was to be given freely. Also a pint of porter and also whiskey if necessary.

December 12th.—The patient had not rested throughout the night; there was low muttering delirium, the pulse was 136. In the night she got out of bed and attempted to leave the ward; this occasioned displacement of the fracture, and was followed by some hæmorrhage; the leg had to be readjusted. Stimulants and nourishment were given freely, but the patient gradually sank, and died at ten o'clock that night.

On examining the bone after death the fracture of the tibia was found to be partly oblique and partly transverse. The upper fragment was long, sharp and angular, and in the act of walking had apparently been forced into the cancellous structure of the lower fragment; this had occasioned a longitudinal fracture of the lower fragment, extending into the ankle joint. The fibula was broken, as had been supposed, at or about the middle third.

*Case No. 9.—Rheumatic Arthritis of the Hip Joint treated with rest.*  
Reported by Mr. A. J. CATTANACH.

Daniel McColl, aged 14, a boy from the country, was admitted into the Montreal General Hospital on the 1st of October, 1870, suffering from hip joint disease.

*History.*—In September, 1868, the patient was attacked with a severe form of acute rheumatism, which lasted for about a month, after which he gradually began to improve, but complained more or less of a pain in the right hip joint. He continued in a weakly state throughout the subsequent winter, scarcely ever going out of doors, but confining himself chiefly to the house. In the following spring he began to improve slightly, took more out-door exercise, but still complained of pain in the hip on the slightest exertion, which subsequently subsided on giving rest to the joint. In June, 1869, he appeared to be so much improved that his parents decided to send him to a school which was three miles distant from the house, and which he continued to attend till August, walking there and back every school day, but always complaining of pain and tenderness in the evening after returning. After the summer holidays he was not allowed to attend school, as his physician gave orders that he should remain at rest as much as possible for a month or two. This he continued to do during the winter of 1869 70, but still had more or less pain in the right hip, with painful twitchings and startings in the limb at night. In May, 1870, was ordered by his physician to try salt-water bathing, and in July was sent to River du Loup, continued there for about a month or more but without any improvement, and does not appear to have improved since then up to date of his admission into hospital. Patient had always been weak and delicate, possesses all the characteristics of a highly scrofulous diathesis; has had open sinuses on the right arm for upwards of a year, from necrosis of the humerus and from which several small spiculæ of bone have from time to time been discharged. His parents appear to have been healthy, so also his brothers and sisters, but his mother's family appear to have been more or less subject to rheumatism.

When admitted to hospital the patient presented the following symptoms. The attitude of the afflicted limb was characteristic of hip joint disease in the third stage, it was considerably adducted, so that the knee was brought against the lower part of the sound thigh; knee joint was slightly flexed and carried in front of the opposite limb, and foot raised and supported on the points of the toes, the crest of the ilium on the affected side was about three inches higher than the level of the sound side. The nates also were very much flattened over the diseased side, and patient complained of great pain both in hip joint and knee, which was greatly aggravated upon the least motion of the limb.

October 3, Dr. Fenwick stated, he purposed treating this case with absolute rest, and at the same time he should attend to the general health of the patient. In order to carry out these views, it would be necessary to divide the tendons of those muscles which from apparent irritability had become contracted, and which retained the limb in its present position. After having divided the tendons he purposed to place the limb on a long splint, with a pulley and weight attached. He thought that a weight of about 4 or 5 lbs would be sufficient. This was accordingly done. The patient being placed under chloroform, the tendons of the adductor longus and pectineus were divided subcutaneously, and the limb adjusted in a long splint with weight attached.

October 4.—Rested badly throughout the night; suffered much from pain and starting of muscles of limb.

October 5.—Passed a better night, limb still rather painful, but less so than yesterday; the bowels have acted, and the general symptoms are satisfactory. Takes nourishment well.

October 12.—The patient is slightly feverish, the skin hot and dry—tongue coated with a yellowish fur, and feels depressed. Bowels had not acted for two days. An aperient draught was ordered, and the following mixture: chlorate of potash, nitrate of potash; of each ʒi; water, ʒviii; a table-spoonful every three hours. This mixture was continued for two days, when the symptoms above indicated subsided. The case progressed favourably from this time up to the 5th November, when the boy had a slight attack of cold, with sore throat, which readily yielded to a diaphoretic mixture and gargle. The position of the limb is now natural, he lies straight in bed, and there is no apparent difference in the length of the limbs. The treatment by extension was faithfully maintained up to the 18th November, when the splint and bandages were removed. On examining the limb the joint was found stiff but did not give much uneasiness on gentle motion.

November 19.—Dr. Fenwick ordered the limb to be put up in a starched bandage, with pasteboard splint; this was done so that the boy could leave his bed and enjoy exercise. A pasteboard splint was moulded to the body, and extended over the front of the thigh, from the crest of the ilium to the knee. This was applied with a starched bandage. By this means all motion of the affected joint was prevented. The following day he left his bed and sat in a chair. Does not complain of pain; from this date he walked about the ward on crutches, his general health has much improved. He appears cheerful and is getting fat.

December 16.—The starch bandage was removed, and the limb examined. The patient expressed himself as feeling comfortable; he can lean

the weight of his body on the limb, without any pain, and could walk without a crutch, except that the joint feels stiff, and he is afraid to trust himself. The limb was again put up as before, and the boy was permitted to return to his home, in the country, with instructions to retain the bandages on the limb for a few weeks longer.

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PROCEEDINGS OF THE MEDICO CHIRURGICAL SOCIETY OF  
MONTREAL.

MEETING HELD DECEMBER, 22ND, 1870.

The Vice-President, Robert Godfrey, Esqr., M.D., in the chair.

Francis W. Campbell, M.D., L.R.C.P.L., read the following paper on

EXTERNAL DIVISION OF SCRICTURE—DEATH ON THE 6TH DAY.

Patrick McGill, aged 35 years, presented himself for the first time in July, 1867, at my surgery, suffering from retention of urine. He had just arrived from Quebec, and had not made any water since leaving that city, the previous afternoon. He was in great distress, the bladder being largely distended. He informed me he had several strictures, and that only a small sized catheter would pass into the bladder. After considerable difficulty I succeeded in passing a No. 3 catheter, and drawing off a very large quantity of urine. The first stricture was situated about a quarter of an inch from the meatus, the second about one half inch below the meatus, and the third about the junction of the membranous with the bulbous portion of the urethra. He gave me the following history. In 1860, he contracted gonorrhœa, which he treated himself by injections of acetate of lead. The cure of the disease was slow, gleet supervening, and lasting many months. About a year and a half from the appearance of the gonorrhœa, he first noticed a difficulty in making water, the stream being twisted; this gradually increased till 1862, when he sought medical aid; gradual dilatation was made use of, and a very marked improvement took place. He, however, became dissipated in his habits, neglected to attend to his disease, and the result was, the return of the strictures. Although suffering considerably, he did not make any further application to any medical man, save on two or three occasions, when he had retention from over distension, when the catheter was with difficulty introduced and the urine drawn off. At the time of his first visit, there were two fistulous openings in the scrotum through which the urine dribbled away in considerable quantities. I advised his attention to his disease, and the patient left. I did not see anything of him till April of 1868, when I was sent for to attend him. I found him suffering from an attack of infiltration of urine; the scrotum was swollen, and œdematous, and the urine had escaped into the

cellular tissue of the abdomen, which had a reddish erysipelatous look. There was the usual constitutional disturbance. I made free scarifications over the scrotum and abdomen, through which considerable quantities of foetid urine escaped, and applied hot fomentations. Dr. Craik during this attack saw the patient with me in consultation. His recovery was slow. When perfectly convalescent, I attempted to pass a small catheter, and with much difficulty got through the first stricture, which I found was highly cartilaginous, but all my efforts to proceed further were unavailing. I then explained to him what I considered to be the only thing that would afford him relief, viz: the operation for perineal section. In July of the same year, he entered the Montreal General Hospital with a view of having it performed, but only remained one day. He soon after began his dissipated habits and I saw nothing of him till May, 1869, when I again attended him for infiltration of urine. This time the extent of infiltration over the abdomen was much greater than it was during the previous attack, and the constitutional disturbance much more serious, the symptoms being typhoid in their character. I again scarified freely, and after a tedious convalescence he was once more enabled to go about. In the fall of 1869, he called upon me and expressed his desire to have the operation performed, immediately after the new year, as in his present condition his life was a miserable one, but a return to his bad habits prevented its accomplishment. A few weeks ago he again expressed a desire to submit to it, and as he had been perfectly regular in his living since last spring, I consented to perform it. On the 18th of November, Dr. Fenwick saw the case in consultation, and agreed with me, as to its being a suitable one for the operation. Upon the 27th of November, assisted by Drs. Fenwick, Craik, Ross, Reddick, and Rodgers, I performed what is now generally known as Syme's operation for perineal section or external perineal urethotomy. The patient being well under the influence of chloroform, Syme's stricture staff was passed with some difficulty through the strictures till its shoulder rested well up against the upper part of the third. I then cut down through the perineum, and without much difficulty reached the staff, and having inserted my knife in the groove, divided the stricture, the shoulder of the instrument passing instantly through it. Previous to withdrawing the staff, I passed a director through the wound, and into the posterior portion of the urethra. This served as an excellent guide to the passing of the catheter. The staff was withdrawn, and a No. 8 Catheter passed, when several ounces of urine came away. It was secured in the usual manner. Considerable difficulty was experienced in passing the instrument through the two undivided strictures, and the existence of several false passage

in the prostatic portion gave some trouble. The amount of hæmorrhage was not excessive. The patient was put to bed, and the wound dressed with carbolic lotion  $\mathfrak{z}$ ji. to  $\mathfrak{z}$ viii of water. The room was darkened and the most perfect quiet enjoined.

*Evening.*—He passed a tolerably comfortable afternoon, with the exception of irritability of the stomach, which will not retain anything. Believing this due to the chloroform did not order medicine. Urine has passed freely through the wound, but none through the catheter. Skin cool; pulse 94.

November 28th.—Passed a restless night, owing to the continued vomiting; bowels moved early this morning, but could not use the bedpan, so was lifted and made use of a chamber; wound looks well, a little urine passed through the catheter when I removed plug. Does not complain of anything but the vomiting; pulse 98; tongue lightly coated; ordered small draughts of soda water and milk: Evening;—is easier: vomiting not so frequent; has retained a little beef-tea; pulse same as in morning; ordered a grain of opium in pill at bed time.

November 29th.—Says he is decidedly better, passed a tolerably comfortable night; vomiting ceased entirely, but a nasty hic-cough troubles him, frequently coming on during sleep; wound looking remarkably well; urine coming copiously through wound, and to some slight extent through the instrument; tongue still coated with a white fur; pulse has fallen to 80; did not take out the catheter to day as it was decided on the day the operation was performed to allow it to remain in for four days, owing to the difficulty experienced in passing through the two anterior strictures.

