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Delivered at the Inauguration of the New Medical Faculty of the University of Toronto.

BY PROF. R. RAMSAY WRIGHT, M.A.,

Professor of General Biology and Physiology.

It is as a University Professor, as distinct from a University College Professor, that I have been requested to deliver the first public lecture of the New Medical Faculty, and I owe my sincere thanks to the Vice-Chancellor and other authorities for the distinction conferred upon me in selecting me to perform this task.

On such an occasion it seemed wise not to choose a subject belonging to my own particular department, but rather to select one of general educational interest, and it occurred to me that I would satisfy my own proclivities towards looking at all things from a standpoint familiar to the biologist, and possibly interest you for a short time by calling your attention to some phases of the

EVOLUTION OF MEDICAL EDUCATION,

especially to those during which so intimate a connection with the universities became first established, as we hope henceforth to have in the University of Toronto.

To do so it is necessary to look back some eight centuries to the mediæval universities. These seats of learning were at first but few in number, and owed their origin for the most part to some cathedral or monastic school which had afforded instruction to the youth of the neighborhood in the elements of grammar, logic and rhetoric. The special reason for this growth of the higher institution out of the lower seems to have been the attachment to these schools of learned men, able to give more advanced instruction adapted to the immediate wants of the society of the day, so that Paris became celebrated as a centre for philosophical and theological knowledge, while Bologna gathered within its walls those who desired to become learned in the law. At first these centres confined themselves to their specialties, and only in later times did they offer instruction in all the branches of learning. The word *university* had, therefore, nothing to do with implying the universality of the teaching, but rather referred to the community or guild of those prosecuting the higher studies in any particular city.

Having been attracted to such centres by the fame of their masters, the scholars remained to teach, being almost obliged to do so in order to meet the wants of the constantly increasing numbers of students. They thus themselves became masters or doctors, titles which were then practically synonymous. This rapid growth in the number of students is one of the most striking characteristics of these early universities —as many as 30,000 scholars, it is stated, were in Oxford six hundred years ago—and this growth was unquestionably due not only to the awakening interest in learning, but also to the smallness of the number of places where instruction could be had, to the scarcity of books, and the

consequent limitation of learning to those who had access to oral instruction.

In these early days an imposing pile of buildings was not a necessary adjunct to a university, for the masters generally taught in their own houses, and the scholars sought accommodation where they could find it. Of course such a large concourse of students taxed the capacity of the mediæval towns, and eventually a number of inns, or hostels, or halls were started, each under the supervision of a master, in which the students could find board and lodging.

These halls were a step in the development of the *colleges*, which resembled them in every respect except that they were endowed by the wealthy so as to provide board and lodging for poorer students, and also for some masters to superintend their preparatory training. Eventually, when the number of students decreased through the multiplication of centres of learning and the distribution of printed books, the colleges sometimes (as in Oxford and Cambridge) sufficed to accommodate all the students, admitting those by payment who were not provided for by the endowment.

As there were no university buildings, so there were no imposing graduation ceremonials nor formal examinations, the scholars, after making themselves proficient, receiving permission to teach from their masters, and then being styled themselves masters or doctors, while the bachelor's degree was a later sign to mark the attainment of a stage half-way to the full degree.

I have said sufficient to show that the prime function of the university in these days was teaching, by masters who professed special branches of learning, while the chief educational value of the colleges consisted in the life in common, under certain domestic restrictions, and in the intellectual fellowship to be had within them.

After this glance at the nature of the medi æval universities, let me now proceed to show, a matter of special interest to us to-day, how the earliest of all originated in a school of medicine—the famous school of Salerno, near Naples. During the early centuries of the triumph of the Christian faith, the practice of medicine was largely in the hands of monks who devoted themselves to the study of the art, handed down its secrets through the members of their brotherhoods, and continued the good work which had previously been done by the priesthood or families of Æsculapius, which, as has been said, among all pagan institutions most closely resembled the monastic brotherhoods in their conviction of the religiousness of a life devoted to the relief of suffering.

