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THE

MEDICAL CHRONICLE.

Vol. V.]

MAY, 1858.

[No. 12.

ORIGINAL COMMUNICATIONS.

ART. XXXII.—*Clinical Lecture on Inflammation and Perforation of the Appendix Vermiformis.* By R. P. HOWARD, M.D., Professor Clinical Medicine and Medical Jurisprudence, McGill College.*

GENTLEMEN,—In my last lecture your attention was directed to the circumstances which caused the death of an old man, a hoary-headed septuagenarian, cut off suddenly, in advanced age, by a common disease. In to-day's, we are to dwell upon those which induced a similar issue to the case of a young woman, in the vigour of youth and health—an issue brought about by an unusual affection.

Bridget D—, a stout healthy woman, aged 22, was admitted into Hospital on the 13th day of January, 1857, in my absence and after the visit. She stated that her bowels had not been moved since the 8th; and they had no doubt been confined then for two days, as she had taken a dose of oil that morning (the 8th), but had thrown it up. The House Surgeon, Dr. Craik, saw her about 8 P. M.; there was slight pain over pubis, but no fever. He ordered an enema; but its administration was imperfect, owing to the instrument breaking.

On the 14th, at the noon visit, I found her complaining of uneasiness,

* This lecture was delivered in January, 1857. A few additions have been made to it since, chiefly in the citation of cases illustrative of the remarks made.

amounting to pain in the abdomen; the pain not severe, nor as much thought of as the constipation and sense of distension. She was thirsty; the tongue rather thickly coated with a dirty yellow-white fur; moist, and not red at edges or tip. There was occasional vomiting, but she did not say much of it; and the emesis was not frequent. The first touch of the abdominal parieties appeared to give pain, but steady firm pressure was well borne. Decubitus natural; knees not drawn up. No distress of countenance, beyond slight anxiety; pulse soft, about 76. A powder, composed of gr. v. Hydrarg. Submur., and gr. xx. Sodæ Sesquicarb. was ordered, to be followed every four hours by a Seidlitz powder, until bowels act.

15th. The powder was retained, but the Seidlitz draughts rejected. No change in the constitutional or local symptoms. Pulse soft, and otherwise normal; wishes more drink; constipation persists; catamenia appearing. To have gr. x. Ext. Colocyntha Co., and gr. v. Hydrarg. Submur. in pill, and a large enema of gruel and castor-oil; Sinapisms to epigastrium at intervals of a few hours.

16th. By omission, the pills were not given until seven last evening; and the bowels have not responded. This morning, signs of collapse appeared, and emesis became frequent; the ejecta consisting of thickropy, bilious-looking matters. At noon the collapse was marked. Face and extremities livid, general surface cold, sunken eyes, pinched features, great restlessness, weakness of voice, pulse small, scarcely perceptible at wrists, tongue cooler than natural, thirst urgent, appearance strikingly like Cholera, abdomen rather tympanitic. Having introduced the long tube about 9 inches it bent upon itself, and, being rather flexible, I could not pass it farther; an enema of warm water and oil returned immediately, unsoiled. A blister to the abdomen, a teaspoonful of wine every quarter of an hour, with small doses of opium and calomel every hour. The enema was repeated, with the previous result, at 2½ P. M., but the collapse steadily increased, then delirium set in, and death occurred at 3½ P. M.

Sectio cadaveri 22 hours after death. About two pints of yellow sero-purulent fluid in general peritoneal cavity; small intestines, and parietal peritoneum attached at many points by recent soft flakes of lymph; the intestinal sulci filled with lymph and pus, and their coils adherent; the serous membrane rather more vascular than natural; no strangulation, invagination, or twisting of the intestines. Ascending and transverse colon contains an abundance of healthy, soft feces; lower end of ilium of a dark green color, and adherent to situation of the appendix cæci; serous coat of this portion of small intestine and of the

cæcum rather injected, but their mucous coat not at all so. Appendix cæci of a dark green colour; adherent to margin of pelvis, and by its free extremity to the right ovary, which, with the broad ligament of same side, is similarly discoloured; it is also softened, much thickened, and gangrenous, and presents two large perforations with soft floughing edges. An intestinal concretion, about the size of a marrow-fat pea, occupies its cavity at the site of one of these openings.

This, then, gentlemen, was an instance of an affection, which, although not very uncommon, is yet so infrequent that more than one example seldom occurs in the practice of a single individual—at least in cities of the size of Montreal.

Its infrequency may also be inferred from the silence observed on the subject by most writers on Practical Medicine. None of your ordinary hand-books contain more than a passing allusion to the occurrence of inflammation, or perforation of the Appendix Vermiformis. Even the Cyclopædia of Medicine, so comprehensive in its consideration of medical subjects, pays no attention to this; and the pains-taking and learned Copland devotes but one column of his article on the Cæcum to a brief account of inflammation of its Appendix. Indeed the only English papers that I can refer you to for a tolerable account of the symptoms and progress of inflammation and perforation of the Appendix Cæci are two excellent but brief communications by Dr. Burne, in the 20th and 22nd vols. of the Medical and Chirurgical Transactions—one by Dr. Pepper in the Philadelphia Philosophical Transactions, vol. i p. 296, and one by Dr. Lewis in the New York Journal for November, 1856.*

Let this be my excuse for bringing the subject before you at some length to-day. And perhaps the best way to do this will be to read you the particulars of three other cases which have occurred in this city within the past few years. The first occurred in the practice of Dr. Wolfred Nelson, and was published by that gentleman, and by the late Dr. Crawford, in the British American Journal of Medical and Physical Science for 1847, (p. 258). I shall condense the report as much as is consistent with the exhibition of its characteristics.

Rev. Caleb Strong, while otherwise in good health, complained to Dr. Nelson on Friday, 1st, at 3 P. M., “of a fixed pain at the bottom and on the right side of the belly. The tip of the finger can cover the part. The pain is much increased when there is a peristaltic motion of the

* The last two papers were not within my reach when this lecture was delivered. There are numerous cases scattered through the Periodicals, and the subject is mentioned by Dupuytren, Munière, Grisolle and other French authors, in connexion with “Abscesses of the Right Iliaic Fossa.”

bowels; violent gripings occur every 20 or 30 minutes." No thirst, but dryness of mouth, tongue white, skin cool and moist, pulse 80, and soft. Aperients having been administered, an alvine evacuation was procured in the evening, with temporary benefit. After a restless night, the general symptoms were stationary, but the pain and griping were on the increase, although the bowels had acted; the conjunctivæ acquiring a yellow tinge. A free blood-letting at 3 P. M. was followed by faintness, a "copious liquid stool," much flatus and relief. The calomel was continued every hour. At 7 P. M. he was "better than at any time yet, but that little place is always very painful, and the griping, though less often, is very severe." Morphia was added to the calomel, and a blister applied.

At 2 A. M. on the 3rd, the patient became suddenly worse; the surface cool; pulse 90, and weak; pain in the part intense; running down to the anus and end of the urethra; mouth dry. He observed to his physician, "If you could only open that small place, how it would relieve me." 12 leeches were applied. At 9 A. M. the surface had become warm; the pulse 120, small and hard; the abdomen tense, and the pain more diffused. At 1 P. M. the "pain had shot all over the abdomen"; pulse 140, small and hard; breathing hurried; 18 leeches were applied, and a large blister. At 9 P. M. the symptoms much aggravated. He died at 2 A. M. on the 4th. The section exhibited, besides general peritonitis, a gangrenous state of the appendix vermiformis, which contained two small portions of gall stone, and a little thick dark fluid. The mucous lining of the cæcum was quite normal.

In the March number of the same journal, and year, Dr. Holmes, Prof. of Medicine in this College, also published an example of the same affection. The subject of it was a large, healthy child of 20 months. "He became indisposed on the night of Thursday, (10th March, 1842), being restless and feverish, but not complaining of pain.

"The next day he was languid and dull, indisposed to exertion, and unwilling to be amused. On the Sunday he appeared better, but on Monday relapsed into a dull, quiescent state, not seeking to leave his bed, disliking the approach of other children, and unwilling to be disturbed, yet without any marked symptom of disorder. He continued without much alteration till Thursday (17th), appearing to have no particular uneasiness, except a feeling of tenesmus, and an inclination to remain a long time at stool. During this time he had taken some doses of laxatives. He had made no complaint of pain or griping; there was no swelling of the abdomen; and no pain had been observed to be felt on handling him.

On Thursday evening, I was sent for, in consequence of a sudden change in the symptoms, and on arriving found the child in a state of collapse—his face pale, skin cold, and pulse nearly extinct. The abdomen was free from swelling; there had been no vomiting; and I elicited no sign of uneasiness when I pressed upon it. He had been put into a warm bath before I arrived, and had appeared pleased for a few moments, by slapping the water in a playful manner, but soon let his head fall back as if exhausted. Ammonia and brandy were administered; but he sank rapidly and expired, apparently quite conscious, and uttering his mother's name."

At the examination of the cadaver, besides a limited peritonitis in the vicinity of the cœcum, a perforation of the Appendix Cæci, with soft diffuent edges, was found. The cavity of the appendix contained a small whitish friable concretion.

Dr. Campbell, our Professor of Surgery, has likewise placed on record the particulars of a case of perforation of the appendix:

On the evening of the 30th July, 1854, L. M., a healthy boy, 11 years old, "was, some hours after eating a hearty meal, attacked with pain in the bowels, vomiting and purging." Next morning, the purging had ceased, but the pain and vomiting continued. Calomel and rhubarb were prescribed in aperient doses every three hours, and a sinapism applied. In the afternoon the pain was referred principally to the right iliac region, which was slightly tender to the touch; in all other parts, pressure well borne. Pulse 84, soft; skin cool and moist. In addition to the powders, prussic acid was given; fomentations applied, and an enema administered.

1st August. Bowels moved freely this morning; pain and sickness much relieved. The retching returned in the evening, and, although slight pain was complained of in the abdomen, it was quite flat and soft, and the pulse only 90. Turpentine stuping was repeated, and a good dose of calomel and opium given.

On the 2nd the symptoms suffered "no material change"; there was, however, "slight tympanitis; the desire to evacuate the bowels was frequent, and the attempts to do so ineffectual"; pulse 100, without hardness. The calomel and opium were continued every four hours; enema a repeated, and a poultice laid on the abdomen.

3rd. Passed a restless night, considerable jactitation, pulse becoming more rapid, tongue furred, tenderness extending over abdomen; no especial fulness to be discovered on the right side, where pain was first

• Medical Chronicle, Oct., 1854, p. 175.

complained of; bowels not yet acted on; vomiting continuing. Croton oil was given every two hours, in half drop doses, and at four o'clock in the afternoon the bowels were once freely moved, with manifest relief to all the symptoms. This favorable change continued till midnight, when there was a recurrence of the former symptoms, but with increased severity. In the morning of the 4th I found my patient's pulse 120 and weak; his tongue was coated, and his features were becoming pinched. There was considerable abdominal tension, and constant vomiting.

A large blister was applied, and the calomel and opium given every two hours. From this period he sunk rapidly, and died about 3 P. M.

The *post-mortem* examination exposed an "intense and extensive peritonitis"; the appendix vermiformis swollen, dark, and perforated; and containing a concretion the size of a pea, and two others about the size of a grape-seed. The edges of the perforation were "soft and livid."

Two other instances of the disease, which occurred in this city, you will find related by the late Drs. Carter and Crawford,—that by the former in the *Montreal Medical Gazette*, June, 1844, (vol. 1, p. 72); that by the latter in the *British Am. Journal of Medical and Physical Science*, May, 1847, (p. 17). They are both of much interest; but Dr. Carter's case is remarkable, as affording a proof of the occasional (very seldom, it is true) spontaneous discharge through the abdominal walls of the products of the inflammation, excited by disease of the appendix vermiformis.

A close examination of the four cases I have related, and of others recorded, justifies the assertion, that inflammation and perforation of the Appendix Vermiformis may present the following clinical features during life:—

1st Group. Slight restlessness, apathy and feverishness; absence of pain and of all abdominal uneasiness, save a feeling of tenesmus; the sudden occurrence of collapse without tenderness, pain or tension of abdomen, or any of the usual symptoms of peritonitis; death occurring rapidly.