*Evening.*—In much the same condition as at morning visit; complains much of the hic-cough; pulse is somewhat higher, being again 98; ordered a drachm of Hoffman's anodyne (Spts. Ether Sulph. Co.) with a drop of hydrocyanic acid.

November 30th.—Had several hours sleep last night; hic-cough is better; wound is granulating, and in every respect looking well; urine comes freely through opening, little through catheter; bowels moved twice early this morning; cannot use the bedpan; pulse 98; tongue looks much as it has from the first, a light white fur covering it; takes nourishment in small quantities often repeated, and retains it.

*Evening.*—Patient not so well; hic-cough returned during the afternoon, and is very troublesome, recurring every ten or fifteen minutes; skin is hot and dry, and his pulse has risen to 120; tongue more thickly coated, still white; is very thirsty, has not had anything approaching a rigor; urine is flowing freely through wound, which still looks well, also

to some extent through catheter when the plug is removed; no abdominal tenderness; ordered a drop of Fleemings tincture of aconite, every three hours, and toast water to drink.

December 1st, 10 a.m.—Patient slept at brief intervals during the night; hic-cough still persistent; heat of skin less, and some signs of perspiration, pulse 120; tongue same as previous report; on examining the abdomen there is slight tenderness over upper portion upon superficial pressure, which is relieved by continued deep pressure; has no pain unless when pressure is made; no tenderness over bladder and lower portion of bowels; wound looking well; took out the catheter; the aconite to be continued, and to have beef essence at short intervals.

2 p.m.—At my request Dr. Fenwick saw the patient in consultation when his condition was much as reported at 10 a.m., save that there is now copious perspiration; brandy in tea spoonful doses was ordered every half hour; beef juice also to be continued. Dr. Fenwick expressed himself favourably as to the issue; aconite discontinued.

6 p.m.—There is a slight improvement; hic-cough is better, not being so frequent, and pulse has fallen to 115.

11 p.m.—Is evidently still better; tongue looks as if it were about to clean; only had hic-cough once during the past two hours; pulse is 108 and weak; still perspiring freely. To be well watched during the night, and to have nourishment, and stimulants regularly every two hours, and oftener if he showed signs of weakness.

December 2nd, 10 a.m.—There is a decided change this morning for the worse, although the report is that he passed a fair night. The pulse has risen to 130, and is small in volume, and the perspiration is profuse: warm on body, but cold and clammy on hands and face; no alteration in appearance of tongue, which is better than two days ago; wound looks nicely, and urine passes freely; to have his brandy increased to half an ounce every half hour, and beef juice at intervals.

1 p.m.—Dr. Fenwick again visited my patient in consultation. Condition same as at 10 a.m.; pressure upon abdomen gave same results as noted on the 1st.; hot fomentations were directed to be applied over the upper part of abdomen, otherwise to continue as before.

6 p.m.—Is evidently failing, although he expresses the belief that he is no worse; retains all the nourishment given him.

10 p.m.—The fatal termination of the case is now only a question of a few hours, the hic-cough is again exceedingly troublesome, coming on every few minutes; pulse is difficult to count and very feeble; voice is husky, and the perspiration cold and clammy; intellect is perfectly clear.

December 3, 1.30 a.m.—On calling at this hour, I learned he had



just expired. Till within an hour of his death he was perfectly conscious.

*Post Mortem.*—Sixteen hours after death. On opening the abdomen there was evidence of peritonitis, recent adhesions, especially at the upper part of the bowels, with a few patches of effused lymph. The liver was about normal size; both kidneys were examined, and appeared normal in size. On cutting into them Drs. Fenwick and Ross, (who were present) believed they exhibited signs of commencing fatty degeneration. On this point I was not clear. Prostate gland examined, and found in a condition such as might have been anticipated from such an old case of urinary disease. The coats of the bladder were much hypertrophied, and the prostate considerably enlarged.

*Remarks.*—This case is interesting to the profession, as an example of a usually successful operation, proving fatal from a most unusual cause. Various authors in describing the operation, allude to its possible fatality, mentioning as causes from which deaths have occurred:—shock, erysipelas, pyemia, and urinary infiltration, but I find no mention of any case terminating fatally from peritonitis. Carelessness in passing the staff into the bladder after the division of the stricture, might so wound it as to set up peritonitis, and to prevent such contingency, I need hardly say my friend Dr. Fenwick, who had charge of it, was fully alive. The late Professor Syme, who introduced this operation, in his admirable "Clinical Observations," issued in 1861, states that when he first performed it, he simply recognized sources of danger, hemorrhage, and urinary infiltration, both of which might to a certainty with care be prevented. In time, however, he recognized another source of danger vividly brought to his attention by the death of a gentleman upon whom he had operated. He thus describes it: "I was unexpectedly led to recognize another source of danger, which could not possibly have been anticipated; this is constitutional disturbance, proportioned in degree to the patient's excitability, and induced by the irritation of urine breaking through a recently established union between the cut edges of the urethra. The ordinary symptoms of this are rigors, vomiting, and quick pulse." In the case just detailed my patient did not have any rigors, and the vomiting which occurred for the first thirty hours I still believe to have been due to the chloroform. Indeed if the history of the case be examined carefully it will be found that my patient progressed as favorably as could have been anticipated for the first three days, when the pulse rose from 98 to 120. At this time there was no abdominal tenderness whatever, and indeed when it did make its appearance the following day it was limited to the upper portion of the bowels, and

was relieved upon deep pressure. I was therefore inclined to look upon it as due simply to over distension from the large quantity of fluids taken. It was not till twelve hours preceding his death, that Dr. Fenwick or myself entertained the idea that sub acute peritonitis was present, and even then we entertained hopes of his recovery from the apparent non-activity of the disease. To account for this apparently rare complication is a matter of some difficulty, yet it is just possible that being unable to make use of the bed pan, and having had each time his bowels were moved, to be uncovered, lifted and placed upon a chamber, that this exposure brought on the peritonitis, which carried him off. Certain it is that it was an accidental complication, which so far as I can see, no foresight could have prevented. With regard to the operation itself the only point worthy of note was the introduction of a director through the wound into the posterior portion of the urethra, previous to the withdrawal of the staff, as recommended by Erichsen. The facility with which it guided the passage of the catheter into the bladder, was such as to thoroughly commend its adoption.

Dr. FENWICK said he had performed this operation eleven times, principally in the Hospital. He stated that being present and assisting at the operation, it was performed with all care, and he looked for a successful issue. He could not account for the peritonitis in this case; it was certainly not due to wound of the peritoneum, as he had himself carefully inspected the parts, and none such was to be found; further if it were from extension of inflammation from the bladder, we would expect to find some pelvic cellulitis, or positive evidence of inflammatory action in the bladder, but this was entirely absent; a large amount of effused lymph was found on the small intestines.

Dr. CRAIK had known the patient and his history for a considerable period; had attended him eight years ago for strictures which were exceedingly irritable in their character; found that introduction of catheter was frequently followed by rigors and fever; his constitution was an excessively irritable one, and he had been very intemperate; in his opinion this condition of his system had had much to do with the unfavorable result. Remembered a case of perineal section under the late Dr. Crawford, which occurred in the General Hospital, and proved fatal. The operation was performed for acute retention of urine, following rupture of the urethra, the result of a fall; within twenty-four hours symptoms of blood poisoning showed themselves, from which the patient did not rally, but died comatose.

Dr. HOWARD would ask more particularly what was the state of the mucous membrane of the urethra and prostate? If unusual inflamma-

tion were found in the bladder and prostate, we might suppose the peritonitis to be from extension; any operation in the pelvis was liable to be followed by peritonitis. Operations for fistula in ano have occasionally proved fatal in this way.

Dr. HINGSTON looked upon the operation as a formidable one; for himself, would rather perform lithotomy; he had never operated till a few days ago, having with the exception of the case alluded to, succeeded in curing the stricture by gradual dilatation. The case in which he had performed the operation was one of stricture, the result of an injury; had experienced severe hæmorrhage, which necessitated the plugging of the wound; would ask Dr. Fenwick for what class of cases he operated, and whether for *elastic* strictures as the number appeared to him to be large.

Dr. FENWICK.—Of seven cases he called to mind at the moment, in two he could not pass an instrument at all, in another there was complete obliteration of the urethra, about one inch in extent, commencing about one and a half inches from the point of the penis; was obliged to cut down and find the urethra, pass a director forwards and slit it up, then passed a large catheter; did not generally operate for elastic stricture; always adopted the plan followed in Dr. Campbell's case of first passing a director into the bladder to act as a guide, before withdrawing the staff.

Dr. McCALLUM had operated four times; two recovered without a bad symptom; in the other two there were severe rigors and high fever. All recovered.

Dr. DRAKE said he had operated twice; one case was that of an old man, who suffered from severe chronic cystitis; he recovered completely from the operation, but died some considerable time after from the bladder affection. His second case was one in which Dr. Fenwick had operated some two years before, but the man had allowed the stricture to contract; had tried Holt's dilator without success as the stricture proved to be resilient; he made a good recovery.

Dr. SCOTT has operated successfully by cutting on the end of a catheter where no staff could be got into the stricture.

Dr. HOWARD thought distinction should be made between operations for traumatic lesions and those for ordinary stricture. Had never seen any considerable hæmorrhage in the cases at the General Hospital; had seen Smith, of London, operate in one case where severe hæmorrhage occurred.

Dr. HINGSTON was glad to find that the results of this operation in Montreal had been satisfactory; he believed them to be better than those attained across the Atlantic. would ask if fistulous openings had been often found to remain? Also how long the catheter was generally left in after the first introduction?

Dr. FRANCIS W. CAMPBELL in summing up the debate, said the very gratifying fact had been elicited that a large number of successful operations of perineal section had taken place in Montreal. The great point of interest in his case was the origin of the peritonitis, and as there was no question as to its not being due to wounding of the peritoneum, some other cause had to be looked for. He very willingly admitted the liability to peritonitis in all operations about the pelvis, as mentioned by Dr. Howard; this with the irritable character of the patient's constitution, and a somewhat careless exposure, as alluded to in the paper, all combined to set up inflammation of the peritoneum. He hardly agreed with Dr. Hingston in considering it a very formidable operation, although one not to be undertaken without much consideration, for Professor Syme, to whom the introduction of the operation was due, had up to 1863, operated on 108 cases, with only two deaths. In other hands, however, the success has not been quite so great. Dr. Howard had enquired as to the condition of the prostate gland, and the mucous membrane of the bladder. The former was very much enlarged, and as might have been anticipated the walls of the bladder were much hypertrophied, otherwise healthy.