One of these monastic institutions, that founded by Saint Benedict at Monte Cassino, near Naples, in the middle of the sixth century, made special progress in the healing art, owing to its possession of the Greek medical classics, Hippocrates and Galen, which, although familiar in the form of translations to the Arabian physicians of those times, were not then accessible to the rest of Europe. For it must be understood, that after the decline of the Greek school of medicine the art had made far greater progress in North Africa than in the rest of the civilized world. The Arabian physicians had not only profited directly or indirectly by the teaching at the University of Alexandria, but had by personal researches extended their knowledge. So it was that a Christian monk named Constantine, who fled from Carthage to Monte Cassino in the middle of the eleventh century, and who had studied medicine many years among the Arabs, was able to bring with him to the Benedictine Monastery such additional accomplishments as at once made him famous. It was to him that the Salernian school owed its immediate origin. The monks had previously extended their teaching to students without their walls, but Constantine's fame soon attracted large numbers of eager scholars from all parts of the world, so that, as no tests or limitations of any sort were imposed, instruction was eventually to be had not only in Latin for the Christians, but in Hebrew for the numerous Jews who took advantage of the opportunities offered.

In a few decades the instruction crystallized into a regular university course of three years in arts and five in medicine, all of which a scholar was obliged to attend before he received his doctorship or permission to teach. The regulations enforcing this were first made

definite by Roger II, King of Sicily, in 1137, who forbade the practice of medicine within his dominions to any who had not taken the full course at Salerno, and thereafter practised an additional year with a physician. This monarch may thus be credited with the imposition of the *first State examination in medicine*, and simultaneously with the formation of a class of licensed lay-physicians, who soon spread throughout Europe the fame of the Salernian school. How far medicine had advanced in this corner of the world may be judged from the fact that surgeons were licensed only after they had devoted a year of study specially to surgery and anatomy. Now in the rest of Europe surgery was held in very slight esteem for centuries afterwards, and was practised only by barbers. Indeed it is not so long ago, only in 1745, that the Company of Surgeons in England obtained a charter of incorporation independent of that of the Company of Barbers with which they had formerly been united. As for anatomy, if we compare the provisions for its teaching with what existed centuries later in England, we shall see how far in advance of its time Salerno really was. We read, for instance, of the conditions which the Lecturer in Anatomy in Oxford had to observe in 1620. He was obliged to give three distinct lectures on a skeleton in the Michaelmas term, and to give an account of the bones, and their office, situations, etc., also four distinct lectures or demonstrations on the soft parts of the body of a malefactor during the Easter term.

For many years Salerno remained the chief European medical school, but Bologna, in the North of Italy, soon added a medical faculty to the existing ones of arts and law, an example followed by Paris at a later date; France having been previously supplied with its physicians from the University of Montpellier, long famous for its medical teachings. Another offshoot of the Salernian school was the University of Naples, established in 1224 by Frederick II, Emperor of the Romans, who appears to have attributed great importance to its medical side; while adopting the Salernian curriculum in medicine, he also framed careful laws regulating its practice. For example, the poor were to be treated gratis, and no partnership with the apothecaries of the day was permitted. But Frederick also accorded to the members of the university valuable privileges, such as were at a later date enjoyed by the University of Paris under Charles VI; among these were immunity from all sorts of taxes, customs dues, etc., the exercise of the profession of teaching being accepted as a full discharge of their obligations to the State. He, likewise, adopted certain plans for the protection of his university, such as imposing penalties on students going past its doors, and, above all, forbidding the inauguration of competing institutions within the realm. The constitution of the University of Naples, however, did not affect so much the character of the later institutions as did Paris and Bologna. The latter soon became a formidable rival of Salerno as a medical school, following the example of Salerno in admitting women as well as men to the privileges of the university, and outstripping our modern co-education movement so far that we read of women-doctors learned in the law and in medicine lecturing within the halls of the university, and even of a female professor of anatomy.