Dr. Holmes' case illustrates this group.

2nd Group. Mere general discomfort and uneasiness, or declining health; no symptoms of abdominal or intestinal derangement, until the sudden manifestation of the symptoms and signs of general peritonitis consequent on perforation of the appendix,—death ensuing in 24 hours, less or more.

Parkinson's case in *Medical Chir. Transactions*, vol. 3, page 57, illustrates this.

3rd Group. The symptoms and cause very much those of ordinary intestinal obstruction: thus pain in the right ilio, inguinal or supra-pubic region; nausea, vomiting, constipation, some abdominal fulness; absence of all inflammatory symptoms as indicated by the pulse, countenance, skin, and state of abdomen; the constipation does not yield to rather active purgatives and enemata; suddenly, symptoms of peritonitis, with collapse and death in 24 hours.

My own case illustrates this group.

4th Group. Same features as last, except that pain is more marked and more fixed in right iliac fossa, and the bowels yield to active purgatives, but the relief is only temporary, and slight in degree; suddenly the symptoms of peritonitis, early collapse, and speedy death.

Illustrated by Dr. Nelson's case.

“ “ Dr. Burnes' 7th case, *Med. Chir. Trans.*, vol. xx, p. 224.

“ “ Dr. Marsh's case, *Dublin Med. Journal*, vol. 18, p. 337.

5th Group. Symptoms and signs of local circumscribed inflammation in the right iliac fossa; (pain, tenderness and fulness there; hot skin, quick, small pulse; vomiting and constipation;) these succeeded by gradual sinking and death, a distinct, deep-seated tumour forming or not in the right iliac fossa; or, by recovery, abscess forming and opening internally, or more rarely, externally.

Illustrated by Dr. Burnes' 6th, 8th, and 13th cases, *Lib. Cit.*, 20th vol., p. 226, and vol. 22, p. 47.

“ “ Dr. Carter's case.

“ “ Dr. Ogier Ward's case, *Med. Times and Gaz.*, April, 1855, p. 353.

6th Group. Same invasion and progress as last, except that *suddenly* there are symptoms and signs of *extension* of the inflammation over the *general* peritoneum, and death is accelerated.

Illustrated by Dr. Burnes' 15th case, *Lib. Cit.*, vol. 22, p. 55.

“ “ Dr. Law's case, *Dublin Med. Journal*, vol. 18, p. 336.

“ “ Dr. Paterson's case, “ “ vol. 26, p. 412.

Diagnosis.—As regards the diagnosis of this affection, inflammation, ulceration, and perforation of the *appendicula vermiformis*—it is quite obvious that in the first class of cases in which the symptoms are latent throughout, mere collapse preceding death, as in the example related by Prof. Holmes, no correct opinion can be formed.

2. The second class, where there is an absence of all evidence of intestinal derangement, until the sudden irruption of the symptoms of intense peritonitis is also beyond the reach of positive diagnosis, the sudden outbreak of the general peritonitis may be referred to perforation of the

cæcum, colon, duodenum, *ilium* or stomach, as well as to perforation of the appendix *cæci*, or to exposure to cold, or to the presence of renal disease, (Brights' kidney), or to the extension of disease from the ovaries, etc.

Fortunately these two classes are very rare.

3. The third class of cases, those in which there are the symptoms of obstructed bowels, without those of inflammation, the constipation not yielding to rather active purgatives, and symptoms of acute peritonitis suddenly setting in, cannot, in my opinion, be distinguished from cases of *obstruction*, dependent upon twisting of the intestines, incarceration of them by false membranes, holes in the mesentery, malformations of the omentum, etc.; reduction of the calibre of the bowels by chronic structural diseases, or perhaps spasmodic or simple over distension and enlargement of the colon etc.*

It was to this class that our patients' case belonged, in her the symptoms were nearly those of ordinary obstruction, there was slight abdominal pain, unyielding constipation and occasional emesis, but neither flushed face, hot skin, quick sharp hard pulse, nor decided abdominal tenderness, and these circumstances together with the short period she was under my observation, extenuate at least, if they do not excuse my referring the symptoms to obstruction of the bowels with probably slight enteritis, rather than to destructive inflammation of the appendix vermiformis. However, from what I have read on the subject, I am disposed to regard such cases as Bridget D.'s as of very rare occurrence.

4. The fourth class of cases, those in which together with the symptoms of obstructed bowels there is a fixed severe pain in the right iliac fossa, and the yielding of the bowels to purgatives is not followed by striking and permanent relief, may be known for mere obstruction of the bowel, the condition with which it is most likely to be confounded, chiefly by the following circumstances,—the pain begins at and occupies the natural situation of the appendix, it is often quite circumscribed—and deep pressure may elicit tenderness and detect perhaps a fullness or even tumour there, and lastly and chiefly the evacuation of the bowels by purgatives and general treatment, is not followed by permanent relief the pain and other symptoms continue and advance, or if temporarily relieved return speedily in their former violence.

Now, intestinal obstruction is not necessarily situated in the right iliac fossa, and the evacuation of the bowels by medicine is followed by immediate, and, as a general rule, permanent relief. Moreover, the consti-

* See case by Dr. Banks, Dublin Quar. Jour., new series, Vol. 1, p. 235.

pation which attends inflammation of the appendix generally yields to active purgatives, which is not the case in intestinal obstructions, and the former is less often attended by fœcal vomiting than the latter.

The fifth and sixth classes of inflammation of the appendix will be known from intestinal obstructions, not only by the deficiency just mentioned as existing between this affection and the fourth class of cases; but also by the existence of the local and general symptoms of inflammation from the first, whereas these symptoms succeed those of obstruction in case of obstructed bowel.

It is a much more difficult matter to distinguish inflammation of the appendix from *inflammation* of the *cæcum* or typhlo-enteritis; indeed in many instances I incline to think it cannot be done.

Both affections frequently occur in healthy persons, free from previous derangement of the bowels unless it be constipation; but the symptoms are generally more acute, and the issue more rapidly and certainly fatal in the former than in the latter; death often ensuing in the former in from 3 to 8 or 10 days. In typhlitis the progress is less rapid, and the termination less fatal; the action of the bowels is more frequently followed by relief and recovery; ulceration and perforation are much less common, and when they do obtain, they are more prone to cause lumbar or iliac abscess than to open into the peritonæum, just the opposite of the tendency of perforation of the appendix. Signs of fœcal accumulation are less obvious in perforation of the appendix than in inflammation of the *cæcum*; the former affection occurs at all ages from infancy to senility, the latter most frequently in adults. Moreover, some of the causes of the two differ. Thus typhlo-enteritis is not unfrequently caused by kicks and blows over the region of the right iliac fossa, and occasionally even by the pressure of a hernial pad, while the appendix from its small size and peculiar situation very seldom suffers from external violence or pressure. I know of only one instance in which a kick seemed to have excited this affection, and in that a concretion was found in the appendix.*

Inflammation of the *cæcum* is said to be occasionally consequent upon suppression of the catamenial or hæmorrhoidal discharge, that of the appendix acknowledges no such origin; a frequent cause of inflammation of the *cæcum* is the accumulation of hardened fœces in its interior, producing palpable tumour, having the shape and site of that portion of the large intestine; now, although, inflammation of the appendix may be occasionally excited by the entrance into it of hardened fœces, yet this is rare, and when it does occur, no palpable tumour exists at first, much

* Transactions of the Pathological Society, London, Vol. vii. p. 212.

less one having the volume and shape of cæcal stercoral tumour. Lastly, while the eating of indigestible and acerb fruits is an *alleged cause* of both affections, in inflammation of the appendix the fruit is usually if not invariably of a kind which contains stones, such as plums, cherries, or large hard seeds, as raisins, apples, pears, etc.

Perforation of the *cæcum* by ulceration also produces symptoms very similar to the affection under discussion, but then it would appear to be a much less frequent lesion than perforation of the *appendix*, the discharge is also of much longer duration, being an affair of weeks or months, while perforation of the appendix so far at least as its symptoms are concerned is one of days merely, or in very rare cases of two or three weeks; the former is generally preceded for weeks by ill health, deep-seated pain and tenderness in the right iliac region and diarrhœa, the evacuations being tinged or streaked with blood, whereas the latter occurs indifferently in the healthy or the infirm, and is not preceded by symptoms of intestinal derangement. When the perforation occurs in the former case, the most frequent consequence is the formation of a fecal abscess external to the peritoneum which commonly points either above Poupard's ligament or at the outer edge of the quadratus *lumborum*, often causing much sloughing of the integument and deeper tissues, and discharging pus and feculent matter; in perforation of the appendix the most frequent consequence is a more or less extensive peritonitis, most developed in the pelvic cavity and vicinity of the *cæcum*; circumscribed abscess is less frequent, and when it does occur, is generally within the peritoneum and has very little tendency to point externally, but very much to open into the general peritoneum. In brief this is a very valuable point of distinction between the two affections—for while in perforative disease of the *cæcum* the collection of pus usually tends to open externally, in perforation of the *appendix* this seldom if ever occurs, so seldom that I know of only one well authenticated instance,* that already spoken of as having been published by the late Dr. Carter of this city.

One remark more before speaking of the treatment suited to the disease under examination; although the appendix may become highly inflamed, ulcerated and even extensively destroyed by sphacelation, the morbid action extends with extreme rarity to the *cæcum* itself. In nearly all the reported dissections of these cases where the

* In Dr. Burns sixth case, (*Med. Chirur. Trans.* Vol. xx. p. 22,) a post peritoneal abscess formed; and in his eighth, sloughing of the iliacus muscles and post peritoneal cellular tissue occurred, yet in neither case was there any sign of the pus escaping externally.

state of the mucous coat of the cæcum is alluded to, it is stated to have been normal. The morbid action is essentially local, and excited by a local irritation, usually mechanical. We have another illustration of this tendency to the localization of morbid action where the operation of the cause is chiefly local, in some cases of strangulated hernia; the strangulated portion of the intestine with a portion of its covering sloughs and is separated, and the patient recovers with an artificial anus; so in some cases of intussusception where the powers of life are maintained, the invaginated portion alone perishes, and the continuity of the canal is preserved without the morbid action involved in the process extending to adjacent or continuous portions of intestine. The operations for the radical cure of hernia are based upon the same pathological law. The surgeon expects to excite a localized inflammation in the part, which shall not propagate itself to the general peritoneum for integuments.

The treatment which I am disposed to advise in this generally fatal affection, is that suggested by the nature of the case. The exciting cause being almost invariably a foreign body in the appendix, and therefore beyond the reach of direct removal, we should attempt to moderate and control the inflammatory action excited by its presence, and favour the efforts of nature to circumscribe and isolate by adhesion and false membrane the diseased part and the products of suppuration and gangrene, or to extrude them from the system.

With this view, when from the circumstances of the case we infer the early existence of inflammation in the appendix we had better leech the part freely, reapply the leeches every 18 or 24 hours for two or three times, and soothe the part by fomentations and poultices. At the same time small doses of calomel and opium should be given to the extent of producing the specific effects of mercury and keeping the pain in abeyance. I would not recommend any but the mildest measures for the evacuation of the bowels, such as emollient enemata, and small doses of Epsom or Rochelle Salts, or Soluble Tartar, largely diluted, or castor oil, if the stomach will tolerate them. If there is much emesis, the salines may be given in effervescence, or a mild aperient pill may be tried, but enemata will be the most likely to agree and succeed.

When the signs of tumour become well marked, and we suspect a circumscribed peritonitis, absolute rest is an essential item in the management of the case; any premature muscular effort being very likely to break the tender adhesions or fresh lymph by which the diseased part is surrounded.