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MEETING OF THE SOCIETY HELD JANUARY 7TH, 1871.

The President G. W. Campbell, Esq., A.M., M.D., in the Chair.

Dr. Fenwick read the following paper on

EXCISION OF THE KNEE JOINT.

Excision of the knee joint has been sufficiently often performed by surgeons both in England and America, to justify the procedure in suitable cases. By request of our president, I am induced to lay before you the results of four cases which have been operated on by myself during the last five years. The first of these cases was in a young lad of 18 years of age, who was admitted into the Montreal General Hospital in April, 1865. Seven years previous to his admission he had received a kick on the knee from a cow, acute synovitis set in, for which he was leached and treated with absolute rest; various local applications were made, and after confinement to his bed for several weeks he was able to get about; but the joint was still swollen, tender, and rather stiff. From this period he was able to walk, always, however, with a limp, and he was conscious that he could not trifle with his knee. This deprived him of joining in sports of boys of his age; slight blows or twists were followed by fresh inflammatory attacks, necessitating his remaining at rest for days.

Two years before his admission into the hospital he suffered from pain in the joint at night, and frequent starting of the limb, which interfered with his rest. These attacks were of so frequent occurrence, that worn out by annoyance he at length sought admission into the Hospital. This patient came under my care on the 1st May, 1865, and I continued the treatment which had been adopted up to the 15th of that month. It was noticed that his health was beginning to suffer from the confinement. He complained of much pain, chiefly at night, and we found it necessary to give him anodynes to secure rest. I determined to take down the limb, as it had been put up with Scott's dressings, and rested on a double inclined plane. Having removed the dressing I found the joint one inch and a half larger than its neighbour, the synovial membrane felt thickened and pulpy, and on rotatory and lateral movements of the joint a distinct roughness was detected. The examination gave much pain, which continued for some hours. The second day after this examination, on the 17th May, 1865, in consultation with the Hospital staff, it was decided to excise the joint, which operation was performed in the usual way, adopting the semi-circular incision. There is no necessity in my taking up the time of this meeting by giving a daily record of this case, as the case has already been published and will be found in the third vol. of the *Canada Medical Journal*. The object I have in repeating here the history of this case is to lay before you the results which are well shown in the photographs, which are submitted and which illustrate the muscular development and growth of the limb, as the man has increased in stature since he left the Hospital, and there is not any more shortening of the limb than there was after the success of the operation; the shortening is at present about one and a half inches, but as will be perceived on comparing the photograph which was taken six months after the operation, with the one which was taken a week or two since, the muscles of the thigh and leg have very much increased in size. The man at present can walk any distance without fatigue, and he does not use a stick.

The second case operated on was that of a young man from Quebec, aged 22, who was admitted into the Montreal General Hospital on the 18th of May, 1866. Nine years before he had suffered from an attack of acute rheumatism; the disease located itself in the right knee joint, which subsequently became attacked by periosteal inflammation; abscess formed, and several openings were made in the neighbourhood of the joint these discharged freely and several pieces of bone exfoliated. When admitted into Hospital, the joint was partially ankylosed, the limb was bent at right angles, and at the inner side of the thigh close to the joint, here existed a sinus which led downwards and outwards, and on

examining with a probe, bare bone was found. He was anxious to submit to any operation to save the limb. In consequence of being obliged to leave the city on business, the operation was deferred until the 21st June, 1866. The case progressed favourably, and he left the Hospital with a useful limb; six months after the operation, I submit two photographs, the one taken prior to the operation, the other after his recovery. I may state that this man visited Montreal, in 1868, and at the time he walked without a stick, and could run and jump; there was very slight halt in his gait; the shortening was fully two inches; I regret that in both these cases the bones removed have been lost. In the other two cases which are still under observation, I have the bones and submit them to the meeting.

The third case was that of a young man who had suffered from rheumatism in early life. On admission the leg and thigh were found undeveloped; there was partial ankylosis; the leg was bent at right angles, and there existed shortening, by measurement, of about three inches. The limb was quite useless to him as a means of progression, and he walked with a stick; his gait was awkward and irksome, and he was anxious to submit to anything which would hold out a prospect of relief. I am indebted to Mr. John H. Mathieson for the notes of this case.\*

In the fourth case the operation was performed on the 21st December last. The patient, a boy of fourteen years, had been a sufferer with a bad knee, to use the expression of his mother, since his fourth year. When first admitted, in October last, the leg was semi-flexed, exquisitely tender, he would cry out if the bed was touched; he presented a careworn, exhausted appearance, and the knee was very much larger than its fellow, but he did not bear handling much, as it gave great pain, which lasted for hours.

There was considerable effusion into the sub-crural pouch of the synovial membrane. Under these circumstances I placed the leg at perfect rest in the extended position, retaining it there on a well padded McIntyre splint; this had to be done under chloroform, and while he was fully under the influence of the anæsthetic I availed myself of the chance of examining the joint, when I found thickening of the tissues around the joint and marked roughness, as though from erosion, of the cartilages, both between the ends of the bone as well as between the patella and anterior surface of the condyles of the femur. The subsequent treatment consisted in absolute rest, good nourishment and warm

\* The report of this case appears in this number of the journal under the heading of Hospital Reports.

fomentations to the joint. By these means the acute inflammatory symptoms gradually subsided. Subsequently I tapped the joint with a small trochar at the inner side of the thigh and drew off a small quantity, about  $\frac{3}{4}$  ij. of serous-looking fluid tinged with blood. The leg was again re-adjusted in the straight position. This apparently gave him relief, as the nocturnal pains which he had before suffered from subsided. I would have proposed excision at an earlier date, but erysipelas broke out in my wards, and I deemed it more prudent to wait. The operation was performed on the 21st December, and the object I have in drawing attention to this case, although perhaps premature, as the results have yet to be seen, is to mention the method adopted in division of the bones. It has been urged by Mr. Syme and others adverse to this operation that in a growing lad the removal of the epiphyseal end of the femur and head of the tibia will arrest the subsequent development of the limb, and in one of Mr. Syme's cases, who was one of the first British surgeons to resuscitate this operation, the subject was a child of eight years, and although the operation was perfectly successful the limb remained dwarfed, so that when he arrived at full growth there was shortening of some ten inches. Having in view these facts I thought that the diseased bone could be removed, by a semi-circular sweep of the saw. With this end in view I made use of a carpenter's whip saw, which I had adjusted to Mr. Butcher's frame, and removed the end of the femur without taking away the whole epiphyses. The end of the femur after the condyles were removed, presented a convexity, and at one point the cancellous structure was found diseased so that a second small slice had to be removed. The head of the tibia was then attended to, and a slice was removed rendering it concave. After removal of this fragment the patella was also taken away, as it was found in a diseased condition; the leg was then put up in a tin gutter splint, with a vacancy opposite the knee, the upper and lower end being connected by bars of iron bowed outwards. Since the operation the leg has progressed very slowly, for the first few days I thought he would have died from shock, as he was extremely weak; his pulse ranged from 160 to 180, and even now, although suppuration and granulation is progressing slowly, and he is taking nourishment well, yet he is not as I should like to see him. In removing the end of the femur the saw was entered from the anterior surface of the condyles, and as will be seen from the bones shewn a thin slice only was removed. The tibia was somewhat differently treated, as I commenced the section from behind. It appears to me that there are several advantages to be gained by this proceeding. In the first place a very much smaller portion of the bones

is removed, which is of great moment, more especially in a case like that of No. 3 of this series, as in this man the development of the limb had been arrested, and there existed at the time of the operation some three inches of shortening.

Another advantage to be gained by this method of removing the diseased bone is that you secure a wider extent of surface, and furthermore from the peculiar shape of the cut surfaces there is less chance of displacement of the bones from contraction of the hamstring muscles, unopposed by the quadriceps extensor which has been divided. In the three cases reported it was with difficulty that the bones were retained in position, as in all there was a constant tendency of the thigh bone to be displaced upwards. Another advantage is that which has already been alluded to, viz., the saving as much as possible of the epiphyses of the bones in a growing individual, and it was with this end in view that I was induced to perform the operation as described in this case.

The following wood cut gives a very fair representation of the bones.



Dr. HINGSTON would like to ask the operator upon what he grounded his belief in the existence of disease sufficiently extensive to warrant his excising the joint in the third of the cases reported. In that case, according to the record, there was no pain and no sinus or external opening; he would ask, therefore, why might not tenotomy and *brisement forcé* have been first tried, having recourse to excision only as a *dernier resort*? The length of time for which the disease had lasted need not preclude this, for he had himself performed the minor operation in a case in which the ankylosis had existed for sixteen years.

Dr. TRENHOLME would ask if Parke's semi-lunar incision had ever been contemplated as capable of improving the operation. It was explained that in two of the cases reported there was considerable disease of the patella, which of itself would entirely preclude the possibility of this modified proceeding.

Dr. GIRDWOOD thought the concavo-convex section of the bones as practised by Dr. Fenwick was decidedly advantageous, as owing to the peculiar manner in which the bones were thus fitted together, there was very much less risk of displacement, owing to contraction of the muscles, than after the old plan when the bones are sawn quite transversely.



The President said that Dr. Fenwick's cases were remarkable as a record of four successive successful operations. The operation itself is still regarded as a doubtful one by many eminent surgeons, principally for two reasons; in the first place, it not unfrequently happens that the limb left after excision is not as useful as would be an artificial leg: and secondly, in some hands, the mortality of this operation has proved greater than in amputation through the lower third of the thigh. With regard to Dr. Fenwick's novel method of sawing the bones he would remark that this plan could only be beneficially followed when there existed, as in this case, a minimum amount of disease. If the disease in the condyles was extensive, as it often is, division in the manner proposed could not be effected so as to save the epiphysis. He believes the plan a good one, rendering the co-aptation more accurate and steady than could otherwise be possible. The average time required for complete cure of these cases is about from 200 to 300 days; it will, therefore, be seen that in the cases brought under our notice, firm union and use of the limb have been acquired in a considerably shorter time than this, and therefore they may all be looked upon as *rapid* cures. The results were extremely satisfactory, and he would congratulate his friend Dr. Fenwick upon his marked success in his knee-excisions up to this time. He would mention that Dr. Cheever of the Boston City Hospital has lately given an account of six cases operated upon by him. Of the six cases, one was fatal, two required subsequent amputation, and three recovered: in one of these three cases, the patient, after sixteen months treatment, was still obliged to carry a splint. Dr. Cheever, from these results, was inclined to favour amputation in the lower third of the thigh rather than excision of the joint.

Dr. F. W. CAMPBELL had seen all of Dr. Fenwick's cases, and was anxious to know if he could assign any reason for the more than usual shock that followed the last operation.