In spite of such advantages, the revival of systematic medical education in Europe, which had largely contributed to build up the universities, did not lead to such rapid progress as might have been expected, for the system of scholastic disputations extended to the medical as well as to the other faculties. In these disputations the candidate for a degree publicly defended a series of propositions, and was opposed in argument by certain of his fellows. The truth of the proposition was not held of so much importance as the form of the argument, and if the disputant succeeded in resting his argument securely on some dictum of Aristotle, Hippocrates, or Galen, he was considered to have established his position, however much at variance with facts an appeal to nature might have demonstrated his proposition to be. It is not surprising that such a spirit should have interfered with scientific progress, and yet it is wonderful that the reign of authority in medicine should have lasted as long as it did. Its persistence in England may best be illustrated by recalling that a certain Dr. Geynes was

cited before the College of Physicians in London in 1559, because he had impugned the infallibility of Galen. After a formal recantation of his heresy, he was allowed to retain his fellowship. This, it must be understood, occurred half a generation after Vesalius had conclusively demonstrated many of Galen's anatomical inaccuracies.

However, the College of Physicians had probably not more than its share of the conservatism which is proper to corporations.

Some reference to the origin of that institution is necessary to explain its rapid rise in importance, and the gradual divorce of medical education from university education in England, which accompanied it, and which has persisted to this day. Up to the beginning of the sixteenth century the only physicians who were recognized as such, were graduates of Oxford and Cambridge, or of the foreign universities, but a host of unrecognized practitioners existed throughout the country who "professed physic rather from avarice than in good faith," and consequently the university graduates in London got themselves incorporated as the College of Physicians, with powers to examine and license such minor practitioners in the city and suburbs as did not proceed to practice through the regular channel of a university degree. The fellowship was limited (until comparatively recent years) to graduates of Oxford and Cambridge, and the licensing powers of the college were afterwards extended from the metropolis to the rest of the kingdom. The licensing power having thus been partly transferred from the universities to certain of their graduates resident in London, and the opportunities being much better there for education in the practice of medicine, the universities were deserted by students of medicine, and the numbers of those aspiring to a university degree became smaller and smaller. It was otherwise in Scotland and the continent of Europe, for there the connection between medical education and the universities has never been dissolved and continues as intimate as ever. In London, on the other hand, there arose the purely professional hospital schools, and it is only during the last fifty or sixty years that the metropolis has witnessed a reunion of medical with other university studies within the walls of University and King's Colleges.

To complete my sketch of the connection of medical education with the universities, it is necessary to explain that within the last decade there has been a very remarkable activity in the pursuit of the sciences in Oxford and Cambridge, accompanied by an effort to regain that share in medical education which had almost entirely drifted from them. The movement has already met with conspicuous success in Cambridge, where the graduates in medicine are ten times as numerous as they were ten years ago. In the "Student's Handbook for Oxford, for 1883," it is stated that the university offers instruction in medicine, "as being necessary for a philosophical view of biological science," but arrangements made since then indicate that the university proposes to go further than this, and to follow close in the footsteps of Cambridge.

It is, however, in the Scottish and Continental universities that we realize to what importance the Medical Faculty may attain. Edinburgh has nearly three times as many graduates in medicine as she has in arts in each year, and while the latter contribute some $2,500 in the form of graduation fees to the university chest, the graduation fees of the former amount to between $30,000 and $35,000 annually.

Again, in the Prussian universities more than half of the degrees annually conferred are in the Medical Faculty, and this in spite of the fact that a degree in Germany does not now carry a license to practise. It must be understood, however, that although such is the case, the State examination for license is conducted by university professors, and medical education can only be obtained at the universities.

I have not time to do more than indicate of what immense advantage to science this fostering of medical education by the universities has been. Suffice it to say, that when the physical and natural sciences had been almost entirely ousted from their proper place in the philosophical or arts curriculum, they were received and nurtured by members of the medical profession whose names consequently occupy the most honoured places in the history of the inductive sciences.

Let me now proceed to glance at our own condition in the light of the historical sketch I have given you.

The functions of a modern university may be described as including the prescription of a course of studies for its undergraduates, the control of their training and instruction, the examination of the results thereof, and the awarding of appropriate distinctions in the form of degrees. It will hardly be disputed that the most important of these is the teaching and training of the students, and yet in the English universities, so entirely had the colleges usurped that function in the beginning of this century, that the university as a teaching body was practically in abeyance. So it came to pass that when more than fifty years ago the demand for a non-sectarian university sprang up in London, a precedent existed for limiting the functions of the new institution to examining and conferring degrees, although the originators of the scheme certainly never looked forward to such limitation.

