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THE MANAGEMENT OF ABORTION.*

By DR. R. W. POWELL,
OTTAWA.

IT is not my intention to launch out into some startling developments as to the management of abortion on such an occasion as this. Indeed, I would not deem it consistent with my present object in introducing this subject for your consideration in this discussion to deal with it in any other manner than the purely orthodox.

To such an audience as this, I am quite aware that I need not attempt any flights of fancy, nor do I flatter myself that I can advance any ideas as to how abortion should be managed that are not perfectly familiar to you all. All I hope for and all I ask is to have the privilege accorded me by your committee to introduce the subject to your favorable notice, knowing its great importance to us all as everyday general practitioners. I feel persuaded that those gentlemen who are to follow me will give me due credit for dealing with the subject in a general way, so that they will in no wise be hampered in dealing with any branch of it from their own point of view.

*Read at the meeting of the Ontario Medical Association.

First, in what way shall we deal with a woman who has shown a marked tendency to abort, or who, let us say, has not yet succeeded in bringing her offspring to maturity? This is a wide field, and affords ample scope for any man's pen; but I must ask you to be content with a brief survey of this branch of the subject.

It is admitted that, among general causes, syphilis stands out prominently as a cause of abortion, and it would appear that in such cases, so long as the poison is active, just so long will the uterus show a disposition to get rid of its contents. I am of opinion that an ovum diseased in this manner is the irritant which brings on the uterine contractions, due, no doubt, in some cases, to its premature death, and in others to the diseased blood circulating in the vessels of the uterine wall rendering the muscle unhealthy, and thus unfit to retain the strain put upon it by the development of its contents.

This, to my mind, is a fortunate provision of nature against the maturing of unhealthy offspring. It is in such cases as these that mercury has shown some of its greatest triumphs. I need not dwell on the course that ought to be pursued, excepting to guard you against always directing treatment to the mother, because it is undeniable that the male parent being a syphilitic may deposit the poison in a healthy woman, or perhaps I should say impregnate her with deteriorated semen, and so bring about the disaster above referred to.

Diseases and unhealthy conditions of the uterus itself are common causes of abortion, but fortunately we find in actual practice that they are equally likely to prevent impregnation occurring. Such causes as endometritis, parametritis, endocervicitis, with its attendant albuminous-looking plug of tenacious mucus blocking the canal and affording an effectual bar against pregnancy, fibroid disease, malignant disease, and that well-known condition of everted and patulous os, owing to a split cervix from former pregnancy, with perhaps an instrumental delivery. Malpositions come in for their fair share of blame, and in some cases rightly so. I need, however, only dwell for a moment on the retroversion and severe retroflexion which, for mechanical reasons, manifestly interfere with the progress of gestation. It is here that we can the most readily succeed by placing the woman in the knee-elbow position and replacing the uterus, retaining it there by a well-fitting pessary till the third month is completed; then, in most instances, it ought to be removed, as it often irritates the vagina if left too long, and besides, by the time mentioned, the fundus has risen out of the pelvis and no longer needs the support given by the pessary.

In the conditions above mentioned as causes, appropriate treatment will have to be rendered. Repeated abortions will sometimes occur in young married women, or, as I have known it, begin to occur after a wo-

man has borne one or more children at full term. This is known as a "habit of aborting," and is often most rebellious, even to well-directed treatment.

Whatever may have been the cause of the first case, we can only conclude that the endometrium has not regained its pristine condition, and is not capable of nourishing the ovum, or perhaps of retaining it. In a large number of instances, I am satisfied that this is due to that notorious pathological condition known as subinvolution.

While it is true that pregnancy offers the only hope of cure for this condition in a vast majority of cases, yet in the case we are now considering of repeated abortion it is this very thing, oft-repeated pregnancy, which is so much to be deplored, because sufficient time is not given for the uterus to regain its normal nulliparous state, and the waning strength of the patient from possibly repeated hemorrhages and constant illnesses is a prime factor in preventing proper and normal involution. Attacking this unhealthy endometrium by swabbing the uterus out with some moderate escharotic is followed by the best results in some cases; accompanied by change of air and scene, seaside resorts, an ocean voyage, moderate exercise and plenty of fresh air and good stimulating food, and, above all, a complete daily evacuation of the bowels in order to prevent vascular stasis in the pelvic organs, and to promote in them a healthy nutrition. All these must be tried and persevered in. With all this, if the patient remain at her home, absence of sexual intercourse must be insisted on for six or eight weeks.

In that other class of cases where no good cause can be assigned, but still the fact remains, we must be guided solely by general and common-sense principles. The nervous system seems sometimes to be at fault. It is here that rest is followed by the happiest results—rest on the back for an hour at a time, at intervals; but, more than all, complete bed rest for some days at the menstrual epoch is demanded, with such other means as will lead to diminish a special irritability, if such a cause is suspected.

What steps shall we take to avert a threatened abortion? The cardinal symptoms indicating this event are hemorrhage and grinding pains, often at first referred to the sacral region, and, later on, occurring in the hypogastrium.

It is true that abortion may happen without both these symptoms existing together, and hence if in a known or suspected case of early pregnancy only one of these symptoms presents itself we may at once place the patient on her guard, and prescribe at least one very important line of treatment, viz., perfect rest in bed on the back. It is quite impossible in most cases to determine whether the ovum is dead or not, and yet if we can once feel assured that it is our line of treatment must be quite different from that we would pursue if the case is one of slight separation of the decidua; be-

cause in this latter case we may properly, and with good prospect of success, hope to arrest the process that is going on, while in the former we ought to encourage its expulsion.

In the cases of repeated abortion where we know how readily the uterus expels its contents, the slightest show of blood-stained discharge must be regarded as the danger signal; albeit we are aware how many pregnant women lose considerable quantities of blood without apparent inconvenience, or without in any way interfering with gestation.

Complete rest in bed on the back must be enjoined, and avoidance of all excitement; plain, easily-digested food allowed; and the exhibition of those drugs known by experience to diminish uterine irritability, and generally to prevent muscular contraction. We have in opium a powerful means for fulfilling these indications, and it is well known how great a tolerance there exists in these cases for the drug. It is therefore to be given in full doses, and repeated sufficiently often to keep up its effect. Solid opium, morphia by the mouth or hypodermically, laudanum per rectum or in mixture, and also suppositories, may be used in such a case, at the discretion of the practitioner. *Viburnum* also has been highly lauded; pot. bromide is often very useful. These measures frequently avail to stave off the abortion, and if they do we should insist on the patient remaining in bed a week at least after the symptoms have entirely disappeared, and to resume her ordinary mode of life and avocations gradually, and with care to avoid all those causes which tend to a recurrence of the symptoms. Sexual exercise must be prohibited for a time. I regard this as imperative, and I am satisfied that by being indulged in it is constantly the cause of a recurrence of the symptoms after a successful treatment on the lines above indicated.

If in spite of treatment the symptoms persist or increase, as shown by greater and more frequent pain, increase of discharge containing clots, and accompanied by amniotic fluid, and on examination we find a soft, patulous os with a dilated cervix, and perchance the presentation of a soft mass of membranes therein, we may conclude that the abortion has become active, as distinguished from threatened; and while it is true that such cases have often been known to become self-arrested and pregnancy continue uninterrupted, yet the rule is that abortion occurs, and our treatment ought to be directed towards effecting that result.

How do we conduct a case of actual abortion? The great desideratum is to secure the throwing off of the ovum with its membranes entire. This once assured the treatment is, in a large majority of cases, very simple.

In primiparous cases my experience has led me to regard the "let alone" policy as the wisest, as in them we rarely find hemorrhage excessive, owing to the slow dilatation of the cervix and the complete manner in

which the ovum fills the canal, thus affording the best safeguard against undue hemorrhage. It is nature's tampon. If the pains are regular and good, nothing is demanded except rest in bed. I am not in favor of even vaginal douches in such a case, unless the lochial discharge is offensive, and then I favor weak solutions of permanganate of potash in boiled water, and a good pad of sublimate jute to receive the discharge. If the pains are not good, then the exhibition of a good preparation of ergot will assist matters. It is important to secure the expulsion of the ovum as quickly as possible, because the longer it remains *in utero* the greater the disintegration of the membranes and the formation of septic fluids, and consequently of their absorption through the veins and lymphatics in the vicinity. It is notorious, however, that the process of expulsion in these cases lasts often several days. Even so, if the lochia remains of good quality and is not offensive, and the patient's temperature remains normal, or nearly so, with a pulse under one hundred and no chills, I am entirely opposed to active interference in any manner as regards the removal of the ovum. Any interference will militate against what I began by saying was the great desideratum, viz., the discharge of the ovum entire.

In cases where the hemorrhage is excessive, and is coming away in clots, and especially where the patient is multipara, the vaginal tampon, properly applied and tucked well around the cervix, is a useful means of assisting the process of dilatation. It likewise, by preventing the continuance of hemorrhage, allays the patient's fears. It saves much valuable time to the practitioner, and when the patient lives at a distance is necessary to ensure her safety. I know of few more comforting and consoling moments than retiring to rest after an anxious hour or two towards the mystic hour of midnight leaving a vagina comfortably packed with an aseptic tampon, and giving a promise to call in the morning.

A different picture is presented to us when the amniotic sac ruptures and the ovum is discharged minus the decidua. It is here that our judgment, experience, and patience are often severely taxed. To control the hemorrhage, which is usually severe in these cases, I am in the habit of administering gallic acid and ergot, combining a little morphia and spirits of chloroform with it if the pains are severe and hard to bear. The morphia allays the acute character of the pains, while it does not altogether arrest them, and, if the cervix is not yet dilated, no good can accrue by permitting undue suffering, and until it is dilated we cannot expect the ovum to be discharged. This I say in defence of the addition of any preparation of opium to the mixture, which, according to my previous remarks, would be contraindicated when the abortion is inevitable. The tampon I have found to be a useful measure in these cases, as limiting the hemorrhage, and, I believe, promoting dilatation of the cervix; but it ought

to be changed every four or six hours, according to the severity of the pains and the amount of the hemorrhage. Many a time have I pursued this course, and on the removal of the second or third tampon found the decidua wholly discharged and lying in the vault of the vagina, to my entire satisfaction and complete peace of mind. The case, however, does not always pursue this amiable course; the bleeding persists, the patient is getting weaker, the pains are diminishing, and still the decidua remains *in utero*, and no doubt are the direct cause, by their incomplete separation, of the continued and often alarming hemorrhage.

What are we to do? It is plain we must interfere and effect their removal. My own partiality is for the index finger. It is a natural curette, if it is clean, with a sentient surface at one end, and connected at the other with an educated brain. It is freely movable at will, and altogether is admirably adapted to scoop out the cavity of the uterus; but, alas! sometimes it is too short to fulfil its functions.

The description we read in books as to the facility with which we can scoop out the uterus with the finger is all nonsense. We are told to insert it up to the internal os, then to go up one wall clearing it off, then across the fundus from one corner to the other, and, finally, down the opposite side, sweeping everything in its path. The grand result of this often corresponds to the "Frenchman and the Flea": "You put your finger on it, and it's not there." Still, it is a useful act, and in a soft, patulous cervix with yielding abdominal walls, and patient who wont resist you all she knows how, it often succeeds, and we are rewarded with a handful of membranes and a rapidly ceasing hemorrhage.

I do not think much good occurs from immediately washing out the uterus, as is so often advised. Such, at all events, has not been any practice unless the character of the discharge demands it. An offensive discharge, a chill and a rise of temperature following the abortion, would indicate to me that a douche and an intra-uterine one was demanded. So far I have favored the carbolic acid and permanganate of potash for this purpose. I have not used peroxide of hydrogen for this purpose, but its excellent reputation as a destroyer of germs and pus points to it as a valuable means of effecting the object we have in view. I have not spoken of the curette or the placental forceps as a means of removing the contents of the uterus, because they are only means of effecting the same purpose for which the finger is used. In many cases, they are an unfortunate necessity. In all cases they must be used with great care and skill; and in some cases they are positively unjustifiable.

I forbear to speak of the result of neglected abortion. The subinvolution, the leucorrhœa, the menorrhagia, the sacral pain, and the general malaise and the invalidity unite to compose a picture often the result of

crass ignorance, or, what is more to be deplored, gross carelessness, on the part of some one ; yet nevertheless a field full of honor, of good will, and of handsome fees, reaped with zeal into the gainers of our everlasting friends, the gynecologists.

(TRANSLATION.)

LITHOPÆDION.

Report of a case presented to the Berlin Medical Society,

BY DR. GOTTSCHALK, BERLIN.

Translated by

W. LEHMANN, M.B.,

Physician to House of Providence and Home for Incurables.

THIS child, which I removed this afternoon from a fifty-four-year old patient by laparotomy, was carried by its mother for thirty years. The mother menstruated first at fifteen, was married at twenty-one, and at twenty-two gave birth to a daughter, who died two years ago of tuberculosis. The second year afterwards she again became pregnant, and went on in the usual way without any abnormal symptoms until the end of the term, when pains came on and lasted several days, without making any progress towards delivery. Dr. Rudolphi, of Neustrelitz, who was called in, found the abdomen so distended that he could not at once make a diagnosis ; but the pains continuing and becoming stronger and stronger, and the os not dilating at all, he concluded that it was a case of extra-uterine pregnancy, and laparotomy in those days, thirty years ago, being very little thought of, he left the patient to her fate. Nature, however, came to her assistance. She was confined to bed for eighteen weeks with a severe attack of peritonitis, with repeated chills and high fever, but she recovered, and menstruated regularly again until the menopause, which occurred at fifty years of age. She said that so long as she wore a bandage which held the child back well in the abdominal cavity she experienced very little trouble. About two years ago, as a result of a severe bodily exertion, the child seemed to suddenly sink lower in the abdomen, and from that time she began to have difficulty with her urine, and other symptoms of pressure in the pelvis. The physician in attendance said that the head, which previously lay in the left iliac region, had now descended partly into the pelvis. He ordered a bandage, which gave very little relief, but it was found that suspending the patient head downwards caused the child to slip back to its old position in the

abdominal cavity, and gave relief of the troublesome symptoms. This plan of treatment, which always gave relief, lasting from one to two weeks, was kept up until a few months ago, when this natural and rational method failed ; the child could not be got back out of the pelvic cavity, but sank deeper and deeper, and the incarceration symptoms, especially of the urinary bladder, became rapidly worse, and the patient was sent to me for operation.

I found the patient in an extremely reduced and weakened condition, the pelvic cavity completely filled by a bony-hard tumor, which plainly had the configuration of a child's skull. The sagittal suture was in the right oblique diameter, and the posterior fontanelle could be felt anteriorly and to the left. The occiput rested immediately behind the symphysis, deep on the floor of the pelvis, the position being just what one might expect in the second stage of normal labor, except that the head was not in the vagina. The uterus was small, and lay pressed against the hollow of the sacrum. The tumor extended upwards into the abdominal cavity as far as the umbilicus, and could be felt through the atrophied abdominal wall as a bony-hard, irregularly shaped tumor, broader above, and with dull projections on both sides a little below the umbilicus corresponding to the extremities. The diagnosis after this finding was clear. An attempt under anæsthesia to push the head back out of the pelvis failed, and the miserable condition of the patient, together with the danger of gangrene of the bladder from pressure, urged the necessity of a laparotomy.

When the abdominal cavity was opened, the surface of the tumor was found adhering very extensively to the parietal peritoneum and omentum, and after these had been loosened partly by the fingers and handle of the knife, and partly by the use of the scissors, very extensive adhesions to the intestines, bladder, and pelvic peritoneum were also found ; but by adding a cross incision to the usual longitudinal incision in the abdominal wall more room was obtained, the adhesions were removed, and by the help of the assistant's hand in the vagina the tumor was elevated out of the pelvic cavity. It was then found to be connected to the uterus in the same manner as an ovarian tumor. It was attached to the posterior surface of the ligamentum latum, and to the ligamentum infundibulo-pelvicum. It was torn from its attachments by lifting it out, and in consequence there was profuse hemorrhage—which could only be stopped by extensive ligaturing—from the gaping spermatic vessels and from the posterior surface of the ligamentum latum, which was here very vascular. The spermatic artery was almost as large as the iliac. The ligamentum ovarium and the long distended unchanged tube extended upwards and outwards to the place of attachment of the tumor. The uterus was pressed flat and twisted, and from its anterior surface strands of connective tissue extended to the

bladder. The appendages of the right side were perfectly normal, but the left ovary was entirely wanting. The patient has recovered well from the shock and exhaustion of the operation, has a good pulse, and I look for a favorable termination.

[Supplement by the proofreader: The patient has made a good convalescence, perfectly free from fever.]

That this was a case of ovarian pregnancy is proved to a certainty by a close examination of the specimen. You see the tumor, covered by a thin membranous enclosed sac, which is firmly adherent to the several millimeter thick calcareous layers lying underneath. I have partly prepared this membrane. You can see with the naked eye different corpora lutea, which are pressed flat, and therefore appear very large. You can also make out several individual follicles. It is therefore doubtless that the whole ovum lies enclosed in an ovarian sac. You see here on the one side also the second stratum, the calcareous layer being dissolved away, and you will find on the inner surface still the placenta with the vessels beautifully preserved. You can also see the membranes starting out from the attachment of the placenta. This condition of the placenta also goes to prove that it was a pure ovarian pregnancy. The child itself is, as you see, well preserved; the skin of the extremities is partly encrusted with calcareous matter; the hair of the head and finger nails are very plainly visible. It lies in extreme flexion; the spinal column and head flexed *ad maximum*. In these days, when every extra-uterine pregnancy is looked upon as a dangerous neoplasm and immediately operated upon, one very seldom has the opportunity of seeing cases of this kind. It is interesting to see how nature, in such cases, can bring about a cure, and we also see how, after thirty years, unhappy conditions can arise which make a laparotomy necessary. Pure cases of ovarian pregnancy like this have only very seldom been observed. The lithopædion weighs nearly five pounds.

DISCUSSION. Herr Hahn: I operated on a case of lithopædion several years ago which also had been carried by the mother about thirty years. It was interesting, as was also the Wurzburger case described by Virchow, and which had been carried thirty-two years, because it could be microscopically proved that the muscles were completely preserved. One could make out the transverse striation very plainly in most of the muscles, and in other organs also lying under the petrified layer individual parts, as bone, intestine, etc., were so well preserved that they could be demonstrated microscopically as such.

Selected Articles.

OPERATIONS TO PRESERVE THE UTERINE APPENDAGES.*

By W. M. POLK, M.D.,

Professor of Obstetrics, Diseases of Women and Children, University of the City of New York ;
Gynecologist to Bellevue Hospital ; Obstetrician to the Emergency Lying-in Hospital.

THE first case presented to-day will probably afford an opportunity to demonstrate a procedure with which many of you are no doubt familiar, namely, the enucleation of a cyst from an ovary, leaving the sound portions of the organ. Those of you who have been here for the past two years are familiar with the reasons for the attempt to preserve the sound portions of diseased ovaries when it is feasible, and you have had many opportunities of witnessing from your seats in this amphitheatre the various steps required in such an operation. The principle involved in the attempt to preserve ovarian tissue lies in the belief that among women in general, especially the young and those who are married, ovulation is essential to their mental and physical well-being, and therefore an attempt is proper, in appropriate cases, to preserve as much of the ovaries as is compatible with safety to the patient's life.

The objection has been made that these operations are unjustifiable, as they seem to tamper with the life of the patient ; but you must not forget that the mortality of abdominal section, in the hands of a competent operator, is to-day reduced to a point which makes the procedure one of so little risk that the above criticism is robbed of much of its force. We will not attempt to discuss this bearing of the question here, however, but shall proceed at once to the operation.

Section, in this case, has revealed to us two ovaries, each containing a cyst, one as large as a lemon, and the other as large as a pigeon's egg. Under the usual methods of procedure, both these organs would have been removed ; but you saw the ease with which the cysts were opened, their contents evacuated, the sac wall removed from its bed, the defect in the organs corrected, and their return to the abdominal cavity. In order that you may understand what was done, I will describe the procedure in detail. First, as to the anatomy of the structure in question : These cysts were single, there, fortunately, being none other in either organ. Their composition being identical, what is said of one applies equally to the other.

* Clinical lecture delivered at the Bellevue Hospital, New York.

Taking the larger one, we find from without inward that it has its peritoneal covering, then the tunica albuginea, then the sac proper, which corresponds, no doubt, here to the epithelial lining or membrana granulosa of the Graafian follicle. Be that as it may, however, the lining membrane is the essential structure in the development of the cyst. It is to that, then, that attention should be chiefly turned. Before speaking, however, of its enucleation, it is proper to call attention to the blood supply, because upon the management of the bleeding points which occur in connection with such enucleation depends, in a measure, the success of the whole operation. The vessels that are concerned are those which lie just outside the membrana granulosa, consisting of the tunica propria in the normal follicle. They are branches of the ovarian vascular system, and run from the bottom of the sac upward and outward, to be distributed over the surface of the cyst. They can be secured, however, by ligatures, passed, if need be, on needles.

In this case, the course pursued, as those nearest will easily see, was—first, the ovary and cyst were withdrawn from the abdominal cavity intact, the pedicle being long enough to permit of it, an incision then made directly into the cyst, and its contents—the straw-colored serous fluid—evacuated. The cyst wall was then seized with a pair of hæmostatic forceps and separated from the outer linings; then, with the assistance of the finger, it was easily enucleated, all parts of it being removed. This left a considerable area of peritoneum and tunica, upon the inner surface of which were numerous bleeding points. The expanded structures were cut away near to the level of the ovarian surface proper; the bleeding points in the cut edge were then secured, and the edges of the opening, which now remained in the ovary, brought together by means of a Lembert suture. This bringing together of the peritoneal surfaces of the base of the cyst, and turning in the cut edges in such a way as to fill up the hole in the ovary, is an important step. The procedure, as you see, is comparatively simple, and when conducted in the manner in which it was performed in this case—outside the abdominal cavity—occupies but little time.

In the case of intra-ligamentary cysts, the method of procedure begins with the enucleation of the ovary from its position in the folds of the broad ligament. It is best, therefore, in these cases, to make our primary incision through the peritoneal covering, then enucleate the ovary proper from its embedded position, bringing it as near the surface as is possible before beginning with the enucleation of the cyst. Having opened the cyst, however, the method of procedure in all cases is the same—that is, first, removal of the cyst wall; second, cutting away all excess of tissue which had been thrown around the cyst proper, the securing of bleeding points, then inversion of the cut edges, so as to leave a smooth and as

natural a surface as possible for contact with the surrounding peritoneal surfaces.