Dr. FENWICK in reply to Dr. Hingston, said he was under the impression that in case No. 3, he had made out distinct roughness, though he would not be certain, as motion in the joint was very limited, the tibia and fibula were dislocated backwards and the patella was firmly adherent by bony union to the external condyle of the femur; this condition was noticeable in the bones submitted. He was not favourably impressed with the minor operation as styled by his friend Dr. Hingston, as he had seen *brisement forcé* result disastrously on more than one occasion; still he freely admitted, that it was a justifiable proceeding in suitable cases, but he did not think that any surgeon would have attempted it in this case. To Dr. Trenholm he would state that no other method of operating but that described had been contemplated. In reply to Dr. F.

W. Campbell who had asked to what he attributed the amount of shock in the fourth case which was not noticed as following the operation in the other three; he (Dr. Fenwick) would remark that shock was noticed in all the cases recorded, but in the case of the boy recently operated on it certainly was greater and was prolonged. Upon examining the record of cases published in the London *Lancet* and elsewhere, it will be found that this appears to be a peculiar feature after this operation. Shock is far greater after excision than after amputation; it appeared to him that it was this fact which induced many surgeons to regard this operation as more formidable and attended with greater risk than amputation at the lower third of the thigh. He could not agree in opinion with those surgeons, alluded to by our president, who maintained that in some cases the limb after excision was not as useful as an artificial leg. Sir W. Ferguson regards the saving of the limb, even if there is many inches of shortening as far preferable to any artificial leg, inasmuch as the patient does not suffer mutilation, and above all retains a foot and ankle joint.

Dr. Fenwick went on to say that he would watch the last case operated on with increased interest and that he hoped at a future day to be able to lay before the members of the society the successful results.

The Society then adjourned.

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## CORRESPONDENCE.

*To the Editors of the Canada Medical Journal.*

OTTAWA, January 24th, 1871.

GENTLEMEN,—The document I send you with this note was sent to me from Toronto more than a year ago, for signature by members of the profession here. It was, unfortunately, lost for some time, and having now recovered it, I beg leave to ask you to find space for it in your valuable journal.

I remain your obedient servant,

WALTER JAMES HENRY.

TO THE PRACTITIONERS OF MEDICINE AND SURGERY OF THE PROVINCE OF ONTARIO.

GENTLEMEN,—We think it incumbent on all of us loyal to our profession to protest against, and endeavour to obtain the repeal of, those clauses of the present Medical Act which would force us into a degrading and hitherto unheard of association with persons styling themselves homeopaths and eclectics, the Act not only giving to such persons a large

representation in the Medical Council, and thereby great power in determining what medical education in this Province shall hereafter be, but also providing that there shall be a college of physicians and surgeons composed of the orthodox practitioners of medicine and surgery, and of homeopaths and eclectic *made surgeons by Act of Parliament!*—licensed surgeons of Ontario! A Medical Council or College so composed is not elsewhere to be found, and we are sure that the physicians and surgeons of all other countries would feel themselves aggrieved and degraded by a Legislative Act associating them, *volentes, volentes*, with such persons. We, therefore, call upon you, for the credit of our profession and of ourselves, if for nothing else, to join with us in protesting against any association with a class of persons not elsewhere recognized by the practitioners of scientific medicine and surgery. The Royal College of Surgeons of Ireland, in 1861, passed an ordinance that “no Fellow or Licentiate of the College shall pretend or profess to cure diseases by the deception called Homeopathy, or the practice called Mesmerism, or by any other form of quackery;” \* \* \* “that no Fellow or Licentiate of the College shall consult with, meet, advise, direct, or assist, any person engaged in such deceptions.”—(Vide *Lancet* of Nov. 9, 1861.)

This is so thoroughly in accordance with our views that we hereby declare that we will not willingly meet in consultation any Homeopath, Eclectic, Hydropath, Mesmerist, or the like.

We trust that those medical practitioners who think as we do, will forward their names to any of the undersigned, with instructions that they may be added to the signatures of those who hereby join in this protest and declaration.

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|--------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| W. R. BEAUMONT, F.R.C.S., Eng. (1844, Hon.), Toronto.                          | LACHLAN W. MACFARLANE, M.D., Toronto University.                      |
| EDWARD M. HODDER, M.D., F.R.C.S., Eng., (1854, Hon.) Toronto.                  | W. WINSLOW OGDEN, M.B.                                                |
| C. J. PHILBRICK, F.R.C.S., Eng., (1850) Toronto.                               | J. BROWN, M.D.                                                        |
| JAMES RICHARDSON, M.D., M.R.C.S., Eng.                                         | JAMES NEWCOMBE, M.D., L.R.C.P., M.R.C.S., Eng.                        |
| W. B. NICOL, M.D.                                                              | JAMES BOVELL, M.D., L.R.C.P., Eng.                                    |
| JAMES THORNBURN, M.D., Edin. and Toronto Uni.                                  | JOHN YOUNG BROWN, M.D., M.R.C.S.E., M.P.                              |
| WM. CANNIFF, M.D., M.R.C.S., Eng.                                              | C. B. HALL, M.D.                                                      |
| J. T. BUALL, M.D., M.R.C.S., Eng.                                              | J. ALGERNON TEMPLE, M.D., M.R.C.S., Eng.                              |
| N. BETHUNE, M.D., Edin., F.R.C.S., Edin., Toronto.                             | WM. OLDRIGHT, M.A., M.D.                                              |
| GEORGE WRIGHT, A.M., M.B., Toronto.                                            | J. N. AGNEW, M.D.                                                     |
| O. S. WINSTANLEY, M.R.C.S., Eng.                                               | A. A. RIDDEL.                                                         |
| JOHN E. KENNEDY, A.B., M.B., Toronto.                                          | JAMES ALLEN, M.D.                                                     |
| J. P. RUSSELL, M.D., Edin. (1846.)                                             | A. M. ROSEBRUGH, M.D.                                                 |
| E. J. BARRICK, M.D., M.R.C.S., Eng. and Edin., L.R.C.P., London and Edinburgh. | R. A. REEVE, B.A., M.D.                                               |
|                                                                                | HUMPHRY EWING BUCHAN, M.A., M.D., L.R.C.P., Edin., L.F.P.S., Glasgow. |
|                                                                                | GEO. RYALL, A.B., M.D., T.C.D.                                        |

- J. BYRES LAING, A.M., M.D.  
 D. MACKINTOSH, M.D., Edin., Pres. Hamilton Med. and Surg. So.  
 ISAAC RYALL, M.B.  
 ARCHD. E. MALLOCH, M.D.  
 G. W. ROSEBRUGH, M.D.  
 T. CROOKER, M.D., M.R.C.S., Eng., L.R.C.S., Edin.  
 J. M. HAMILTON, R.N., Surgeon.  
 CHAS. F. BULLEN, M.D., C.M.  
 JOHN MACKELCAN, M.R.C.S., Eng. (1827.)  
 E. L. MACKELCAN, M.D.  
 ALEX. C. REID, M.D., C.M.  
 JOHN A. MULLIN, M.D., Hamilton.  
 W. L. BILLINGS, Surgeon, &c.  
 THOMAS WHITE, M.D., Hamilton.  
 J. D. MACDONALD, M.D., L.R.C.S., Edin.  
 DAVID KEAGEY, M.D., M.R.C.S., L.R.C.P.  
 WILLIAM J. A. CASE, M.D., Hamilton.
- THOS. DUGGAN, L.M.B., (1833.)  
 C. O'REILLY, M.D., C.M.  
 J. W. ALWAY, M.D., Smithville.  
 ENOIH ALWAY, M.D., Smithville.  
 HENRY T. RIDLEY, M.D.  
 E. HENWOOD, L.M.B.
- OTTAWA, ONTARIO.
- EDWARD VAN CORTLANDT, M.R.C.S. and Lic. Ap. C.  
 J. MCGILLIVRAY, M.D., Montreal.  
 J. A. GRANT, M.D., M.R.C.P., Lond., M.R.C.S., Eng., F.R.C.S., Edin., &c.  
 E. MACDONELL, M.D.  
 WALTER JAMES HENRY, M.D.  
 JOHN SWEETLAND, M.D.  
 ALFRED CODD, M.D., C.M.  
 E. C. MALLOCH, M.D., C.M., M.R.C.S.L.  
 J. T. C. BEAUBIEN, M.D.

## REVIEWS AND NOTICES OF BOOKS.

*Spermatorrhœa, its Causes, Symptoms, Results, and Treatment.* By ROBERT BARTHOLOW, A.M., M.D., Professor of Materia Medica, in the Medical College of Ohio. New York: William Wood & Co., 61 Walker street. Montreal: Dawson Bros.

The rapidity with which the various editions of this work have been sold, is good evidence of its value. It certainly is a really instructive little manual, and gives a fair epitome of the existing knowledge upon the subject, with a considerable amount of original matter. He attacks Lallemand's teachings, which have very generally been received by the profession, with much vigor. After quoting authorities in support of the opinion entertained by himself, that in the disease there was neither inflammation of the prostate or seminal ducts he says

"I may also refer, in opposition to the views of Lallemand, to my personal observations. I have had numerous opportunities to ascertain— if it exist—a causative relation between the lesions of the generative apparatus and spermatorrhœa described by Lallemand, but hitherto have failed to observe this connection. I lately made a most careful dissection of the sexual apparatus of a young man dead of double pneumonia, who was known to have practised masturbation in an extreme degree for many years. Besides a catarrhal condition of the mucous membrane of the seminal and prostatic ducts, and of the *vesiculæ seminales*, there was literally no lesion of these organs. I therefore reject this position of Lallemand as untenable, and as leading to improper methods of treatment."

Spermatorrhœa is, in the view of the author, a *neurosis*. Although structural alterations may be coincident, they are not causative.

In the treatment of this affection, we find he places his chief reliance on the bromide of potash, a remedy which we have used with a considerable amount of success. The disease is, however, one exceedingly difficult of permanent cure, at all events to the patient's satisfaction, for unless the involuntary discharge of semen be completely arrested, he is not likely to consider himself well. This, is in our opinion, an impossibility, and we are glad to notice that on this point our author is with us, and confines the term Spermatorrhœa to that condition in which involuntary seminal loss occurs with sufficient frequency to produce a definite morbid state. We believe that to a certain degree seminal emissions of an involuntary character take place as the direct result of physiological laws, and that it is the duty of the humane physician to so inform his patient, who has generally been worked up to a pitch of nervous excitement by reading some of the many quack publications upon this subject. We know from experience how difficult it is to reason with one so situated, but it is the true course nevertheless. Many very useful hints may be gathered from the perusal of the volume, which we very willingly draw our subscribers attention to.

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*Renal Diseases, a Clinical Guide to their Diagnosis and Treatment.*

By W. R. BASHAM, M.D., Fellow of the Royal College of Physicians, Senior Physician and Lecturer on Medicine, Westminster Hospital, &c., &c. With illustrations, Svo: p 304. Philadelphia: Henry C. Lea, 1870.