The University of Toronto was modelled after the London institution, having, however, the advantage over its prototype of including in its senate representative teachers, who secured for the Arts Faculty at least the closest harmony between the teaching and the examinations. The result of that harmony is to be seen in the constantly increasing number of graduates in arts during the last thirty years. But no such close connection has hitherto existed between the university and the instruction in medicine with a result which, tested in the same way, is just as deplorable as the other is gratifying. It is to remedy this defect in our organization that the step has been taken which we inaugurate to-day.

We have felt in the past that many of our medical graduates exhibited but little sympathy with an institution, whose halls they only entered to be subjected to rigorous examinations, where no opportunity was offered them of becoming penetrated by the *genius loci*, and no chance of meeting so as to develop any corporate spirit, or to have intellectual fellowship with the students of other faculties. We propose by our present action to remedy these great defects in the future, and congratulate ourselves that while London is still clamoring for a "teaching university," we have advanced a step further and secured ours.

I have spoken hitherto chiefly of the university as a place for the education of its undergraduates, but we have seen that it has a higher function than that—the advancement as well as the diffusion of learning. Bacon complained at the beginning of the seventeenth century of the necessity for guarding the universities from becoming mere professional schools, and we have to guard against our faculty having no higher end in view.

How are we to account for the fact that the German universities have been able hitherto to keep this higher function steadily before them, and have thus secured their present acknowledged supremacy in the domain of the physical and biological sciences? It is the result of money spent liberally by the Government with hat object. The Government contributes 72 per cent. of the annual cost of the universities, 44 per cent. of which is devoted to the equipment and maintenance of institutes which serve for investigation as well as for teaching in the various sciences. While it may very properly be contended that the mere preparation of a lad to enter a profession ought to cost the country nothing, it is quite otherwise in regard to this higher function of the university, and it is worth while to inquire what machinery is employed in Germany to perform it.

No doubt the form of examination for doctorship, which is virtually a thesis requiring some original research, tends to keep this desirable end before the minds of the students, but the most important work is done by the body of teachers, which is kept so large as to subdivide the drudgery of teaching, while in the scientific branches of medicine, like human anatomy, pathology, therapeutics, and hygiene, the chairs are generally so endowed as to enable the professors to dispense with practice, and thus devote themselves to research, and to the discovery of improved methods of teaching.

I trust we may look forward to a time when, through public benefaction, or otherwise, our university may be similarly situated.

The German universities are, further, peculiar in the large number of young teachers—the

privat-docenten—who, in their relation to the university, recall the fact that every doctorship was at first a permission to teach. Many of these *privat-docenten* have now assistantships, and it would be well if we had a series of assistantships in our medical faculty similar to the fellowships in University College. Young men who have succeeded in obtaining a university degree and a license to practise, are usually bent on at once testing their qualifications for success, and, indeed, are often obliged to do so. They rarely have so much love of learning for its own sake, or are rarely so circumstanced as to be able to give up two or three years to special studies such as would enable them to make any real advance in the science or practice of medicine. Some inducement must be held out to cause them to do so, and the best inducement to suitable men is the assuring of the means of subsistence for three or four years, access to university facilities for research during that time, and the opportunity of teaching in the branches of their special studies, for the maxim *disce docendo* would seem to be nowhere more applicable than in the various sciences.

If I were to detail all the methods which occur to me in which our university could be helped by public benefactions, I should certainly exceed the time allotted to me, but I cannot refrain from referring to the magnificent gifts of citizens in Montreal to McGill College, in the form of medical buildings, museums, additions to the library, a botanic garden, of all of which we are in urgent need.