Some one asks the question as to the likelihood of other cysts appearing at a later period in these organs. It is to be confessed that the precise determining cause of the cyst, in any one instance, has not yet been clearly defined. In general, however, I think we are justified in believing that a peritoneal inflammation, brought there, as it so often is, through the tubes, is the starting point. The ovary, in common with structures near the end of the tube, becomes involved in the inflammation; and while the acute phases of the disorder may subside, yet such damage is wrought in the ovarian stroma as to initiate changes which, at a later period, show themselves as these cysts. It is fair to assume that if cysts are to be developed in an ovary, they will show themselves at about the same period of time. If, therefore, we have an ovary that shows but one or two or at the most three cysts, I believe we are justified in feeling that, with the removal of these cysts, the remainder of the organ is reasonably secure. Be this as it may, so much importance do I attach to the preservation of ovulation in most women, especially the younger married women, as has already been said, and, on the other hand, such is the relative safety of abdominal section in educated hands, that to preserve the one I should not hesitate to advise risking a repetition of the other.

You have seen this and similar operations in this amphitheatre since your entry into this institution, two years ago, as since 1884 it has been the custom, as a matter of clinical routine, to perform abdominal sections before the class. With the erection of the present amphitheatre, on an average two abdominal sections a week have been performed before the class during the college year, and in all that time, since 1884, but one of these patients has died, and that one from hemorrhage.

PYOSALPINX.

This patient reports to us to-day in order that we may determine the result of an operation performed upon her one year ago in this amphitheatre. A reference to the case-book shows that it was an instance in which the outer extremity of the tube, which was distended with pus to the size of a pigeon's egg, was amputated just inside the dilated portion, the ovary being undisturbed. In other words, the case was one of pyosalpinx. Prior to operation she had suffered from the characteristic symptoms of recurrent pelvic inflammation. At the time of operation both tubes were found to be filled with pus. The right ovary also contained pus, but the left was free from it. We removed the right tube and ovary in the usual manner, but upon the left side simply removed the dilated portion of the tube, the pyosalpinx proper.

The patient made, as you see, an excellent recovery, and now, at the

end of a year, returns to report her condition. Before speaking on that point, however, I have a word to say concerning the method of determining the presence or absence of pus in an ovary. Wherever a pyosalpinx exists, if the process be anywhere near the acute stage, no matter whether it be an original acute process or a secondary one, there is a possibility that purulent infiltration may be present in an ovary, and yet not show itself by distinctive features upon the surface.

In a chronic or subacute pyosalpinx, an associated purulent inflammation of the ovary would be evident in the form of accumulations cystic in character, these being recognized by the enlargements which they occasion. In either instance, it having been determined to preserve the ovary, it is important to have the means of detecting the presence or absence of pus in this organ. In the case of the cyst, an aspirating needle would determine it, but an aspirating needle would not answer in the case of a diffused purulent process. Here I know of nothing except direct incision of the organ which will enable us to determine the question. In this patient the inflammatory process being somewhat nearer an acute than the chronic stage, I resorted to incision of the ovary upon the two sides, so that in stating that the right ovary contained pus, and that the left ovary was free from it, I was sure of my position. In answer to your question as to the manner of operating in these amputations of the tube, I will say that the tube is cut off, as a rule, almost opposite the centre of the ovary, although the point of dilatation may be about opposite the outer third of that organ ; it is subject to a variation, however, dependent upon the encroachments of the dilatation. In passing your ligature so as to effect the amputation, it is passed through the mesosalpinx, immediately beneath the tube, at the point you select for amputation. It is then brought around outside the tubo-ovarian ligament or fimbria, close to the ovary, and tied. This secures all the vessels passing between tube and ovary in the mesosalpinx of the amputated portion. The tube is then amputated and cut away from the mesosalpinx. The tube is thus outside the ligature. The action of the ligature, thus placed, is to draw the ovary in close relation with the cut end of the tube and place it near the uterus, securing it a good position, which, as you see, in this case has been maintained. The little bleeding which occurs sometimes from the walls of the tube is easily stopped by pressure forceps or hot sponges.

Do not for a moment suppose, gentlemen, that it is our expectation that pregnancy will be possible in this case. We aim to preserve ovulation in a young married woman, not only because we feel that in her particular case the mental effect of such a preservation is desirable, but also because in her, as in all young women, the preservation of ovulation insures preservation of the nutrition of the organs of reproduction. Atrophy,

with its attendant inconveniences, is the rule where ovulation ceases, whether at twenty or at forty. You can readily understand that such atrophy, in a case like this, would be, apart from every other question, undesirable. Menstruation in the woman has been regularly maintained up to the present time. During the first four months it was excessive; since that time it has diminished, and, while present, is less than it was under former normal conditions. As you see, the nutrition of the tissues has been preserved, and this is especially well shown in the condition and appearance of the mammary glands. The woman is in excellent health and does her daily work with comfort.

We began the operation designed to preserve the uterine appendages in 1885, at the time when the furore over the total extirpation of the appendages, even in mild forms of disease, was at its height. I well remember the first case operated upon here, and the looks of incredulity upon the faces of the older members of the class (most of them practitioners) who listened to my outline of the plan proposed, doubting not only the practicability, but also the justice of the procedure. You, however, who have witnessed the results of the work performed in years gone by may in your own work justify the teachings in this direction which have formed a part of your regular course of instruction during the past two years. In opening the abdomen in cases of chronic disease of the appendages, let me again urge upon you the propriety of making such incisions exploratory in their nature, leaving the question of removal of one or all of the appendages until after the organs have been exposed. I submit to you certain propositions which are the outcome of the work in this department which I have had the honor of conducting before you in this amphitheatre.

First, having made your incision, let the condition in which you find the ovary be the main factor in determining the question of procedure. If need be, the state of the ovary (as I have already suggested) may be determined by an exploratory incision or puncture.

Now, if the ovary contains pus, you should remove it, and with it the associated tube, my idea being that whenever an ovary is removed the tube should accompany it. If the tube contains pus, the ovary being free both from pus and from disseminative cystic degeneration, you are at liberty to amputate the tube, leaving the ovary; it being understood, however, that the patient is at liberty to demand the removal of all the appendages if she should so wish. The same general remark applies to cases of hydrosalpinx and hematosalpinx.

As you have already seen, cysts of the ovary do not, of necessity, call for entire removal of the organ. Where they may be enucleated, pursue that plan, following out the suggestions of operation as already outlined.

An ovary which is enlarged from congestion, as in prolapse, can be cured by suspension better than by removal. Tubes with the fimbriated extremity open, even though adherent and affected with parenchymatous inflammation and endosalpingitis, do not require removal, except when they open into *pūs-loculi*, as in certain cases of pelvic abscess. The tube whose outer edge is closed may be opened and cleansed, its inner and outer coats united, and then returned to the abdominal cavity, provided it does not contain pus and possibly old blood, or its walls destroyed, as in hydrosalpinx. This is a procedure which you have witnessed here time and time again, and the results, in all cases which we have been able to reach, have been such as to justify the wisdom of the procedure.

Once for all, understand that adhesions do not demand the removal of the tubes and ovaries unless they be so dense that in breaking them the appendages are seriously injured. This presupposes that the appendages in themselves are not sufficiently diseased to demand removal.—*International Clinics*, vol. iii., 2nd series.

Clinical Notes.

MUCOUS COLITIS.

By J. T. FOTHERINGHAM, B.A., M.D.,

TORONTO.

MRS. R., married, *æt.* 44, wife of shopkeeper.

Family history. Father died, *æt.* 60, of pneumonia. Mother living, *æt.* 74, stout, and in good health but for rheumatism. Six brothers, *æt.* 50, 48, 46, 36, 34, and 25, and one sister, *æt.* 40, all in fair health. One died at the age of fifteen months from a summer diarrhœa.

Personal history. As a child had measles, scarlatina, mumps, and, at the age of fourteen, diphtheria. Apart from accouchements has never had any serious illness, but has always suffered from general debility from overwork and gestation. Was married at seventeen, and has had eight children and four miscarriages. Lived on a farm in North York till six years ago. Since then husband has been a small shopkeeper. Did the usual farm work, sometimes with maids' help, sometimes without, including the dairy work for from six to twelve cows.

Present condition. Spare, "nervous," and debilitated in appearance, apparently hysterical, but very well controlled.

- (1) Respiratory system normal, except for a tendency to bronchitis.
- (2) Muscular and cutaneous systems normal.

(3) Circulation system, normal, except for the quickened pulse of debility.

(4) Genito-urinary system, normal. Began to menstruate at seventeen, and has now at the age of forty-four begun to see signs of climacteric.

(5) Nervous system, temperament is volatile and rather melancholic. Has a well-marked paralysis agitans of head, especially well seen on any excitement—dates from thirteen years ago, after a period of two years incessant care of her mother-in-law, eighty-two years old, who was completely helpless, had to be spoon-fed, and was a great worry to her. Gestation going on at the same time. Until four years ago it was intermittent, but has been since then chronic, though varying in severity.

(6) Digestive system. False teeth worn. Gastric digestion at times much impaired, diet limited to one or two articles, such as bread and tea. Appetite had been very good. Intestinal digestion—no special disorder until ten years ago, while at the fifth month of pregnancy, and during the period of anxiety referred to above in connection with her mother-in-law, aggravated by the presence of workmen engaged in house alteration, who, as usual in the country, boarded where they worked. She was suddenly one day, while engaged in soap-boiling, seized with an attack exactly like many scores of others since that time, and described as follows :

Prodromata. Vague, melancholic feelings, sense of depression, poor appetite, but no special physical signs except pain, the immediate precursor of diarrhoea.

The attack. The pain was crampy, sudden, beginning in the pit of the stomach and descending till felt mainly in the hypogastrium, when a diarrhoeic movement would occur, and the pain begin to subside. Severe depression and nausea, never leading to vomiting, were even more annoying than the pain. Every four or five minutes the need to go to stool would be imperative, and after three or four free liquid—not flatulent or fermentative—stools the paroxysm would cease, having lasted about half an hour. Within an hour or so, she always felt brighter and better than before. There was never much tenesmus, but a tenderness over the lower abdomen, and, in the patient's own words, "the first two or three stools seemed to be just the food I had taken, and the last seemed as if the bowels themselves were coming away." The final movement consisted of glaring yellowish mucus, probably bile-stained, and many varying-sized shreds of whitish membrane, flattened or roundish, one-third to one-half an inch wide, and some four or even six inches long, not unlike pieces of pork rind floating in boiling soap, to use her own simile, or portions of dead round worm from a child. The attack occurred usually near the same hour each afternoon, sometimes at night, rarely in the morning. This would seem to indicate some dependency upon the state of exhaustion,

nervous and muscular, which the patient reached in the later hours of the day. She could never associate it with meals or any irregularity of diet, but often noticed that exposure to cold would precipitate an attack. Sometimes for six or seven weeks she would have an attack at nearly the same hour every day, nutrition, of course, suffering severely. In the intervals of the diarrhoea she was constipated, and, as she says, "hardly ever had a natural movement."

Treatment. Though general treatment had frequently failed before, she showed prompt improvement when put upon an easily assimilable form of iron, one of the latter-day peptonates, with the active principles of cod-liver oil, in a menstruum of wine. She was given also, after each meal, one pancreatic pill (P.D. & Co.) with coating insoluble in stomach. After being under treatment for about two and a half months, she reports permanent recovery, intestinal digestion normal, and her diet list extended to include any of the ordinary articles of food in good amount.

The notes on this disease are but few in our ordinary works of reference. Very varying opinions have been held as to its etiology and pathology. Osler, who may be taken as representing the latest and safest opinion on the subject, says: "The cases are almost invariably seen in nervous hysterical women, or in men with neurasthenia. . . . Microscopically, the casts are, as shown by Sir Andrew Clark, not fibrinous, but mucoid, and even the firmest consist of dense opaque transformed mucus. It is due to a derangement of the mucous glands of the colon, the nature of which is quite unknown." It would seem that in this case, at any rate, since the supplying of the natural ferment artificially acted so well, the mucous secretion was disordered in some way because of the deficiency of the *succus entericus* in some other of its normal constituents. In *The Practitioner* (London) of March last, a study of a series of cases was published by E. M. Light, M.A., M.B., London, under the title "Desquamative Enteritis," an excellent contribution, with a most exhaustive bibliography appended. He states that the removal of the membranous cast shows a mucosa "denuded of superficial epithelium, but presenting no evidence of ulceration or loss of substance." He sums up the diverse opinions of writers as follows: "Trousseau says it has an inflammatory origin. Perrond considers the causations to be nervous. Powell thinks that the mucous products may be derived from the 'exhalents.' H. Bennett, that it owes its origin to its association with chronic enteritis. Golding Bird believes that the colonic follicles are the source of the membranous substances. Grantham attributes the disease to the administration of mercury and aperients, and looks upon struma as a predisposing cause. Arthur Farre believes the formation to be of a confervoid type, an 'oscillatoma,' the result of sporules swallowed by the patient. Sir James Simpson thinks

the casts are the product of a papular eruption of the lower part of the small intestine and colon." He gives a generally favorable prognosis, and as to the main lines of treatment insists upon rest, in bed if necessary; the absolute avoidance of purgatives; restriction of diet to prevent as much as possible the formation of fæces, and the avoidance, therefore, of such foods as bread, eggs, coarse-grained vegetables, etc. He uses warm emollient enemata for constipation, warm olive oil frictions to the abdomen, recommends the wearing of wide flannel roller to support and protect the abdomen, and, as for drugs, gives foremost place to opium, mentioning also the prolonged use of drop doses of liquor arsenicalis—the latter, though he does not say so, probably in the intervals, and the opium during the paroxysm.

A CASE OF TETANY.

BY A. S. FRASER, M.D.,

SARNIA.

FRANK K., journalist, aged 30 years, had been suffering from chronic gastritis for more than a year, when he was referred to me by Dr. Knight, of Wallaceburg. He had severe pain in the stomach, which was nearly continuous; he vomited frequently, and had become very much emaciated. I instructed the patient in the use of a stomach tube, from which he derived great benefit. The pain left, vomiting ceased, and he gained flesh and strength. Using the stomach tube frequently, he had very fair health for about eight months, when the old symptoms reappeared, and notwithstanding frequent irrigation pain again became severe, and the vomiting very annoying. The patient appeared to have, at times, a craving for the most indigestible food that could be had. One day he ate a quantity of fried mushrooms, and although his wife, who partook of the same food, suffered from a sharp attack of diarrhœa in consequence he did not appear at all affected. Four days afterwards, however, having some gastric discomfort, he used the stomach tube, and brought away a number of pieces of mushroom, which did not appear to have been at all affected by their prolonged stay in the stomach. In about an hour after having used the stomach tube on this occasion, it was noticed that his articulation was imperfect, and that he had slight spasms of the facial muscles. Immediately after this there occurred a strong contraction of the flexors of the hands and feet, extending rapidly to those of arms and legs. It was noticed that the hands were not clenched, but the thumb was

turned inwards; the fingers were straight, but strongly flexed at the metacarpo-phalangeal articulations. In about a minute the spasms ceased, but returned after a few minutes with greater violence, subsiding after one or two minutes and again returning. Four attacks occurred within an hour, each beginning in the extremities, but involving more muscles than the one preceding it. During the fourth attack dyspepsia was extreme, and after it had subsided the patient was in such a state of collapse that those about him thought he was dead. He slowly rallied, and, as the spasms were commencing for the fifth time, a hypodermic injection of a quarter of a grain of morphia was administered. The muscles at once relaxed, and there was no return of the spasms. The intellect remained quite clear throughout. As the patient felt the last attack coming on, he said, "Another will finish me." In a few days he was able to go about and attend to his business. His health failed so much during the next few months, that he decided to go west, in the hope that a change of climate would benefit him. Although in a very feeble state he succeeded in getting as far as Montana, where he remained for a month. Returning at the end of that time, it was evident that his end was approaching. He had persisted in the use of the stomach tube, and had occasionally slight spasms of the extremities, but not sufficient to give him any annoyance. Five days after the patient's return the tetany again appeared, the spasms being confined to the extremities, and continuing until his death, which occurred three days later. The stomach tube had not been used for a week when the spasms came on for the last time.

A *post-mortem* examination of the stomach showed that the capacity of the organ was normal, but the walls were very thick, particularly in the pyloric region. This thickening was found by microscopic examination to consist entirely of an increased amount of connective tissue in the sub-mucous coat. The epithelial lining of the stomach had almost entirely disappeared; no examination was made of the other parts of the body.

I am indebted to Dr. Knight for notes of this case, which was under his care for more than two years. Several physicians were consulted during the progress of the case, and the patient was carefully examined repeatedly, yet no complications, apart from the tetany, were ever discovered.

It is said that tetany occurring in gastric disease is due to the absorption of toxic matter from the stomach, and that the spasms are likely to come on after the stomach has been washed out. If this is true, it is somewhat remarkable that the removal of decomposing mucus and undigested food, also probably in a state of decomposition, should be followed by the absorption of poisonous matter. In the case above described it is interesting to note that although tetany, when associated with gastric

disease, is said to be always fatal, this patient, having had a very severe attack, did not appear, after the immediate effect had passed, to be any worse.

Another curious circumstance was the sudden stoppage of the spasms by the prick of the hypodermic needle, as the effect was so instantaneous that it could not have been due to the absorption of the morphia; and it might be argued from this that whatever may be the nature of the toxic agent causing the spasms, its action probably consists in holding in abeyance the inhibitory mechanism, rather than increasing the irritability of the motor centres.

LOCOMOTOR ATAXY IN A GIRL OF FOURTEEN, WITH PROBABLE MODE OF ORIGIN.

BY W. B. THISTLE, M.D., L.R.C.P. LOND.,

TORONTO.

E. B., a well-grown, fairly healthy-looking girl, was admitted to Victoria Hospital under my care on account of difficulty in walking.

The following history was obtained from the mother: The parents are living and quite healthy. Brothers and sisters are all in good health, and none of them has suffered from disease or nervous symptoms of any kind. The patient has never been very strong, and has always been somewhat nervous; when excited she trembled, and had slight twitching movements. Until May, 1891, she enjoyed good health, but at that time had what was said to be measles, accompanied by very sore throat, and followed by desquamation of the skin, and later by much swelling of hands and feet. Shortly after this she complained of dizziness, loss of sight, and abdominal pain. However, these symptoms soon passed away, but were followed by very considerable loss of power, so much so that she was for a time quite unable to walk or stand up, and it was noticed that there was much weakness of the hands and she had great difficulty in grasping or retaining hold. After some months the power gradually returned and she was again able to walk, but there still remained a peculiarity of gait and much uncertainty. During this time she frequently had cramp in the legs, but at no time has there been any severe pain. Her general health has been fairly good. The mother had noticed no other symptoms.

Present condition. Patient is well nourished, but somewhat anæmic. Muscles are everywhere round and firm, with the exception of those of the hands; in these there is evidence of fairly extensive atrophy, and the hands have the peculiar cold, clammy feeling usual in atrophied parts. The gait is very suggestive. The feet are lifted high, and carried forward in an

irregular, uncertain sort of way, and finally brought down flat on the floor. The toes are extended to the full at the metatarso-phalangeal articulation, but the distal phalanges are strongly flexed, producing the peculiar arching of the toes seen in the typical tabetic foot. There is a tendency to stagger from side to side when walking, and this is much increased when turning quickly. On attempting to stand with the eyes shut and the feet drawn together, she invariably staggers and falls. The knee-jerk is absolutely gone on both sides, but the cutaneous reflexes are preserved. Sight is good, and there is full power of accommodation. Reflex to light is active. No bladder or rectal symptoms. There is no co-ordination shown when the patient attempts to touch a given point—bring the fingers together quickly, or place her finger on her nose. Tactile sensibility is somewhat impaired. Sense of temperature is normal, and painful impressions are received as in health. She complains at times of numbness in the legs, and has cramps, but at no time has there been severe pain.

Diagnosis. There would seem to be no doubt as to the existence of a lesion in the posterior columns, since there is ataxy with complete loss of knee-jerk and slight loss of tactile sensibility. The case is therefore locomotor ataxy. The loss of muscle sensibility, giving rise to absence of knee-jerk and ataxy, shows that the degeneration affects to a very great degree the posterior median columns; while the very slight loss of tactile sensibility, together with the fact that the cutaneous reflexes are preserved, indicates that there is very slight affection of the postero-external columns. The fibres for the conveyance of painful impression and sense of temperature, being situated in the lateral columns, escaped altogether.

The earlier symptoms following the scarlet fever—for without a doubt it was scarlet fever and not measles—I interpret in this way: The loss of sight, headache, etc., were no doubt uræmic, because associated with diminished urine, dropsy, and occurring during convalescence from scarlet fever. Still later there is a history of extensive paralysis coming on suddenly and gradually clearing up; this, together with the fact that there is at present extensive atrophy on both hands, makes it clear that anterior poliomyelitis succeeded the uræmic symptoms.

Regarding the causation of the posterior sclerosis, since it followed directly the poliomyelitis, I am inclined to look upon it as an extension of the inflammatory process in the slow form of a degeneration from the anterior cornua to the posterior columns. It is a recognized fact that the reverse condition does occur when, in the course of locomotor ataxy, there is extension of the degeneration to the anterior cornual cells, and as a result progressive muscular atrophy. Again, in acute anterior poliomyelitis, it is well known that this disease is at times followed by spastic paraplegia, as a result of extension from the anterior cornua to the pyramidal tracts.

The rarity of locomotor ataxy of spinal origin in early life, together with the absence of marked sensory symptoms, makes one think of the hereditary form of ataxy said to be the rule in children; but the absence of hereditary syphilitic taint, the freedom of the child from any of these symptoms until subsequent to the scarlet fever, the non-appearance of similar or any nervous symptoms in other members of the family, and the absence of the peculiar speech and eye defects, make it impossible to term it Friedreich's disease.

Progress of Medicine.

MEDICINE

IN CHARGE OF

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Home for Incurables.

THE PÉTRESKO METHOD.