Special attention has been paid during the past few years to bed-side instruction, and it has long been recognized as the most essential part of medical education. Seeing is believing; it is at the bed-side that the student is taught what to observe in disease; each symptom, as it makes its appearance, has a special significance, and if proper attention is paid, and its important connection recognised, it becomes an integral part of the map of the disease it accompanies. This fact is well recognised by both teacher and student, so that to both the importance of careful clinical observation becomes obvious. Clinical examination has more recently been regarded as the most positive proof of a student's efficiency, so that when he goes out into practice he may be able from symptoms present to form a lucid and clear judgment of the nature of the disease he has to encounter. With a view of promoting a clinical knowledge of a class of diseases which present many difficulties, Dr. Basham has prepared this work, trusting that it may afford to the student and junior practitioners a practical guide which will be of use in bed side observation.

The author had divided his subject into three headings or parts. In part 1st, he treats of diseases of the kidneys "marked by symptoms more or less of an inflammatory character." Diseases having for their causes various injuries, such as blows, kicks, or substances applied to the skin. Secondly, substances taken internally, which have a specific stimulating effect on the kidneys. Next we have those affections resulting from certain febrile poisons. The agency of cold and wet in inducing acute morbus Brightii or inflammatory dropsy; nephritis associated with gout. An excess of uric acid passing through the kidney giving rise to gravel. The deposit of tubercular matter or tubercular nephritis, tubercular pyelitis and serofulous pyelitis, cancerous nephritis, peri-nephritis, nephritis induced from parasitic causes and the nephritis of pregnancy.

In the second part, the author treats of chronic renal affections, and describes four varieties, or post mortem conditions met with in that group of diseases designated chronic albuminuria, or chronic morbus Brightii.

"I. The small red contracted granular kidney. The cirrhotic kidney of Dr. T. Grainger Stewart, and Dr. Harley.

II. The large granular fatty kidney.

III. The amyloid kidney.

IV. The atrophic, contracted, nodular, gouty kidney."

The author draws a distinction between the small red contracted granular kidney, and the nodular atrophic contracted gouty kidney, this latter, a condition which is never seen except in persons who have suffered from gout in some shape.

The third part of the book is devoted to the clinical significance of the urine. Its properties, physical, clinical and morphological as indicative of renal disease. This part is illustrated with twenty-one microscopic representations of urinary deposits.

The work is concise, practical, and will be found of great use by practitioner and student.

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## PERISCOPIC DEPARTMENT.

### Surgery.

A NEW AND MOST USEFUL EYE SALVE IN "GRANULAR LIDS"  
AND IN ALL CASES OF CHRONIC OPHTHALMIA.

By JOHN WILLIAMS, Physician and Surgeon.

After long experience, I can speak most confidently of this ointment, for the composition of which I now publish the following formula:  
℞. Arsenici Sulphureti. 2 gr.; Unguenti Citrini, 2 3; Axungiæ Preparat, 6 3. M. Bene. In cases of "granular lids," accompanied with

most inveterate "pannus," and in almost all cases of chronic ophthalmia, in which the conjunctiva has become almost cuticular, I have found this ointment particularly useful. Ophthalmia is well known to be very prevalent in the city and county of Cork, so that I had very many opportunities of proving the efficacy of this ointment. The upper eyelids should be everted in cases of "granular lids," and about the size of a hemp seed of this ointment should be applied with a camel-hair pencil, which must be introduced into the superior palpebral sinus, to the diseased conjunctiva. In suggesting this local remedy I am not unmindful of *general* treatment, without which *any* local remedies are almost useless.—*Dublin Quar. Jour. Med. Science.*

#### SYPHILITIC GONORRHOEA.

Prof. W. A. Hammond, of New York, in his "Lectures on Venereal Diseases," maintains the following propositions: 1st. "That the virus of an infecting chancre, when deposited on a secreting mucous surface upon which there is no solution of continuity, may give rise to gonorrhœa, unattended by chancre, but which is syphilitic in its character, and capable of producing constitutional disease. 2d. The matter of such a gonorrhœa is capable of causing an infecting chancre either by natural or artificial inoculation, which chancre is followed by constitutional syphilis."—*Philadelphia Medical and Surgical Reporter.*

#### NEW TREATMENT OF PILES.

At the last meeting of the British Medical Association Dr. Daniel Maclean, of Glasgow, read a paper of great interest, published in the Association's *Journal*. After speaking of the pathology of hæmorrhoids, he says:

Seeing, then, that all kinds of piles have necessarily a sac or cell with fluid contents, and that, so long as this sacculated condition continues, you have an abnormal condition of parts with its accompanying suffering; and so long as the vessel or vessels are unable to perform their functions properly, from the continued injection of blood against the already overstrained walls, the obvious mode of treatment is to support the weakened walls, and then empty the sac, as you would do in a case of hernial tumor by a process analogous to the reduction by the taxis. This is a method of treatment not mentioned by authors, but which in my practice I have found eminently beneficial.

Hæmorrhoids after parturition generally come on in patients who are of a soft, loose habit of body, or who are, at all events, flabby and relaxed in the perineal region. In treating them, I first get a free evacuation of

the bowels by some aperient medicine; and when the effects of the medicine have passed off, I order the parts to be well fomented for a few hours, to relieve as much as possible the irritation and spasm of the parts. I then proceed to apply the taxis to the tumor. Taking a piece of soft, well-oiled cloth, and grasping one of the tumors—if there be more than one—with two fingers and the thumb, thereby encircling the enlargement, and curving the fingers so that they cover the fundus of the pile. I proceed to press the tumor toward the mouth of the sac, with a kneading motion, continuing for a little time until I find the swelling become gradually smaller under the manipulation, and there only remain the thickened integument and whatever effusion of serum may have taken place into the cellular tissue.

In the beginning of the application of this process, the pain is sometimes considerable; but, as the tumor becomes emptied, the pain decreases, and, when it is fully reduced, a great sensation of relief is experienced. The reduction of the first hæmorrhoid being completed, the same procedure is applied to the others in rotation; and, the whole being reduced, astringent lotions or ointments are applied to the part, and the operation is complete.

We are now at liberty to proceed with the removal of the primary cause, if any exist, and there is usually some such cause in cases other than post-parturient. In these last, their acute origin is much more recent, and therefore much more easily subdued; but whatever the cause, the method of treatment is still the same, and will be found of value.

Looking to the pathology of hæmorrhoidal tumors, containing, as they do, a single sac, or a plurality of sacs, with fluid contents, the first principle of treatment is to empty the cavity of its fluid, remove all tension and irritation, and enable the tissues to resume their normal condition.

In external and intero-external piles, they are—if not seen sufficiently early—besides the fluid contents, what I have called the results of the hæmorrhoidal condition, viz., the coagulated or semi-coagulated blood the infiltrated cellular tissue, and the thickened integument. Having emptied the sac by the process mentioned, I continue the taxis to what remains of the tumor, either at that sitting or at one subsequent, and generally get quit of the static materials. What remains is removed by natural agency. It might be objected that the forcible propulsion of coagulated blood into the current of the circulation would give origin to the formation of an embolism in some distant part, and by that means act as a source of danger to the patient; but, whatever force this objec-



tion may have theoretically, it does not hold good in practice, as it might be expected to have shown its evil consequences in the course of the two or three years during which time I have employed the plan. The same or an analogous condition of parts is seen in the veins surrounding a varicose ulcer. You have little knobs at different parts in the course of these vessels, which, from their solidity, size, and shape, can only be coagulated blood obstructing the venous return, and keeping up the congestion surrounding the ulcer. By applying the kneading process, and causing the patient occasionally to do the same, you gradually reduce the amount of hardness in the part, and ultimately remove the occluded state of the vessel, but in no case does the patient suffer afterward from embolia.

In internal piles, the application of the taxis is conducted in the same manner, but here it is necessary to cause the extrusion of the tumors, and this can be done as in the removal by the ligature, by passing an injection of tepid water into the rectum, and then getting the patient to expel them by straining, when the same process is gone through as in external piles, and, on the return of the bowels, we attend to the constitutional disorder and give injections of astringent lotions, etc.

When the internal variety of this tumor takes place in females who have had children, the reduction of the swelling may often be accomplished through the walls of the vagina; more especially if the parts are relaxed, which in the majority of women is the case.

#### MR. SKEY ON GONORRHOEA AND GLEET.

Gonorrhœa consists in a purulent discharge from the urethra or vagina following sexual intercourse, attended with symptoms of more or less severity. These I shall not dwell on. General opinion adopts the belief that an attack of gonorrhœa results from intercourse with a woman who is herself the subject of that disease. I doubt the soundness of that opinion. How often in the course of the career of a surgeon has he had the opportunity of ascertaining this fact by personal examination of both parties? I am far from asserting that it is not communicable from one to the other sex. That fact is, I believe, indisputable; but long and ample experience has taught me, as I shall from that experience tell you, that gonorrhœa in the female is by no means essential to its production in the male, and I think you will find, on careful inquiry and examination, that the very large majority of cases of gonorrhœa in the male are the result of intercourse with women who have no ascertainable form of purulent discharge whatever. It is a remarkable fact that some men are much more prone to gonorrhœal disease than

others. Some men pass through the ordeal of London life without having been once the subject of the disease; while others, pursuing a similar career of dissipation, take the disease three or four times in as many years. It is also worthy of observation that gonorrhœa is a disease of early manhood and not of middle life. It is most severe from eighteen to twenty-three years of age, and the first attack is, as a rule, the most severe, but not invariably so.

I am quite certain that I have seen cases, and among the most severe cases, of gonorrhœa the result of intercourse *immediately* after the catamenial period. Mr. Abernethy was perfectly familiar with the fact that a man having intercourse with a healthy woman might become the subject of the common or soft sore; while to other men the same woman proved perfectly harmless. If venereal sores, why not gonorrhœa? If you ask me by what process of supposed inoculation the gonorrhœal matter makes its way down the urethra, I really cannot answer you; but it is a curious feature in the disease, and as the same locality is affected in cases in which the disease results from intercourse with women either during or immediately subsequent to the catamenial period, in whom there is no suspicion of gonorrhœal discharge, it is quite certain that in ordinary cases the inoculating matter makes its way three-quarters of an inch along the narrow canal of the male urethra? I do not assert that such women are absolutely healthy as regards the genital system, but I do not say they are not so. It is probable that they are the subjects of some form of discharge or secretion, innocuous both to themselves and others, that is capable of developing disease of a severe form in some constitutions, but not in others; for I fully believe the constitution is involved in the liability, and that gonorrhœa is not simply and entirely a local affection.