If fluctuation can be felt, or if the tumour appear to approach the surface this should be promoted by frequent fomentation and poulticing;

but this tendency towards the surface does not appear to be common in this affection. Dupuytren* made an incision into the abdominal parietes in a case apparently of this kind, and evacuated a considerable quantity of foetid pus, the wound remained fistulous, and the patient survived 13 months with four fistulæ communicating with the seat of disease. In 1348 Mr. Hancock published a case† of perforation of the appendix in which he made an incision into the abdomen, evacuated a quantity of offensive turbid serum, with fibrinous flocculi, followed in 13 or 14 days by two small balls of fecal matter, surrounded by calcareous deposit, which from their size he imagined must have escaped by ulceration from the appendix. The woman recovered. The circumstances which would justify incision or puncture in a case of this kind, in my opinion, are the following:—A palpable tumour, emphysematous or fluctuating, and the presence of symptoms indicative of sinking, or, of well marked, typhoid symptoms,—the treatment, so far, having been of no avail. It is, however, an operation not to be rashly performed, and all the circumstances of the case should be well weighed before deciding upon its necessity. Throughout the case, the patient's strength and resources should be maintained by broths, jellies, juice of beef, &c.; and by quinine and stimulants, when suppuration has occurred, or typhoid symptoms threaten. It is said the matter even in this affection has made its way into the bowel, and the patient has recovered.

ART. XXXIII.—*Cases of Uterine Polypus.* By DR. SHERIFF, Huntingdon.

Having lately treated three cases of uterine polypus successfully, without the aid of any of the numerous instruments recommended for the extirpation of these tumours, by many eminent surgeons, I thought that it might be useful to relate my mode of procedure, as I believe that many practitioners have been deterred from operating because they thought they were not possessed of the requisite instruments.

The first case I treated was a Mrs. Graham, aged 40, the mother of seven children, the youngest eight years old, her husband still alive. I visited her first at 11 a.m., the 24th August, 1856. Says that she has had her menses regularly since the birth of her last child, but that for over two years they have been profuse, lasting generally nine days, and frequently discharging clots. Has been much weakened thereby. Began menstruating this time on the 19th inst. Yesterday the 23rd. was seized with pains coming at regular intervals, like the pains of labour.

* *Lecons Orales*, t. 3, pp. 521.

† *Banking's Abstract*, vol. 8, p. 284.

Are very severe at present, coming on every five minutes accompanied with a signal discharge of a dark coloured watery fluid. Has severe pyrexial symptoms, pulse 120, lower part of abdomen tender. On examining her vagina I found the mouth of the uterus dilated, and a fleshy substance like a placenta protruding an inch and a half. About 2 p.m. the pyrexial symptoms ceased with profuse sweat, pulse becoming natural. Fever returned in about three hours, and as the pains continued very severe, accompanied with great faintness, nausea and vomiting, I administered an enema of laudanum and starch, which soon gave relief.

25th, 8 a.m., had severe pains all night, but had ceased. On examination I found the vagina filled with a soft tumour, pulse 120, has constant vomiting. I made several attempts to pull the tumour through the external parts, by pulling with a finger hooked through the tumour, and also with a hook but failed, partly owing to the excessive faintness which each attempt caused. Ordered beef tea, enemas, and small doses of morphia and quinine.

26th. Still vomiting, continue the enemas and anodynes. Vagina to be regularly washed.

27th. Has rested well, vomiting ceased. Great foetor from vagina. Again attempted to extract the tumour, and tried to detach it from the uterus. I succeeded in getting a finger up to the insertion in the uterus and pinched off a portion, but was again obliged to desist from the syncope which came on. Continue washing out the vagina with warm water, and a weak solution of chloride of lime.

31st. During the last few days has improved and feels much better, pulse 110, of good strength. Continued discharge of a terribly foetid dark green coloured fluid from vagina. I again attempted extraction and this time succeeded in extracting a large portion much decayed and awfully foetid. I tied a ligature round the base of the tumour to facilitate matters afterwards, and cut off what was extracted. Continue the quinine and the washings of the vagina with the enema pump.

Sept. 5th. Remains of tumour separated yesterday. Foetid discharge still continues, but not so abundant. Had severe rigor and high fever last night, pulse 90.

7th. Complains of pain in calf of left leg. On examination I found it hard and swelled, and veins in thigh tense and painful. Her leg continued swelled and painful for a few weeks, but she eventually recovered and is now in perfect health. Her menses returned at the proper time, and have continued regular ever since without any hemorrhagic symptoms. This may be called a case of spontaneous cure.

CASE 2.—Miss Ross, aged 30, a large sized woman, but pale, and has an anemic appearance, consulted me first in November, 1855. States that about 18 months ago four of her menstrual periods were attended with severe pain and the discharges of pieces of membrane. Since then her menses have been very profuse, always lasting over a week, and frequently much longer. I made an examination and found the uterus apparently tumified, but could discover no tumour. I gave her infusion of matico and ergot, and applied blisters to her back, and made her use acetate of lead injections. Under this treatment she partially recovered but occasionally had severe hemorrhage. In the fall of 1856, she went to Montreal, and was for several months under the medical charge of an eminent practitioner there. For four months he pursued an almost similar treatment. He then discovered by the speculum ulceration of the cervix and cauliflower excrescences, which were removed by the Potassæ cum calce. Miss R. returned home in May, much improved in health and apparently cured. Her menses were not profuse, and she was stout and had a healthy appearance. In October hemorrhage again began, and now it was almost again continuous and not at intervals as before. She again consulted me in the middle of February, and on examining I found a firm round fibrous substance partly protruding through the os uteri. Being able to pass my finger round it, I knew it must be a polypus. I commenced giving her $\frac{ʒ}{i}$ tincture ergot three times a day, with injections into the vagina of tannin and acet. plumbi. I continued this treatment for six days, and I then found that the uterus had still further expelled the tumour. I now proceeded to tie it in the following manner. I placed my patient on the edge of the bed half reclining and half seated, with her feet resting on a bench, and legs well separated. I now introduced two fingers of my left hand into the vagina, and grasped the tumour, pulling it slightly down. I then cautiously introduced a long tenaculum, and hooked it firmly into the base of the tumour. I now pulled steadily downwards until it nearly reached the perineum. I now gave the tenaculum to an assistant to hold, and I slipped over it and then over the tumour a stout cord, until it reached the navoid pedicle. I then drew the knot as tightly as I could and removed the tenaculum. Next day everything was going on well, and a slight foetor was felt from the vagina, on the second day I applied another ligature for fear the first should become too soon slack. This precaution, however, was unnecessary. On the third day from the application of the first ligature, they both separated, and I extracted the tumour without any difficulty. It was firm, hard and white, about the size of a pigeon's egg. No untoward symptom occurred in this case, and my patient soon made a good reco-

very. She had her menses the week following the separation of the tumour, but the discharge was scanty and only lasted a few days.

CASE 3.—A feeble, sickly looking Canadian woman, about 50, called at my house on the morning of the 22nd March. She stated that for two years she had been labouring almost constantly under a hemorrhage from the vagina, which prevented her from working and had wasted her strength. I examined and found a soft polypus, like the preceding case hanging from the fundus of the uterus by a navoid neck. The uterus was open, and the pedicle could be easily reached.

On the 23rd I proceeded to the woman's house, and tied it precisely in the same manner as the last.

On the second day a green fetid discharge began to come from the vagina, and on the 26th four days after the application of the ligature it separated bringing with it only a little skinny substance. The bulk of the tumour having previously rotted away. Every thing went on well, and the woman is now in good health. It will be noticed that the tumours in the two last cases came away much more speedily than the time laid down in books. The first coming away in three days and the last in four. The usual time being from six to twenty-one days. I am inclined to think that the early separation in my cases was caused by the tumours being tied while the pedicles were stretched and consequently narrower. When the strain was removed the pedicles shrunk up again, and in this manner tightened the ligatures. The pedicles in both cases were about the size of a goose quill.

SURGICAL EXPEDIENTS.—For a number of years I have used a blunt silver probe bent into a hook, to remove foreign bodies from the nose, such as peas, indian corn, beans and slate pencils.

For many years I have used pessaries made of bees wax, which are far superior to any that can be bought, as they can be moulded into any shape, are cheap and very durable. For many years I have used tumblers and wine glasses, and even tea cups, for cupping, as they are better than cupping glasses, and they can always be procured without difficulty.

FRANCIS SHERIFF.

REVIEW.

ART. XXVIII.—*The enlarged Prostate, its pathology and treatment ; with observations on the relation of this complaint to stone in the Bladder.* BY HENRY THOMPSON, F. R. C. S., M. B., London, Assistant Surgeon to University College Hospital; consulting Surgeon to the St. Mary-le-bone Infirmary, etc. 1858. pp. 320. London: John Churchill, New Burlington Street.

Mr. Thompson has, in the work before us, completely exhausted the subject of Prostatic disease, and we are much mistaken if his book will not always hold a high place among special treatises of a classical character. His views on many points connected with the Prostate differ materially from those ordinarily held, and to such points, therefore, we will more particularly direct the attention of our readers.

In a paper published in the "Philosophical Transactions" for 1806, entitled "An account of a Small Lobe of the Human Prostate Gland, which has not before been taken notice of by Anatomists," Sir Everard Home announced the existence of a third or middle lobe of the prostate, situated beneath the r of the bladder, and adjacent portion of the urethra, and consisting of a rounded or triangular mass intimately connected with the two lateral lobes and fitted in between them on the under side. He formed his opinion after the examination of five organs dissected by Sir Benjamin,—then Mr. Brodie. Since his time British Anatomists and Surgeons have continued to describe the gland as being formed of three distinct lobes. Those of the Continent, however, seldom give such a description of its arrangement. Mr. Thompson ignores the existence of a third lobe as a part of the normal anatomy of the organ, and he does so on the strength of the information which he derived from the careful dissection of upwards of sixty specimens of the prostate. His description of the conformation of the gland is so lucid, and agrees so perfectly with our observations that we give it in his own words:—*Two lateral divisions or lobes make up the greater portion of the mass or body. Each may be supposed to resemble in form a truncated cone with a convex base. These being placed side by side, with a small interval between them for the urethra, the outline of the body is indicated, and may be tolerably well represented by the conventional form of heart which is seen on playing cards, excepting that the width requires to be increased relatively to the length. Between these two lateral parts the prostatic substance is continuous above and below the canal; in the first named situation, forming a stratum which extends forwards to the*

apex, but not quite to the base of the organ. Below the urethra another stratum extends throughout the whole length of the lateral lobes, and is thus about one-fourth longer than the upper stratum. It is, as a rule, thicker also, and much more so behind than before. In the centre of its base the two ejaculatory ducts, closely applied to each other side by side, enter a funnel-shaped cavity, in its substance situated usually about three or four lines beneath the posterior urethral orifice. These are directed forwards and a little upwards (in the erect position of the body) from the base to about the centre of the organ at the verumontanum. That portion of the posterior uniting stratum which lies above these ducts, is that to which the name of "third" or "middle lobe" has been given; and this part it is which often appears to increase most rapidly when disposition to enlarge is present. It then becomes more or less lobular, being spheroidal or pyriform in shape, by development upwards towards the cavity of the bladder, but in a condition of health does not appear to be so. It might be named "the medium portion," or, better still, "the posterior medium portion," as more correctly indicating the part referred to; at all events, as not involving assent to the disputable theory which assigns to it an independent anatomical character. This lobe was well known to some of the earlier pathologists, who recorded it as belonging to morbid anatomy. Morgagni, in particular, described it under the name of "caruncle," being "beyond a doubt an excrescence of the prostate gland." Valsalva, Valisneri, Santorini and others held a somewhat similar opinion. According to Prof. Gross, who is one of the greatest living authorities on all subjects connected with the urinary organs and their affections, this lobe is not always found in the normal state of the organ. "It is," he says, "of a rounded form, and of variable dimensions; it rarely exceeds the volume of a pea, and is sometimes so small that it can hardly be said to exist. Indeed, the most careful dissection occasionally fails to detect it."