In an editorial in *Medical Record* on "the Therapeutics of Pneumonia," the Pétresko method is thus spoken of:

It is a treatment devised by Dr. Z. Pétresko, professor of therapeutics at Bucharest. The plan was first recommended in 1883, after it had been tried for two years. In the same year, Dr. Brailov, a pupil of Pétresko, gave a favorable opinion of the digitalis treatment. Pétresko again wrote upon this subject in 1884, reporting one hundred cases. Another article was written upon it in 1886 by Dr. Pacleano, reporting one hundred and eighty-two cases. In response to some criticisms, Pétresko had made an analysis of the digitalis used in Bucharest, and found it as strong as preparations used in Berlin, Paris, and Strasburg. In 1887 M. Antonin published a doctorate thesis giving the results of Pétresko's treatment in all his cases of pneumonia from October, 1886, to July, 1887. He states that the mortality was reduced to 1.21 per one hundred among 577 cases. Pétresko reported the results of his treatment again at the Therapeutical Congress at Paris in 1888. Naturally, he was rather severely criticized by the eminent gentlemen who heard him.

In 1880, one of Pétresko's pupils, Dr. Constantinesco, published a thesis in which he reported 816 cases treated, with a mortality of 2.06 per one hundred.

After eight years of persistent work, Pétresko succeeded in getting his method tried elsewhere. In 1891 Dr. Filk, of Vienna, reported sixty-one cases treated by large doses of digitalis, with a mortality of only one.

The previous mortality had been 15 per 100. From the same city, however, there came a slight set back to the practice. Professor Drasche used the drug in doses of three to four grammes daily—doses smaller than those recommended by Pétresco—and got unfavorable results. In April, 1892, Dr. R. Hoepfel, of Barnan, reported good results from the high dosage.

Several Paris physicians have announced their general belief in the harmlessness of digitalis in very large doses, but give no specific reports upon its use in pneumonia.

Such is the state of the case at present. It will be seen that Pétresco is still backed up almost entirely by his own statistics, because his method has not been extensively tried elsewhere. Still, he has made out a very good case for himself, and has at least proved that the pneumonia of Bucharest is best treated by digitalis.

The method itself is simple. The patients are given from four to six grammes (sixty to ninety grains) of powdered digitalis daily. The medicine is administered every one or two hours in the form of an infusion.

CURE OF ANEURISM BY BACELLI'S METHOD.

Pritchard reports a case of Bourget, at Lausanne, Switzerland, in which an aneurism of the descending aorta was treated by this method. It had passed by pressure-absorption the body of a vertebra and two ribs, and formed a tumor between the spine and the scapula. A watch-spring 2mm. broad and 37 ctm. long, with a spiral 5 ctm. in diameter, after being boiled in hydrochloric acid (to sterilize it and to form a film of ferric chloride to start the coagulation process), was introduced through a small slit into the sac. The slit was then closed. The subjective symptoms were relieved. One month later, the tumor was found by exploratory puncture to contain no blood, and the pulsations had increased in extent and intensity. Improvement at time of report was steadily progressing.—*Medical Record*.

GASTRIC CRISES IN FLOATING KIDNEY.

The gastric crises which sometimes occur in cases of floating kidney were recently discussed at a French medical society. Dr. Mathieu had observed patients in whom there had been severe attacks of vomiting ten or twelve times a day for a fortnight or even more. There was a strong resemblance to some of the gastric crises of locomotor ataxia. There was severe abdominal pain. In a few cases there was enough gastric dilatation to suggest constriction of the pylorus. It was very possible that the symptoms resulted from a temporary displacement of the kidney, and more or less torsion of its pedicle. The best treatment for floating kidney he had found to be rest and the abdominal bandage, with a large and soft pad over the kidney. At the time of the lighter gastric crises he had used

chloroform, cannabis indica, and a milk diet, with some success, but for the more severe cases he had not found much relief by drugs. Of surgical attempts to fix the kidney, he believed there had been twenty-six successes and eleven failures. Dr. Legendre agreed that the misplaced kidney probably pressed sometimes upon the pylorus, and by that means excited the vomiting, but he did not think the vomiting could always be stopped by getting the kidney into its right place again. Dr. Guyot had observed for forty years cases of floating kidney, but had not found gastric dilatation or fits of vomiting. Dr. Rendu gave an account of the case of a lady in whom there had been many gastric crises. At first they were considered to be due to a pre-ataxic condition; later, when they were accompanied by jaundice, to gallstones; and finally, when the jaundice no longer recurred, to floating kidney. A surgical operation to fix the kidney was contemplated, but before it was performed the crises ceased completely, and the problem of the origin of the symptoms remained unsolved.—*Medical Record*.

PRIMARY TUBERCULOSIS OF THE TONSIL, CHEEKS, AND LIPS.

Dr. Lloyd recently showed a case of this kind at a meeting of the Johns Hopkins Hospital Society. The case was of interest from the fact that the disease, as it appeared upon the face and the mucous membrane of the mouth, resembled somewhat a syphiloderm. The history of the case is briefly as follows: Six years ago she had a fibroid tumor of the uterus, and she consulted a physician, who placed her upon iodide of potash and mercury for the purpose of causing absorption of the growth. She has thus been for the past six years on the iodide and mercurials. After taking the iodides for three or four years an eruption appeared over all the body, resembling, as she states it, smallpox. Two years ago an ulcer appeared upon the right tonsil, and an irregular, soft, small ulcer appeared on the inside of the left cheek. Half a year ago the ulcer spread to the upper lip, which became greatly swollen and extended down to the lower lip. We saw her a week ago for the first time, and our diagnosis lay between specific trouble and epithelioma. She was seen by three throat specialists, and they thought it a cancer of the tonsil, which it resembles closely. The skin lesion looked like specific trouble. A section of skin was taken out and examined by Dr. Barker, who found it to be tuberculosis. This variety of tuberculosis of the skin is exceedingly rare. In four thousand *post mortems* made by Chiari, only five cases of tuberculosis of the skin were found. These occurred in the regions where the mucous membrane and the skin come together, on the lips and about the anus, and in one case on the skin back of the ear. Any one might make a mistake in diagnosing such a case, and had we not made a micro-

scopical examination and stained for the bacilli we could never have diagnosed it correctly. Upon the side of the right cheek there was a large patch resembling rupia, but upon removing the crust the lesion looks like tuberculosis. The patient has had many of the symptoms of syphilis—rheumatic pains, falling out of hair, etc.—*Medical Record*.

PULMONARY EMBOLI FOLLOWING MERCURIAL INJECTIONS.

Interstitial injections of mercury, so largely used at present in the treatment of syphilis, are sometimes dangerous. Dr. Blaschko has reported two cases in which the injections of mercury were followed by pulmonary symptoms. In the first case, the patient complained of thoracic pain, coughed, and had accesses of oppression. On the day after the injection, the respiration became difficult, and the patient coughed bloody sputa. The second patient also complained of pain in the side, coughed, expectorated bloody sputa, and had a little fever. The symptoms in both cases disappeared in about three days. In a third instance, the patient had violent attacks of cough after the injection. These symptoms are explained by the author as being due to emboli caused by the paraffin employed as a vehicle for the mercurial preparations, which are insoluble, and are only suspended in the liquid. The writer believes that the mercurial injections give the best results in the treatment of syphilis, but that they must be administered by themselves, as in this manner they produce no untoward effects. The injections should not be so frequent in individuals affected with pulmonary troubles, especially phthisis.—*Therapeutic Gazette*.

THE DIAGNOSIS OF ASIATIC CHOLERA.

This was the subject of a few remarks by Dr. William H. Welch. The diagnosis of Asiatic cholera is of great interest, and the undertaking is one of much importance. The importance of the diagnosis varies at the time of the epidemic. It is important to make the diagnosis of the first case, or of the first few cases, as early as possible. The recognition of this is essential for preventing the epidemic. Then even after the epidemic has broken out, it is desirable to make the diagnosis early because the treatment should begin as early as possible, as it is then more effective. Nevertheless, it is not a bad mistake if cases of diarrhoea are called Asiatic cholera, for other diseases are often called cholera.

The means at our disposal independent of the existence of an epidemic are the symptoms and the *post-mortem* appearances. The diagnosis after death is an important pathological aid of the disease. Experience during the last epidemic of cholera at Hamburg and elsewhere is conclusive that there is no diagnostic symptom or pathological lesion of cholera; there is

only one thing, and that is the determination of the organism, the comma bacillus of Koch, in the discharges. When we consider the different classes of cholera, it is almost impossible to classify them. We have on record pathological studies of hundreds of cases, and we find that in eight to ten in every one hundred the cholera bacillus has been found in the stools of healthy persons who have had to do with those sick, those with no symptoms of the disease and with no diarrhoea, but who are with the sick and in the hospitals. So far, it has only been found in healthy persons who are near the sick. Then there are those cases of the Asiatic sort with diarrhoea and in no way differing from ordinary diarrhoea, but it is simply cholera without vomiting, in which the cholera bacilli are in the stools. These are not diagnostic without the bacilli. Then there are those cases of cholera, that is, cases that present more or less the symptoms of cholera, but do not pass into the asphyctic or algid condition of the disease, with diarrhoea, rice-water discharges, vomiting, cramps, complete suppression of urine, absence of the radial pulse, and aphonia. This is cholera. Of these cases there should be a very strong suspicion. The term is applicable only to a minority of the cases. According to the reports from Hamburg, we must not expect to have typical rice-water stools; they are more often absent than present. They have a color, and frequently contain some bile, and are green or yellow. In the asphyctic stage the disease is more characteristic; there is complete suppression of urine and the urine secreted in the algid stage is called the last urine, and no more can be obtained with a catheter, and there is no more urine until this stage passes away.

The prognosis depends upon this stage. If it lasts seventy-two hours, it is said to be hopeless. The character of the first urine passed after this stage is awaited with great interest. It always contains albumin and casts, and the prognosis is always more favorable the larger the number of casts, for they must be washed out. The absence of the radial pulse is another symptom of importance. There is no correspondence between the strength of the heart-beat and the absence of the pulse, indicating that this absence of the radial pulse is, in part, caused by the spasmodic contraction of the blood vessel. The heart is often quite strong. There is loss of voice or hoarseness; extreme coldness of the extremities, with the internal temperature normal or a little above. There is often six to eight degrees difference between the temperature in the axilla and that in the vagina or rectum. There is sinking in of the face, and the eyes take on that peculiar color which is described in the old books. Exactly these same symptoms may occur in cholera nostras, but an absolute diagnosis cannot be made from these alone. The disease may go into a typhoid state and end there. The fulminating variety is where the symptoms come on with

great rapidity. The impressions from the cases at Hamburg are that death was due to intoxication, and not so much to draining away of the body fluids.

There is nothing in these symptoms, taken by themselves or together, to constitute a diagnostic landmark, nor in the *post-mortem* appearances that are decisive. All the usual *post-mortem* appearances are found in those cases, and the results are not pathognomonic. We cannot make a diagnosis of Asiatic cholera from the *post-mortem* appearances. Koch's comma bacillus is the only true diagnostic point, just as the tubercle bacillus in tuberculosis. It is a difficult work, more so than the recognition of the tubercle bacillus, and it is doubtful if the general practitioner, even if he should have the knowledge, would have the time to go through the methods necessary to make the diagnosis. We first make cover-slip preparations from the rice-water stools, taking up the large rice lumps, and if they contain a large number we may be sure, but if only a few are present it is not safe to make a diagnosis in this way. There are probably one or two in every city capable of making a diagnosis from the stools, and who are able to study the organism suspected. More frequently cultures are made, and that requires twenty-four to forty-eight hours to make the diagnosis, but sometimes it can be made immediately, and it is positive. The cases where these methods have failed are very very few, and those of failure are regarded as curiosities. He should be prepared to make examinations at the Johns Hopkins Pathological Laboratory for any physician, and if any one should have a suspicious case he may send a specimen of the stools in a wide-mouth bottle tightly sealed with paraffin or sealing-wax, and this may be sent by mail with safety and will last a long time.—*Report of Medical and Chirurgical Faculty of Maryland in Medical Record.*

THERAPEUTICS

IN CHARGE OF

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ARSENIC IN RODENT ULCER.

Lassar, of Berlin, reports two cases of rodent ulcer cured by arsenic, given both internally and by hypodermic injection, without any local treatment. Two to three drops of Fowler's solution were given three times a day, and a small syringe full of a one per cent. solution of arseniate of soda at a dose, about twenty injections being made during the course of the treatment.—*Berliner Medicinische Wochenschrift.*

W.L.

URTICARIA.

R.—Chloral hydrat.,
 Pulv. camphoræ,
 Pulv. gummi arabic.....aa 3j.
 Triturate to liquefaction and add
 Cerat. simplicis..... ʒj.
 M. S.: Apply topically.

—*L'Union Médicale.*

BROMIDE OF STRONTIUM IN VOMITING.

Dr. Justus Coronedi reports a number of cases to prove that bromide of strontium is an excellent remedy against vomiting, the only failure being mechanical vomiting in the course of a case of carcinoma of the pylorus and liver. He gave bromide of strontium (Merck) fifteen grains, one to three times a day, either before or immediately after eating. He also found it very effective in allaying pain in the stomach. Professor John Dougall, Glasgow, after all other remedies had failed, administered bromide of strontium to a woman who had suffered for a long time from chronic gastritis with frequent vomiting. He gave thirty grains three times a day. Improvement began after the first dose, and in fourteen days the woman was cured.

Fedorow highly recommends hydrastis canadensis, fluid extract, twenty drops four times a day, in inveterate vomiting of pregnancy.—*Therapeutische Monatshefte, June, 1893.* W.L.

ALUMNOL.

A new astringent antiseptic, occurring as a fine white non-hygroscopic powder, soluble in water, alcohol, and glycerine, but not in ether. Recommended strongly by Heinz and Liebrecht in $\frac{1}{2}$ to 2 per cent. solution for washing suppurating surfaces and wounds; 10 to 20 per cent. for small abscesses and fistulæ where local stimulation is required; 3 to 6 per cent. salve for torpid chronic ulcer; also in dermatology, gynecology, laryngology, ophthalmology, and obstetrics. Dr. Chotzen regards it as a specific in gonorrhœa. He gives an injection four times a day of a 1 to 2 per cent. solution in water, and finds that the gonococci disappear in three to six days, after which he gives one injection each day. It causes no pain. He also recommends it in ulcer molle, balanitis, eczema, acne, urticaria, sycosis, favus, psoriasis, seborrhœa, erythema exudativum, prurigo, etc. It has the advantage of being very moderate in price.—*Therapeutische Monatshefte.* W.L.

THE TREATMENT OF CHLOROSIS.

Dr. Duclos (*Revue Générale de Clinique et de Thérapeutique*) regards true chlorosis as consisting essentially in an auto-infection of intestinal origin. He insists upon a daily evacuation of the bowels, obtained not by purgatives, but by injections, either simply of water, perhaps with glycerin or oil, or slightly saline, aiming to secure a spontaneous evacuation at the same hour; or suppositories of soap, cacao-butter, or glycerin can be used; if simple means fail, then castor oil can be employed; avoiding, however, the salines. Iron is important, of which the ammonio-citrate is placed at the head; other forms may be used, but the simple will be always the best—to be always given with the meals. The patient should eat whatever the stomach will accept and digest without constipation or diarrhœa, but an exclusively animal diet should not be allowed. The activity of the skin must be maintained by warm general rain douches, or by friction. Outdoor exercise is prescribed. Deep inspiration of air is necessary, or, in special cases, short but repeated inhalations of oxygen, either pure or mixed with a definite quantity of air.—*American Journal of the Medical Sciences.*

EXPERIMENTS WITH PIPERAZIN AND OTHER URATE SOLVENTS.

Dr. William A. Meisels, in the Budapest Pharmacological Institute, first experimented on pigeons by tying the ureters in order to get a uric acid sediment on the peritoneum of the liver and the endocardium and pericardium, but found that the birds died too soon. He then gave neutral chromate of potash hypodermically, and recommends very strongly this method of producing a separation of uric acid in the system, especially as it was found in the joints. A pigeon was given 0.01 grammes of neutral chromate of potash in a 2 per cent. solution hypodermically every day, and 0.20 grammes of piperazin by the mouth. At the section, no uric acid was found on the serous membranes, while a control bird exhibited on section a whitish parenchymatous inflammation of the kidney, and the tubuli recti completely stopped up by uric acid concretions. Similar experiments with baborate of sodium and carbonate of lithium caused the investigator to arrive at the following conclusions:

- (1) Piperazin is able to prevent the occurrence of urate deposits in birds, and to dissolve the already existing deposits. Piperazin has no influence on the ordinary functions of life, nor on digestion. It does not appear to have any diuretic qualities.
- (2) Carbonate of lithium, administered by the mouth, is not able to dissolve the urate deposits in birds, and, in contradistinction to piperazin, exercises an injurious influence.

(3) Sodium boracicum ; as also

(4) Sodium phosphoricum possesses no power either to dissolve urate deposits or to hinder their occurrence in birds.

(5) Piperazin and lithium carbonicum are able, even in very weak solutions, to dissolve uric acid and uric acid calculi, while baborate of soda and phosphate of soda have not this power.—*Therapeutische Monatshefte*, May, 1893.

W.L.

CAFFEINE IN ALCOHOLICS. BY CZARKOWSKI.

From personal observation on four cases, Czarkowski considers the use of caffeine to be contraindicated in alcoholic subjects. In all his cases there was cerebral excitation, that disappeared on stopping the use of caffeine. The first, suffering from mitral insufficiency and œdema, showed signs of agitation with "l'humeur gaie" after having taken two grains of the drug. On discontinuing the drug the patient became quite melancholic, and retained no remembrance of what had gone on during the period of excitement. The second case had nephritis. Caffeine was given to him in 20 centigram doses. After the fifth dose, cerebral excitement and hallucination, followed by loss of consciousness, which lasted several hours, came on. In the third, suffering from typhus fever, after several 60 centigram doses, there developed violent delirium with destructive tendencies. He retained no recollection of his condition after his recovery. The author comes to the conclusion that caffeine should be given to alcoholic subjects only with the greatest care, and then with instructions to attendants to discontinue the administration on the least manifestation of excitement.—*Bul. Gén. de Thérapeu.*

J.A.A.

THE EFFECTS OF SOME ANTISEPTIC SOLUTIONS ON THE COMMA BACILLUS.

BY G. G. BORCHOFF.

The author has studied the effects of the following solutions on Koch's bacillus :

(1) Corrosive sublimate, 1 in 1000.

(2) A mixture of 1 pint of sulphuric acid and three parts carbolic acid, of the strength of 6 in 100 of water.

(3) A mixture of quick lime and water, 20 in 100.

(4) A solution of carbolic acid, 5 in 100.

The following procedure was used :

He put equal parts of the antiseptic solution and choleraic dejections that contained the bacilli into a test tube. After a certain exposure he took samples to make gelatine plate cultures, with the following results :

(1) The corrosive sublimate, unless it came in contact directly with the microbe, had a very slight germicidal power.

(2) The lime mixture killed them in the majority of cases ; but the mixture had to be well stirred up with the dejections.

(3) The mixture of sulphuric acid and carbolic acid, as also the carbolic acid solution, always killed the bacilli, and this without having to shake up the mixture.—*Bul. Gén. de Thérapeu.* J.A.A

NOTES ON NEW REMEDIES.

Ichthyol.—Still reported useful locally in erysipelas, eczema, rheumatism, metritis, parametritis, ovaritis. A fatal case occurred from applying a thirty-three per cent. solution to a freshly curetted uterine cavity.

Iodoform is said to be disguised by camphoid, cumarin, terpineol, menthol, or essential oil of coriander.

Methylene blue colors the urine and causes some strangury, but no albuminuria. A little nutmeg relieves the strangury. It is effective in malaria, but not superior to quinine. It exerts no action in tuberculosis, and may be used to diagnose it from malaria. A ten per cent. solution was used locally for diphtheria successfully, and in cystitis it has been praised.

Naphthalin for all kinds of intestinal parasites. One gramme removes a tape-worm entire. Castor oil is given after it—to adults, with it—to children. An ounce burnt in the bedroom on each night cures pertussis in two or three nights. It is so irritant to phthisis that it may appear diagnostic.

Naphthol is best used in the form of naphthol camphor, formed by heating one part of beta-naphthol with two parts of camphor, until a homogeneous melted mass forms. Air and light decompose it. It is injected into tuberculous glands, and other tuberculous nodules, joints, cavities, abscesses, etc. It is used undiluted.

Paraldehyde has succeeded in tetanus and in maniacal insomnia in mild forms. It is probably diuretic.

Pental, an anæsthetic, requires about $5\frac{1}{2}$ fluid drachms to produce anæsthesia for minor work. It is not so deep an anæsthetic as that of ethyl bromide, but safer, and has no bad after-effect. Sensation is lost before consciousness.

Phenacetin has had its best field in influenza. It is safer than antipyrin or acetanilid, and more enduring.

Piperazine sustains its place as a solvent of uric acid, and has been applied locally with success in one per cent. solution to gouty sores.

Resorcin has gained favor in diarrhoea, gastritis, gastric ulcer, gastric cancer, for insomnia of nervous excitement, typhus and phthisis, pruritus, locally for ulcers, and for pertussis.

Salicylamide has less taste than salicylic acid, is more soluble, acts quicker, in smaller doses, and is more analgesic. Dose 3 to 5 grains several times a day.

Salol has been used with success in dysentery, infantile diarrhoea ; many report favorably in cholera, chronic cystitis, and gonorrhoea. It is used as a pill coating, insoluble in the gastric juice ; made of salol 4 parts, tannin 1, and ether 20. This is varnished on in several coats.

Salophen does not decompose into carbolic acid, as does salol. It is very effectual in acute rheumatism, and does not weaken the heart, or produce albuminuria or smoky urine.

Somnal fails as a general hypnotic, but is useful in the insomnia of convalescence, pertussis, laryngeal spasm, asthma, chorea, and nervous cough. It is safe and uniform in action.

Sulphonal has won a place in treating the insane. A very important hypnotic.

Terebene, an agreeable antiseptic and deodorizer. A five per cent. solution is a good surgical dressing. The vapor is of use in bronchial affections and phthisis.

Urethan, a mild hypnotic, especially useful for children.—*Times and Register.*

THE EFFECTS OF MASSAGE. BY DR. JAWADSKI.