It is needless to quote examples, but I have never, for many years, been consulted in a case of gonorrhœa or primary gleet that I have not made at least a verbal inquiry as to the source of the disease. It has been suggested, as a mode of getting over the difficulty, that the cases I allude to are not examples of true gonorrhœa? Then what constitutes true gonorrhœa? If copious purulent discharge from the urethra, attended by burning pain during micturition, and chordee at night, do not constitute true gonorrhœa, my knowledge of that disease is defective. Gleet is a modified form of gonorrhœa, and exists either as a primary or as a secondary affection. Protracted gonorrhœa almost invariably runs into gleet, or an attack of gleet may be the direct consequence of sexual intercourse in a man, especially towards middle age. Primary gleet is uncommon in boyhood, or in early manhood. The discharge in either

case is rarely very great, nor is the pain in micturition severe. Active exercise, whether on foot or on horseback, very hot weather, excess of wine, very late hours, all tend to increase the evil, whether of the primary or secondary form, and to bring it in the direction, and sometimes even up to the level of a gonorrhœal affection. Purulent discharges from the urethra, like exanthematous diseases, have a given term of progress, maturity and subsidence. The average duration of a case of gonorrhœa is from six to eight weeks—that is, if left to nature. For gleet the term is uncertain. When a case of gonorrhœa runs into gleet, weeks and months may be required for its cure, whereas primary gleet is usually curable in a fortnight or three weeks.

The difference between the two cases of primary and secondary gleet depends on the previous treatment of the gonorrhœa. If, in consonance with a too prevalent pathology, we class a case of gonorrhœa among the inflammatory diseases, and treat it with supposed antiphlegmonous agents, among which may be included purgatives and other depletive medicines, reduced diet, vegetable food, and the entire suspension of vinous and fermentive drinks, which have hitherto formed a part of the daily diet of the affected persons—then, as a rule, the active gonorrhœa runs into gleet, and, the same remedies being continued, the gleet will be protracted to the extent of weeks, months, and in some constitutions, even of years. In fact, the gleety discharge, which consists, for the most part of a watery ichor, containing more or less pus globules, is a sort of dropsy of the urethra, and the more we deplete the more persistent is the discharge. When I was on duty in the out-patient department of St. Bartholomew's Hospital, a man applied for treatment of a gleet of three years' duration. He belonged to a large brewery in the Mile-End Road, and had been accustomed to drink two quarts daily of strong ale, but had, by medical order, totally abstained from his accustomed drink from the commencement of his malady. I ordered him to return immediately to his former beverage. Within a fortnight he had entirely recovered.

In the treatment of gonorrhœa, we should always keep in mind the important fact that it has a natural period of subsidence, or cure, if untreated; that at the expiration of six to eight weeks it will die a natural death. Therefore, it cannot be a wise or judicious proceeding to commence the treatment by active purgation, or other form of depletion. I believe a mild aperient or two to be unobjectionable, and I have found benefit from a powder containing twenty grains of jalap and two drachms of powdered gum arabic, taken at night in half a tumbler of milk. This may be repeated for two or three nights, and then I think we should rest on our oars for a week or ten days, abstaining from active exercise, but

adhering to the usual habits of diet, unless the daily consumption of wine or other alcoholic drinks is large; if so, I would reduce them partially, both in quantity and potency. As early as the local pain and profuse discharges are somewhat reduced, I advise you to resort to iron, quinine, or other tonics, and to increase the consumption of wine on the same tonic principle, commencing with a moderate dose, and increasing the quantity rapidly up to a full dose of the compound medicine. I generally prescribe ten or twelve grains of the citrate of quinine and iron twice daily. At the expiration of about a week from the commencement of the treatment by tonics, I would suggest a simple injection of one grain of sulphate of zinc to the ounce of water, to be used night and morning, and then thrice daily. It may be necessary toward the latter stage, if the progress is slow, to add ten minims of copaiba balsam twice daily. Beer is unobjectionable.

In cases of primary gleet, the success of the tonic treatment above mentioned is remarkable, as it will often, in mild cases, cut the disease short in three or four days; but in such examples there is an entire absence of painful micturition and chordee. If these symptoms are present, the tonic agent, should not be resorted to until the expiration of a few days. If, unfortunately, orchitis should occur, pending its existence, the treatment by tonics, most valuable in its absence, should not be resorted to.—*Lancet*.

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### Medicine.

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#### ON THE TREATMENT OF HÆMOPTYSIS.

By Dyce Buckworth, M.D., Assistant Physician to St. Bartholomew's Hospital.

Among many problems in therapeutics awaiting solution upon a basis which is satisfactory to the scientific inquirer, and therefore due to the claims of legitimate medicine, stands the question as to the value and *modus operandi* of styptic agents when given internally. They are constantly made use of, and both the routine of practice and popular demand tend, I believe, to encourage their employment with unnecessary frequency.

I propose to discuss briefly in this paper the practice of treating hæmoptysis with styptic remedies.

In estimating the value of any special plan of treatment, it is, of course, necessary to pay special attention to the cause and tendency of

the morbid condition or symptom we try to rectify or relieve. In the more apt language of my distinguished former teacher, Professor Hughes Bennett, "a correct pathology must ever precede scientific therapeutics."

With regard to hæmoptysis, then, we find that in the great majority of cases it is a symptom of pulmonary consumption. The occasional bleeding from thoracic aneurisms, and those arising from pulmonary congestion, secondary to heart disease, may be said practically to call for no interference with styptics; neither do the occasional small hæmoptyses which occur in the course of chronic bronchitis and emphysema. It is, however, a question with some whether the hemorrhage in pulmonary apoplexy should be restrained. The late M. Trousseau advised the use of ipecacuanha in these cases, and wrote favorably of it. [I cannot myself see that it is desirable to check the *expectoration* of blood in such a case, though any remedy that would prevent hemorrhage into the texture of the lungs might justly be extolled.] Passing by the comparatively rare cases of cancer and hydatid of the lungs as affording causes for hæmoptysis, we are left mainly to deal with that arising from phthisis; and in reviewing the causes and results of this accident it is proper, in the first place, to bear in mind that death directly from it is the rarest of occurrences. During the largest hospital experience of the last twelve years, I have myself seen only one death from the cause. An accurate diagnosis should be made; so far as is possible. It is certainly wrong to percuss the chest, or make any such physical examination of it as entails movement or disturbance to the patient. The bleeding is usually from small bronchial, arterial, or from pulmonary venous branches, eaten into by ulceration. It is always recognized as from these sources, unless the blood be distinctly venous in appearance, when, as most rarely happens, a branch of the pulmonary artery has ruptured.

I believe that a large number of cases of simple hæmoptysis require no medicinal treatment whatever. The occurrence is often so regulated as to be what we may call self-limited; that is, a vessel or some small vessels rupture, they bleed for a time, and they cease to bleed. The analogy in this respect, I believe, between such a breach and a similar one elsewhere on the body, is not so distant as may be at first supposed. Many cases of pulmonary hemorrhage terminate in this way. In the meantime there may have been wise or unwise measures employed to check the process, and these are not unlikely to win credit for the satisfactory result.

I need hardly say here that this is no evidence whatever to us as therapeutists.

How often, indeed, are practitioners summoned to cases of hæmoptysis

and on arrival find there is nothing for them to do. The patient's condition in the meantime may have been most inconducive to the result. He is perhaps found lying on a warm feather bed, in a close room, surrounded by anxious attendants: Perhaps the only favouring circumstance in a somewhat severe case may have been the partially syncopal condition, induced by alarm at the sight of blood, which moderated the cardiac action.

Nothing beyond rest and suitable hygienic practice is called for; but if there be interference with medicine, the result will be perhaps set down to the particular drug employed. There is no doubt that many agents have not only gained, but maintained, a reputation as hæmostatics on the credit of cases similar to the above. And, indeed, if we boldly survey the whole field of therapeutics, we find the same sort of faith to prevail only too largely.

So much, then, for those cases, a large number, as I have stated requiring no interference with drugs. We are compelled, however, to treat a hæmoptysis which does not cease spontaneously.

It is first to be borne in mind that, with perhaps one exception, to be presently mentioned, we are not in possession of the means to effect a change in the vascular walls in a short period of time. Some hæmostatics no doubt act rapidly, by altering the relations between the blood and the vessels.

“In all cases,” remarks Professor Bennett, “the best remedy is perfect quietude and avoidance of every kind of excitement, bodily and mental. Astringents have been recommended, especially acetate of lead and gallic acid; but how a few grains of these remedies, introduced into the stomach, can operate upon ruptured vessels in the lungs, I am at a loss to understand; and I have never seen a case in which their administration was unequivocally useful.”

This is a bold assertion as to styptic drugs; but in the class of cases we are now considering, I believe it will not deter the practitioner from interference. It is my conviction that we are warranted by the results in employing certain drugs in severe and prolonged hæmoptysis. It is perhaps too much the habit to give opium and powerful astringents in these cases. To be of any use, ℞j to ʒss of gallic acid should be given every half hour at first; or gr. ij. to v. of the acetate of lead as often. The result of such medication, in many instances, is so to disturb the digestive powers and nutritive processes as to throw back the patient, and render the hemorrhagic attack altogether a very severe accident for him. I believe the value of opium in hæmoptysis to consist, not only in its general calmative powers, diminishing irritability and checking cough,

but also in its local tonic action upon the small vessels. That continued doses of acetate of lead produce a marked effect upon a ruptured vascular surface, I entertain no doubt. We are, it is true, met with the difficulty of supposing that a few grains introduced into the mass of the circulation—say gr. x to lb. 15 of blood—should act in so decided a manner. “We must remember that though only a minute quantity at a time is presented to the injured capillary, that quantity is continually succeeded by others as the course of the circulation passes over the part. Lead is absorbed with ease, excreted with difficulty. It diminishes the red corpuscles, and thus directly counteracts the hemorrhagic diathesis.”

I believe, however, that in many cases we may dispense with this remedy, as also with gallic acid, in favour of the more simple plan I shall now mention. On the occurrence of continued hæmoptysis, all other remedies should be withheld, and a simple astringent or slightly aperient medicine given. A good form is *m x* to *m xv* of dilute sulphuric acid, and, according to the state of the bowels, 3 ss to 3 j of sulphate of magnesia may be given with this in some spearmint water every half hour at first, and then less frequently. In addition to suitable posture (semi-erect) and other well known favouring conditions, absolute silence should be enjoined, and the patient urged to refrain from coughing as much as possible. Should the bleeding continue, we should place a bladder of ice, or a frozen compress, between the scapulæ for a short time. This sometimes acts promptly, no doubt by reflex action, and probably this is the only means whereby a rapid change can be induced in the vascular walls. Should this fail, tinct. digitalis should be given (*m x* or *xv*) with each dose of the astringent saline. In addition to this, if the case appears obstinate, a blister should be painted on the front of the chest, if possible under the clavicle of the side believed to be affected.