A knowledge of the average size and weight of the prostate is of considerable importance for a correct appreciation of its various diseases and for the proper performance of the operation of lithotomy. The measurements in the adult, as given by our author, are:—From base to apex, $1\frac{1}{4}$ to $1\frac{1}{2}$ inch; greatest transverse diameter, about $1\frac{1}{2}$ inch; greatest thickness, about $\frac{2}{3}$ to $\frac{7}{8}$ of an inch. These agree nearly with the dimensions given by Senn and Gross. The former found the gland to measure nineteen lines in width at the centre of its transverse diameter, and only thirteen lines at its vertical direction along the middle line. Radii diverging from the urethra to the circumference of the organ, measure, towards its inferior and middle part, from seven to eight lines, directly

outwards, nine lines, and towards the inferior and external part, from ten to eleven lines. The latter observer found the average length to be twenty-one lines, the width eighteen lines, and the thickness nine lines. All these measurements are less than those of Dupuytren, on which his calculations for the bilateral operation in lithotomy were based. He represented the prostate as measuring twenty to twenty-five lines in its transverse diameter, and ten to twelve in thickness. The extent to which the incision through the prostate should be made in lateral lithotomy, may be approximately determined by ascertaining from these measurements "the length of a line directed downwards and outwards from the centre of the urethra (which may be regarded as corresponding in the operation with the bottom of the groove in the staff) to the outer border of the organ at its vesical extremity. This line may be considered as falling midway between the horizontal and vertical planes, forming with each, therefore, an angle of 45° , when the patient lies in the position for lithotomy. It may be accurately deduced from the form and measurements given above, and has been verified by numerous actual sections of the organ. Average measurements of healthy prostate in direction described $\frac{7}{8}$ of an inch. Ditto of small prostate, weighing under four drachms, $\frac{3}{4}$ of an inch." Mr. Thompson finds the prostate to weigh rather more than four drachms and a half; Prof. Gross about five drachms, whilst in different anatomical works it is represented as weighing between six and eight drachms.

Senile enlargement of the prostate is a most troublesome and intractable form of prostatic disease. It is emphatically an affection of old age, although many aged persons are quite exempt from it. Various causes have been assigned for its production. The etiology however is in a most imperfect condition. There are doubtless many causes, such as excessive venery, gonorrhoea, &c., which are real exciting causes; but many others, such as gout, rheumatism, sedentary habits, horseback exercise, &c., are purely conjectural, and have been advanced in that haphazard kind of way which has done so much to invest medical subjects with an uncertainty which is sometimes bewildering to the student. If observers were to form their conclusions only after careful investigation of numerous cases, instead of jumping, as is too often done at present, at an opinion from observation of an isolated case, fewer errors would creep into the science and practice of medicine. It needs only that some celebrated man, or one having a certain notoriety in the medical world, record a case that has been preceded or ushered in by some singular phenomenon, or where some marked and anomalous symptom has declared itself during the progress of the disease, that

once authorize the medical book-maker to award a place to such phenomenon or symptom in the etiology or symptomatology of the particular disease referred to. Thus we find in modern works of medicine and surgery, which are commonly the labour of the mere compiler, the most opposite and contradictory conditions stated to be, on the authority of Prof. A and Dr. B, predisposing or exciting causes of the same morbid state. This is markedly exhibited in the works of those who have written on senile hypertrophy of the prostate. "Almost all known causes of disease in general have been alleged to be so, of this one in particular. Every diathesis—gouty, rheumatic, tubercular, syphilitic—has been arraigned as the offending cause. Every form of local excitement possible to the pelvic viscera has been similarly held accountable. Thus it follows that the bearing of any single circumstance becomes neutralized in the concurrence of numbers. Every proposition finds its refutation in the presence of some other one among the multitude." (p. 64.) In fact there is nothing in the particular mode of life of the individual or in pre-existing disease which we would be warranted in regarding as an operating cause in the production of hypertrophy of the prostate. In simple terms, it appears to be a disease to which old persons are liable, but which is by no means a necessary or usual concomitant of age. The structural elements of the gland have a tendency to hyper-development, which tendency increases and is more apt to become manifest with the advance of years. And lastly, everything which tends to produce congestion of or determination of blood to the organ may determine the action of this tendency, or if the hypertrophy has already begun to assist materially in its progression.

The effects of enlarged prostate in relation to the functions of micturition and to the condition of the bladder are exceedingly important. M. Mercier has lately pointed out that true *incontinence* of urine in old persons is very rare; and Mr. Thompson believes that as a consequence of prostatic hypertrophy it never exists. Involuntary micturition is a common and troublesome phenomenon in elderly persons, that has been usually referred to a paralytic condition of the bladder, instead of being attributed, as it should be, to mechanical obstruction. It has been supposed that the bladder may be paralyzed in its body while the neck retained its nervous supply; or the neck be paralyzed while the body remains unaffected. In the former case, the bladder becomes unable to expel its contents, and retention of urine is the result; in the latter the outlet of the bladder is open, and consequently offers no obstruction to the flow of urine, which escapes from the bladder as fast as it is conducted into that viscus from the kidneys by the ureters. This is true

incontinence of urine. The term, however, should not be applied to that involuntary micturition which is the result of the mechanical obstruction caused by the pressure of an enlarged prostate. The conditions present are the very opposite to each other, and, therefore, by applying the term *incontinence* to both, it is certain to give rise to incorrect notions regarding the pathological state, and mislead the practitioner as to the treatment necessary to be adopted. When considerable obstruction to the flow of urine is caused by an hypertrophic prostate, the patient may not be able to expel his urine by a voluntary effort. The bladder thus becomes permanently distended by an accumulation of the urine, unless it be drawn off by the catheter, and the fluid gradually increasing in quantity opens out the orifice and escapes spontaneously. "The bladder is, in fact, *engorged*, and the urine *overflows*." The results in their orderly sequence are Retention—Engorgement—Overflow.

"Real incontinence, then, is a rare occurrence in the adult male. That it is so is one of the most salutary and important lessons which the student can learn. It should be held as an axiom, the importance of which it is impossible to overrate, that AN INVOLUNTARY FLOW OF URINE INDICATES RETENTION NOT INCONTINENCE." (p. 88.) The most common appearances which the bladder presents in these cases are hypertrophy and dilatation. In long continued and extreme cases the ureters and pelvis of the kidney also become much dilated. *Sacculation* of the bladder is also common. It commences as a mere indentation, which gradually enlarges, and is formed by the protrusion of the mucous membrane through separated fasciculi of the muscular structure of the organ.

We have merely adverted to one or two of the many new and interesting points which Mr. Thompson has brought forward in his excellent treatise. Want of time prevents us from dwelling so fully on the subject as we intended at the commencement of our notice. We advise our readers, however, to get the work and make themselves individually acquainted with its excellencies.

CLINICAL LECTURE.

(From *Virginia Medical Journal*.)

On Ready Diagnosis. B. Prof. FERGUSON of Strasbourg.

"Qui voit tout, abrège tout."

"The art of diagnosis consists essentially in the combination of all the elements which can aid, directly or indirectly, in the elucidation of diseases." This incontestable axiom is made to do good service by the investigators of our day, who are prone to exaggerate the value of each of the thousand minute details with which they are occupied, sometimes

before their reality even has been sufficiently established. To this fever for inventions, this accumulation of hypothetical and often contradictory results, the name of "progress" is given. Be it so! Science indeed advances and is enriched daily; but it is in much danger of being buried beneath its mass of treasures, unless some one shall arrange them, assorting the crude products, and assigning to each its degree of value in every day practice. This nobody seems ready to undertake. Every one brings his grain of sand to the edifice, no one directs where it shall be placed; there are laborers in cohorts, but no architects, for we cannot so designate even the best of our authors of treatises on practical medicine. Once a book on practice was an event, and when Fernelius, Sydenham, Stoll, Borsieri, Cullen, or Pinel, published the results of long and conscientious study and meditation, their magistral works made a deep impress on the field of science, and commanded the attention of the world. Now-a-days ten neophytes set to work,* separately and silently, and relate what others do before they have learned what they will do themselves, commencing the novel by the last chapter. as the saying is, with the sole object of gaining by the speediest road a place at the professional banquet.

Hence we examine these compilations in vain for those large views which open up new horizons and strip the veil from obscurities. We find no harmonious whole, no lucid simplification. Open any modern pathological treatise you please at the article *Pleurisy*, for example, you will be told that inspection, palpation, mensuration, percussion and auscultation serve to diagnosticate this disease. The enumeration is exact, but as to any comparisons or reflections on the relative value of these various semeiotic means, they are not to be found, and the student is left to attach the same importance to dullness and to egophony; it will be unhappy for him, indeed, if the author does not insinuate that resonance and amphoric murmur are the rule, under pretext that these phenomena have lately been observed in a few cases of pleuritis. Turn over to *Typhoid Fever*: you will learn that fever, prostration, delirium, the fuliginous tongue, cœcal gurgling, epistaxis, diarrhœa, etc. are the fundamental features of this affection, whence it results that all these symptoms have the same significance which is requisite in order to inculcate the idea of a general affection, *totius substantiæ*. When you encounter in practice typhoid fevers without a typhoid state, or frank phlegmasiæ

* It is scarcely necessary to remind the reader that a number of the recent German and French works on practice have been compiled by association of from three to twenty collaborators.—*Trans.*

presenting the same phenomenal portraiture as is here ascribed to typhoid fever, you may get on as best you can. It is thus that confusion is eternalized; it is this want of comparison and logic which perpetuates chaos and maintains the authority of our modern augurs.

“A disease, that is to say, a group of morbid elements, being given, ascertain the order of their subordination over to the other,” or the degree of influence which each of them exercises on the rest. The mode in which this problem has been comprehended and solved, is in truth the history of medical science, for it immediately conjures up every system of doctrine. According to the ideas which have prevailed on the nature and essential elements of disease, vitalism, humoralism solidism etc. have flourished or decayed. We do not propose to enter on this vast subject. We accept the notion of diseases commonly presented and ask for a thread to guide us through this immense labyrinth. In the first place, we may lay down: 1. That in a practical point of view there is no single essential element for all diseases, that is to say, that each of the exclusive doctrines is vitally defective and inadmissible; 2. That the principal elements vary or may vary in each class of diseases; thus in a given neurosis, the element strength or the element debility may alternately dominate; 3. That this same variability, in a practical point of view, of the dominant elements, may present itself in each disease or in each particular patient. The demonstration of these propositions, which remove us far from the exclusive vitalist, organicist, and chemical doctrines, would embrace the entire field of pathology. We will attempt, however to sketch a general outline, to suggest the processes by which a solution of the proposed problem should be attained.

We know that there are dominant and subordinate, morbid elements. But our ignorance of the primary, essential, really dominant elements is often so great, that, to our astonishment, we often see a secondary or apparently accessory element assume a predominant importance in a therapeutic point of view. Such in a multitude of cases is the element *pain*. This fact does not imply the absolute pre-eminence of this element. The toxic principal is the essential element in cases of poisoning and in contagious and infectious disorders, in syphilis, variola, typhus, etc. The rational indication is to eliminate or neutralize the toxic agent. But it is only in the minority of cases that we have the ability to do this; yet we still cure intoxications for which we have no direct antidote. Sometimes this is by allowing nature to act, as in the febrile exanthemata. In other cases, it is by combatting the effects of the poison, and keeping the patient alive till its virulence is exhausted, an inpoisoning by acid or narcotic substances; and though, in these cases, we direct our

attention to the secondary elements, to the inflammation or adynamia, the poison indirectly opposed, is still the capital element. It is this, that renders the maxim *naturam morborum curationes ostendunt* a most fallacious one, for it would require us to admit as many essential natures in the same disease as there are therapeutical methods applicable to it.

Having premised thus much, let us enquire what are the sources whence the so called primary or capital elements of diseases are to be derived. Of these sources, the most natural is unquestionably afforded by *etiology*, as indicated by the aphorism *sublatâ causâ tollitur effectus*, an aphorism as delusive as the last. We have shown elsewhere the obscurities and fallacies which often oppose the search for the real causes of disease, and have concluded that the causes of importance as regards treatment are constitutional causes difficult to reach, which happily do not always prevent recovery. So that this etiological doctrine, so imposing at the first glance, has a much more limited application than is commonly imagined, as we have shown in speaking of poisoning.

The most fruitful source whence important and positive elements of disease are to be derived is, despite what is said to the contrary, organic and functional *symptomatology*.