The author has studied experimentally on dogs the rapidity of absorption of toxic substances by the tissues under the influence of massage, and has come to the following conclusions :

(1) Massage (friction), in the direction of or towards the heart, accelerates the absorption of liquid substances introduced subcutaneously.

(2) Massage augments considerably the effect of substances introduced hypodermically. From a therapeutic point of view, this fact derives some importance, because with a small dose of a drug accompanied by massage we can obtain the same effect as with a larger dose, not using massage.

(3) The longer the massage is practised, the more rapid is the absorption.

(4) The quantity of fluid injected has very little influence on the rapidity with which absorption takes place during the practise of massage.

(5) Massage practised on the side opposite to the one in which the injection is made, along with the massage on the injected side, does not increase the rapidity of absorption any more than if massage was done on the injected side only.

(6) The section of a motor nerve has no influence on the rapidity of absorption.

(7) Massage produces a dilatation of the blood vessels of the organ operated on.

(8) After section of a sciatic nerve, the fluid injected beneath the section is absorbed more rapidly.

The effects of massage on absorption does not depend on a constriction, nor on a dilatation of the blood vessels, as a result of stimulation of the peripheral sensory nerves. Massage cannot, then, but have a mechanical effect. It produces quite mechanically a dilatation of the blood vessels, and drives the blood from the organ operated on into the general circulation, and in this way is it that it contributes or assists more rapid absorption.—*Revue Chirurgicale*. J.A.A.

OBSTETRICS

IN CHARGE OF

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MENORRHAGIA and metrorrhagia have been controlled by the hypodermic use of atropine in one two-hundredths of a grain dose, after other hæmostatics had failed.—*Dmitriuff*.

LABOR pains are brought on, Freund claims, by galvanism applied to the mammæ (cathode), and abdomen (anode); five to seven milliampères being employed.—*New York Medical Record*.

THE QUANTITY OF LOCHIA.

At a meeting of the Obstetrical Society of London, held May 3rd (*British Medical Journal*), Dr. E. Giles gave the result of investigations on the quantity of lochia after labor. The method employed was described, and sources of error discussed. The conclusions derived from observations on sixty cases were as follows: (1) The average normal quantity of lochia is about $10\frac{1}{2}$ ozs.; (2) the duration of the discharge is, on the average, nine or ten days; (3) the degree of "parity" does not influence the quantity; (4) non-suckling does not increase the discharge; (5) the quantity is generally greater in younger women up to the age of twenty-five; (6) the weight of the child has a slight, and that of the placenta a well-marked, influence, the quantity increasing with the weight of the placenta; (7) the quantity increases with the amount of hemorrhage at the time of labor; (8) the lochia are more abundant in the case of those who habitually menstruate profusely; (9) the quantity is generally greater in the case of women of darker complexion.

ALBUMINURIA IN RELATION TO PARTURITION.

Aufrecht (*Centralb. f. klin. Med.*, June 3rd, 1893) records some investigations in which the urine was examined before and after labor, all possible sources of contamination being avoided. Of 32 cases none had albumen before labor or just after the commencement of the pains, but in 18 albumen, varying in quantity from 1 to 2 to $\frac{1}{4}$ pro mille, was found after labor. In all these cases the albumen disappeared in twenty-four hours. Epithelium, but no casts were present. It is concluded that labor, or rather the pains, cause the albuminuria by producing some stagnation in the venous system, including the renal veins. Thus the urine should be examined before labor, and if albumen is present the case should be watched, as an increase is likely to occur during the labor. If eclampsia appears at the beginning of or during the pains, the labor should be hurried on as much as possible, as, according to the author's experience, renal disease with albuminuria is without exception the cause of eclampsia. The function of the kidneys is further compromised by long-lasting pains, and the danger to the mother increased. Where artificial delivery cannot yet be effected, chloral is most suitable. Again, albuminuria and cylindruria are separate processes, the latter having nothing to do with the transudation of albumen through the renal vessels. Casts are the product of inflammatory irritation of the renal epithelium.—*British Medical Journal*.

ANÆSTHETICS IN LABOR.

Dr. E. P. Davis contributes an article on this subject in the *Philadelphia Polyclinic*, which also appears in abstract in the *Therapeutic Gazette*. He thinks the use of anæsthetics is clearly indicated in the majority of cases of labor. He considers that, when properly administered, they do not produce any depressing effect, even when valvular lesions of the heart are present. There is in many cases a considerable amount of conscious suffering, independent of the uterine contractions, which causes cerebral inhibition, and this, in turn, stops temporarily the muscular contractions of the uterus. An agent which removes such inhibitory action of the cerebrum leaves the ganglionic centre of the spinal cord free to furnish the uterus with the normal stimulus essential for rhythmical contractions of the uterine muscle. The element of shock in prolonged and difficult labor may be lessened by the skilful use of anæsthetics. A further advantage gained is the diminished tendency to laceration of the birth canal of the mother. He has found that, in certain difficult cases, when a slight disproportion between the fœtus and the pelvis exists, the anæsthetic has often prevented the necessity for the use of the forceps. He admits that the administration of the anæsthetic to the extent of pro-

ducing a profound anæsthesia is dangerous, because it favors depression and post-partum hemorrhage. As a rule, he prefers chloroform; but, in dealing with post-partum hemorrhage when manipulative interference is required, and in abdominal sections for any complication of parturition, he chooses ether.

I agree with most of the author's conclusions; but I have observed that in a certain class of patients the administration of chloroform, however carefully it may be done, retards labor to a serious extent, and causes a certain amount of post-partum hemorrhage. For these reasons I look upon its indiscriminate routine use in labor, as is the custom in certain quarters, with considerable dread.

A.H.W.

THE INFLUENCE OF ERGOT ON THE INVOLUTION OF THE UTERUS DURING THE LYING-IN PERIOD.

In the *Lancet* for November 19th, 1892, Mr. Herman contributes the following article:

In the "Transactions of the Obstetrical Society of London," vol. xxx., for 1888, will be found a paper by C. Owen Fowler and Mr. Herman, in which observations are detailed pointing to this general conclusion: "That the administration of an ergot mixture during the first fortnight of the lying-in period appreciably increases the rapidity with which the diminution in size of the uterus goes on." This conclusion was reached by comparing the average rate of involution (*a*) in a number of cases, taken without selection, in which ergot was given, with (*b*) the average rate of involution in an equivalent number of cases, also taken without selection, in which ergot was not given. In the *Annales de Gynécologie*, vol. xxix., for 1888, p. 175, is published an investigation by Dr. Emile Blanc, of Lyons, conducted in a very similar way, but which led him to the conclusion that "ergotine administered during the first five or ten days of the lying-in period exerts no favorable influence on the uterine involution." Dr. Blanc's research was quoted at the time in several English journals.

These two investigations seem to contradict one another. Mr. Herman desires to point out that they do not; but that, on the contrary, they confirm one another, and show the real value of ergot in the lying-in period. The reason that Dr. Blanc's conclusion differs from that of Dr. Fowler and Mr. Herman is this, that he chose the cases in which to test the effect of ergot. He took only cases of "normal delivery at full term, excluding premature labors, cases with febrile disturbance, and all cases needing any intervention" (p. 177). These cases excluded are just those in which the causes known to hinder involution are present. Dr. Fowler and Mr. Herman took cases without any selection, and therefore among theirs were

included cases in which the cause of subinvolution were present. Dr. Blanc's research shows that in a normal lying-in the uterus completes its involution as well without ergot as with it. The paper by Dr. Fowler and Mr. Herman shows the beneficial effect of ergot in counteracting the causes which retard involution. Dr. Blanc's paper contains nothing in opposition to this view; on the contrary, he expressly says, "Against secondary hemorrhage the drug maintains its position. Its action is the more efficacious the nearer the delivery." The practical conclusion is that while in a perfectly normal lying-in ergot is not required, yet when any cause of imperfect involution is present, or suspected to be present, ergot, given throughout the lying-in period, will counteract its influence, will promote involution, and should be given.—*Therapeutic Gazette*.

SURGERY

IN CHARGE OF

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APPENDICULAR COLIC.

Dr. J. F. Binnie, of Kansas City, in the *Annals of Surgery*, in reporting a case of appendicular colic, says:

Cases of colic of the vermiform appendix must be of by no means rare occurrence, but owing to a variety of circumstances they have been rarely described or diagnosed. One of the reasons why we have not heard more of this trouble is that cases of it have been mistaken for or classified as appendicitis, typhlitis, or perityphlitis.

Chronic catarrh sometimes partially or completely closes the opening of the appendix into the cæcum, and the efforts of this organ to expel its contained mucus gives rise to cramp-like or colicky pains.

That the vermiform appendix has great expulsive power is shown by a case mentioned by Dr. Parker Syms, in which "during oöphorectomy the vermiform appendix came into view, and, although healthy, was removed

because of its great length (over five inches), lest it should cause future trouble. The point of interest connected with one of the cases reported was that after its removal it continued for almost ten minutes to squirm on the plate very much as a grub worm might do, and, finally, a formed fæcal movement took place from it." An organ with this amount of expulsive power, if irritated, and especially if, owing to swelling, stenosis, or twist, its outlet is more or less completely closed, may well give rise to intense colic.

Can we make a differential diagnosis between appendicular colic and appendicitis? *Prima facie*, one would be inclined to say yes. One would *imagine* that in the colic there would be no fever during the attacks, and that the pain would be relieved by pressure; that between the attacks pain and tenderness would be entirely absent. But a careful study of the few cases reported shows such an idea to be erroneous. We may have high fever during an attack of colic; we do have very marked tenderness, especially over McBurney's point; we may have extreme collapse and all the signs and symptoms of acute perforative appendicitis. In the *intervals* between the attacks we may and do have that classic sign of appendicitis, tenderness at the McBurney point, and palpation may give us a sensation of increased resistance or fullness. Altogether, it seems to me that with our present knowledge, or want of knowledge, while a diagnosis of probability may be made, a positive differential diagnosis is rarely possible. Of course, these remarks do not apply to some cases of chronic appendicitis which have reached the stage of suppuration, the suppuration being localized by the formation of adhesions all around. Here we may have positive signs of inflammation, even fluctuation and inflammatory œdema of the skin. Where pus is believed to be present, it may be demonstrated by the use of the long needle and the Pravaz syringe. This method of exploration is, however, unsatisfactory, because, when by its means pus is not found, we are no more sure of its non-existence than if no exploration had been made. A much more satisfactory method of exploration is by incision, which gives positive results, and is *at least* no more dangerous than the former procedure. Exploratory incisions may be made under cocaine anæsthesia with satisfaction where a general anæsthetic is contraindicated. Such explorations, whether made by the needle or the knife, must be carried out with full aseptic precautions.

Where there is some probability of the trouble from which a patient is suffering being appendicular colic, we may follow the treatment outlined by Gersuny and Beuer, who claim to have cut short attacks of this trouble by massage applied to the right iliac region. The cases spoken of by Gersuny and Beuer have never come to anatomical demonstration. My strong personal belief is that the treatment for appendicitis and

appendicular colic ought to be the same, viz., removal of the offending organ. The operation, when performed by a surgeon who understands and *practises* clean surgery, is accompanied with but trifling danger, while appendicitis is a constant menace to life, and appendicular colic is apt to render life miserable. The treatment by massage already referred to may do good in cases of pure colic; but should the diagnosis be at fault, and the disease be appendicitis (an error in diagnosis likely to occur in the most experienced hands), then the massage is calculated to do great and irretrievable harm.

LISTER'S PRESENT ANTISEPTIC PRACTICE.

Among the benefactors of the race of the nineteenth century, Sir Joseph Lister stands first and alone, practically because of what he has taught us regarding the antiseptic treatment of wounds.

In connection with the London post-graduate course, Sir Joseph Lister recently delivered several lectures upon this subject. From an editorial based upon these by J. E. Pilcher (*Annals of Surgery*), we take the following :

When the lecturer first entered upon this subject—knowing, as he did; that wounds, with rare exceptions, underwent putrid suppuration—he naturally considered them very favorable soil for the development of septic organisms. The experiments of Pasteur made it evident that the air of every inhabited place teemed with microbic life. Not understanding how to discriminate among them, it was supposed that any one of them would produce serious mischief in a wound. This is now known to be incorrect. In the first place, it is known that normal blood serum is by no means a favorable soil for the growth of bacteria, provided that they are in an attenuated condition. Secondly, and of even greater importance, is the fact that the living animal body has the power of defending itself against microbes introduced into it, chiefly by the process of phagocytosis. By the light of these facts, it is recognized that microbes in the form in which they are present in the air are not likely to develop in wounds, whence the once dreaded atmospheric dust may be disregarded in our operations. This renders unnecessary either irrigation or spraying, which is a form of irrigation.

The points requiring attention are the exclusion from wounds, during operation, of the grosser forms of septic mischief, such as exist in impure sponges, in dirty instruments, or in any unclean material upon the surgeon's hands, or the patient's skin. The *entourage* of the operation is managed by covering the region around it with towels soaked in a trustworthy

antiseptic solution to avoid contamination of the wound from hands which, have been in contact with septic objects.

For the purification of sponges there is nothing better, after all, than the agent first used—carbolic acid, which is greatly superior to corrosive sublimate. It is a happy circumstance that the organisms having the most resisting spores do not enter into surgical consideration. The surgical microbes are almost exclusively sporeless micrococci, although some are much more resisting than others, as, for instance, the staphylococcus pyogenes aureus; and in such solutions as would be employed in surgery carbolic acid destroys this organism much more rapidly than does the bichloride of mercury.

The tubercle bacillus—a spore-bearing microbe—was shown by the experiments of M. Yersin, at the Institut Pasteur, to be killed in thirty seconds by a 5 per cent. watery solution of carbolic acid, and in a minute by a 1 per cent. solution, while a $\frac{1}{10}$ per cent. corrosive sublimate solution required ten minutes to accomplish the result.

The lecturer found this a very satisfactory matter, since it gave experimental demonstration of a fact of which he had long been convinced by experience, that tubercle bacilli would not be found in sponges if they are kept a considerable time in 5 per cent. carbolic solution. He treats his sponges in the hospital by washing them with soap and water, and afterward with soda; then thoroughly washing again with water, and, finally, after drying, put to steep in a 5 per cent. solution till they are required for use.

He emphasized the inconvenience of sterilizing instruments by boiling, and the ease with which sterilization by immersion in a 5 per cent. carbolic solution may be accomplished. With regard to the length of time instruments require to be left in the solution, much depends on the care with which they have been washed before being put away. Toothed instruments, such as forceps, require especial attention; they should always be brushed with a nail brush before they are dried, so that there may be no crusts of dried blood upon them, which the carbolic lotion might require a considerable time to penetrate. If this has been done, they can be sterilized in a very short time. In the lecturer's private practice instruments are put into 5 per cent. carbolic solution just before the patient is brought into the room; the time during which he is anæsthetized and other preparations are made is quite adequate for sterilization.

In purifying the skin of the patient, contact with the antiseptic lotion for hours, as is sometimes done, is unnecessary; a few minutes' action of the 5 per cent. carbolic lotion being really sufficient.

Carbolic acid is not only a more efficient surgical germicide than corrosive sublimate, but it is much more efficient in cleansing the skin. It

has a powerful affinity for the epidermis, penetrating deeply into its substances, and it mingles with fatty materials in any proportion. Corrosive sublimate, on the other hand, cannot penetrate in the slightest degree into anything greasy; whence those who used it require elaborate precautions in the way of cleansing the skin.

The sponges, during operation, are washed in $2\frac{1}{2}$ per cent. carbolic lotion, and before closing the wound is washed with the same solution.

Sir Joseph then proceeded to a discussion of iodoform as an antiseptic, remarking that while it seems to have little effect upon the development of bacteria, it certainly exercises an important antiseptic influence in wounds, which probably is due to its chemical action upon the products of the bacteria, rendering mere toxins harmless. In circumstances where the exclusion of septic agencies is impossible, as in operations upon the anus or in the presence of putrid sinuses, iodoform is of very high value. In compound fractures, while the wound should be purified with carbolic lotion, iodoform should be used in the dressing. A porous material impregnated with it, when soaked through with blood or serum, will allow the microbes of external defilement to propagate in its substance. It is essentially in the interior of the wound that the virtues of iodoform are displayed.

An external antiseptic dressing, the lecturer remarks, should have four essential qualities to be ideally perfect: (1) It should contain some thoroughly trustworthy antiseptic ingredient. (2) It should have that substance so stored up that it cannot be dissipated to a dangerous degree before the dressing is changed. (3) It should be entirely unirritating. (4) It should be capable of freely absorbing any blood and serum that may ooze from the wound.

The carbolic gauze formerly used contained a sufficiently efficient antiseptic, but, as it was volatile, it was perpetually flying off in spite of all attempts to fix it, and it was uncertain in how many days it might have so far disappeared from the dressing as to leave it untrustworthy. Carbolic acid also had the disadvantage as an element of an external dressing that, acting with peculiar energy on the epidermis, it interfered seriously with cicatrization, and the interposition of a "protective" was necessary to shield the wound from its action. Moreover, the resin contained in the gauze for the purpose of fixing the carbolic acid detracted from its efficiency as an absorbent of blood and serum.

Corrosive sublimate had the advantage of not being volatile, but it was readily washed out of the gauze or wool charged with it, and under some circumstances it proved very irritating; the discharge, passing from one part of the dressing to another, took up more and more of the bichloride

in its passage, and sometimes became so strong a solution of the salt as to cause vesication.

The double salt is very little soluble in blood serum, requiring between two or three thousand parts to dissolve it, so a small quantity will long outlast a free flow of discharge through it. With regard to its antiseptic power, even the small quantity dissolved by serum proves ample to prevent bacteric development. When mixed with serum and corpuscles, it prevents putrefaction in smaller quantity than any other antiseptic known. The severity of the test of an antiseptic is in proportion to the amount of albuminoid substances in the solution tested ; and when the red corpuscles are mingled with the serum, as is the case in the first twenty-four hours after the infection of a wound, a much larger amount of the antiseptic is needed than with the serum only. Four times more corrosive sublimate is required to prevent putrefaction in serum and corpuscles than in serum only. The double cyanide answers the purpose in half the quantity that is necessary with corrosive sublimate.

After trying various dyes for a considerable period, the lecturer has settled upon an aniline dye, the hydrochlorate of mauveine, known in commerce by the name of purified rosolane. This dyes the white double cyanide a mauve color,

In changing the gauze, the dyed cyanide is diffused with the pestle and mortar in a 5 per cent. solution of carbolic acid, in the proportion of about thirty grains to the pint ; the gauze, which must be of thoroughly absorbent quality, is drawn in a thickness of about eight layers through the liquid.

The dried cyanide power may be mixed up with the carbolic lotion into a sort of mud or cream, which may be applied with a camel's hair brush to parts where there is very little space between the wound and the source of septic contamination. The lecturer by this means has repeatedly been able to avoid suppuration in the vicinity of the anus. The mass of antiseptic salt upon the skin prevents the microbes from working their way into the wound under the narrow strips of dressing alone available. There are also situations, such as the pubes, where the cyanide cream applied to the hairs converts them with great advantage into a part of the antiseptic dressing.

In changing the dressings, he makes it an invariable rule to cover the wound with something reliably antiseptic before washing surrounding impure parts, so as to avoid the chance of defiling the wound with them. While it is doubtless true that the dressing that is applied immediately after operation might in most cases be left untouched for several days, nevertheless, when the discharge is free, Sir Joseph prefers to remove the first dressing when the first twenty-four hours have passed. Thus the

serum and corpuscles are gotten away, which, constituting the largest amount of discharge in the case, also test the antiseptic dressings the most severely.

While any opinion which Sir Joseph Lister might express with regard to antiseptic surgery would be heard with profound attention by the surgical world, the address, of which we have quoted the larger portion, giving the details of his methods at the present advanced stage of his work, is a most exceptionally interesting contribution to surgical literature.

BILIARY CALCULUS CAUSING INTESTINAL OBSTRUCTION; LAPAROTOMY; INTESTINE SUTURED AND REPLACED; RECOVERY.

Dr. Tenillon reports the case of a woman, 46 years of age, who had suffered for a long time with biliary colic. Finally, symptoms of intestinal obstruction came on. Five days after the commencement of these symptoms the abdomen was opened, and a lump, quite hard, was found above the ilio-cæcal valve. A longitudinal incision along the intestine, large enough to extract the calculus through, was made. The calculus was five centimeters long and nine centimeters in circumference. The intestinal wound was closed by three rows of fine silk sutures.

All symptoms ceased immediately. The patient recovered completely, experiencing at present no pain or inconvenience.

A similar case was published in France by Pouzet, and another by Dr. Thiriar, in Belgium, in 1891. There have been performed twenty-three operations, with seven cures, for this condition.

Dr. Tenillon says "that death has most often resulted because of peritonitis after the operation; also because of too long delay in operating." Operate early.—*Bul. Gén. de Thérapeu.* J.A.A.

THE CAUSE OF DEATH AFTER BURNS.

Salvioli (*Centralblatt für Chirurgie*, January 28th, 1893) says that the cause of death after burns is due largely to the involvement of the blood vessels in the different organs. According to Bizzozero, the great increase of blood plates in the normal circulation is essentially the result of burns. When the mesenterium of mammals is examined microscopically, and then heated to a temperature of from 50 to 55 C., it is noticed that the flow of blood becomes quickened, and that the blood plates collect along the walls of the vessels and cause the formation of white thrombi. These, in turn, are torn loose by the blood stream, and as a result we have an enormous number of emboli. In certain cases, and especially when considerable heat has been applied, the blood does not circulate. This condition of stasis is partly due to thrombotic and embolic conditions, which stop up the arteries; partly to contraction of the arteries; and, lastly, to a

change in the red blood corpuscles, which become sticky and hang together, and thus hinder the blood flow. After death, numerous emboli are found in the lung parenchyma and many blood-plate thrombi in the vessels. To prove that these results are due to the increase in number of the blood plates, we have only to defibrinate the blood, and the application of heat will produce but little effect. In performing this experiment, it is necessary to remove a large quantity of blood defibrinate by whipping, filter, and again inject into the animal. This should be repeated ten times in two hours. Through this process the blood loses its power of coagulation, and is poor in blood plates. Before this procedure, one plate to thirty-five corpuscles was counted; after it, one in two hundred and seventy.—*University Medical Magazine.*

GENITO-URINARY AND RECTAL SURGERY

IN CHARGE OF

EDMUND E. KING, M.D. Tor., L.R.C.P. Lond.,

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MASSAGE OF THE PROSTATE.