The ordinary habits and remedies may be resumed in a day or two after the cessation of the hemorrhage.

The above description comprises the most beneficial method which I have witnessed, and, in setting it forth here, I need not say that there is no novelty in it. I do believe, however, that it deserves to be employed more frequently, instead of the medication with opium and powerful astringents.

Of the value of ergot, turpentine, and common salt, remedies frequently employed and lauded, I have no experience. I imagine the actions of opium and ergot are not dissimilar as regards their effect on the small blood vessels.

Digitalis has fully vindicated its right to a high place in our list of hæmostatics. It is believed to produce its effect independently of any

action on the circulation. Dickinson suggests that it influences the muscular fibres of the uterus in cases of menorrhagia, in which it is of great value.

Ipecacuanha enjoys considerable reputation as a hæmostatic, especially in the Parisian school. I think the following experience of it in hæmoptysis worth recording in this place. I employed it in two bad cases, and watched its effect in a third. In only one of these was the result satisfactory.

CASE 1.—A farm labourer, aged twenty-one, admitted into hospital with a second attack of hæmoptysis, which had persisted for five days. Sufficient evidence of mischief was elicited at the left apex. I gave him gr. ij pulv. ipec. 4tis horis. This caused only slight nausea. Next day hæmoptysis continued. Ordered gr. v. 4tis horis. This caused vomiting, but was persisted with. Hæmoptysis not checked. A blister under the left clavicle was of no service. The bleeding ceased gradually in two or three days, the patient taking, in the meantime, sulphuric acid and digitalis mixture.

CASE 2.—J. P., aged 35. Royal Dockpord policeman, was admitted into Plymouth Hospital with severe hæmoptysis. Known to be a subject of chronic phthisis for last three years. Ordered by the late Inspector General, Dr. Stewart, 3 ij vin ipec. (=gr. v pulv. ipec.) secundis horis. This caused vomiting, and the remedy was suspended in favour of gallic acid, which failed, and was replaced by sulphuric acid and digitalis mixture, which likewise was of no avail. The man died purely from hæmoptysis and syncope in three days, and on examination I found several bronchial ulcers in the left apex, communicating with branches of (probably) the pulmonary vein.

CASE 3.—Out-patient, aged 64, hale looking man; had suffered for some days with hæmoptysis. Physical signs *nil*. To take m x vin. ipec. (= gr. ss) ter die. No benefit derived in a week, when gr. v of gallic acid were ordered ter die. Next week hæmoptysis no better; blood was brought up in my presence; to take gr. ij pulv. ipec. ter die. On the second day of this treatment the hæmoptysis ceased completely. The powder was taken till the fourth day, when it proved purgative, and was suspended. No nausea was produced. In six months time, no change in condition of chest, and no further hæmoptysis.

In two of the cases nausea occurred. Trousseau maintained that neither this nor actual emesis interfered with the good result. One naturally fears the disturbance to the circulation in vomiting, but this circumstance is not proved to contra-indicate nauseant remedies. The styptic action of ipecacuanha, if it really exist, is not yet explained. I



have elsewhere shown that the theory of its bleaching the lungs is untenable, and that these organs, on the contrary, are found full of blood after its use. I am disposed to believe that this drug does not act similarly on all individuals, and that, just as the dust of it excites an asthma in some persons, and is harmless to the air passages (in small quantity) of others, so the nervous arrangements of some may be more susceptible to its action. Laycock believes that it excites a similar contraction in the vascular to that which it promotes in the bronchial tubes of some persons.

The hæmostatic action of nauseant remedies are perhaps partly explainable by the calmer state of circulation they induce.

In many cases, I believe, we may bear in mind the opinions of the late Dr. Theophilus Thomson and other authorities, which teach that oftentimes in phthisis moderate hæmoptysis is useful, and seems to retard a fatal issue.

In conclusion, I would make one or two remarks as to the effect which is sometimes set to the account of steel and cod liver oil in causing hæmoptysis in cases of phthisis.

Cullen forbade the use of ferruginous medicines as styptics, because they "contributed to increase the phlogistic diathesis of the system;" he also condemned Peruvian bark for the same reason.

There are those who deny the truth of this, and consider that even if such were the case, no harm would result. I suppose few remedies are more largely employed. If iron be withheld from the cases where there are manifestly present pyrexial symptoms, hardly any complaint could be made.

In these instances the remedy is unsuited, and quinine replaces it with much advantage. And so with cod-liver oil. It is not, however, possible in every case, to say whether one or the other will positively prove harmful, and the truth in the matter is, I believe, comprised in the following, which is the experience of my colleague, Dr. Andrew, viz., that both steel and cod-liver oil do cause hæmoptysis in a certain small number of phthisical patients, who, therefore, cannot take these remedies. The greater number, however, bear both well without any such occurrence being fairly chargeable to their use.—*Practitioner*.

**HYSTERICAL RETENTION OF URINE.**—Mr. J. Waring Currant (*Medical Press and Circular*) has found retention of urine in hysterical young women to be relieved by having them suddenly plunge the hands in very cold water. They call out lustily for the urinary apparatus, and pass large quantities of the so-called hysterical urine. The procedure thus obviates the objectionable resort to the catheter. Nearly every one must have experienced the desire to urinate after thrusting the hands or other parts of the body into cold water.—*Med. Review*.

## Midwifery.

7. *On the influence of Chloral on the Pain of Parturition.* By E. LAMBERT, ESQ.

[*Edinburgh Medical Journal*, Aug. 1870.]

In this paper, read before the Edinburgh Obstetrical Society, the author alludes to the fact that "when chloral was brought before the profession, Sir James Simpson was foremost in prosecuting inquiry into its therapeutic value, and published a paper on the subject in the *Medical Times* (London). The author remarks that "chloral could not claim to supplant chloroform, since it abolished consciousness to a less extent, placing the patient, as it were, midway between consciousness and unconsciousness, and rendering her incapable of that control which is essential during the close of the second stage; but this admission only placed in a stronger light the admirable properties of the agent when applied to the relief of pain during the first stage of labour, at a period when it is generally conceded that chloroform is hurtful.

As the hypnotic of this first stage, chloral stands as yet unrivalled; we have only to remember that opium, our only sure refuge, must be administered with the knowledge that we are conspiring, though for a higher end, against the course of labour."

The author reports eleven cases, in the history of which, and in the comments upon them, some interesting points are developed. He arrives at the following conclusions:

1. Chloral is an agent of great value in the relief of pain during parturition.

2. It may be administered under favourable circumstances during and at the close of the second stage, with the result of producing absolute unconsciousness in the same sense in which we understand unconsciousness under chloroform.

3. When thus given successfully, it has this advantage over chloroform, that it requires no interference with the patient.

4. It is desirable to retain chloroform in the position which it at present occupies in midwifery, and to reserve for the agency of chloral the first stage of labour. If, however, chloral or some agent having analogous properties is found successfully to relieve the pain of uterine contraction, the use of chloroform will be restricted to a lesser period of the duration of labour, or to the facilitation of manual or instrumental interference.

5. It is demonstrated that a labour can be conducted from its commencement to its termination, without any consciousness on the part of the patient, under the sole influence of chloral.

6. The exhibition of chloral in nowise interferes with the exhibition of chloroform.

7. The proper mode of exhibiting chloral is in fractional doses of grs. xv. every quarter of an hour until some effect is produced; and according to the nature of that effect the further administration is to be regulated. Some patients will require doses of 3i; and it is better to produce an anæsthetic effect by 3iii given in the space of two hours than by 3i given singly.

8. The effects of chloral are continued beyond the period of completed parturition, and the repose experienced by the patient after her labour is one of the favourable circumstances to be noted in considering its application to child-birth.

9. Any stimulating effects, in the form of general excitability, occasionally observed during the administration, have passed away very rapidly.

10. Chloral not only does not suspend, but rather promotes uterine contraction by suspending all reflex actions which tend to counteract the incitability of the centres of organic motion.

11. Labours under chloral will probably be found to be of shorter duration than when natural, for unconscious contractions appear to have more potent effects than those which are accompanied by sensation of pain.

12. Experiments are required in order to determine whether there exist the same antagonism between ergot and chloral as is known to exist between strychnia and chloral.

13. The general conditions under which chloral is to be administered are the same as those which regulate the administration of chloroform, and the rules laid down by Sir James Simpson in connection with this subject must be rigidly adhered to.

#### SUBNITRATE OF BISMUTH IN CHOLERA INFANTUM.

In *The American Practitioner*, W. Walling, M.D., gives the following account of this remedy: Having had satisfactory success with subnitrate of bismuth in the treatment of cholera infantum, I am induced to submit the results of my experience to my professional brethren. In private practice and in the Western Dispensary of Louisville, I have had an opportunity of treating thirty-three cases of this disease during the past season. In the first case in which I prescribed the bismuth vomiting was intractable, and it was this symptom which led me to make trial of the remedy. The effect was prompt. Not only was the retching arrested, but with it all other symptoms were relieved. Since then I

have used the bismuth to the exclusion of all other internal remedies, except occasionally in malarial cases the sulphate of quinine. I prescribe it in doses of ten grains to a scruple, repeated every second hour, until relief is experienced. I direct it to be given in the mother's milk, recently drawn; or, if the child is not at the breast, in any article of food it may be taking.

The shortest period in which I have arrested the disease with this remedy is seven hours, or after the administration of four doses. The longest time that I have had a patient under treatment with it was three days. The average duration of the thirty-three cases was fifteen hours.

I have enjoined, in all cases, abstinence from all articles of diet but milk, and have directed this to be given in small quantities and at regular intervals.

Of the thirty-three cases which have fallen under my care this season, not one has had an unfavourable termination. In some the symptoms were violent. In a number the hygienic circumstances surrounding the little patients were exceedingly unfavourable.

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RETRACTED NIPPLE.—At a meeting of the Boston Obstetrical Society in October, (reported in the *Boston Medical and Surgical Journal*), Dr. Lyman related the case of a woman whose nipple was so poorly developed as to be apparently on a level with the breast. After the confinement the breast could not be evacuated; the consequence was an excessively troublesome abscess. In her next pregnancy the plan was adopted of breaking off the neck of an ordinary wine bottle (with smooth lips), and binding it on to the breast in such a manner that the circular rim of glass pressed upon the areola around the base of the nipple. This was done for ten days preceding confinement and the result was most satisfactory. Not only was a deep circular depression made around the nipple, but the latter became more elevated; and the success of the experiment was established by the ease with which the child, when born, accomplished the act of sucking.—*Medical and Surgical Reporter*.

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## Materia Medica and Chemistry.