It is true that behind an inflammation or other organic lesion, there may exist, and often does exist, a general or special cause; but too often, alas! this cause is occult, and quite beyond the reach of remedies. We are forced then to come down to the obvious phenomena, and to accept them, at least provisionally, as primary elements, especially when the other phenomenal details of the disease naturally flow from them. Such are, in general, idiopathic inflammations; such are certain diathetic affections even, as tubercle and cancer; such certain functional diseases without appreciable material lesions, designated neuroses. The best that we can do in these cases is to attack the visible and tangible element, else we strike in the dark, and may deal a blow to the patient rather than to the disease.

In a practical point of view, then, the so called organic or symptomatic classifications of diseases are less vicious than they appear. They are as rational as circumstances permit, inasmuch as they express the positive facts, beyond which we can ascend only by inductions which practical experience and humanity condemn: *nil magni facias ex mera hypothesi*.

The *progr. ss* of diseases is a more limited but less certain source of capital elements. Thus the intermittent character of disease is often of such predominant importance, as to be the one fact to be taken into consideration, as in pernicious fevers. The slow or rapid, acute or chronic,

progress of a disease is also a major element, which is the basis of most important practical determinations; for just as it is imperiously necessary to combat promptly and vigorously diseases which place life in immediate jeopardy, as pneumonia, peritonitis, or meningitis; so it would be most irrational to attempt to jugulate disease of slow progress.

The *terminations* of disease are likewise the source of important indications, according as they result fortunately by the unaided powers of nature, as in erysipelas, simple icterus, etc. or lead to grave complications as in suppuration in pneumonia, aneurism in endocarditis, etc.

The ancients attributed great importance to *prognosis*; but prognosis is only a deduction from the causes, progress, and terminations, and consequently is comprised in these elements.

Complications constitute, in certain cases, elements of greater gravity than the primary disease itself: for example, the cerebral and pulmonary complications of typhoid fever, meningitis in erysipelas of the face, pericarditis endocarditis in articular rheumatism, etc.

Lastly, the *treatment* is the source of most important indications; for there is no better guide, practically, than the results of the medication employed, and nothing indicates more positively the necessity of a change of measures than the negative or injurious effects of those previously used. It is this incontestable principle which furnishes empiricism with the strongest argument it possesses.

From these brief considerations, it results that each element belonging to diseases may, in its turn, constitute the leading element. Hence the insufficiency of exclusive doctrines; for the relative importance of these varied elements cannot be predicated in advance and essentially depends on the peculiarities of each particular case.

Our present intention is to examine the relations of the elements belonging to the class of symptoms, which form the principal, though not unique basis, on which diagnosis is founded. The student who has been initiated into a knowledge of the characteristic signs of different diseases, by learning individual symptoms, should proceed to study the symptomatic elements, hitherto separately considered, in these relations to one another, in their rational connection, in a word. This intellectual labor constitutes what I call the *ready method of diagnosis*, which conducts us, by the shortest path, to a sufficient knowledge of the disease.

I use this term in opposition to the *classical method*, which arrives at a knowledge of diseases only by reviewing methodically and minutely, in accordance with a given formula, all the details of the case. In instituting a parallel between these methods, I do not pretend that the former is surer than the latter, or sufficient for every case. On the contra-

ry, the classic method is more complete and solid. But in a multitude of cases, an adequate knowledge of the case may be acquired, without pursuing the interminable meanderings of the classical process, and the latter can add nothing but a conjoinative evidence to the precise diagnosis already attained.

If the ready method had no other use than to abridge the examination, and exhibit the talent for observation and tact of the practitioner, its advantages would be small. But it spares the patient much fatigue, and relieves him from prolonged manipulations, dangerous mental and physical efforts and varied annoyances, entailed by the stereotyped examination in true classical style. Important facts are brought out clearly, stripped of superfluous accessors, and unobscured by erroneous or equivocal replies from the patient. Moreover, expeditious diagnosis is a practical necessity, not only in reference to the patient too feeble to comply with the exigencies of the classic mode, but in regard to the majority of practitioners, who either know, or, at all events, practice no other. It is a delicate subject to treat, but it must be admitted that the complete classical method is almost confined to the schools and the savans. It is notorious that, as soon as the students leave the benches, they forget the use and utility of the thousand minutiae they have been taught. Pressed for the time, harrassed by the difficulties, the prejudices, the vexations encountered at every step in private practice, very many come to be satisfied with a ready method of diagnosis of almost any sort; and God knows what sad blunders result from this voluntary constrained negligence.

It is with a view of offering to practitioners of this class an equivalent, in facility, for their habitual methods, but an equivalent far superior in value and security, that I have undertaken these disquisitions on diagnosis; which I would term the elements of medical algebra, were not the metaphor too ambitious and false; false, inasmuch as our art can never pretend to the precision of mathematical science.

Without going back to Pinel, who seems to have first conceived the idea of framing a formula for the interrogation and examination of patients, who ever has turned over the pages of one of the innumerable clinical manuals, compends or treatises published in the last thirty years, must have noticed the formal systems of examination; which, under the pretext of preventing the practitioner from blundering, inveigle him into a labyrinth, and take him through endless windings to a goal he might generally reach in a straight line. The laudable intentions of teachers have led, in fact, to those interminable books of questions, of which three-fourths, at least, are foreign to the case in point. I have never known

a student or physician willing to load his memory with these ponderous protocols, even were they signed Bouilland or Piorry. For common sense teaches that the interrogation should be confined to subjects necessary for the elucidation of the case in hand, which is commonly to be attained by simple and natural means, as we shall see.

Thus, for what are termed the *preliminaries* of the case, the *sex* and *constitution*, we see the *age*, written on the features, need hardly be ascertained mathematically. *Sex, situation, marriage, maternity*, the *number* and *health* of *children* and of *parents* are of importance in certain cases only. The *profession, regimen* and *antecedent diseases*, are common places of no value in a multitude of cases. None of these circumstances will lead us to the diagnosis of a disease, though many of them it is well to know, when the diagnosis is once established.

Coming now to the *present disease*. In many cases of external affections, medical or surgical, the disease stares us in the face, and abridges the interrogation greatly. Without speaking of traumatic lesions, all diseases affecting the skin and the mucous membranes accessible to the eye or touch: next all diseases which are reflected exteriorly: icterus, scurvy, chlorosis and other cachexies, typhoid diseases, convulsive and paralytic affections, diverse dropsies, etc. etc. all give their name at the first glance, and require but few questions. In some instances the sense of smell instructs us before or simultaneously with the sense of vision: as in gangrene, the puerperal state, cancer, the typhoid state, etc.

In the exclusively internal diseases, after a careful glance at the general physiognomy of the case, the first question should be: *Where do you feel pain?* the hand pointing out the exact seat indicated by the reply. The second question is this; *How long have you been sick?* and the reply informs you whether the disease is acute or chronic. Provided with these two notions, *seat* and *duration*, the examination already assumes a precise direction, and you proceed, without waiting for other information, to the exploration of the organ or apparatus supposed to be affected, adopting first those means which procure the most precise information, and often the diagnosis is evolved in this first enquiry.

Having ascertained the material or *organic* conditions of the disease, as far as possible, you proceed to investigate the *functional* symptoms of the diseased organ, always in the order of their importance in a diagnostic point of view.

The disease once ascertained with precision, the hardest part of the task is accomplished. It remains to obtain information relative to the *etiology, progress, complications, and therapeutic means*, respecting all

the *anamnestics*, in short that, may be of utility. But the examination is concisely conducted in the directions indicated by the determined nature of the disease.

We see that, apart from the two questions already given, the examination is altogether a relative affair, and admits of no mixed formula. But, as we shall see, there are particular formulæ applicable to particular diseases, formulæ often susceptible of great abbreviation.

Having achieved the examination of the organ and disease, it is requisite to pass the other organs in review according to some settled plan, the choice of which is unimportant. Be careful to seek first for the capital symptoms, the presence or absence of which implies the integrity or alteration of the organ or function under examination. Thus the *epiphenomena* or *complications* are detected, and they must be looked for, even in the absence of suspicious symptoms.

But there are local diseases without pain, general diseases which cannot be accurately determined affections, in short, without local symptoms or seat; such are certain phlegmasiæ, termed latent, many organic lesions, some neuroses, intermittent fevers in the interval, certain humoral diatheses. We are then compelled to adopt the formal classic method, abbreviating as we can, and adhering strictly to enquiries relative to the organic and functional state, before descending to commonplace aimless questions. Example: a patient presents himself with no actual symptom, and gives us no information. We proceed to the examination, and discover a tumefaction of the spleen. It is highly probable that the patient has intermittent, a fact determined by a few questions. Another subject presents no appreciable material lesion, and we can elicit no satisfactory replies; but a paroxysm soon supervenes of chill, and sweating, and again reveals to us the nature of the affection. Such cases are among the most unfavorable to the ready method; but in such the classical method does not shine. Another example; a woman reduced to marasmus has been attended by several physicians who have not ascertained the nature of her complaint. We examine the details of the case, and are not more fortunate than our predecessors. But the idea occurs to us to taste (!) the urine, and we detect a diabetes mellitus. In fact the sweet taste of the urine is a pathognomonic sign offering one of the most striking examples of ready diagnosis.

These enigmatical cases constitute what I call *veterinary medicine*, in which the physician, in the absence of verbal information, is compelled to proceed as in the cases of animals. These cases are frequent; for they comprise, apart from stupid people, children, foreigners, delirious, apoplectic, asphyxiated patients, etc. etc. The best plan in every case is to

proceed at once to search for the affected organs, by the material processes of palpation, percussion, auscultation, etc. These cases have not been sufficiently provided for by the classic method.

Diagnosis, in general, should be divided into positive or negative, according as its object is to determine the presence or absence of lesion. Positive diagnosis arrives at the most insignificant symptoms, and negative diagnosis elicits the organic or functional evidence which imply the integrity of organs. The latter often leads to the former, as when, without any preliminary indication of the seat of trouble, we are compelled to pass all the organic apparatus in review.

The most constant effect of an organic lesion is to produce functional derangement; therefore from the integrity of function, we infer the soundness of the organ. On this principal, the theory of negative diagnosis is founded on the determination of the most significant functions, just as positive diagnosis is based on the determination of the most expressive symptoms. This premised, I proceed to certain formulæ for negative diagnosis, applicable to the principal organs.

Digestive apparatus.—Have you appetite? How is your digestion? Are your bowels regular? affirmative replies on these three points afford a strong presumption that the disease is not located in the digestive organs; for there is scarcely any affection in this system, that does not modify the appetite, digestion, or defecation.

Respiratory apparatus.—Do you breathe well? have you cough? Do you raise? Satisfactory replies make it probable that these organs are in a good state, for dyspnoea, cough and expectorations are inherent characteristics of most disorders of this apparatus.

Circulatory apparatus.—Do you feel your heart beat? This is about the only question you can address to common people; but it is adequate in most cases, almost every heart disease producing palpitation or præcordial distress. The pulse and auscultation will clear up the diagnosis.

Cerebro-spinal apparatus.—Here questions are, strictly speaking superfluous. The physiognomy, the speech, the gait and motion, almost always indicate at once whether nerve centres are intact.

Apparatus of special Sensation.—Do you see and hear well? Such are almost the only questions appertaining to this category; for the organs of taste and smell belong to the digestive and respiratory apparatus, and skin diseases reveal themselves.

Urinary apparatus.—Do you urinate without trouble? Is your water clear? These two questions are in general sufficient.

Genital apparatus.—Inspection, and the two preceding questions

suffice in the case of males. In females, we enquire: Are you regular? Have you the whites? Replies to these questions convey what is essential respecting puberty, pregnancy, the menopause, the different affections of the uterus and vagina; for disordered catamenia and vaginal discharges of some sort characterize almost all the sexual derangements of females.

We see by these examples how easy it is to arrive at a negative diagnosis, by keeping to the radical essential elements, which imply the rest. Of course, where practicable, the *ready diagnosis* should be corroborated by other questions and the usual methods of exploration. I wish simply to say that a negative diagnosis, sufficiently accurate for the generality of cases, may be attained very promptly. It should be an invariable rule to accompany or follow the interrogation by palpation and inspection of the organs examined. An abnormal swelling, in the provocation of pain by pressure may throw a flood of light on the morbid condition, which normal conformation and insensibility confirm the replies favourable to the idea of health.

PERISCOPE.