Although we should like to see a system of fellowships for the encouragement of post-graduate studies in medicine, yet the practice has been discontinued of giving awards in the shape of scholarships and medals for distinction at the annual examinations. It has been thought that these stimulate a particular sort of preparation —cramming—which is especially undesirable in professional training. The four years of medical study are so short, and the burden of knowledge to be acquired so heavy, that the greatest judiciousness is required on the part of the teachers to ensure that the necessary training of the senses and judgment shall accompany the mere memorizing of facts. Facts are easily lost if not bound together by principles, and consequently it will be our aim to send out our students not only well equipped for practice but with a clear conception of the main principles of the medical sciences. These have made such progress within recent years, especially in directions which prove the close bond of union between them and other branches of biological inquiry as well as physics and chemistry, that it has become all the more necessary for the student to lay a broad foundation of the physical sciences and general biology before he begins to devote himself to his special work. In this respect we are able to offer unusual inducements, for our medical students will share in all the advantages enjoyed by our students in arts.

Just a word to those undergraduates who propose to take advantage of the instruction offered by our new Medical Faculty. As matriculated students of the university you have undertaken certain responsibilities. I told you that the word *university* referred primarily to the community of interest of the members of a sort of literary republic. In this way are explained such old forms as "The University of the Masters and Scholars of Paris." Remember, then, that the reputation of the university and of our new Medical Faculty depends not only on the masters but also on the scholars. It is our intention to do everything in our power towards giving you a thorough and practical education in the science and practice of medicine. Let it be your care to profit to the utmost by your opportunities, and thus do credit to the institution which you will be justified in speaking of from to-day as your Alma Mater.

EXPERIENCE WITH TRACHEOTOMY IN DIPHTHERITIC CROUP.

BY ARCHIBALD E. MALLOCH, M.D.

(Paper read at the Canadian Medical Association Meeting, Hamilton, Sept. 1st, 1887.)

With intubation of the larynx, occupying the attention of so many, it may be of interest to bring under your notice my cases of tracheotomy in diphtheritic croup, that, added to those reported at your last meeting, as well as to those referred to at the two last meetings of the Ontario Medical Association, some idea of

the success of the operation in Canada may be formed.

Again, that as the success has been fair—one in 3_4 cases, and greater with the last—some may be encouraged to perform the operation who might have been deterred by the adverse experience expressed at the Ontario meetings alluded to.

It might be as well to remark, that only two or three cases have been refused, in which the ordinary necessary attendance could not be obtained, or the disease had affected the throat and nose so extensively that a favorable termination under any treatment could not be looked for. Our experience in Hamilton, however, is that with extensive disease in the fauces and nares the larynx generally escapes.

In this city, for many years, we have had the sad experience of having diphtheria with us always, and I believe I express the opinion of the profession here when stating that diphtheritic croup unoperated upon is almost always fatal. The only case of recovery that has fallen under my observation after the full development of the symptoms of stenosis, occurred in the practice of Dr. Macdonald, and in this, with the sad experience of many fatal cases unoperated upon, he had advised the operation. The percentage of recoveries after operation, small though it be, has been so much better than when the cases are not operated on, that no hesitation is felt in advising the operation whenever there is retraction of the chest walls.

In the list of cases appended, the name of the attending physician or of the assistant is given, as well as the reason for classifying the case as one of diphtheria, that all possible doubt of the nature of the complaint may be removed.

With regard to the question of membranous croup, the experience has been that with membrane found in the trachea, small patches of it are to be seen in the fauces if the parts are carefully examined, so that idiopathic membranous has come to be looked upon as synonymous with diphtheritic croup. The percentage of recoveries, though not so favorable as that reported by Dr. Geo. Buchanan, of Glasgow, by the late Prof. Spence, of Edinburgh, and, more recently, by Robt. Wm. Parker, of London, who have obtained one in three, can be improved, in all probability, by experience in the after-treatment.

In all the cases steam has been employed: at first by caging the crib bed and passing steam into it from a kettle; but the heat and restraint were objectionable, and the ventilation so doubtful, that the method was soon discarded, and the simple one of having a pail of boiling water constantly at the side of the crib, with a canopy over its head, was adopted, which, by supplying enough moisture, necessitates the constant attention of the nurse. With the first cases the after-local-treatment consisted only in having the inner tube removed and changed from time to time, and occasionally of having a feather passed through the outer tube into the trachea, to clear out mucus, etc., and to excite a fuller inspiration. With later cases, whenever there was difficulty in breathing, drops of hot water were trickled from the feather into the trachea, which, while irritating the passage and causing deeper efforts at inspiration, at the same time softened the firm, sticky, brown encrusted matter which so often adheres to the ends of the tubes and to the trachea.