### THE ALKALINE SULPHITES AND HYPOSULPHITES.

Extract from a Lecture Introductory to the study of Diseases of the Skin, by  
Dr. McCALL ANDERSON.

Some years ago Polli of Milan made experiments with the sulphites and hyposulphites of potash, soda, and magnesia. Having proved, by ex-

periments—"first, that sulphites, when administered to a living animal are carried, *as such*, into the circulation, and diffused all over the organism without the slightest inconvenience to the animal; and, secondly, that the presence of these salts in the liquids and solids of the body retards the putrefactive fermentation for a very considerable period:..... he took two dogs of about the same size, and equally in good health; he fed them exactly alike for five days, with the exception of administering to one of them two grammes of sulphite of soda daily—the other dog getting exactly the same food, minus the sulphite. At the end of five days he injected into the femoral veins of both animals one drachm of pus taken from a foetid abscess occurring in a broken down constitution. The operation in both cases was carefully performed, and the animals suffered but little. Immediately after the injection both dogs appeared stupefied; they lay down and refused all food, remaining quite prostrate for twenty-four hours. On the following day, however, they both seemed a little better and took some food. A second injection of pus was now practised on both animals to the same amount, but the first dog had, the meanwhile, been getting two grammes of sulphite daily, while the latter was only getting plain food. The effect of the second injection was most interesting; both the dogs were affected instantly alike; both were seized with stupor; in both the pulse was rapid but feeble, while the respiration was greatly accelerated; both dogs refused to eat; both lay down in a state of stupor; and, when made to rise and walk, they tottered and reeled across the room. The first dog, however, continued to receive daily, a dose of two grammes of sulphite of soda, and in four days was so far recovered as to be able to eat his food with relish, while the wound in the femoral vein was rapidly healing. The other dog fared differently; he got no sulphites either before or after the operation, and the result was that he daily became worse; the wound in the thigh became gangrenous, the limb swelled up, and ten days after the second injection the dog died, with all the symptoms of typhus; the first dog being already about and well."\*

One other experiment may be mentioned. Polli "took two large dogs, as similar as possible both in size and health, and, having administered to one of them eight grammes daily of sulphite of soda, he injected into the femoral veins of both dogs three grammes each of the muco-purulent discharge obtained from the nares of the same glandered horse which had served for a previous experiment. The first dog, which had received the sulphites, seemed at first to suffer the most from the injection. It at once fell to the ground as if stunned, and its breathing was rapid and panting; but in a few hours it began to recover, and the following day it was able

\* Dublin Quarterly Journal of Medical Science, Vol. XXXVI., p. 470; article by Dr. De Ricci.

to eat. The second dog bore the operation better, and did not appear to sustain so severe a shock; but on the following day it began to mope, towards evening it was very drowsy, and with difficulty it could be got to stand; by the third day the animal's extremities had become œdematous and painful; by the fourth a purulent discharge was running from its nose and eyes, and the wound in the thigh was now almost gangrenous. On the fourth day the animal died, worn out by pain, fœtid suppuration and diarrhœa. The first dog was by this time completely recovered.\*

For further details I must refer those who are specially interested in this subject to Dr. De Ricci's paper, and Professor Polli's work "On the Use of Alkaline Sulphites in the Treatment of Diseases depending on Morbific Ferments."

Acting upon these data, and believing that impurity of the blood lies at the root of those cases of recurrent furunculi in which no local or special constitutional cause can be detected, I made a trial of the hyposulphite of soda in this complaint; and in some instances I was surprised at the result, as in the following case:—

"A young man of good constitution, but who for some months had suffered from a series of boils, appearing principally upon the legs, came for advice to the Dispensary for Skin Diseases. The complaint had not moderated in the least when I saw him; for the furunculi were coming out in rapid succession. I prescribed for him half a drachm of the hyposulphite of soda, thrice daily, in water: and from that day he never had another boil."

Before giving the medicine we must take inquiry as to the condition of the general health, especially as to the state of the bowels, which are frequently constipated, and correct any derangement which may be present. It should be given largely diluted, as in the following prescription:—Hyposulphite of soda, an ounce and-a-half; simple syrup, one ounce; cinnamon water to twelve ounces. A table-spoonful in a large wineglassful of water thrice daily, on an empty stomach.

Dr. De Ricci prefers the sulphite of magnesia for internal administration; "because it is not so unpalatable, and is less likely to produce diarrhœa; and because in consequence of the atomic weight of magnesia, it contains, bulk for bulk, more acid than the soda salt." He cites a case of chronic pemphigus in an old gentleman over eighty, in which the external use of a saturated solution of sulphite of soda, and the internal administration of the sulphite of magnesia, had a remarkably beneficial effect.\* It appears, then, that the alkaline sulphites and hyposulphites are of value in the treatment of some diseases of the skin; and that they are deserving of a more extended trial than has heretofore been accorded to them.

\* *ib.*, p. 407. † Dublin Quarterly Journal of Medical Science, vol. xlii., p. 363.

# Canada Medical Journal.

MONTREAL, JANUARY, 1871.

## THE BODY SNATCHING CASE AT LACHINE.

A great deal of unnecessary publicity has already been given by the sensational press of this city to this *cause célèbre*, and after columns of maudlin bunkum have been set and printed and read by the million, it has been established that some person or persons, known or unknown, have done the good people of the village of Lachine out of one hundred and twelve dollars. This is virtually all that the public have ascertained from the effusion of printers ink which has been expended in this case, and this is all the public ever will know. Further deliberation, if it does occur, between the parties will be conducted with closed doors, and even the inquisitive reporter or correspondent of the press will be left out in the cold. We wish him no special harm, nor do we invoke on his head a blessing or a curse, but *en passant* we must say that we do not admire the style of articles published by some of our daily papers. They are mawkish, flippant and not in keeping with a respectable and high toned journal.

Now with regard to the so-called outrage, we approach the subject with regret and full of sympathy, and at the same time we would point out a remedy which would, if faithfully carried out, put a stop once and forever to a repetition of such scenes. We in Canada have always believed that we are a law-abiding people, we pride ourselves on being so, and as compared with other communities we are so. There is a law on our statute book which is being constantly set at defiance, and that is the provision of the anatomy act passed by United Canada in 1844. By the provisions of this act all paupers dying in any poor house or hospital, receiving Government aid, or gaol, shall remain in the dead house of that institution for a certain number of hours; if at the expiration of that time the body remains unclaimed by *bona-fide* relatives or friends, the authorities of the institution are required to inform the inspector of anatomy, who shall hand over the body to any school in the vicinity for the purposes of dissection. The law recognises the great necessity of fostering the study of anatomy, and in doing so provides

an ample supply without in any way outraging the feelings of any class.

There are, however, unfortunately corporations and communities which afford aid and succour to the poor, who systematically send for burial all the paupers who die in their poor-houses. We have two large hospitals in Montreal, and from one of these institutions no pauper dead are ever handed over to the inspector of anatomy for the purpose of dissection. These institutions have each a full staff of medical officers, men who freely sacrifice the best hours of each day in the gratuitous performance of their duties in attendance on the sick poor. And all that these gentlemen ask, in this connection, is that the anatomy act be carried out faithfully. Why should the good ladies of the Hotel Dieu Hospital indulge in maudlin notions about the desecration of the dead? Have they not sufficient confidence in the common sense of their medical staff to know and feel sure that no such desecration is permitted in any well ordered school of anatomy? Are they not aware of the fact that the remains of the dead after dissection are carefully collected, placed in coffins and buried in consecrated ground?

But will some of these ladies, who are acquainted with the manner in which these matters are managed abroad, call to mind that in Paris the Government insist on the bodies of all persons dying in public Hospitals, being given over for the purposes of anatomy; what is the consequence? that Paris is the school to which all surgeons, who can afford it, both French and Foreign, resort for the purpose of completing their education practically, and furthermore that such a thing as robbing a church yard, or breaking into a vault, let alone taking the bodies therefrom of "persons belonging to a religious order," is a crime unknown in the Modern Babylon.

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#### SIR WILLIAM LAWRENCE AND CHLOROFORM.

The *London Lancet* tell us that, at a meeting of the Edinburgh Royal Society, Prof. Christison made some remarks on the discovery of chloroform, which illustrate how nearly Sir J. Y Simpson was anticipated in his introduction of this anæsthetic into practice. In the summer of 1847, a few months only before Simpson's discovery was announced, Lawrence had repeatedly used in practice an anæsthetic which came recommended to him under the name of chloric ether; and while he and his assistant were busily contriving how to concentrate their chloric ether, not recognizing the fact that it consisted merely of chloroform dissolved in rectified spirit, Simpson's discovery came forth and put a stop to their inquiries.



## A NEW METHOD OF DELIVERING THE AFTER-COMING HEAD IN CONTRACTED PELVES.

In arrest of the head at the brim in original breech cases, or after version has been resorted to, Dr. William Goodell (*American Journal of Obstetrics*, November, 1870) advises the following method, which he has repeatedly found successful. After grasping the neck and ankles of the child, the first movement of traction is to be made in the direction of the axis of the *outlet*, in order that the sacral side of the head may descend and be nipped by the promontory at the highest point possible. This manoeuvre lengthens the lever-arm, represented by a line drawn from the base of the skull to the point nipped by the promontory. Without for a moment relaxing the traction-force, its direction must now be changed to that of the axis of the superior strait, by firmly pushing the child's body backward upon the coccyx. Thus, the gain in the leverage will cause the pubic side of the head not only to glide more readily over the smooth under surface of the pubic symphysis, but also to describe a shorter arc of a circle around the promontory as a centre of motion. After the extrication of the head from the brim, the line of traction must be accommodated to the curve of Carus. Great advantage will be gained if an assistant makes firm pressure upon the vault of the child's head through the abdominal walls of the mother.

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### HOLT'S OPERATION FOR STRICTURE OF THE URETHRA.

In a communication to the Medical Society of London, November 14, 1870, Mr. J. D. Hill (*Lancet*, December 10, 1870) gave his experience in the treatment of urethral stricture by rupture. He had submitted one hundred and twenty patients to the operation, of whom two, the subjects of organic disease, died. His conclusions in reference to the procedure are as follows: that the operation is the most satisfactory method of treating any form of organic urethral stricture which is amenable to dilatation, and, with careful attention to preliminaries, there is no more risk in its employment than in ordinary catheterism; that when the latter is followed by bad symptoms, then Holt's operation is contra-indicated.

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### TREATMENT OF ENLARGED TONSILS IN CHILDREN.

Dr. James Martin states (*British Medical Journal*) that an eminent Dublin practitioner finds the sulphate of potassa, administered daily for a month or six weeks, almost a specific for enlarged tonsils in children. From five to fifteen grains are given every morning, with a small quantity of rhubarb and aromatics. The dose should produce mere laxity of the bowels, and must be diminished if it causes purging.