Nouvelles recherches sur l'importance des fonctions des capsules surrénales. Par le DR. E. BROWN-SÉQUARD.

La grande découverte du Dr. Thomas Addison, découverte destinée à prendre rang parmi les plus importantes de notre siècle, attira mon attention presque aussitôt après sa publication. J'avais déjà publié, en 1851, un fait assez remarquable à l'égard des capsules surrénales (1). J'avais trouvé que la section d'une moitié latérale de la moelle épinière, dans une partie des régions dorsale et lombaire, sur les cochons d'Inde, produit d'abord une congestion et après plusieurs mois, une hypertrophie des deux capsules surrénales. Cette relation singulière entre la moelle épinière et ces petits organes est bien digne d'attention, d'autant plus que, ainsi que je le montrerai dans un autre travail, il y a lieu de penser que dans quelques cas de fracture du rachis, une congestion considérable des capsules surrénales semble devoir être rangée parmi les circonstances qui hâtent la mort. Mais je laisserai de côté, dans ce mémoire, les relations entre le système nerveux et les capsules, et je m'occuperai surtout de l'importance des fonctions de ces petites glandes.

Dans mon premier travail à ce sujet (2), j'annonçai que chez tous les

(1) *Comptes rendus de la Soc. de Biol.*, t. III, 1851, p. 146, et *Gaz. méd.*, 1852, p. 73.

(2) *Comptes rendus des séances de l'Acad. des sciences*, 1856, vol. XLIII, p. 422.

animaux sur lesquels j'avais enlevé les deux capsules surrénales, ou une seule, la mort était survenue rapidement. Mais, en me fondant sur ce que j'avais vu deux animaux (un chien et un chat), chez lesquels je n'avais enlevé qu'une seule capsule et qui semblaient devoir survivre à l'opération, lorsqu'ils furent tués accidentellement ; en me fondant aussi sur ce qu'une seule glande peut suffire à remplir les fonctions de deux semblables, je déclarai que bien que je n'eusse pas vu jusqu'alors un seul animal survivre définitivement à l'ablation d'une seule capsule surrénale, je croyais probable, qu'en multipliant les expériences, on verrait des survivies définitives après cette opération.

J'annonçai de plus que la mort après l'ablation des capsules survenait trop tôt pour qu'on pût l'attribuer exclusivement à une lésion des reins, du foie ou du nerf grand sympathique.

Enfin je fis remarquer que le sang des animaux, dépouillés de capsules surrénales, semblait se charger d'un principe toxique. Du moins ce sang, pris sur des lapins à l'agonie, après la perte des capsules, et injecté dans les veines de lapins ayant perdu, depuis quelques heures seulement, une seule capsule, les faisait mourir rapidement ; tandis que, d'un autre côté, du sang de lapin en bonne santé, injecté dans les veines d'un lapin à l'agonie, après l'ablation de l'une ou des deux capsules, le faisait revenir à la vie pour quelques heures.

En outre, j'ajoutai que l'ablation des reins tue moins vite que celle des capsules surrénales.

M. Gratiolet écrivit à l'académie (1) qu'il avait fait, sur des cochons d'Inde, quelques expériences dont il résultait que l'ablation de la capsule surrénale gauche n'amenait pas toujours la mort, tandis que celle de la capsule surrénale droite causait constamment la mort par suite d'une inflammation du foie et du péritoine.

Dans un second travail que je présentai à l'académie (2), à la séance suivante, j'insistai sur ce fait que la mort ne pouvait pas dépendre d'inflammations accidentelles qui, se développant lentement, ne sont pas arrivées à un degré suffisant d'intensité lorsque la vie cesse, pour que l'on considère ces inflammations comme ayant causé la mort.

Peu de temps après, je publia un mémoire très étendu sur la physiologie des capsules surrénales (3), mémoire dans lequel se trouvent exposées presque toutes les recherches que j'avais faites jusque-là sur ces petits organes. Avant d'aborder l'étude des faits nouveaux que je me

(1) *Comptes rendus de l'Ac. des sciences*, 1856, vol. XLIII, p. 468.

(2) *Voyez Comptes rendus*, 1856, vol. XLIII, p. 542.

(3) *Arch. génér. de médecine*, oct. et nov. 1856, p. 385 et p. 572.

propose de publier ici, je vais donner une analyse rapide des résultats généraux consignés dans ce mémoire.

1^o A l'égard des nerfs, j'ai trouvé chez le lapin, le cochon d'Inde, le chien et le chat, que les capsules ont dans leurs nerfs quelques fibres de Remak, que les fibres à double contour y sont rares et que les fibres sympathiques de Bidder et Volkmann y abondent.

2^o J'ai constaté que, sur les lapins, les capsules sont souvent plus sensibles que la peau des membres, car, lorsqu'on les écrase, il est fréquent que l'animal crie, tandis que le pincement de la peau ne le fait pas crier. La sensibilité des capsules est vive aussi chez les chats, mais elle est moindre chez les chiens, et surtout chez les cochons d'Inde.

3^o Les auteurs qui ont cru que les capsules sont des organes transitoires et que leur activité n'est grande que pendant la vie embryonnaire, se sont certainement trompés. Ils ne se fondaient que sur le rapide développement des capsules chez l'embryon humain, et sur cet autre fait qu'à la naissance les reins sont moins développés que les capsules. Mais en admettant l'exactitude de cette assertion, elle prouve seulement que les fonctions des capsules ont plus d'activité que celles des reins pendant la vie intra-utérine dans l'espèce humaine. Chez d'autres mammifères et chez quelques vertébrés à sang froid, le développement des capsules n'est pas plus rapide que celui des reins. J'ai constaté d'ailleurs que les capsules surrénales gagnent notablement en poids à partir de la naissance jusqu'à l'âge adulte, et moins chez l'homme, cependant, que chez les chiens, les chats, les cochons d'Inde et les lapins. De ces faits j'ai conclu que les capsules surrénales ne sont pas comme le thymus chez la plupart des animaux, des organes transitoires, appartenant seulement aux premières périodes de la vie.

4^o J'ai constaté que la survie moyenne, après l'ablation simultanée des deux capsules surrénales, était de 9 heures et quelques minutes sur les lapins, de 14 heures sur les chiens et les chats adultes, de 8 heures sur deux souris, de 13 heures sur onze cochons d'Inde adultes, de 23 heures $\frac{1}{2}$ sur quatre jeunes cochons d'Inde, de 37 heures sur onze chiens et chats très jeunes. Ce qui donne comme moyenne générale 17 heures $\frac{1}{2}$. En multipliant ces expériences, depuis la publication de mon mémoire, j'ai obtenu des résultats qui ne diffèrent guère des précédents, ainsi que je le montrerai tout à l'heure.

5^o J'ai annoncé que j'avais vu survivre des chiens et des cochons d'Inde, après l'ablation de la capsule surrénale droite, celle que, suivant M. Gratiolet, on ne pouvait enlever sans produire une péritonite et une hépatite mortelle. Cependant j'avais vu que la mort avait lieu assez fréquemment et assez rapidement, après l'ablation d'une seule capsule

(la droite ou la gauche), surtout chez les lapins, pour pouvoir conclure que, même dans ce cas, la mort semblait due à l'absence de l'organe enlevé.

6° Parmi les symptômes très intéressants que l'on observe après l'ablation des deux capsules, j'ai signalé surtout un affaiblissement considérable et des troubles constants de la respiration et de la circulation. La force des mouvements du cœur est toujours diminuée ; quand à la vitesse de ces mouvements elle est d'abord diminuée aussi, mais plus tard, alors que la respiration d'abord activée devient gênée et lente, le cœur bat plus vite. Pour les détails de ces faits je renvoie à mon mémoire ; mais je crois devoir ajouter ici qu'il n'y a pas de *fièvre*.

7° Les animaux ayant perdu les deux capsules surrénales refusent de prendre des aliments. J'ai vu cependant deux exceptions à cette règle.

8° Dans les dernières heures de la vie il y a quelquefois du délire et très souvent des convulsions. Celles-ci ressemblent, le plus souvent, aux convulsions dues à de la strychnine. Quelquefois il y a des convulsions épileptiformes, avec tendance à rouler, tantôt d'un côté, tantôt de l'autre. Chez les lapins assez souvent il y a eu du tournoiement.

9° J'ai trouvé, dans le sang des animaux dépouillés des capsules, plus de pigment qu'on n'en rencontre ordinairement, et souvent ce pigment était en plaques bien plus larges que le diamètre des capillaires de l'encéphale.

10° J'ai constaté que la formation de cristaux du sang, différant par quelques caractères de ceux qui proviennent du sang normal, s'opère souvent *spontanément*, très vite et quelquefois en très grande abondance, dans le sang extrait des vaisseaux d'animaux dépouillés des capsules surrénales.

11° J'ai cherché par des expériences nombreuses à montrer que la mort des animaux dépouillés des capsules ne peut pas être attribuée, ni entièrement, ni même principalement, à des causes accidentelles, telles qu'une péritonite, une hémorrhagie, une néphrite, une phlébite des veines rénales ou de la veine cave, une hépatite ou une excitation des filets du nerf grand sympathique.

12° J'ai signalé ce fait singulier que, si les animaux dépouillés d'une seule capsule meurent avant le développement d'une péritonite intense, on les voit souvent *rouler*, comme après la piqûre du pédoncule cérébelleux moyen. Il importe de remarquer que le roulement commence par le côté *gauche* si c'est la capsule *droite* qui a été enlevée, et *vice versa*.

13° J'ai trouvé qu'une maladie extrêmement fréquente chez les lapins, à Paris, maladie qui semble causer toujours la mort et dans un

temps très court, semble liée à une production exagérée de pigment et à une inflammation consécutive des capsules surrénales. Les symptômes de cette maladie sont les mêmes que ceux de l'ablation de ces petits organes.

14° J'ai essayé de montrer que la plus grande analogie existe entre les symptômes de la maladie dont je viens de parler, ceux de la maladie d'Addison et ceux que l'on peut observer après l'ablation des deux capsules.

15° J'ai fait voir que les fonctions des capsules surrénales doivent être d'une très grande importance, puisque l'ablation de ces petits organes amène la mort plus vite que l'ablation des reins.

16° En rapprochant les faits que j'ai trouvés chez les animaux de ceux observés par le Dr. T. Addison et d'autres, on constate qu'en l'absence des fonctions des capsules surrénales, il se fait une accumulation de pigment, dans le sang chez les animaux, et dans la peau chez l'homme. Il y a donc lieu de supposer qu'une des fonctions des capsules consiste en une modification d'une substance douée de la propriété de se transformer en pigment, modification d'après laquelle cette substance perdrait cette propriété.

A continuer.

The Medical Chronicle.

LICET OMNIBUS, LICET NOBIS, DIGNITATEM ARTIS MEDICÆ TUERI.

THE DISCLOSURE.—Our Correspondent who signed himself "a veritable M.D.," having no longer any reasons for withholding his name and address, has boldly declared them in a letter which will be found immediately following this notice. Its author, Dr. Stevens of Dunham, thus enables us to fulfil the promise, implied in our last, of affording this information, after a little while, to the gentlemen who had sought it. In the publication of the original letter we were moved by no hostile feeling towards any one, nor had we the slightest desire of using it as a means of prejudice or injury. Altogether irrespectively of any personal feelings,—we gave it insertion simply because it referred to a matter of public interest, affecting the rights of the profession generally. Not having an actual knowledge of the circumstances involved, we refrained from expressing an opinion as to their veracity or not

feeling assured that if the charges alleged were unfounded, they would meet with a prompt contradiction. Replies, as our readers know, were duly received, and with them they have been made acquainted. They have accordingly been put in possession of both sides of the question, together with such explanations as were considered necessary.