Thure Brandt, to whom we owe the introduction of gynecological massage, was the first to propose it in the treatment of prostatic affections. The diseases of the prostate, particularly hypertrophy of this organ, are trophic affections. Age and posterior urethritis are the causes of trophic changes in the prostate. Massage, by stimulating the circulation in the prostatic vessels, improves nutrition, and aids in the absorption of pathological products. The operative technique is simple. The bladder being emptied, the lubricated index finger is introduced into the rectum. With the pulp of the finger, gentle repeated pressures and rubbings of the tumefied gland are practised. The rubbing, according to Brandt, should be from within outwards; that is, toward the pubic arch. Volianski, on the other hand, directs the movements to be made in the other direction, in the course of the lymphatics. The sitting should be of from one to three minutes' duration. The author reports five cases in which he has attained very satisfactory results by this massage.—*Bul. Gén. de Thérapeu.* J.A.A.

URETHRAL STRICTURES IN THE FEMALE.

Genouville (*Annales des Maladies des Organes Genito-Urinair*, 1892) points out, as a proof of the extreme rarity of stricture of the female urethra, that not more than sixty cases have been reported. The most frequent cause is gonorrhœa, which existed in a little more than one-third

of the cases. Traumatism is also a relatively frequent cause, the female urethra being injured during the course of a prolonged and difficult labor. Some authorities have described a form of senile stricture which is attributed to a thickening of the urethro-vaginal cellular tissue. In the female, as in the male, the results of injury to the urethra develop more speedily than those following gonorrhœa. The functional signs of stricture of the urethra vary from simple discomfort in micturition to complete retention. The symptoms increase in severity more rapidly in the female than in the male. This clinical fact is due, the author holds, to the fact that in the former the bladder is less powerful than in the latter sex. In cases of obstruction in the urethral canal, the bladder of the female becomes more readily fatigued, and its inferiority is shown by the early development of functional failure. Urethral stricture in the female is capable of producing cystitis and ascending pyelonephritis in every respect analogous to those produced in the male. The complications may result even from a slight stricture of the female urethra. The treatment most frequently practised in cases of stricture of the female urethra has been that of gradual dilatation. Urethrotomy and electrolysis have also been tried, but not to such an extent as would justify any definite conclusion.

Total urethrotomy, or division of the whole thickness of the urethro-vaginal wall at the seat of stricture, is advocated as furnishing a better security against recurrence of the stricture, since it removes, from a functional point of view, the strictured portion of the urethra, and consequently excludes any possibility of relapse.—*University Medical Magazine*.

METHYLENE BLUE IN ACUTE NEPHRITIS.

Acting upon the assumption that acute nephritis is due to infection with a special micro-organism—the streptococcus described by Mannaberg—Netschajeff, of Moscow (*Deutsche med. Woch.*, May 18th, 1893), has made use of methylene blue, which is excreted in the urine, and has the power, as he ascertained, of preventing the growth of various bacteria in culture media with which it is mixed. The dose given was $1\frac{1}{2}$ grains in capsules, thrice on alternate days. The number of cases treated was fifteen. The urine was stained blue usually in an hour, and on the next day the quantity of the urine was increased, while the amount of albumen and casts gradually diminished. No unpleasant effects were noticed. The rapidity of the recovery in three cases, which are related at length, was remarkable. In one, a man aged 30, suffering from acute nephritis for the first time, the treatment was begun on the tenth day after he noticed general œdema. Four days later the quantity of the urine was nearly quadrupled; casts, which had previously been plentiful, could no longer be found; the quantity of albumen had diminished; and the

œdema was limited to the lower limbs below the knee. On the seventh day all the œdema had disappeared, the albumen had entirely disappeared, and the quantity of urine was about thrice what it had been at the commencement of the treatment. The patient left the hospital nine days after receiving the first dose of methylene blue. In another case a man, aged 36, an habitual drinker, the treatment was commenced on the sixteenth day of his illness. The quantity of the albumen was reduced to half, the quantity of urine more than tripled on the fourth day of treatment; all œdema, which had been general, had disappeared after four days more; and two days later the urine had ceased to contain albumen. In the third case treatment was commenced on the tenth day of the illness, when there was general anasarca and dilatation of the heart, the patient's general condition being bad. All the œdema and albuminuria had disappeared completely on the sixteenth day of treatment, and the quantity of urine was nearly quadrupled. Netschajeff considers that it would be improper to ascribe the improvement to a diuretic action of methylene blue, since in other conditions, such as failure of cardiac compensation and cirrhosis of the liver, it has no diuretic action. He believes that the effect is due to a restoration of the renal function brought about by the specific action of the methylene blue, which renders the kidney tissues an unsuitable nidus for the development of the streptococci.—*Epitome British Medical Journal.*

HYPODERMATIC METHOD IN THE TREATMENT OF SYPHILIS.

Dr. J. William White, of Philadelphia, has gone very thoroughly into the hypodermatic treatment of syphilis (*University Medical Magazine*, May and June, 1893). He has reviewed the treatment from its inception, has obtained the opinion of all the leading syphilographers in America, and from the consensus of opinion expressed he has drawn the following conclusions:

In the light of the evidence presented above, it seems to me safe to assert that: (1) The hypodermatic treatment of syphilis has not as yet shown results which warrant its adoption as a routine method to the exclusion of or in preference to other methods; but, on the contrary, has some apparently insuperable disadvantages, and even dangers, which render it improbable that it ever will be so adopted.

(2) The circumstances under which hypodermatic medication should be employed may be summarized as follows: (a) Those cases in which other methods of treatment have been tried and failed; (b) those cases in which, owing to idiosyncrasy or intercurrent disease, the skin and the digestive tract cannot be used for the introduction of mercury; (c) those cases in which, owing to grave and advancing lesions, rapid mercurializa-

tion is absolutely necessary ; (*d*) those cases in which obstinate localized lesions can be most directly reached by this plan ; (*e*) possibly those cases referred to by Jullien, in which early differentiation between syphilis and malignant disease, or tubercular ulceration, is extremely important, should be included in this list ; I certainly feel inclined to employ the method in all doubtful cases which admit of it, particularly in those conditions of the tongue which often leave the surgeon for a considerable time in doubt as to their exact nature ; anything which promises to shorten this period of doubt, by rendering the therapeutic test more rapid and more certain, would be of great advantage ; I should, however, in such instances, feel obliged to use potassium iodide by the mouth at the same time ; (*f*) a theoretical possibility of the employment of mercury hypodermatically has suggested itself to me, but, I have not as yet actually employed it. It may be that its use by this method will aid in shortening the period of doubt which often intervenes between the appearance of the primary sore and the development of general adenopathy, or of the exanthemata. If in the presence of a sore of uncertain character the employment of mercury hypodermatically resulted in rapid cicatrization, no local treatment being employed other than cleanliness, it might occasionally throw light upon the case without being open to all the objections which attend the systematic and slower administration of mercury by the mouth. It is possible that the idea is worth a trial in exceptional cases, but I do not think it should be adopted as a routine practice.

(3) As to the choice between the two great classes of mercurials, the soluble salts are to be preferred to the insoluble in the large majority of cases as more exact in the matter of dosage, and much less dangerous and less likely to be followed by local disturbances. They are always to be used when there is need for rapid mercurialization.

The insoluble salts should probably be reserved for those cases in which frequent visits to the surgeon are impossible, and in which no contradictions exist. In cases of defective kidneys, diabetes, profound anæmia, marked atheroma, great debility, etc., such methods are dangerous, and the case, even if urgent, will probably do better under some other form of treatment.

(4) Finally, as to the special preparation to be employed : Among the soluble salts, the bichloride is probably to be preferred. The results from its use are not strikingly different from those obtained from the other compounds of this class but its stability and great solubility and its germicidal qualities seem to warrant its selection. The disadvantage is the pain which it causes ; but the evidence in this direction shows that in the hands of impartial investigators not responsible for the introduction of the particular substance employed, each of the salts on the list produces a con-

siderable amount of pain and a not inconsiderable number of accidents or complications. Probably the bichloride is freer from objectionable features in respect especially to the production of suppuration than any of the salts of mercury.

Among the insoluble salts, calomel and the yellow oxide are to be preferred. It would appear that the latter is a little less active, but at the same time much less irritating. Gray oil is the most available form of administering metallic mercury.

HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

WILLIAM OLDRIGHT, M.A., M.D. Tor.,

Professor of Hygiene in the University of Toronto;

AND

E. HERBERT ADAMS, M.D., D.D.S.

SMALLPOX IN ENGLAND.

There were 537 cases of smallpox in the Metropolitan Asylum Board's hospitals on the 20th of May. The latest reports say that smallpox is decreasing in England.

HOSPITAL FOR CONSUMPTIVES.

A hospital for consumptives has been established at Agincourt, in the Department of the Oise, by the municipal authorities of Paris. The measure was rendered urgently necessary in consequence of the overcrowding of the general hospital by phthisical patients.—*Medical Record.*

A NATIONAL BUREAU OF HEALTH.

The question of the establishment of a National Bureau of Health for the United States has been rather prominent of late, and it is to be hoped that the idea will be consummated in the near future. Many great questions of quarantine and public hygiene could be more successfully dealt with by such a central health organization.

SYSTEMATIC SANITARY INSPECTION.

The summer corps of the Board of Health of New York city began work on July 5th. The corps is composed of fifty physicians, each one having charge of a district, in which he is expected to visit and inspect every tenement house, reporting on its sanitary condition, and prescribing for the sick poor who may be unable to pay for medical attendance.—*Medical Record.*

THE DIAGNOSIS OF DIPHTHERIA.

The Board of Health of New York city will hereafter undertake to make bacteriological cultures of all suspected cases of diphtheria occurring

in the city. As many cases reported as diphtheria are not true diphtheria, the advantages of such a procedure will be obvious to all. It will, however, entail an immense amount of extra work on the department. Should the experiment prove successful in New York, it would be well if the Toronto Board of Health would undertake similar duties.

TUBERCULOUS MEAT.

The following resolution has been passed by the Incorporated Society of Medical Officers of Health of England :

While awaiting the report of the Royal Commission on Tuberculosis, it is the opinion of this society that the presence of tubercle at any stage in more than one part or organ of a carcass, or the presence of tubercle in any other than the primary stage (crude tubercle) in any single part or organ of a carcass, is sufficient and proper ground for the condemnation of such carcass as unfit for human food ; and that all butchers' meat or other flesh coming within the above description should be condemned accordingly.—*Public Health*.

RELATION OF FLIES TO THE SPREAD OF DISEASE.

Sawtschenks (*Hygienisches Rundschau*, April, 1893), after mentioning that Grassi, Cottani, Sizzoni, and Simmonds showed that flies might carry on their surface bacteria, describes a series of experiments to ascertain whether cholera bacilli could live in the alimentary tract of the fly, and be found alone in the excreta. He found that flies which had fed two hours previously upon cholera bacilli excreted numerous saprophytic and some cholera bacilli. After 6 to 24 hours the cholera bacilli increased, whilst the saprophytes diminished. It was possible to prove the presence of the cholera bacilli in the intestine, nor did they lose their virulence after twenty-four hours' sojourn in the alimentary tract. He further thinks that they multiply in the intestine. Flies fed upon the excreta or the intestinal contents of cholera cases showed the presence of the characteristic bacilli.—*Public Health*.

A STANDING COMMITTEE ON CHOLERA.

The Standing Committee on Cholera of the College of Physicians of Philadelphia issued a circular on June the 20th asking the organized cooperation of the physicians of Philadelphia in their efforts to prevent the appearance of cholera during the coming summer. Physicians in each ward from the number of those volunteering for the public service will be asked to observe especially—as they may readily do in their daily rounds—the conditions of the streets, alleys, sewers, and gutters, and to report to the committee on the performance and thoroughness of the work of street-cleaning contractors, etc. It is also desired that they should observe

as far as possible, the sanitary condition of dwellings, especially noting nuisances which need to be immediately remedied. Reports should be immediate, explicit, and concise. Necessary blanks for the purpose will be supplied by the committee. If cholera appears ambulance corps, nurse corps, etc., will be organized by the committee. The committee will work in conjunction with the Board of Health and other civic authorities.

THE CHOLERA.

Reports from Mecca show that the cholera is raging to an almost unparalleled extent, even for that hotbed of epidemic disease, 830 deaths having occurred there in four days ending June 20th; 445 on Sunday, June 25th; and only one less than a thousand on Monday, June 25th. This is the largest number reported during the present epidemic, but there is no reason why it should not be exceeded, except that the material for the disease to work upon must become exhausted in the course of time, notwithstanding the fact that the pilgrimage to Mecca is very large this year. The latest advices from Russia indicate that the disease is diminishing in that empire. There can be little doubt that the cholera prevails to a considerable extent throughout France, though the authorities are pursuing the foolish, if not criminal, course of attempting to conceal the extent of its ravages. Cases are reported from the coast towns in both the northern and southern portions of the country, and the fact that the authorities in Montpellier and elsewhere are voting large sums for the building of temporary lazarettoes for the reception of cholera patients bears witness to the prevalence of the disease in those places. Cases are reported in Alais, Nantes, Toulon, Hyères, and Cette, and the disease exists also in Malta and Cephalonia in the Mediterranean, and in Catalonia, Spain. The reports from Hamburg are more cheering, no new cases having occurred there during the week ending June 23rd.—*Medical Record.*

Editorials.

THE ONTARIO MEDICAL ASSOCIATION.

IT is satisfactory to know that the affairs of this vigorous association are in a prosperous condition; but it is somewhat unfortunate, at the same time, that the recent thirteenth annual meeting was below the average of the last few years in some respects. The number of those present fell far below ordinary high-water mark, being 141, while last year it was 200. It has been stated by some that the character of the papers read, and the

accompanying discussions, were up to the average. The old proverb about comparisons is worthy of consideration in this relation, and we are not disposed to be aggressive in this particular line.

We think it time that the association should advance, not simply maintain its average. It is strong in numbers, in enthusiasm, and in the ability of its members. It contains the best elements of the profession in the greatest province of the Dominion; it has always been well officered and well managed in every respect; its prospects were never brighter than at the present time. However, the future success will depend on the faithful work especially of the younger members, who, we hope, will rise equal to the occasion, and imitate a few who read excellent and carefully-prepared papers at the last meeting.

The social features of the meeting were particularly pleasant. The luncheon given by the Toronto members was the most successful and enjoyable in the history of the society. Dr. Burns made an admirable chairman. He presided with grace and dignity, spoke pleasantly, always knew when to stop, and put everybody in good humor. Those bright and witty Irishmen, Drs. Hillary and Sullivan, fairly excelled themselves—if such be possible—and carried up the crowd from the regions of anatomy and pathology to the highest realms of fun and good fellowship. Dr. Sheard, president of the Canadian Medical Association, spoke well, making an earnest appeal for the support of all present towards the coming meeting in London in September next.

The association is deeply indebted to the president and directors of the Victoria Hospital for Sick Children for their generous entertainment in their magnificent building on the first day of the meeting. A number of good men and women in Toronto have been doing, in a quiet but effective way, noble work, which has culminated in the erection of one of the finest structures for the treatment of sick children that the world has ever seen. "May God bless and prosper them" was probably the silent prayer of all who had the privilege of being present.

We will not attempt to express the delight of those who were able to accept the invitation to visit the Lakeside Home on the following day. It was a revelation to many, if not all, to learn how much was being done for the treatment of the poor sick little ones in the summer months. John Ross Robertson, in the erection of this noble charity, together with his intelligent and unwearying care of these young sufferers, will leave one of the grandest and most enduring monuments that this province has ever seen or ever will see.

It is only fair to refer to the good work done in the interests of the meeting by the president, Dr. Hillary, of Aurora; the secretary, Dr. J. Gibb Wishart; and the other officers of the association. We desire to con-

gratulate the new president, Dr. McFarlane, on his election, which was very popular, and, at the same time, to express the hope that the next meeting may be the most successful one in the history of the association.

ONTARIO MEDICAL COUNCIL.

THE recent meeting of the Ontario Medical Council was, in many respects, a satisfactory one. At the first session, Dr. Fowler, the retiring president, delivered an address which was dignified and temperate in tone.

The first business of importance was the election of the officers for the coming year. Dr. C. T. Campbell, of London, was elected president; and it was generally admitted that he performed his duties at the meeting in a most able and impartial manner. The election of Dr. Philip to the vice-presidency gave general satisfaction. The other officers elected were: Registrar, Dr. R. A. Pyne; treasurer, Dr. W. T. Aikins; solicitor, Mr. B. B. Osler; official stenographer, Mr. Alexander Downey.

After a number of notices of motion had been introduced, Dr. Henry made enquiries as to the "gerrymandering" of the constituencies under the new Medical Act. Dr. Williams, in reply, said the Legislative Committee (appointed by the council) knew very little about it, as the bill had been introduced without the sanction of this committee. The learned ex-president evidently considered that the council had received a broad-sized snub from the Ontario Legislature; and a careful consideration of all the circumstances connected with the amended act, including the arrangement of the constituencies, will make most people think that he is not far wrong.

One of the earliest reports was that of the Discipline Committee, dealing with the cases of Dr. McCully and Dr. Anderson, and recommending that sentence be suspended during the good conduct of the offenders. Both had acknowledged unprofessional conduct, and made ample apology. We have no time now to discuss the work of the Discipline Committee in detail; but we have much pleasure in testifying to the general approval on the part of the profession of the valuable work done by this able and hard-working committee during the past ten years. A few have expressed some dissatisfaction; but the majority, including many "Defence" men, approve.

Dr. Philip brought up the subject of certificates for professional nurses from the various hospitals in Ontario. He thought it might be advisable for the council to conduct the examinations and grant the certificates to the graduating classes in all parts of the province. The matter was

referred to a special committee. After a careful consideration of the proposal, and a consultation with Dr. O'Reilly, of the Toronto General Hospital, it was decided best to defer the matter for a year. The Education Committee made a very important change in deleting therapeutics from the subjects required at the primary examination, and placing it on the list for the final.

We regret that the council decided to continue a subsidy to the *Ontario Medical Journal*. The action of the council last year certainly caused us considerable surprise—to put it mildly. We heard all the arguments advanced in favor of the procedure, and watched the results. The following, in brief, are some of the results: a heavy blow has been struck against original research and independent medical journalism; a gross injustice has been done to *The Canada Lancet* and THE CANADIAN PRACTITIONER, the two old and recognized medical periodicals of Ontario, which have invariably given the council a hearty, though independent, support. The council has gained no strength from the paid support of its subsidized journal.

The Lancet has already spoken on the subject briefly, but in a dignified manner. We have been asked, What will THE PRACTITIONER do under the circumstances? We have no hesitation in giving our answer. We will continue to support the council. We will in the future, as we have in the past, uphold the college as the great medical parliament of the province, but we respectfully decline to sell ourselves to that body. We united with *The Lancet* in offering to publish the proceedings of the council free of charge, and thus save some hundreds of dollars of the subsidy. Many members acknowledged that, in not accepting the offer of *The Lancet* and THE PRACTITIONER, the council was doing the profession an injustice, without securing any compensating advantage; but they thought that it was only fair to give the company which published the new journal one more year's subsidy, in the hope that it might thereafter be able to stand alone. Although we do not consider that there is much in the argument, we will give the majority of the council credit for purity of motives, where indifference did not prevail. A small minority of the council, in openly canvassing for a scheme which it was hoped would help a brother member in a private speculation, have acted in a way which is certainly not above criticism, although it may be considered by a very few as quite honest and honorable. Even the Toronto city council, low as it has fallen, has always refused to give a contract to a company in which one or more of its members are interested.

We regret very much the tone of certain articles in the *Toronto Mail*. Wholesale abuse of that newspaper, which is one of the best on the continent, will, however, do no good. The discussion on the sub-

ject in the council was a varied one in more respects than one, and, on the whole, was altogether too long. Some discussed the matter in a calm and dignified way; others spoke like angry schoolboys who had been hard hit and wished to talk loud. The unwise conduct of a few injudicious orators gave the *Mail* a good opportunity, in its reply, to laugh the council out of court.

Meetings of Medical Societies.

REPORT OF THE THIRTEENTH ANNUAL MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

Held in Hall, Educational Department, Wednesday and Thursday, June 21st and 22nd.
Reported by Dr. J. N. E. Brown, Official Stenographer to the Association.

The thirteenth annual meeting of the Ontario Medical Association met in the hall of the Educational Department of the Normal School on June 21st, at 10 a.m.; Dr. R. W. Hillary, of Aurora, in the chair.

Vice-Presidents Dr. Brock, of Guelph; Dr. McKay, M.P.P., of Ingersoll; Dr. Sheard, president, and Dr. Birkett, of Montreal, secretary of the Dominion Association, were invited to seats on the platform. Dr. Wishart then read the minutes of the last meeting, which were carried.

After the reading of several letters of regret and the reception of a number of new members, the first paper was proceeded with.

As Dr. Powell was absent, the president called on Dr. A. A. MacDonald, who read an excellent paper on

CHOLELITHOTOMY WITH CHOLEDUODENOSTOMY FOR THE RELIEF OF CHOLÆMIA DUE TO OBSTRUCTION OF THE COMMON BILE DUCT.

Below is an excerpt from the paper:

Gallstones may exist for some time in the gall bladder and produce no definite symptoms, but not so when they become impacted in the common duct. The treatment for this latter condition has heretofore been unsatisfactory, but now such an advance has been made in the way of surgical treatment that it appears that it will be placed on a scientific and satisfactory basis. Chronic jaundice depends upon obstruction to the flow of the bile. Where the jaundice is due to a new growth, the following are some of the symptoms: emaciation, dyspepsia, flatulence, absence of bile in the fæces, its presence in the urine, etc. Death ensues usually within a year. When due to impacted gallstones or stricture, the symptoms are not so constant, and the case may last for years. The pres-

ence of gallstones in the gall bladder cannot be accounted for, although they are frequently found at autopsies in subjects over sixty years old. The assigned causes are: sedentary habits, too much starchy food, constipation, tight-lacing, etc. In order to treat these cases successfully, the bile must re-enter the intestine. The doctor then outlined the history of a case he had upon whom this was attempted. After an incision through the abdominal wall, the gall bladder and the duodenum were opened and through each incision was put one of Murphy's buttons. These were then approximated, bringing the two serous surfaces together. The patient's jaundice disappeared, but death ensued. A *post mortem* showed non-union owing to lack of vitality of the tissues.