JOURNAL DE LA PHYSIOLOGIE DE L'HOMME ET DES ANIMAUX, PUBLIÉ SOUS LE DIRECTION DU DOCTEUR E. BROWN-SÉQUARD.—Many of our readers being of French extraction we have often regretted that we had no Parisian exchanges, so that we might from time to time bring before them articles written in their own language. We hail, therefore, with great satisfaction, the appearance in Canada of the Journal, the title of which we give above, and from whose pages we transfer to the columns of our present number a portion of a paper from the pen of the distinguished editor-in-chief. The "Journal de la Physiologie" is to be published quarterly. Each number will contain 216 pages. The first has been brought out in good style by Messrs. Balliere & Son of Paris. The agents for America are Messrs. B. Waterman & Co., New York, who will supply it to subscribers for about \$5 per annum. Under the management of that eminent physiologist Brown-Séquard, ably assisted, as he will be, by Ch. Robin, Ch. Ronget, and Tholozan, men of mark and distinction in the scientific world, this Journal is sure to succeed in every respect.

DEATH OF DR. CHURCH, M. P. P.—It is our duty to announce the sudden death in Toronto, last month, of Dr. Church, the representative in Parliament of Leeds and Grenville. Dr. Church had resided since the commencement of the session, in Mrs. Brown's boarding house, King street West, and dined there, as usual, at two o'clock on the afternoon of the same day. Although at times before suffering from ailments which were believed to partake of a rheumatic nature, he was then in his customary health and spirits; and when, after dinner he separated from friends to retire to his room, it was with the view of completing letters connected with the business of his constituency. In about twenty minutes afterwards, Col. Playfair, M. P. P., visited Dr. Church's room; knocking without receiving a reply, he opened the door, and then discovered the Doctor in his chair, with his face upon the table, dead. Aid was immediately obtained, but without being of the slightest avail: the attending physician, Dr. Ogden, expressed an opinion that the death had resulted from apoplexy.

L'ECRASEUR IN CANADA.—In a communication over the signature of Arthur Ricard, M.D., which appeared in some of our daily newspapers, occurs the following passage :—

“ Dr. Delisle is probably the first person who, publicly, has made known in America *L'Ecraseur* and its effects. Honor then to Dr. Delisle! honor to this distinguished scholar of the Canadian Medical Schools, who, after receiving the instructions of the greatest masters of Europe, has come amongst us to make known the good results obtained by the Surgical Art.”

The writer is evidently ignorant of what is done beyond his own little sphere, and appears, like too many others, to think that the small circle within which he moves comprises the world itself. Had he known anything of American literature he would not have committed so palpable an error as to attribute the introduction of the *Ecraseur* into this quarter of the globe to Dr. Delisle. Indeed, had he even been acquainted with the literature of the town in which he resides, he must have known that this instrument has long before now been in use amongst us. For his edification we would especially refer him to the *Medical Chronicle* for December, 1857, where he will find recorded a case of internal piles, admitted the preceding February into the Montreal General Hospital, and treated by Dr. MacCallum, professor of clinical surgery, with the *Ecraseur*. The remainder of the paragraph above quoted needs no notice.

Memorial of the College of Physicians and Surgeons, C. E., proposed to be submitted to his Excellency the Governor General.

“ That by the position of the College of Physicians and Surgeons, as representing the Medical profession in the Province of Lower Canada, it has been entrusted with interests of great vital importance, inasmuch as these interests are intimately connected with the welfare and happiness of the people :

That at a semi-annual Convocation of the Governors of the College, held at Quebec in the month of October, 1856, a Resolution was unanimously adopted by that body, appointing a Committee for the District of Quebec, and another for that of Montreal, for the important purpose of “ ascertaining the best means of extending the usefulness of the College to the Medical profession, and the public in general ”:

That voluminous Reports thereon, were at a subsequent meeting of the Board of Governors, submitted to its consideration, and approved :

That at the meeting of the Board of Governors, held at Quebec on the 13th October last, it was deemed necessary—founded on the Report of the two Committees specially assembled at Montreal on the preceding day—to modify the proceedings involved in the various subjects embodied in the Reports previously alluded to, and to nominate the two Vice-Presidents, with associative power,

to carry into effect, through your Excellency's assistance and that of the Legislature, the Report of the College, embodying several important measures. With regard to that portion which comes more immediately within the action of the latter, your Memorialists would respectfully beg leave to draw your Excellency's attention to that part which has reference to the education and qualifications of Apothecaries, Chemists, and Druggists, with necessary provision for the inspection of Drugs, and stringent regulations for the Sale of Poisons.

As it must appear to your Excellency that the subject involves interests of the highest importance to society, and in a great measure the safety and protection of life, we would earnestly recommend to your Excellency's consideration the Bill hereunto annexed, as taken in part from Sections of 27th Will. IV. Chap. I, and intitled "Bill for the Regulation of the Studies of Apothecaries and the Sale of Poisons."

The other subjects included in the Report of the Board of Governors of the College of Physicians and Surgeons, come more immediately under your Excellency's prerogative, and among them one has reference to "the appointment of a Commission, under whose directions should be enforced those hygienic rules or measures which have been recognized as serviceable, during the prevalence of epidemics, for securing the health of towns, &c."

On this portion of the Report your Memorialists would respectfully observe :

That as sanitary measures are incontestably of the highest importance to all countries, and particularly to this Province, where largely populated localities extend, in a direct line of communication, several hundred miles, thus bringing the inhabitants into constant and immediate intercourse with those but recently landed from on Board of ships,—in which not unfrequently the most malignant and contagious diseases have prevailed during long voyages at sea,—we regret that the Provincial Act now in force, and commonly called the "Central Board of Health Act," should have been so framed as to prove extremely defective in its operations.

An extended experience of those calamitous and disastrous periods in which it has been enforced, has fully convinced your Memorialists that this Act is altogether inadequate for ensuring those comprehensive and vigorous measures so urgently demanded on the approach and invasion of a great and destructive pestilence or malignant disease ; and the better to provide to the population at large the benefit and protection of well-considered and efficient sanitary measures, with all the appliances that modern science can devise, we would most earnestly recommend to your Excellency that none but men of distinguished professional acquirement and practical experience should be entrusted with the execution of these measures,—the more especially as their minds will have been trained to the investigation and solution of abstruse subjects, and therefore emergently prepared to engage in all enquires connected with public hygiene, with correct information and without prejudice.

As it is, furthermore, evident that it can only be in proportion to the extent to which these measures are scientifically and systematically carried out, that any substantial benefits can be secured, your Memorialists would with deference suggest, that that Act should receive such amendments as would enable Commissioners, appointed under its provisions, to take such measures of promptitude

as will meet the exigencies of the case, for the prevention, or at least the mitigation, of these diseases, without reference to the approbation of their directions and regulations by any other executive authority. This is an exception which of late years has loudly called for public consideration, and particularly during the existence of a pestilential type of typhus, in seasons of scarcity and general destitution among the labouring classes, and the unexampled intensity and fatality of cholera.

Your Memorialists may be permitted to submit, that, as the College of Physicians and Surgeons should, in our opinion, present the aspect of a vigorous energetic corporation, whose deliberations have constantly in view, not only the honor, elevation, and usefulness of the Medical profession, but essentially the welfare and interest of the public, we deem it also one of our duties to awaken a stronger feeling than heretofore, in the public mind, in favour of our Provincial College, and to endeavor by every public means to create a closer bond with the Government of the country. We do under no less an analogy than the College of Physicians of London, as well as those of Paris and other Continental countries, these learned bodies being affiliated to and associated with their respective governments in all matters connected with so important and vital a subject as the public health.

Your Memorialists having in view the rapidly increasing population of this part of the Province, and the inevitable future inadequacy of the Beauport Lunatic Asylum to meet the wants of a most unfortunately afflicted portion of the human family, would respectfully represent to your Excellency the necessity for the early erection of an asylum in the immediate neighbourhood of the City of Montreal, on the unoccupied grounds which have been for so many years purchased for that purpose by the Provincial Government. Your Memorialists deem it their duty to bring this subject prominently before your Excellency, as one embodying the truest principles of philanthropy.

Another important subject has also engaged the attention of the Board of Governors, and, as it bears reference to "the appointment of medical men as Coroners, or Associates, especially in the large cities of the Province," your Memorialists would respectfully observe, in conclusion, that, as it has long been a matter of common assent in England, Ireland, the United States of America, and Upper Canada, strengthened by the opinion of the highest judicial authorities in these countries, that a knowledge of medical science, comprising medical jurisprudence, in the broadest acception of this term, is the most material qualification for the peculiar, and often difficult, complicated, and delicate functions which a coroner has to perform, they would earnestly solicit, that in the exercise of your Excellency's prerogative, appointments to an office of such unquestionable importance in its connection with the criminal jurisprudence of the country, should alone be conferred on persons of acknowledged distinguished acquirements in the medical profession, as being more peculiarly qualified to discharge effectually the duties of that office."

HOSPITAL REPORTS.

Fracture of the Acromion Process extending into the Acromio-Clavicular Articulation, with subsequent dislocation of Acromial Extremity of the Clavicle. Reported by Mr. W. HARKIN.

John Lynch, aged 41, a shoemaker, was admitted into the Montreal General Hospital, March 5th, 1858, under Dr. MacCallum.

The patient is a man of spare habit and dark complexion. His health has been generally good. On the 1st of March he was walking on George Street, when he slipped and fell, striking first upon his right hand, which he put out to save himself, then rolled over and struck the point of his shoulder against the sharp edge of a door. Upon rising he felt a severe pain in his shoulder, and was unable to raise his arm, or to move it much except backwards and forwards, and could not fully extend the forearm. He applied to a medical gentleman who proceeded as if to reduce a dislocation by putting his heel into the axilla and making powerful extension. It was afterwards put up with a pad in the axilla and strips of plaster across the shoulder, and some bandages.

These soon fell off, and when he came to the Hospital the symptoms were as follows. The shoulder was depressed, and there was a hollow on its superior part. The clavicle and with it the acromion process of the scapula were separated from the latter bone nearly two inches, being directed downwards and a little forwards. He could not move the arm without experiencing great pain, and could not raise it more than two inches from his side. When the arm was raised he could hold it for a short time in the extended position, the shoulder being rounded on each side but depressed in the centre. On placing one hand over the extremity of the acromion and pressing up and rotating the humerus with the other, a distinct crepitus was perceived. The deformity was easily removed by elevating the humerus, but returned immediately when the support was taken away. Fracture of the acromion process of the scapula was diagnosed, and it was treated by a pad placed between the elbow and side, the elbow supported in a short sling, the arm bandaged to the side, and pressure exerted over the acromion by a few turns of a roller. This brought the parts into accurate apposition, and the natural contour of the shoulder was restored. Matters progressed favorably until the fourth day, the bandages merely requiring to be tightened occasionally, when a great and unnatural protrusion appeared over the acromion. This proved to be the extremity of the clavicle, and Dr. MacCallum accounted for its dislocation in the following way. The

fracture had extended into the acromio-clavicular articulation, rupturing the acromio-clavicular ligaments, the superior at least. When the arm was bandaged firmly to the body and the shoulder raised by a short sling, the acromion was fixed from below by the ball of the humerus pressing on it and acting as a splint, while it was secured from above by the turns of the roller which were carried over it. The clavicle was thus placed between two fixed points, and certain movements of the body would act with greater power on its scapular extremity than if the shoulder and arm were free. In consequence, therefore, of some sudden movement of the body during the night while the patient was asleep, the force of which was expended principally on this extremity of the clavicle, it was thrust through the ruptured ligament and became placed upon the acromion process. He stated further, that deformity was almost inevitable in consequence of the compound nature of the case, but that the man would have notwithstanding a very useful limb.

The clavicle was then reduced as well as possible by drawing the shoulders forcibly backwards; and in addition to the bandages, &c. which had been previously employed for the fracture, there was an apparatus adjusted to keep the shoulders in this position. This consisted of a cross made of wood well padded and laid against the back, and to which the shoulders were firmly bandaged.

On the 10th April, five weeks from the time of his admission, he left the Hospital. Union has now taken place, and at the site of fracture there is a distinct ridge as if from the presence of "ensheathing callus." The prominence produced by the dislocated clavicle has much diminished, and there is not the same amount of flatness of the shoulder. The motions of the arm are perfect in a direction forward and backward; he can raise his arm freely, to a certain extent but he cannot extend it fully without experiencing some pain.

Conical Cornea, treated by Paracentesis Corneæ, combined with pressure.
Reported by Mr. LOUIS ROBITAILLE.

Mary Quinlan, aged 18, who was admitted into the Montreal General Hospital for Common Continued Fever, came under the care of Dr. MacCallum on the 1st February, 1858. While under treatment, attention was drawn to her right eye, in consequence of the peculiar brilliancy of the cornea. She states that while young she was much troubled with sore eyes; and, as far back as her memory serves her, she has had great difficulty in distinguishing objects with the right eye. Latterly, this imperfection of sight has increased so much, and interferes to so great a

degree with her movements, she has found it difficult to obtain employment as a servant, or to retain a situation. When she looks at an object, a black spot, sufficient to obscure it, intervenes between the object and her sight. Has suffered for years from a constant pain extending across the right orbit, from the inner to the outer angle. Has had likewise pain in the forehead of an intermittent character.

On examination, the eye has a lustrous appearance; and when she looks at a person, her head is held downwards and towards the right shoulder, imparting an awkward and sheepish appearance to the patient. The central portion of the cornea is raised into a cone with a somewhat pointed apex, whilst the circumferential portion appears to retain its natural convexity. On the point of the cone there is a transparent depression, resembling much the appearance left after the absorption of a phlyctenula. The elevation of the cornea is best perceived by examining the eye in profile, or by making the patient close the eye. In the former case, it looks as if there was a conical crystal affixed to the front of the cornea; in the latter, the prominence is readily perceived protruding the upper lid. When the left eye is closed, and a hand is held at some distance before the centre of the cornea of the right eye, she can merely perceive that there is some object before the eye. If it be held, however, near the outer or inner portion of the circumference, she can make out the object as being a hand.

On the 18th February, the operation of paracentesis corneæ was performed, giving escape to a considerable quantity of the aqueous humour. Immediately after the puncture and discharge of fluid, the cornea became more rounded, and the patient declared that she could see much better. The eye was left in this condition until the next day (19th Feb.) when an accurately fitting compress was carefully adjusted over the globe of the eye, and retained in its position by means of a bandage. She was ordered at the same time the following mixture:—℞ Quin-Sulph., gr. viii.; Pot. Iod. ℥ii.; Acidi Cit. ʒss.; Aquæ ℥vi. A tablespoonful to be taken three times a day. The compress and bandage were left on, being occasionally adjusted, until the fifth of March. On removal it was found that the eye still presented the same brilliant appearance, but that the corneal cone was not so prominent as it had been. The patient says her sight has improved, and is desirous to have the operation repeated. All pain in the orbit has completely disappeared. On the 9th of March the cornea was again punctured, and in the evening of the same day the compress and bandage were applied. They were removed on the 28th March, a few days before she left Hospital. There is still some elevation of the centre of the cornea. She is satisfied, how-

ever, that her sight has materially improved. When the hand is now held before her eye she can count the fingers with ease, and the outline of every object is very distinct. There is not the same uncertainty in her movements that there was previously, nor does she appear to be so awkward in her manner.

Melanopathia in a patient with Mitral valve disease of the Heart, &c.

Reported by Mr. WM. HARKIN.

C— aged 39, was admitted into the Montreal General Hospital, March 24th 1858, under Dr. McCallum. Has no family history of hereditary disease, and his own health was pretty good till the year 1852. Was a hotel keeper, but of temperate habits and his business obliged him to be on foot for 18 or 20 hours each day. In 1844, he had frequent attacks of palpitation and dyspnoea. Dropsy first made its appearance in October, 1852, but for a year previously he felt his health gradually declining. The dropsy began first in his feet and ankles and became general, but disappeared under treatment by the May following. He has had a similar attack every winter since, and with each attack he has had a cough and expectoration like at present. The chief medicines he took were Tr. of Aconite and Iodide of Potassium, of this latter he has taken an immense quantity. Has been able to attend to his business every summer hitherto, either as hotel keeper or bookkeeper, and he blames standing so much during summer for the return of the dropsy in winter. His ankles were never quite free from swelling from the first attack till a few weeks ago.

Present attack commenced in November last, and the swelling disappeared about the 1st of February (1858). the cough began about 7 weeks ago and continued to grow worse till he entered Hospital, when his condition was as follows: considerably emaciated except his face which was somewhat bloated looking, and suffused, eyes dull and heavy, conjunctivæ of a yellow tinge, lips livid, great dyspnoea very much increased by the least exertion. Skin somewhat harsh and dry, pulse irregular, weak, small & 64, and respiration 20 per minute, bowels costive, cough frequent and troublesome, increased by least exertion, expectoration about 8 ounces daily, and mucopurulent without any tinge of blood, urine high colored from bile, and scanty, when he walks he feels a desire to micturate. Inspection, chest symmetrical, except at the junction of 4th and 5th left ribs, with their cartilages, where there is considerable bulging. This was caused by a fall that he got from a horse 12 years ago. The left side of the chest measures at the nipple 18 inches, and the right 18½ inches,

at the same point. No sinking above the clavicles, but the carotid arteries pulsate so strongly, that he complains of it. There is visible pulsation in the jugular veins. Percussion yields normal sounds over the whole of the chest, except that the Cardiac dulness is somewhat increased. Hepatic dulness normal. Auscultation—mucous and cooing rales heard over the whole of the chest, but best marked at the anterior inferior part, where they obscure the sounds of the heart.

The first sound of the heart is almost replaced by a murmur best heard beneath the left nipple and towards the axilla, but also heard at the ensiform cartilage and at the junction of the cartilage of the 4th rib with the sternum. The hand placed over the heart feels a slight heaving motion, but there is no fremitus cataire. The second sound of the heart is weak and somewhat obscured both by the murmur of the first sound and by the bronchitic rales in the lungs.

There is a very peculiar discoloration of both legs, almost like log-wood, beginning about two inches below the knees and terminating at the ankles, above and below these points the skin is mottled with spots of a similar color, and there are none on any other point of his body. The color is deepest about the middle of the leg. The veins are knotty and of a peculiar milky appearance, both on the internal and external sides of each leg, being largest and most conspicuous at the ankles and at the heads of the tibia. The legs are of their natural size but have a peculiarly dry feel. The motion of the ankle joints is now perfect, for the first time since his first attack of dropsy in 1852. He was ordered—
Pulv. Jalapæ grs. xv; Scammon. grs. v. Cal. iij.

And a cough mixture of Tr. Sanguinaræ, Vini Ipecac aa ʒ ij., Spir. Ammon, Aromat. ʒ iij. sol. Morphicæ ʒ j., aquæ ad ʒ vj. ʒ ss., to be taken every fourth hour.

April 1st.—Cough less troublesome, expectoration diminishing, sleeps better at night, bowels costive, pulse 60, and irregular, jugulars pulsate and fill from below, murmur well heard at ensiform cartilage, has frequent desire to stool but does not pass anything.

April 7th.—℞ Oleum Ricini ʒ ij.

April 10th.—Pulse weak, irregular and 76. Tongue slightly coated with a yellowish matter. Bowels regular—occasional darting pains in the region of his heart. Urine still high colored and less than a pint in 24 hours, coughs very seldom at night, expectoration much diminished. Legs as formerly.

April 30th.—His bronchitic attack has completely subsided, and the icteroid hue of skin and conjunctiva has disappeared.

QUARTERLY REPORT OF THE MONTREAL GENERAL HOSPITAL, ENDING 22ND APRIL, 1858.

Patients remaining from last quarter,.....	86	Died during the quarter,	5
Patients admitted present quarter, 127		Now in Hospital,.....	61
	213	Discharged,	147
IN-DOOR PATIENTS.		OUT-DOOR PATIENTS.	
Males,.....	74	Males,	618
Females,	53	Females,	660
	127		1278

DISEASES AND ACCIDENTS.

DISEASES, &c.	Died.	A dmit- ted.	DISEASES, &c.	Died.	Admit- ted.
Abscessus,	1		Hysteria,.....		2
Ambustio,	2		Inebrietas,		1
Amenorrhœa,.....	1		Lupus,		1
Anasarca,	1		Luxatio,		2
Anchylosis,	1		Melanopathia,		1
Arthritis,	1		Menorrhagia,		1
Ascites,	1		Molluscum,.....		1
Bronchitis,	5		Morbus Cordis,		2
Broncho-pneumon,	1		Ophthalmia Scrof.,		3
Bursitis,	2		Orchitis,		1
Caries,	1		Paralysis,		1
Cataractus,	2		Paronychia,		1
Conjunctivitis,	4		Peritonitis Puerp.,.....		1
Contusio,	1		Phthisis,	3	3
Delirium Tremens,.....	3		Ptyalismus Acut.,.....		1
Diarrhœa,.....	1		Ramollissement Cerebr,....		1
Dysuria,	1		Resectio Phalangis,		1
Ecthyma,	1		Rheumatismus,		9
Epilepsia,	2		Rubeola,.....		2
Febris Com. Cont.,.....	18		Scarlatina,		2
Febris Ephemeralis,	1		Sclerotitis,		3
" Intermittens,	2		Staphyloma,.....		1
Fractura Comp. Commin., ..	2		Synovitis,		1
" Simplex,	1	4	Syphillis,		2
Furunculus,	3		Tonsillitis,		2
Gelatio,	2		Tumor,		3
Gonorrhœa,	1		Ulcus Cruris,.....		1
Hæmoptysis,	1		" Recti,.....	1	9
Hæmorrhoides,.....	4		Vulnus,		4
Hemiplegia,	1				
Hypochondriasis,.....	1			5	127

OPERATIONS, &c.

MAJOR AMPUTATIONS.—Of hands, 2; of foot, 1; of fingers, 2; of toes, 5. Resection of phalanx, 1; removal of necrosed tibia, 1. **Excisions.**—Of recurring fibroid tumour, 1; of encysted tumour, 2; of epithelial cancer, 1. Removal of internal piles, 2; artificial pupil, 1; keratonyxis, 2; tenotomy, 1. Total, 22.

FRACTURES.—{ Simple—Indoor, 4; out-door, 2 } Total, 8.
 { Compound " . 2 }

DISLOCATIONS REDUCED.—Indoor, 2; out-do. 3. Total, 5.

MINOR OPERATIONS.—Venesections, 6; cuppings, 24; starched bandages applied, 17; hydrocele tapped, 1; abscesses opened and other incisions, 97; teeth extracted, 173; wounds dressed, 15. Total, 333.

ATTENDING PHYSICIANS.—Drs. MacCallum and Scott.

By Dr. Reddy.—Operation for cataract, (Keratonyxis.)

ROBERT CRAIK, M.D.,

House Physician and Surgeon.

MEDICAL APPOINTMENTS.

SECRETARY'S OFFICE,

Toronto, 24th April, 1858.

His Excellency the Governor has been pleased to make the following appointments, viz :

Patrick Edward McKeon, Physician and Surgeon, and Alexander Harvey, M.D., Esqs., to be Associate Coroners for the United Counties of Peterborough and Victoria.

Richard Leech, Esq., to be an Associate Coroner for the United Counties of Leeds and Grenville.

Toronto, 3rd April, 1858.

His Excellency the Governor General has been pleased to make the following appointments, viz :

Easton Hawkesworth, Esquire, M.D., to be an Associate Coroner, for the United Counties of Huron and Bruce.

His Excellency the Governor General has been pleased to grant a License to John Turner Mullin, of St. George, in the County of Brant Esquire, M.D., to practice Physic, Surgery and Midwifery in Upper Canada.

To the Editors of the MEDICAL CHRONICLE.

GENTLEMEN,—I declare myself to be the author of the letter signed "A Veritable M.D.," published in the February number of the *Chronicle*, and that I am in possession of proofs to substantiate the correctness of the charges it contained against the three Governors of the College of Physicians and Surgeons, in the district of Bedford, and am prepared to adduce these proofs before this corporation or elsewhere whenever demanded.

With reference to the questions in the last *Chronicle*, which you suggest should be inquired into, I have no hesitation in replying to each in the affirmative.

Were there unlicensed practitioners practising in the same parts with these gentlemen? YES!

Did the former enjoy a protection from the latter? YES!

Were they there with their consent or upon their invitation? YES!

Did they act in consort with them as assistants or consultants or deputies? YES!

Respectfully yours,

Dunham, C. E.

A. D. STEVENS, M.D.