Dr. N. A. Powell then gave the history of a case in which a similar operation had been performed, but the method employed was that of Gaston—the use of the elastic ligature. The operation was ultimately a failure, for the patient died. He thought the buttons an improvement on the elastic ligature.

Dr. McDonald, in replying, pointed out the fault in Gaston's method to be the closing of the fistula made by the ligature by the process of healing immediately after the ligature had cut through. He then detailed some of the objections raised against the buttons, but showed that they were not at all serious objections. Concluding, he hoped before many months there would be many successful cases reported in this very interesting branch of intestinal surgery.

The president then gave his address. He said he felt much honored at being elected to the position he occupied, more especially as he was absent from the last year's meeting; and also because the position had formerly been filled by such a distinguished array of men. He referred feelingly to the loss the association had sustained by the deaths of Dr. Worthington, of Clinton, and Dr. Henderson, of Kingston, both past presidents of the association. He was glad to know that the matter of reciprocal registration of medical men between Canada and the old land rested with the home authorities, but thought not much could be expected from them when we ourselves had not decided on reciprocal provincial registration. He (the speaker) advocated a Dominion council. He endorsed the raise in the educational standard for medical men in the province. He detailed some of the evils of club practice and denounced it. In regard to the Medical Council, he saw much to approve and some things to condemn; but, as it was constantly improving in many ways, he thought it should be liberally dealt with. He strongly advocated the formation of a club, which might meet in the council building. This would tend to foster a spirit of cordiality and unity among the members of the profession that no other means could. There might be, he thought,

some wards made into which patients brought from outside the city by their physicians upon whom they (the physicians) wished consultation might be placed for a time. The speaker favored the increase of territorial representatives, and in regard to contested elections he approved of the method of having the case tried before the county judge. In concluding his address, Dr. Hillary welcomed the visitors present from the other side of the line, and hoped they would be treated by the members of the association with the same cordiality and good feeling which Canadians received over there.

Dr. McKay moved a vote of thanks to the president for his address, which was carried with applause.

Dr. Hillary replied that he was pleased that his remarks were so well received, and hoped his suggestions would shortly take on some practical form.

The chairman at this juncture introduced the Minister of Education to the association, who said that he did not come to discuss medical questions, but to inquire whether the members of the association were comfortable in the hall. It was an honor to have their presence, and he welcomed them. They would, he said, be welcome at all times they wished to honor the institution with their presence.

Dr. W. B. DeGarmo, the delegate from the New York Medical Association, said his chief duty was to present the greetings and good will of his association; the next was to read his paper,

THE TREATMENT OF HERNIA BY THE GENERAL PRACTITIONER.*

Dr. DeGarmo began by saying that it was impossible to fully discuss so extensive a subject in the short time allotted. Too much time had been spent on the surgical side of the question. He proposed to devote his time to the palliative treatment—means within the reach of every practitioner. The doctor then gave a short account of the history of trusses, pointing out the good qualities and the defects in them. These various trusses were shown. A good truss should hold the hernia completely within the abdominal cavity. No truss for inguinal hernia should have its pad attached by a descending arm. The centre of the pad should correspond to the centre of the spring. He also pointed out the value of the cross-bodied truss. The English truss, however, which had this good point, had too strong a spring. The doctor then showed a truss of his own invention for femoral hernia which filled the necessary requirements demanded in a truss for femoral hernia. After getting a perfectly fitting truss, the practitioner should watch his patient until cured, seeing him at least once a month to see that the hernia was securely held. In infants

*Will be published in a subsequent issue.

the springs used were usually too strong. They should be light, waterproof, and should be left on at nights. The doctor had treated infants as young as ten days old. There was no lack of appliances, the doctor concluded, but there was of medical men who understood the application of them.

Dr. Barrick said that they were all indebted to Dr. DeGarmo for his able address. He (Dr. Barrick) wished to refer to two or three points mentioned by Dr. DeGarmo. The first was with regard to the pad being in line with the spring; the second, the relation of the pad to the internal ring. He said that in old cases of hernia the internal ring was dragged down towards the external ring; therefore, he thought that the English truss, condemned by the reader of the paper, was constructed on the right principle, the pad being below the line of the spring.

Dr. Grasett said that he agreed in the main with what Dr. DeGarmo had said, but he did not like to hear the English truss condemned so strongly, as in many cases of failure it was not the fault of the truss, but was due to some accident by which it was broken or disabled.

Dr. Harvie then read the report of the Committee on Ethics, which was carried.

The president then called on Dr. Powell, of Ottawa, who addressed the association on

THE MANAGEMENT OF ABORTION.*

He said he had no new and startling developments to tell them of, but that he merely wished to bring this important subject under their consideration. Syphilis, either through the mother or the male parent, was one of the commonest causes of abortion, and that in these cases mercury had been found to be very beneficial. Endometritis, fibroids, malignant disease, an everted or patulous os, and malpositions were other causes. The last condition was readily treated by keeping the fundus in its proper position for about three months. Subinvolution was another cause of the aborting habit, and in these cases local applications and general medication were needed. In other cases no cause could be given. Rest was an essential part of the treatment, particularly in threatened abortion. He also recommended absence of sexual intercourse, the use of opium, bromide of potassium, and viburnum. In primiparæ, where abortion had taken place, hemorrhage was often arrested by the ovum itself filling up the cervical canal. In multiparæ the tampon was often necessary. He advised curetting where there was continued hemorrhage accompanied by retention of a portion of the membranes which the finger could not reach.

* See page 483.

Dr. Shaw, of Toronto, agreed with Dr. Powell, but thought that a run-down and irritable condition of the patient was another frequent cause. Respecting opium, he would only use it in those cases where there was both pain and hemorrhage. He would always make sure that the uterine contents were expelled.

Dr. Machell, not being present when the paper was read, asked to be excused from discussing the subject.

Dr. Temple said he did not agree with the paper in one or two points: First, hemorrhage, in his experience, was more severe in primiparæ than in multiparæ; therefore, he would, in treating them, use the tampon. Second, in primiparæ, he believed that abortions were more frequently due to the patients not taking care of themselves, and were not so often due to syphilis. Third, he considered that the after-results, such as septicæmia, etc., were far more to be dreaded than the hemorrhage at the time of the abortion.

Dr. A. H. Wright said that he did not agree with Dr. Temple that accident was the chief cause of abortion, as working women, in his experience, were least likely to abort. To prevent abortion, his treatment was rest, opium, and pot. brom. as an adjuvant. It was, he said, very difficult to decide that any given case was one of inevitable abortion. When it was inevitable, he emptied the uterus of its contents as soon as possible. If the os was undilated, he used the tampon; but, if dilated, he generally used his finger to get rid of the contents. He concluded by saying that cleanliness should be assiduously attended to, and septicæmia would thus be avoided.

Dr. Powell then closed the discussion. He said that he did not agree with Dr. Temple, as he had found that hemorrhage in primiparæ was not so severe as in multiparæ; that the ovum filled the canal, and therefore no tampon was needed. He had not said that syphilis was the great and only cause of abortion, but that it was one of the most fruitful sources of it. With reference to what Dr. Shaw had said, he himself agreed that it was not wise to use opium where it was contraindicated.

The sections then divided, the medical remaining in the large hall. Dr. Brock took the chair, and Dr. Milner acted as secretary.

The association was now addressed by Dr. Wilson, of Richmond Hill, on

THE TREATMENT OF DIPHTHERIA.

The doctor strongly advocated the use of prophylactic treatment in the way of removing all sources of irritation from the mouth, nares, and tonsils, and anything that would cause hyperemia of these parts. The general condition of the system should be kept in the best possible condition, and the hygienic surroundings perfect. Early treatment, the doctor said, was necessary in order to lessen the vitality of the germs, and their virulence

and power of reproduction. When the membrane was small in amount it was possible to keep it rubbed off, and the denuded surface sprayed with bichloride solution. The membrane could be dissolved by papoid, hydrogen peroxide, etc. In many cases where we could not kill the bacilli, we could lower their vitality so that their virulence needed not to be feared. In cases with pain the cold coil should be used. The constitutional treatment consisted in the use of rest, liquid diet, and the administration of tinct. ferri perchlor.

The next gentleman who was called upon to address the association was Dr. Milner, of Toronto, who read a paper on

DIPHTHERIA: ITS CAUSE AND TREATMENT.

The doctor started out by saying that it was hard to say in many cases how the disease was contracted, but he had found it due to direct contagion most often. He then spoke of means to prevent its spreading: isolation, disinfection, etc. In speaking of treatment, he said an external application of turpentine was useful, and that, among solvents, peroxide of hydrogen was the most reliable. If the membrane formed very rapidly, obstructing respiration, it should be removed. Tincture of iron, he affirmed, was our sheet anchor in treating the constitutional symptoms. Stimulants also should be given from the first. The diet should be chiefly iced milk. Speaking of tracheotomy and intubation, he said that intubation should be used in infants under three and a half years old, also in adults. Tracheotomy should be performed in those between three and a half and five years old. The doctor then outlined two or three interesting cases he had had, one of which had been followed by paralysis and death.

A paper was then read by Dr. Bryce on

THE PUBLIC SCHOOLS IN RELATION TO THE DISSEMINATION OF DIPHTHERIA.

He showed by statistics gathered that the number of school children attending school under the age of ten years formed about eleven and four-fifths per cent. of our population, and that 76.3 per cent. of the number of deaths from diphtheria occur before the age of ten; showing that school life is the particularly susceptible age. The doctor showed from epidemics at home and abroad that the schools are a fruitful source of dissemination of the disease. Density of population, ill-ventilation, lack of sunshine, decaying matter, etc., are all helpful in spreading it. The doctor showed that the cubic amount of air space in the rooms used, the cleanliness of the floors, the frequency with which the air is changed, entered largely into the prevention of its spread. The altered humidity of the air in schoolrooms in winter, he thought, was a potent factor in the

spread of the disease, as it materially affected the condition of the mucous membrane of the respiratory tract.

Dr. Wilson then asked how it was that sanitation had decreased all other diseases, but diphtheria had increased.

Dr. Burrows asked if overcrowding of itself was sufficient to cause the disease, and that in dwellings of the poor would not the filthiness present often account for it?

Dr. Spencer said he would like to know why the most unsanitary parts of the city were free from diphtheria, while the parts perfect in sanitation were constantly having cases.

Dr. Bryce answered by saying that if the germs could be kept out of the school from the first, there would be no danger. But in the most healthy parts of the city germs had got into the schoolrooms from some one affected, and were thus spread by the school; and in this way those parts of the city were infected.

SURGICAL SECTION.

The Surgical Section of the association met in the examiners' hall at 4.30 p.m.; Dr. McKay, of Ingersoll, presiding. Dr. J. N. E. Brown was appointed secretary.

Dr. E. A. Spilsbury then read his paper on

DEFLECTION OF THE NASAL SEPTUM AND ITS SURGICAL TREATMENT.

He gave an outline of the pathology of the condition, its symptoms, and surgical treatment. The etiology he considered was traumatic, the symptoms were those of catarrh, buccal respiration with its attendant evils, a change in the voice, etc. The treatment he recommended was removal of the obstruction by incision or by crushing. He gave a history of the different methods employed in operating on a projecting septum, and entered into the details of Delstanche's method, which consists in crushing the septum by using a pair of forceps, having the limb which enters the occluded nostril and which comes in contact with the obstruction, armed with a stellate knife. After being thus straightened, he inserts a splint whose two arms, entering the nostrils, and brought into contact with the nasal septum, hold it in position till healing takes place. The doctor then gave a history of several cases in which he had employed this method with marked success.

Dr. Primrose then followed, his subject being

THE ANATOMY OF THE CHILD.*

This paper was highly interesting because he had frozen sections wherewith to illustrate his paper, and also photographs of the same. He said this method of studying anatomy was particularly useful in learning

* Will be published in *THE PRACTITIONER*.

the anatomy of the viscera and the structure of the joints. He contrasted the anatomy of the child with that of the adult. Many interesting points were to be seen upon examining the various sections, such as the relations of the antrum, the straightness of the nasal septum, the fascia of the eyeball, the horizontal position of the Eustachian tube, the relative position of the temporary and the permanent teeth, the immaturity of the mastoid cells, the "sucking cushion" so-called, the mediastina, the high position of the apex of the heart, the highly-developed diaphragm, the relatively large kidney and suprarenal bodies, the small pelvis, the abdominal position of the bladder, the vertical position of the rectum, and many other interesting features.

WEDNESDAY EVENING.

After the reading and adoption of the minutes of the last session and the reception of new members, Dr. Arnott, of London, read a paper entitled

A REVIEW OF THE DIAGNOSIS AND TREATMENT OF ASIATIC CHOLERA.

He pointed out the difficulty of recognizing the disease before it got a foothold in the community by reason of its similarity to sporadic cholera. He recommended that every case of diarrhoea be treated with all the sanitary precautions with which cholera is. In such a case the appearance of marked nervous phenomena should make us suspicious. The doctor portrayed vividly the various symptoms of the various stages, and emphasized the necessity of becoming absolutely certain of the diagnosis by a bacteriological examination. He described various conditions of the body, and of the surroundings which favored the spread and strength of the disease. In regard to the treatment he went fully into a discussion of the merits of the different plans employed—the eliminative, the astringent, the sedative, and the antiseptic, dwelling on the futility of any and all of them in many cases. The disease ought to be studied from cases uninfluenced by drugs. He opposed the use of alcohol in its treatment. His leanings were towards the eliminative treatment, and the application of heat externally and hot douches per rectum.

Dr. Sloan said that he did not agree with Dr. Arnott when he said that opium and alcohol were narcotics, and not stimulants. He (Dr. Sloan) had treated many critical cases with alcohol and opium which conclusively proved to him that they were stimulants.

Dr. Temple then said that he had seen several outbreaks of cholera in India, and found that, in many cases, drugs were worthless. He thought alcohol was the remedy. Warmth should also be applied.

Dr. Spencer said that he had seen cholera when in the east, and he agreed with Dr. Temple in every particular.

Dr. Hunter then asked Dr. Temple if he would treat the disease among Europeans as he would the people of India.

Dr. Temple replied that he would.

Dr. Barrick said that he had seen an epidemic of cholera in London, England, and that it depended on the severity of the epidemic and not on the treatment as to the number of deaths. At the beginning of the epidemic, the patients got alcohol and died. But as the epidemic got milder, they lived in spite of the alcohol. He closed by saying that he agreed with Dr. Arnott as to the use of alcohol.

Dr. Arnott then closed the discussion by still holding his former position, that alcohol was not a stimulant. It was, he said, an anodyne and antiseptic. He quoted cases from his own experience to vindicate his position.

Dr. Philp, of Hamilton, now read a paper on

THE PREVENTION OF CHOLERA.

He started out by saying that Asia was the breeding place of this disease. The doctor proved, by citing several instances, that the progress of cholera could be checked by quarantine and thorough disinfection. Also that it was mainly propagated by the stools of the patient affected; therefore it was imperative that the water supply should in no way become contaminated with the stools of the cholera patients. All excreta, he said, should be sterilized by carbolic acid or sulphate of iron. All clothing should be thoroughly disinfected which has come in contact with the contagium, great cleanliness should be observed, and the houses fumigated.

The following synopsis of a paper on

CHOLERA

was presented to the association by Dr. Saunders. In speaking of the morbid anatomy, he stated that there were very few characteristic appearances to account for the violent nature of the disease. The speaker described the condition in which the alimentary tract, heart, liver, lungs, and kidneys were usually found. One of the most constant pathological conditions was that the blood was nearly always dark and thick. There were two views as to what caused this. The doctor decided that it was due to the chemical action of the morbid material excreted by the comma bacillus. It must be remembered that the bacillus was destroyed by a heat of 140° F. and by weak disinfectants. Cholera could be diagnosed by bringing a culture of the bacilli into contact with free acid in the presence of oxygen, when a bright red color would be produced.

Dr. Rice, of Woodstock, was now called on and read a paper on

THE SYMPTOMS AND TREATMENT OF CHOLERA.

He said that many cases of dysentery, diarrhoea, etc., under bad hygienic surroundings, would, if they occurred in infectious countries, be classed as cases of cholera. The doctor then proceeded to give the symptoms which were found in the four stages of the disease. Then he dwelt on the treatment, saying that there was no specific line of treatment, but five indications were to be met, viz. : (1) The premonitory diarrhoea ; (2) the loss of liquid by the bowels ; (3) the low temperature ; (4) the toxæmia ; (5) the collapse.

The first condition could be met with calomel, followed by an astringent, with proper food and surroundings. In the second stage a large dose of calomel should be given, followed by successive small doses of the same and opium, or chloral, or chlorodyne, the latter to be given for the pain, if present. The doctor advised the use of hot antiseptic douches with tannin for the serous diarrhoea. For the lowered temperature, he recommended the continuance of the douches, with hot baths. We have, he said, no specific for the toxæmia, but calomel, iron, and quinine have been recommended. In the stage of collapse hot baths were advised, with injections of whiskey, brandy, strychnia, ether, etc. But usually when this stage had arrived the patient was beyond help.

Dr. Harrison, on being called, now addressed the association on the subject of

BLOOD-LETTING.

He said that it had been practised from time immemorial—that Virgil had mentioned it in one of his pastorals. He did not think that there were many men who had graduated during the last fifteen years who knew how to perform venesection. Prof. John Hughes Bennet, he said, gave blood-letting its deathblow by his attack upon it. The doctor thought that its indiscriminate use also assisted. But the doctor felt sure that this was a very useful agent, which was now so universally discarded by the profession. He said that he had perfect confidence in it as an efficient remedy in pneumonia, in which he had often tried it with success. It was useful, too, in emphysema. It was also useful in the various forms of heart disease, particularly where the right ventricle overloaded. He also spoke highly of its use in his own practice in the treatment of apoplexy, and also in eclampsia. Even tuberculous patients were often helped. He stated that it was also useful in chlorosis by stimulating the blood-forming organs.

Dr. Olmstead, in discussion, said that he had not had much experience in blood-letting, but thought it was indicated in conditions of high arterial tension, lividity, and engorgement of the right ventricle, such as is often found in pneumonia and some conditions of the heart. In using it in

cerebral cases we should be very careful, because if the case were one of thrombosis blood-letting would be contraindicated. In chlorosis, he would stick to iron.

Dr. McPhedran said he could not agree with Dr. Harrison's statement that pneumonia was more fatal in the hands of the modern practitioner than formerly, and he had seen statistics to prove this. The object of blood-letting was to relieve the right ventricle. This could be done, in a great many cases, effectually by bleeding the patient into his own vessels by using nitro-glycerine. The speaker had proved this by experience.

Dr. R. A. Reeve said that blood-letting by means of leeches was very serviceable in certain forms of disease in the eye and ear.

Dr. Bromley related an interesting experience he had had with leeches.

Dr. Arnott, of London, said he had proved the beneficial effects of blood-letting in meningitis and in inflammations of the eye and ear.

Dr. McKinnon, of Guelph, said that he had seen beneficial results from blood-letting in eclampsia, pleuritis, and pneumonia, and strongly recommended it in eclampsia.

Dr. Birkett, of Montreal, had seen good results in mitral stenosis in old people from blood-letting by nature's method—epistaxis.

Dr. Barrick related a case of eclampsia where everything else had been tried. Blood-letting afforded immediate relief. He would not advise its use in anæmia.

The president then said that in his younger days he had seen a great amount of blood-letting, and when it went out of use he had given it up, except in eclampsia.

Dr. Harrison closed the discussion by saying that he had tried nitro-glycerine, and was not satisfied with it as was Dr. McPhedran; he preferred the lancet.

THURSDAY MORNING.

The association, after the opening business, listened to an instructive paper by Dr. Holford Walker on the subject of

MASSAGE, AND ITS APPLICATION IN GENERAL PRACTICE.

He defined massage to be "the communication of motion to the tissues of the body, 'at best accomplished by the hands,' the motion controlled by the various movements adopted, and the force used." Strange to say, it would help directly opposite conditions; it would fatten the thin and reduce the fat. Unlike drugs, it did not unpleasantly affect the system. Its effects were mechanical, reflex, thermal, and electrical. The doctor explained how the body cells were stimulated, the movement of the blood quickened, the absorbents stimulated by the first;

how the nervous system was soothed by the light stroking used in the second; how the muscular exercise induced the thermal effects; and, lastly, how the electrical effects were manifested in effecting cures in an unexplainable way of various paralyses of the body. Massage was particularly useful in neurasthenia, rheumatism, rheumatoid arthritis, fractures, sprains, constipation, sciatica, and many other diseases. Even the weakest patients can stand it.

The president said that he had once used massage in his practice, but had let it fall into disuse. He would again make it a study.

Dr. Hunter endorsed all that Dr. Walker had said. He had tried it with gratifying success in fractures. It had given splendid results in the various neuralgias.

Dr. McKinnon, of Guelph, then followed on the subject,

ACUTE GENERAL PERITONITIS: LAPAROTOMY, AND RECOVERY.

He gave a history of the case. The subject was a pale girl, and the attacks sudden and severe. Morphine gave only partial relief, and, after consultation, operation was decided upon, pulse being 100, temperature 101°, and tympanites great. After incision it was discovered that upon the lower anterior wall of the stomach, about two inches from the left extremity, adhesions were found, which, on being separated, disclosed an old ulcer. The distension made it extremely difficult to close up the incision; so much so that the prepared silkworm gut broke, and unprepared silk was used. A drainage tube was left in until the second day. The patient subsequently developed an attack of pneumonia, followed by phlebitis, occurring successively in the left leg, the right leg, and the left arm. These attacks he considered were septic, and due to the suppuration arising from the stitch holes of the unprepared silk. The question, when to operate, is a serious one. In idiopathic and some forms of puerperal peritonitis, the opium treatment was sufficient; but in the perforated variety, unless considerable shock be present, operation was indicated.

Dr. Graham asked his opinion of laparotomy in perforation of typhoid fever.

Dr. McKinnon replied that he had had no experience in operating for that condition.

THE FAILURES AND SUCCESSES OF BROMOFORM IN THE TREATMENT OF WHOOPING-COUGH,*

by Dr. Duncan, was the next paper read. He cited cases where it had been used with little or no effect, and some cases where it had had a toxic effect. Being narcotic, it somewhat unfavorably influenced the general condition of younger children. It was found

* Will appear in THE PRACTITIONER.

by some who tried them that bromide of potassium and chloroform did better. The doctor then gave some reports of its successful use among Toronto and outside men. Some reported that it did not shorten the disease, but cut short the paroxysms. In his own practice he had found, where a small dose was ineffectual, that increased doses gave great relief. It should be carefully prescribed, as there was a case reported where one drachm had been prescribed with four ounces of water, a teaspoonful being the dose. The last dose killed the patient.

The association then divided into sections, the discussion on whooping-cough going on in the Medical Section.

Dr. Stalker, of Ridgetown, said that he had had an epidemic of pertussis in his practice, and that he had tried bromoform, but he found quinine to be better. His treatment was quinine and fresh air.

Dr. Hunt, of Clarksburg, said that he agreed with Dr. Duncan. He had gone through an epidemic of pertussis and found bromoform exceedingly useful, especially in shortening paroxysms.

Dr. Duncan closed the discussion by saying that he would not use bromoform to the exclusion of all other drugs. He would not give it more than three times a day and once during the night.

THE NATURE OF FEVER, AND ITS PHENOMENA AND TREATMENT,

was the subject dealt with by Dr. Holmes, of Chatham. He said that this subject was at the present time employing the attention of some of the ablest men of the profession. The processes which govern the maintenance of the temperature, he said, were but imperfectly understood, and that heat loss was not always uniform, neither was heat production; and, in order that a uniform temperature might be kept, the mechanism governing it must be in intimate relation with heat production and heat loss. Heat production was the result of retrograde tissue change. Four-fifths of the body heat was generated in the muscles. The increased respiratory and cardiac action he explained to be dependent on the increased temperature of the blood. There might be rise of temperature without fever, and also fever without rise of temperature. Dr. Holmes wondered why the profession were hunting around for new remedies when the cold bath was at their disposal. By using it in one hundred cases of typhoid fever, his death rate was only two.

In discussing this paper, Dr. McPhedran said that cold baths were a means but not a specific in fever. He then gave an account of how he would use the cold baths in the various fevers. This, he said, was excellent treatment in the summer diarrhoea of children. The baths ameliorated the symptoms in typhoid, but did not eliminate the poison.

Dr. Hunter fully agreed with Dr. Holmes and Dr. McPhedran.

Dr. Bromley said that he had used jars filled with cold water placed about the patient, but did not use the bath. In typhoid fever, he used the cold bottles and antiseptics.

Dr. Rice asked Dr. Holmes if he would use the bath in a case of summer diarrhœa with a cold surface and an internal temperature of 103° or 104° .

Dr. Holmes closed the discussion by saying that the cold bath shortened the duration of the disease and prevented many nervous symptoms arising. As to Dr. Rice's question, he stated that he had always got excellent results from the cold bath in all cases of summer diarrhœa; he also used massage of the extremities. It had always stopped the convulsions, in his experience, also.

Dr. McPhedran then presented a case of

ABDOMINAL ANEURISM.

After giving the patient's history and showing the members the area of the tumor and of the pulsations, he proceeded to describe the treatment. The patient had come to the General Hospital a year ago last March, and had been kept in bed until October. The treatment was that adopted by Balfour, of Edinburgh—iodide of potash and nitro-glycerine. The nitro-glycerine was increased until the pulse became very small, and soft. He began with 1-100th of a grain and increased it to 1-50th. The diet was light and nutritious, and as little liquid was given as possible. The tumor gradually lessened in size until August, but from August until October there was little change, when he was allowed to go home, with the injunction that he was to do no hard work. However, he worked hard all winter. Now the tumor was somewhat larger than it was. However, the patient was very materially relieved, if not absolutely cured.

Following this was a paper on

THE PREVENTION OF TUBERCULOSIS IN ONTARIO,*

by Dr. E. Herbert Adams, of Toronto. In opening his paper, Dr. Adams gave some statistics showing the immense death rate occasioned by this disease. In Ontario it had claimed 24,437 victims between 1880 and 1890. Thirty-four per cent. of the patients admitted into the Sick Children's Hospital, Toronto, for the same period were tubercular in character. Then, too, the doctor spoke of its ravages among the lower animals, and the danger of their transmitting the poison to human beings; for there was no doubt, in the minds of those who had studied the matter, in regard to its contagiousness. The speaker then dwelt on the predisposing causes of the disease, heredity and unsanitary surroundings being the principal. To lessen this scourge, Dr. Adams recommended the reporting of all cases to the public health department, the inspection of milk and

* Will be published in THE PRACTITIONER.

meat by qualified men, the death of all affected animals, receptacles for sputa in public places, such as railway stations, thorough disinfection of houses after the death of patients, the complete separation of first cases in prisons, etc., and the erection of special hospitals for patients suffering from this disease.

Dr. Burns now read a paper on

POLYMASTIA.

The case was that of a woman who, in her third confinement, complained of swelling in both armpits. She had noticed it before her second confinement also, but not after the first. After the second she noticed a constant oozing in the left axilla, which was much aggravated after the third. On examination a supernumerary mammary gland, quite distinct from the gland proper, and which had a rudimentary nipple about the size of a split pea and from which fluid like milk exuded, was found. This fluid, examined under the microscope, showed the presence of colostrum corpuscles. In the right axilla, in a corresponding position, another one was found. The doctor thought that, if secretion were encouraged, lactation would go on as well and as long from them as from the mammæ proper.

Dr. Primrose said that he had examined the patient, and had found the supernumerary glands quite distinct. He had also examined the secretion from them under the microscope, and had found colostrum corpuscles. The mammary gland, he said, was of the same origin as the sebaceous gland.

Dr. Howitt, of Guelph, next addressed the association on

APPENDICITIS.

He stated that the authorities differed greatly as to the treatment of the disease. The preliminary abscess was usually intra-peritoneal. The appendix generally had a short mesentery. It varied greatly in size and position. This disease was commonest in the young and in males, and was often not manifest during life. The cause, he opined, was ulceration of the mucous coat, caused by fæcal concretions of foreign bodies. After giving the various points in the diagnosis, the doctor spoke of treatment; rest in bed, opium, easily assimilated food were recommended. After the pain had subsided, if twenty-four hours had elapsed, an enema should be given. He would not use calomel. If the symptoms became aggravated and the temperature fluctuated, operation would be necessary. As a rule, this should be done on the third or fourth day, if it is certain pus is present. The doctor described the method of operation in the different forms. He had operated twenty-four times with good success. He then outlined the history of eight cases where the seat of trouble was not in the right iliac fossa.

Dr. Tempie then said that he had only the highest words of commendation for Dr. Howitt's paper. He (the speaker) thought that the diagnosis was at times very difficult. He agreed that it was also very difficult to say in some cases whether one should operate. If the abscess were allowed to rupture into the peritoneum, it was a most serious matter.

Dr. McFarlane also referred to the excellence of the paper. He said that he was much interested in the subject. He agreed with Dr. Temple in the difficulties he had referred to. The doctor then gave a brief history of a typical case, pointing out the most interesting points. Very many cases would recover if left alone.

Dr. Hillary then outlined the history of two cases he had had. In the one he had refrained from operating, and the patient had died; in the other he had operated and found nothing. But, in the latter case, the abscess burst into the bowel, and the patient recovered.

Dr. Howitt then closed the discussion by indicating some of the symptoms which would lead him to operate. They were the increase in the size of the tumor after the third day, accompanied with pain which opiates failed to control, and the appearance of the septic temperature chart.

Dr. A. B. Osborne, of Hamilton, followed by reading a paper on

GONORRHOEAL OPHTHALMIA, INCLUDING OPHTHALMIA NEONATORUM.

He described the peculiar manner in which the gonococcus attacked the conjunctiva, how its virulence depended upon the amount of the invading poison, how the conjunctival secretion was inimical to the poison, and how the quickness with which the eye could close, making it difficult for the finger to touch the conjunctiva, was the reason it often escaped infection. He gave an elaborate description of the various symptoms, both of the earlier and later stages, and also of the sequelæ and complications. He advocated general as well as local treatment. At first, he would treat with antiseptic lotions and cold, and later by astringents, if called for. If the cornea became infiltrated centrally, he would advise atropine; if circum-corneal, eserine would do good. Opium should be given if the pain called for it. Antiseptic midwifery was doing much for the prevention of ophthalmia neonatorum. Its treatment was similar to that of the other. Prevention in both was better than cure. Doctors should advise all patients to be exceedingly careful as to cleanliness. The pregnant woman, if she has any discharge, should be treated before delivery. This was the most fruitful cause of blindness. In the Institution for the Blind in Brantford 16 per cent. of all cases of blindness were traceable to ophthalmia neonatorum.

SURGICAL SECTION.

The minutes of the last session were read.

The next paper handed in was written by Dr. Groves, of Fergus. It dealt with a case of

LAPARO-ELYTROTOMY.

It was a case of a young woman, her first confinement, under Dr. Chisholm, of Wingham. She had been in labor two days and two nights; when Dr. Groves arrived he found her much exhausted. A solid bony tumor filled the pelvis; the antero-posterior diameter of which was less than an inch. An operation was decided upon, although the surroundings were unfavorable. They incised on the right side, parallel to Poupart's ligament, commencing close above the symphysis pubis and extending six inches, a sound being passed through the urethra into the emptied bladder. The section was continued into the vagina, and the child, a strong, healthy girl of average size, extracted. The mother died, but the child lived. The doctor said this operation was much safer than Cæsarean section. He concluded by saying that it was never justifiable to deliberately destroy one human life when there was reasonable hope of saving both.

Dr. P. P. Burrows, of Lindsay, then read a paper on

TREATMENT OF TALIPES VARUS BY CONTINUOUS EXTENSION.

It was unnecessary, he said, to enter into an anatomical description of this deformity, as he had entered fully into the question in the case reported in the *Canada Lancet*, June, 1887. In the case reported he divided the contracted tendons, the plantar fascia, and muscles. Next morning he applied a plaster of Paris splint, with cotton batting padding. After ten days a small portion of the splint below the ankle joint was removed, the foot over-corrected, and fresh plaster applied to secure it in the new position. In thirty days he removed the splint and found the limb perfectly straight. He then had a laced boot put on, stiffened on its inner side.

Dr. Powell, of Ottawa, asked what age the child should be before the tendons should be cut.

Dr. Burrows said that in the child reported the age was four.

Dr. Bryans asked how long the plaster of Paris splint should be left on in a marked case. Dr. Burrows replied that he left it on thirty days.

Dr. Sullivan, of Kingston, asked Dr. Burrows how many cases he had used traction on. He also wanted to know if he would operate before the fourth year. He (Dr. Sullivan) thought that great deformities could not be overcome before the fourth year by traction; nor could talipes varus be overcome where there was contracture of the tendons, etc., without section.

Dr. Burrows said that a moderate case of talipes, if left untreated, became much worse if left long as a result of contraction. He thought counter-extension rational treatment.

Dr. B. E. McKenzie then stated that different specialists had different modes of treatment. He thought no one line of treatment could be adopted for all cases. He said that in children he was cutting less than formerly, and that he never cut the tendon under one year. Often in talipes time was lost in extension when the knife should be used.

Dr. Temple's paper came next :

A FEW BRIEF REMARKS ON SOME OF THE DETAILS WHICH LEND
SUCCESS IN ABDOMINAL SURGERY.

One secret, he said, was attention to details ; another was experience ; another was a good knowledge of the peritoneum, and more especially of its delicate epithelial coat. The patient should be thoroughly anæsthetized, and kept fully under during the operation. The instruments should be sterilized, the surgeon's and his assistant's and nurse's hands should be carefully cleansed ; the sponges should be boiled, and the abdomen around the place of incision made aseptic. It was not necessary, as was done formerly, to completely dry the peritoneal cavity ; the sponging was often done too vigorously, causing inflammation of the delicate membrane. Where it was indicated, Dr. Temple would flush out the cavity with plain boiled water, moderately hot. This had not only a cleansing, but a general stimulating effect, as well as being helpful in arresting hemorrhage. He advised the drainage tube in those cases where there had been adhesions, with more or less oozing, and to be removed within the next forty-eight hours, depending on the color of the fluid. He had not had a case of hernia follow its use. He was not in favor of giving opiates after the operation. No food should be given for twenty-four hours. To relieve thirst, a couple of ounces of water with a little salt in it was useful as an enema. The patient should be kept warm. If tympanites appeared, he would give calomel, followed by mag. sulph.

Dr. Barrick said that he fully endorsed what Dr. Temple had said.

Dr. Atherton said that he agreed with Dr. Temple except in one point : he would not use hot water to wash out the abdominal cavity if there was no pus or other deleterious matter present. When he did use water he would not use it very hot, as in one of his cases he feared the peritonitis which followed the operation was due to it.

Dr. Howitt asked Dr. Temple if he would remove all the fluid from the cavity after the operation before he sewed up. In regard to the drainage tube, he thought that the walls of it should be thick and the holes small, so as to prevent the soft tissues protruding into the opening.

Dr. Powell, of Ottawa, asked Dr. Temple how he would treat the pedicle, and how he treated the abdominal wound externally.

Dr. Powell, Toronto, asked if salt might be advantageously added to the flushing fluid, and what the temperature of the water should be—whether near the highest or lowest allowable temperature.

Dr. Cameron gathered, although he had not been present, that the points of discussion referred to the use of sponges and the drainage tube. The practice of making the "toilet" of the peritoneum had fallen into disuse, and he thought, to some extent, unmerited disrepute. This was, perhaps, on account of the way in which the sponging was done—there was danger that the delicate lining of the peritoneum might be rubbed off. He thought it well to leave it as clean as possible, as any blood clots left would make a nidus for germs. If there was much irrigation, his practice was to pass a sponge into Douglas' pouch and also one into the anterior cul-de-sac, which he removed just before the completion of the operation. Regarding drainage tubes, he said they might be a source of infection. Kelly had pointed out that the tube was a septicode. Therefore, he advised that it be removed as soon as possible; and in regard to its use he would reverse the old maxim, "When in doubt, use the drainage tube," to "When in doubt, do not use the drainage tube." He found that if left in for a period not exceeding forty-eight hours, it did not militate against the closure of the wound. For the immediate purpose of getting rid of deleterious material from the operation, or for warning one of the presence of hemorrhage, the drainage tube was very serviceable. If there were any holes in the side of the tube, they should be as small as possible. If one feared that the lower end would be plugged by soft tissues, it might be obviated by filling the tube with iodoform gauze, allowing the end of the gauze to extend beyond the tube. It would then also establish capillary drainage.

Dr. Temple closed the discussion by saying that he would not use hot water, but warm water. In the case of a simple cyst, he would not use any. He used silkworm gut in stitching up; then he sprinkled on the wound dry iodoform and applied a dry dressing.

In reply to Dr. Powell, of Ottawa, he said that the treatment of the pedicle did not vary much now; that he treated it by simply dropping it back into the cavity after ligation. He ligated by the transfixion method, and did not sear the stump in simple cases. Respecting Dr. N. A. Powell's point, he said he thought salt might be added without the slightest injury. With regard to Dr. Hewitt's question, he said he allowed most of the water to run out, and squeezed a good part of the rest out by pressure on the sides of the abdomen. If there was a little left, he would draw it off through a drainage tube by means of a glass sucker. He advised the use of a small

drainage tube. He could not tell the exact temperature, as he merely tested it with his hand.

Dr. Sloan, of Kingston, asked in what proportion of cases did hernia follow the use of the drainage tube. Dr. Temple replied that it had followed in none of his cases.

Dr. Mackenzie followed by reading a paper on the

MECHANICAL TREATMENT OF TUBERCULOSIS OF THE KNEE-JOINT.*

The doctor had four patients present in varying stages of the disease wherewith to show the nature of the splints used. He first described the mechanism of the joint. It was the joint most often affected by this disease. Fortunately, it (the joint) could be put at rest without confining the patient to bed. The two points in the treatment were to allow the patient to walk without putting the foot of the affected limb to the ground, and in cases of flexion with sub-luxation to correct them. The first was accomplished by the use of a Thomas splint, which the speaker described. The second was accomplished, if the case had not gone far enough for operation, by employing continuous traction from the bottom of the splint. When convalescence had taken place pretty well, the doctor showed how to modify the splint so that part of the body weight might be transmitted through the affected limb to the ground. The cases, whose histories were given fully in the paper, were very instructive.

The report of the nominating committee showed that Dr. L. McFarlane, of Toronto, had been chosen as the next president. He was duly installed.

After listening to the report of the general secretary, which was a full and able one, and to the reports of the various committees, and to the general routine closing matters, the convention was adjourned.

Correspondence.

To the Editor of THE CANADIAN PRACTITIONER.

SIR,—It has occurred to me that a few notes of a trip, taking in the meetings of the American Medical and other associations, some of the health resorts of the west, and the World's Fair, might be of interest to some of your readers, especially as the account of the latter may contain some hints for intending visitors. The C.P.R. train leaving Toronto at 7.20 p.m. was chosen as giving the best opportunity of taking leisurely the

*Will appear in THE PRACTITIONER.

evening meal before leaving, and breakfast on the dining car before arriving. *En passant*, it may be a matter of gratification to us Canadians to find in the remarks upon the transportation building in the official guide to the World's Fair the statement that the C.P.R. train is the most luxurious in the world.

Stopping a day in Chicago, Omaha was reached in time for the last day of the meeting of the Association of Railway Surgeons. Here were read many papers of interest. This association appears to lay itself out to discuss with especial prominence some one subject or group, and at this meeting the spine was selected. Some of the features of this discussion may, with your permission, appear in a future issue. Here and *en route* were met Dr. and Mrs. R. W. Bruce Smith, Dr. and Mrs. Riordan, Dr. H. R. and Miss Elliot, Dr. W. Gunn, and Dr. and Mrs. E. A. McGannon. The last-named gentleman was elected one of the vice-presidents. On the day following the meeting, the Union Pacific Railway generously affording transportation, two excursion trains were started to Denver and the Rocky Mountains. Stops were made at several towns in Nebraska, citizens assembling at the stations to greet us, sometimes with the strains of a band, and carriages being on hand to "show the doctors the town." We were also treated to a sample of the varied moods which nature puts on on these western prairies and slopes. During the afternoon the bright sky to the north became suddenly clouded with an inky blackness, and we had one of those displays of the "artillery of heaven" which are seen to their best advantage on the boundless expanse of prairie or ocean. At the same time torrents of rain and hail were hurled against our cars with such force that umbrellas had to be raised in some of them. When the wind first rose in its fury, our train was observed to slow up. We were afterwards informed that a cyclone had passed a quarter of a mile north of us, and that the slackening of speed was to allow of jumping off if necessary, the porter of our car comforting the ladies with the assurance that "it wouldn't take much to blow de ole Santa Cruz ovah." After about half an hour a lull occurred, and we found ourselves rolling along in a very shallow but expansive lake studded with pearl-strewn islands. Then followed another season of stormy blackness, and then a fine sunset.

As soon as we were astir next morning, the foothills of the Rockies were in sight. The renewed admiration with which one approaches this grand chain of giant sentinels was increased by a combination of circumstances which showed us the full glory of Long's Peak. The sun's rays were just at the proper angle to light up the mass of bright-frosted silver, streaked with ridges of a darker hue. Passing on through a long upward slope of plain, covered with round and flat cacti and sage bush, we reached Denver, and, after a short stay there, proceeded to Colorado Springs.

Hence we ran over to Manitou by the electric railway, catching glimpses of some of those curious monoliths and groups of rocks which constitute "the garden of the gods." The members of our party who drove through the "garden" gave us wonderful descriptions of the sights they had seen, and the remarkable resemblance on a huge scale to various animals. As the afternoon was cloudy, Dr. Riordan and I hurried through the drizzle to the cogwheel railway to make the ascent of Pike's Peak before dark. We were aware that it was probably snowing up aloft, but our scientific ambition would not down, and we were rewarded for our pains. We had some clinical experience, both objective and subjective. Out of a party of about sixty, two were rendered completely *hors de combat*, whilst many more felt "queer." One lady was so prostrated as not to be able to leave the car. She was not in our car, but I was told she had to remain lying down, and that she was very ill. A youth who returned in our car was very faint, and was attacked with cramps and diarrhoea. Whether this latter condition was most due to the change of pressure, the cold, or some irregularity in diet, I cannot say. As regards the subjective experience, when we reached a height of 11,000 feet, I had sensations of giddiness and muscular weakness, and a dull pain over the base of the heart. These symptoms did not increase during the further ascent to the summit (14,147 feet), except the muscular weakness, and I had about the same difficulty in walking into the little refreshment house that one would have after an illness. My friend Riordan said afterwards that I looked pale and pinched, as if I "had been dead about two weeks." I am able to vary the compliment by telling him that his face and throat were about the shade of a half-ripe purple egg-plant—a crimson purple. One of the men who had been engaged in the construction of the railway told me that the workmen could not do more than an ordinary half-day's work in a day, even though they had resided for years around Manitou and Colorado Springs. Before reaching Denver, some of us had found we could not run as far without dyspnoea as we can in Ontario. In some recent issues of the *Globe* and *Mail*, I have seen articles in which these results were attributed to the diminished amount of oxygen per volume of air, and no notice whatever is taken of the mechanical effects of diminished atmospheric pressure on the circulation and respiration. This subject is a complicated one, and would take too much space to discuss it in this letter, and point out the reasons of different effects on different persons (e.g., those recited above), and why the higher altitudes are not suited to persons with weak heart, and to persons of hemorrhagic tendency, and why medium altitudes are so much better suited to some.

Of course we were sorry that the day was not such as would enable us to take in the grand cyclorama which, on a clear day, is spread at the feet

of him who stands on the summit of Pike's Peak; but we consoled ourselves with the reflection that it is not everybody who sees trees feathered out by a four-inch snowfall, and handles icicles one and a-half inches thick, in the month of June.

Our cars were pulled down to Denver during the night, and on the following day we went in observation cars up Clear Creek Canon to a little mining town called Silver Plume (between 10,000 and 11,000 feet). Here a few of our party experienced some giddiness, and many noted the inability for rapid exercise. The trip was a most enjoyable and exhilarating one. The rushing stream, the apparently impassable outlooks, and the way we curved our way in and out, reminded me of Kicking Horse Pass, which you, Mr. Editor, will remember in our C.P.R. trip of 1889, whilst further on we had a repetition of the "Loop." The scenery around the Loop is, perhaps, not quite so massive and rugged as in the case of the C.P.R. "Loop," but it has instead, as one of its central points of view, pretty little Georgetown, with its brightly-painted, picturesque little houses, which we pass, and which appears and disappears again and again, until at last we see it away down behind and below us like "one of the little toy villages which delight the children at Christmas," as one lady remarked.

On returning to Denver I was met at the station by Dr. Rogers, a native of our province, who kindly drove two or three of our party and showed us the sights, amongst them the principal hospital, and in it a patient from whom he had removed the cassarian ganglion for the relief of facial neuralgia. Our party had divided in the afternoon, some going north to Cheyenne and the Hot Springs. The rest of us, after spending a few hours in this beautiful city, returned directly *via* Omaha and Council Bluffs to Chicago. I know that my Canadian fellow-travellers will join me heartily in an expression of thanks to the Union Pacific and Chicago and Rock Island Railways, and to Drs. Galbraith and Harvey Reid, president and secretary of the N.A.R.S., for the courteous and generous treatment received during this trip.

From Chicago we ran up to the meeting of the American Medical Association at Milwaukee. Want of space will prevent me saying much about this meeting, which will be fully reported in the journal of the association. There were, of course, some excellent papers, some of which in the surgical section I had the pleasure of hearing, as also Mr. Ernest Hart's graphic paper on "Water pollution of cholera." This contained some very interesting instances of the truth of this generally received theory of the propagation of cholera. I must, however, take exception to his remarks about quarantine measures. It is all very well to say that our water supplies should be exempt from all danger of faecal pollution—so they should, and we ought not to cease our efforts in this direction until

they are so—but, in the meantime, why should we allow germ-bearing alimentary canals to come in and add their specific germs to this pollution; and, if a case slips through here and there, is it logical to say or do anything to still further weaken the barriers, and thus multiply the risks?

At a meeting of the Chicago Medical Society about ten days later, Mr. Hart did some very plain speaking regarding their unsatisfactory mode of keeping—or not keeping—statistics regarding their water supply. This paper confirmed me in the resolution I had already acted upon of not taking Chicago water “in its purity,” as our Hibernian patients would say, but only in the forms of soup, tea, or coffee, or otherwise boiled. One thing more it suggested to me—not to place too much confidence in the tanks at Jackson Park bearing the legend “sterilized water,” coupled with some such further remark as “This tank contains water specially prepared for drinking, and must not be wasted or used for other purposes.” Mr. Hart asserted that these inscriptions did not prevent the bacteria from varying from 500 to 2,500 per c.c.—a suspicious variation. There are two other kinds of drinks to the safety of which I may allude—the artificially aerated waters, of course, and the Waukesha spring water. This latter is said to be piped into Chicago from the abundant and magnificent supply of Waukesha. It is tapped and procured by the consumer by “dropping a penny in the slot.” I was rather puzzled, however, by reading on some of the fountains something about a flavoring of “Wild Cherry.” This may have been contained in a tank over which Waukesha water was placed after being drawn from the pipes, but I must confess that I did not properly investigate the subject, and merely wish to give my medical friends data to work from. I can assure them, however, that by adopting proper precautions well known to them they can safely visit the White City.

It is unnecessary to say that amongst these precautions I do not include the one fallacy of adding alcohol (or corrosive sublimate), “to kill the bacteria.” Those who perpetuate that jocular phrase know that the bacterium can stand these decoctions at least as well as the stomach of the biped.

Before leaving the great exhibition, I may add, for the information of those who take up their quarters in the other portion of the city, that the most comfortable and speedy way of reaching the former is by the fast trains of the Illinois Central from the foot of Van Buren street (fare, 10 cents each way; time, 15 minutes). I would also advise all who can to choose for the first visit a fine *morning*, and take one of the World's Fair steamers from foot of Van Buren street. The first impression which they will thus receive will be with the sun at their backs, lighting up gloriously the noble columns of the Peristyle and the other buildings, which are seen to the

best advantage by this clear approach from the lake (fare, 15 cents; time, 1 hour). Once also the visitor might take the Cottage Grove cable cars from Wabash avenue to the western entrance of Midway Plaisance (fare, 5 cents; time, 1 hour). This gives the variety of a pretty city-drive, and saves the double journey through Midway on the day one intends to "do" this part of the exhibition. No doubt many whose chief object is the exhibition will save time and energy by billeting themselves near the grounds, where there is ample accommodation. Buy Rand McNally's official guide now and read it cursorily through before you go; but bear in mind that the Anthropological Building has been added since it was written, and this divides, with the Manufactures Building, the surgical hospital and hygiene exhibits. It contains models of the Johns Hopkins and other buildings. It is under the courteous direction of Dr. Brewer. Be sure to register early at the Canada Building, near the Fisheries, and to go to the roof of the Manufactures Building and get the lay of the land. Make use of the intra-mural electric railway for the same reason, and also to husband your strength.

I would like to describe Dr. Senn's surgical clinic, where so much was compressed into one afternoon, and also a pleasant reunion at the monthly dinner of the Practitioners' Club, where Mr. Hart, Prof. Notter, of Netley; Prof. Finkler, of Bonn; Prof. Jurgens, Dr. Gerard, and others, were also guests. Amongst kind friends to be found in Chicago are several Canadians: Dr. Sanger Brown, 24 Washington street; Dr. F. C. Coleman, of the Post-graduate; and Dr. Reynolds, health, commissioner, and many others.

MEDICO.

Toronto, July 8th, 1893.

To the Editor of THE CANADIAN PRACTITIONER :

DEAR SIR,—I notice in the last issue of THE PRACTITIONER a letter signed by Drs. E. A. Praeger and M. S. Wade, in which they assume that I exceeded my duties as Registrar of the Medical Council of this province at the last election.

I might say at the outset, for the information of your readers, that in this province nomination of candidates are not made officially or otherwise, and Drs. Praeger and Wade are cognizant of this fact. It was therefore impossible for me or any one to make an "official list"; so on no consideration can this charge be sustained.

It is quite possible, in answer to a private communication asking me who were standing for election, I gave the names of those who, to the best of my knowledge, were seeking election, but no official list could be given, for the reason already mentioned. I surely had the right to answer my own private correspondence, and even the question as to who were in the field.

When the enquirer penned the letter, he must have certainly expected me to answer him. If not, why did he ask me the question? If I had not done so, I would, no doubt, have been accused from the same source as being an uncivil and discourteous official.

The members of the Medical Council are cognizant of the whole matter, which was brought before them at the last meeting of the board. In justification to myself, I refer your readers to the last clause of the late president's annual report, which is appended, and has been written since the late election took place, and they will be able to judge as to whether my conduct has not been worthy of the position in which I have the honor to be placed. I remain, yours respectfully,

G. L. MILNE.

I cannot close this report without mentioning with satisfaction the harmony and good feeling which have existed among the members of the council during my term of office as president—in fact, during the whole time that I have been connected with the council. I desire also to call your attention to the efficient manner in which the officers of the council have performed their duties, and would particularly mention the Registrar, Dr. G. L. Milne; who has devoted much of his time to promoting the interests of the council and of the profession, and who has discharged the delicate duties connected with his office in a manner which calls for the admiration of all. I have the honor to be, gentlemen,

Your obedient servant,

W. A. DEWOLF SMITH,

President.

New Westminster, B.C.,

April 30th, 1893.

Book Reviews.

THE TREATMENT OF CONSTITUTIONAL SYPHILIS. By Oswald Ziemssen, M.D., Wiesbaden. Pp. 800. Published by H. K. Lewis, 136 Gower Street, London, W.C. Price, 3s. 6d.

This little volume is a very careful résumé of the treatment of constitutional syphilis, and is full of good advice. The author quotes what Kaposi said in 1886 at the Congress of International Medicine held at Wiesbaden, that "syphilis should be regarded as a *curable* disease—indeed as the *most easily curable* of all infectious constitutional diseases"; to which he makes what he styles an amendment, and says that "the radical cure of constitutional syphilis is possible, but there is as yet no certain proof of this at our disposal, relapses having occurred even after many years." This is the great bugbear in the treatment of syphilis, that we cannot be absolutely positive that it is entirely eradicated from the system.

We cannot agree with the author when he advocates (page 17) that the constitutional treatment should commence as soon as the chancre is diagnosed. It is next to impossible to prognosticate in some chancres whether constitutional symptoms will appear or not—whether the lesion is specific or non-specific; whereas, if we await the appearance of the roseola, there can be no doubt about the infection. It has been our rule to await the appearance of the rash, and we are not convinced by the author that we should now do otherwise. The excision of the sore as a prophylactic measure, the hypodermic injection of mercury, and the thermal treatment are all fully considered. The book is a useful one to possess. The typography and binding are neat.

A SYSTEM OF GENITO-URINARY DISEASE, SYPHILOLOGY AND DERMATOLOGY. By various authors. Edited by Prince A. Morrow, A.M., M.D. In three volumes. Published by D. Appleton & Co., New York. Toronto agency, Geo. N. Morany, 63 Yonge street. Subscription only. Volume I., "Genito-Urinary Diseases."

At the present time, the profession appear to demand that the style of publications shall be in Systems or Cyclopædias. There can be no doubt that a work is of far greater value to its reader if the subject-matter in it is treated by an author more specially trained in that particular line of study. This appears to be the idea that Dr. Morrow has started out with, for he has associated with him some of the ablest men on the continent in the several branches on which they write.

"The Anatomy and Physiology of the Genito-Urinary Organs" are carefully gone over in this first chapter by Dr. Geo. Woolsey. "Diseases of the Penis" and "Diseases and Injuries of the Urethra" occupy the next two chapters, and are very carefully treated. The subject of Gonorrhœa is most exhaustingly handled—"Etiology of Urethritis," by Dr. S. Lustgarten; "Acute Urethritis," by Dr. Geo. E. Brewer; and "Chronic Urethritis," by Dr. W. K. Otis. In these three chapters are contained a vast amount of information. The profession at large do not thoroughly recognize that gonorrhœa is a most serious disease; that its after-results are often the cause of untold misery. The perusal of these chapters alone will well repay the purchase of the book. The Endoscope is most carefully explained by Dr. Herman G. Klotz. "Stricture of the Urethra," by Dr. J. William White, is one of the most carefully prepared chapters in the book, and one can refer here when in doubt as to the procedure to follow in any case of stricture. Dr. Belfield has written also very exhaustively on "The Prostate and its Diseases." The surgery of the prostate is now just in its infancy; and when we consider the large number of patients who suffer from prostatic trouble, we can easily appreciate that this should be a very prolific field of surgery in the future. "Tumors of the Bladder," by Dr. Francis Sedgwick Watson, should be read by every practitioner. Cases occur in which these neoplasms, if diagnosed in their early existence, could be rationally and thoroughly treated; but, if allowed to become too extensive, it is beyond the possibility of cure.

We are a little disappointed in the chapter on "Varicocele," by Dr. E. L. Xeyes. In a system such as this is, it does not seem proper to assume that all other operations are bad and useless simply because we do not use them. We should at least describe them, and make whatever comment we choose. The subcutaneous ligature of varicocele is by no means accepted as the ideal operation. There are other operations that produce a better result in a large proportion of cases. There is always the idea of uncertainty when working in the dark, and in any but expert hands this operation is dangerous.

There are very excellent chapters on the "Functional Disorders of Micturition," by Dr. Jos. D. Bryant; "Urinary Fever," by Dr. J. A. Fordyce; "The

Cystoscope," by Dr. William Meyer; "Stone in the Bladder," by Dr. Arthur T. Cabot; "Surgical Diseases of the Kidney," by Dr. L. A. Stinson; "Hydrocele and Spermatocele," by Dr. J. A. Wyatt and Dr. W. W. VanArsdale; "Gonorrhœa in the Female," by Dr. Andrew F. Currie; and many others, that are all excellent.

The publishers have been very fortunate in securing an editor for this system of Dr. Morrow's ability. He is an authority, and has a large experience in this line. The appreciated atlas of skin diseases was also published by Dr. Morrow. The typography, paper, and binding are all excellent, and reflect great credit on Messrs. Appleton. The next volume is devoted to Syphilology.

INTERNATIONAL CLINICS. A quarterly of clinical lectures on medicine, neurology, pediatrics, surgery, genito-urinary surgery, gynecology, ophthalmology, laryngology, otology, and dermatology. By professors and lecturers in the leading medical colleges of the United States, Great Britain, and Canada. Edited by John M. Keating, M.D.; Judson Daland, M.D.; J. Mitchell Bruce, M.D., F.R.C.P.; and David Findlay, M.D., F.R.C.P. Published by the J. B. Lippincott Company, Philadelphia.

This volume, like the previous ones, is really an excellent one. The opening clinic is by Dr. William Pepper on "Congestion of the Kidneys" and "Rheumatoid Arthritis." The two cases of congestion of the kidneys related are of great interest, and the result of the treatment was all that could be desired. The sulphate of sparteine in cases of this kind, in doses of from one-half to three-quarters of a grain, three times a day, seems to work very rapidly and effectually.

We can only take note of a few of the clinics. "Acute Infectious Osteomyelitis," by Dr. L. McFarlane, Toronto, is a very instructive one, and graphically describes this condition of the bones, as also does a case reported by George A. Peters, F.R.C.S., England, in the same clinic. Another very interesting clinic, and by a Canadian also, is that by Dr. Kenneth N. Fenwick, of Kingston, on "Retained Placenta." The many methods of treatment of these troublesome cases are very carefully gone over. The clinic on "Operations to Preserve the Uterine Appendage," by Dr. W. M. Polk, is of sufficient interest to the general practitioner of the present day to be reprinted, and this we have done in this issue. (See page 492). Dr. Polk has written very ably on this subject, and his work has proved that in a great many cases the patients can be permanently cured of very troublesome diseases of the appendages without unsexing them.

"Hypertrophy of the Prostate," by Dr. Francis B. Watson, of Boston, is of exceeding interest. This clinic is illustrated by seven large half-tone engravings of the condition described. Dr. Watson has done a great deal of original research in this particular line of surgery, and from his reports his success has been very great. This unfortunate condition, of such common occurrence, is at the present time amenable to treatment without great danger, and the writer anticipates in the near future that this operation will be much more frequently resorted to.

"Chronic Hypertrophy of the Faucial Tonsil," by Dr. George M. Lifferts, is on a subject of great importance to all general practitioners, and his advice when not to operate is exceedingly good.

This volume, taken as a whole, fully maintains the excellent standard of the series.

We have received the following pamphlets and reprints:

THE LITERATURE OF SEASICKNESS. By Dr. J. A. Irwin. Reprinted from *Medical Record*.

THE CURE OF COMPLETE PROLAPSE OF THE RECTUM BY POSTERIOR PROCTECTOMY. By John B. Roberts, M.D., Philadelphia. Reprinted from *The American Journal of the Medical Sciences*.

A CASE SHOWING SYMPTOMS OF LANDRY'S PARALYSIS: RECOVERY. By Alexander McPhedran, M.B., Associate Professor of Medicine and Clinical Medicine, University of Toronto. Reprinted from *University Medical Magazine*.

Medical Items.

DR. R. A. MCARTHUR has been appointed surgeon to the C.P.R. s.s. *Empress of China*.

DEATH OF PROFESSOR SCHNITZLER.—We regret to hear of the death of Professor Schnitzler, of Vienna, one of the foremost of modern laryngologists, who had done much to advance the science of the subject to which he had devoted his life. He was founder of the *Wiener Medicinische Presse*, and of a medical school extra-mural to the university, in which he never became a professor.

THE seventh annual meeting of the American Association of Genito-Urinary Surgeons was held at "The Four Seasons" hotel, Harrogate, Tenn., on Tuesday and Wednesday, June 20th and 21st. The programme was a very excellent one. The following officers were elected for the ensuing year: President, Dr. George Chismore, of San Francisco; vice-president, Dr. L. Bolton Bangs, of New York; secretary-treasurer, Dr. J. A. Fordyce, of New York; member of council, Dr. R. W. Taylor, of New York.

MEETING OF THE MARITIME MEDICAL ASSOCIATION.—The third annual meeting of the Maritime Medical Association was held in Charlottetown, P.E.I., July 12th and 13th. The following officers were elected: Dr. Walker, of St. John, president; D. A. Campbell, Halifax, vice-president for Nova Scotia; G. M. Campbell, Halifax, secretary; Dr. Dewitt, Wolfville, treasurer. A resolution was adopted that the medical council of each of the provinces be requested to procure such modifications and alterations in the existing laws as will secure, first, uniformity of curriculum of study to be regulated by the respective councils; second, examining boards as the sole authority for medical practice on the same lines as in Ontario, British Columbia, and Prince Edward Island.

NATIONAL ASSOCIATION OF RAILWAY SURGEONS.—The meeting of this association at Omaha, June 1st, was largely attended. The Canadian members of the association, with their wives, formed a pleasant party, and thoroughly enjoyed the hospitalities so generously extended to them by the different railways. They had a Pullman car to themselves from Toronto. After the meeting the Union Pacific Railway tendered the members of the association a complimentary trip to Denver and the mountains beyond. Drs. Oldright and Riordan, of Toronto; McGannon, of Brockville; Smith, of Seaforth; Gunn, of Clinton; Elliott, of Brucefield; Free, of Stouffville; McArthur, of Berlin; and Stevenson, of Iroquois, have returned with pleasant recollections of western hospitality.

AMERICAN MEDICAL ASSOCIATION.—The forty-fourth annual meeting of the American Medical Association was held at Milwaukee, June 6th, 7th, 8th, and 9th, and was attended by over eight hundred medical men from all parts of the United States. Dr. R. A. Reeve and Dr. W. Oldright, of Toronto; Dr. J. A. Mathieson, of St. Marys; Dr. Ferguson, of Winnipeg; Dr. Bruce Smith, of Seaforth; and Dr. H. R. Elliott, of Brucefield, were present from Canada. The meeting, which was a most successful one, was presided over by Dr. Hunter

MacGuire, of Richmond, Va., the president of the association. The annual address in medicine, by Dr. H. A. Haer, of Philadelphia, on "A Brief Review of some Practical Advances in Medicine and Therapeutics," and the address in surgery by Dr. H. H. Mudd, of St. Louis, on "Surgical Problems," were highly instructive. An interesting feature of the meeting was an address by Mr. Ernest Hart, editor of the *British Medical Journal*, London, Eng., on "Cholera." The papers in the twelve different sections were very interesting. The amendment introduced by Dr. C. A. R. Reed, of Cincinnati, having for its object the extension of the association to embrace the Dominion of Canada and Newfoundland, was laid over for consideration at the next meeting, which is to be held in San Francisco. The profession in Milwaukee made the social features of the meeting a great success.

PAN-AMERICAN MEDICAL CONGRESS—SECTION ON GYNECOLOGY AND ABDOMINAL SURGERY.—All members of the medical profession are cordially invited to attend the meetings of this section to be held in Washington, September 5th, 6th, 7th, and 8th. The sessions promise to be exceptionally interesting, many valuable papers having been contributed. Those who may wish to read papers before this section, and who have not sent in their titles and skeleton abstracts are requested to do so at once. Papers have already been contributed by the following distinguished gentlemen from the United States and Canada: Drs. T. Johnson Alloway, Montreal, Can.; A. W. Abbott, Minneapolis, Minn.; J. M. Baldy, Philadelphia, Pa.; H. J. Boldt, New York city; Augustus P. Clarke, Cambridge, Mass.; Ernest W. Cushing, Boston, Mass.; Andrew F. Currier, New York city; L. H. Dunning, Indianapolis, Ind.; George R. Deane, Spartansburg, S.C.; W. E. B. Davis, Birmingham, Ala.; Joseph Eastman, Indianapolis, Ind.; George M. Edebohls, New York city; De Saussure Ford, Augusta, Ga.; William Gardner, Montreal, Can.; T. H. Hawkins, Denver, Col.; John R. Haynes, Los Angeles, Cal.; Edward W. Jenks, Detroit, Mich.; Joseph Taber Johnson, Washington, D.C.; Howard A. Kelly, Baltimore, Md.; Florian Krug, New York city; G. Betton Massey, Philadelphia, Pa.; Lewis S. McMurtry, Louisville, Ky.; R. B. Maury, Memphis, Tenn.; Wm. F. Myers, Fort Wayne, Ind.; E. E. Montgomery, Philadelphia, Pa.; Robert T. Morris, New York city; Charles P. Noble, Philadelphia, Pa.; Joseph Price, Philadelphia, Pa.; George H. Rohé, Baltimore, Md.; James F. W. Ross, Toronto, Can.; Charles A. L. Reed, Cincinnati, O.; I. S. Stone, Washington, D.C.; R. Stansbury Sutton, Pittsburg, Pa.; T. Algernon Temple, Toronto, Can.; A. Vander Veer, Albany, N.Y.; W. B. Ward, Topeka, Kan. W. W. POTTER, executive president; BROOKS K. WELLS, 71 West 45th street, New York city, English-speaking secretary.

OBITUARY.

DR. G. G. CRAWFORD, a graduate of Edinburgh in 1828, died at his home in Toronto, June 20th, at the age of eighty-four.

DR. THOMAS R. DUPUIS died at his home in Kingston on June 25th, after a brief illness. He was born in March, 1833, in the township of Ernestown, county of Lennox. He received his medical education at Queen's College, Kingston, graduating in 1860. He practised for a short time at Harrowsmith. After leaving this village, he spent some years in Odessa. In the spring of 1872 he went to Kingston, where he was in active practice up to the time of his last illness. In 1881 he went to England and became a member of the Royal College of Surgeons. He was successful in practice, and generally recognized as a man with ability above the ordinary, and great force of character. He was well known in medical societies, was vice-president of the Ontario Medical Association in 1882, and vice-president of the Canadian Medical Association in 1886. He was also well known as a teacher through his association with the Royal College of Physicians and Surgeons of Kingston, where he was professor of anatomy and clinical surgery.