Now, however, the nurse is ordered, whenever the sound of the breathing gets tighter, to drop in hot water with a little bicarbonate of soda (20 gr. to $\bar{3}$i.) in solution, and to feather the trachea through the outer tube till the tightness is removed.

It is well to have a number of small squares of old rags handy, that the feather may be drawn through one each time of removal from the trachea, that any of the sticky substance may be caught, as well as any broken portions of its vane. A rag is also useful to entangle any portions of the sticky substance or mucus expelled to the mouth of the tube, which otherwise might be sucked back by the next inspiration. A bunch of these squares and several feathers should be at the child's head at all times, for they may be needed at any moment.

Again, while at first the outer tube was not, perhaps, removed for days, it is now invariably taken out within the first twenty-four hours, and the trachea and larnyx feathered with a solution of corrosive sublimate—1 to 2,000—which for two years I have been using as a

gargle in all cases of diphtheria, with, I believe, improved results.

Should the breathing not be relieved by feathering through the tube, the physician should be summoned, the outer tube removed, and the trachea and larynx feathered directly, or swabbed out with cotton wool on an applicator. In doing this it is necessary to persevere for some length of time: of course, if the fishing with the feather is successful, as shown by the removal of small pieces of this encrusted matter, one will persevere, but failing even to get these, persevere. In one case, after working by these means for twenty to thirty minutes, and failing to give relief, I thought it would be useless to return the tube, as the child apparently had only a few minutes to live. After consideration, however, it was returned, and during the struggle while introducing the tube a deeper inspiration was taken, and a large piece of this brown substance was expelled with such force as to shoot across the room. Immediate relief followed; in fact, the child, who had been struggling for breath for hours, was asleep in a minute. The patient ultimately did well.

This sudden change may seem to some a rather overdrawn picture, but not to those who have relieved the awful struggles for breath either by the operation of tracheotomy or as above. After opening the trachea the change is often so great—from the noisy, struggling respiration to quiet breathing; from the darkness of approaching asphyxiation to comparative pallor—that more than one assistant has said, "He is dead!" The relief is often so great and so immediate that the patients often fall asleep before the introduction of the tube.

The attendant must be carefully instructed to see that the lining of the inner tube is not impaired, though permitting easily the passage of the feather, for not unfrequently a sticky, yellowish-white substance adheres so tenaciously that it requires to be softened with boiling water, and then forced out by using the quill of the feather. It is almost needless to say that, on this account, the inner surface of the tubes should be as smooth as possible.

All the cases have been what is termed "dry ones," necessitating the use of warm water frequently, with one exception, No. 11, in which the discharge bubbled up so freely that feathering was needed almost constantly to keep the tubes patent. This case made a rapid recovery. Mr. Parker notes that the "moist cases," if I may so term them, are the most favorable.

With the first cases the tubes were at once introduced after opening the trachea; but now the lips of the tracheal wound are held apart with retractors, and the trachea and larynx thoroughly feathered with the bicarbonate of soda solution, to remove all membrane and mucus, and then treated with the corrosive sublimate solution. Within the first twenty-four hours the tubes should be removed in all cases, and the trachea and larynx well cleansed and disinfected, and subsequently each day, if not oftener. The reintroduction of the tube the first time is occasionally difficult; but patience, with slight continuous pressure applied, chiefly during a respiratory effort, succeeds. Only once has the tube been guided with the handle of a bistoury, which pressed a lip of the tracheal wound to one side. After the first twenty-four hours the tracheal wound apparently keeps open, and the parts are so tunneled that the tube slips in quite readily.

The ordinary silver tubes, with movable collar attached to the outer one, and provided with a button to lock the inner tube when in its proper place, were employed, but to these there are serious objections. The turning of the button, to permit of the removal of the inner tube, is troublesome to many attendants, and the act often awakens the patient. The collar, and the fixings about it, are so uneven that they soon become encrusted with the discharges, and present anything but a business-like appearance. The chief objection, however, is that the attendant, forgetting the button, only returns the tube till arrested by it, with the result that the end of the outer tube is not freed as it should be, for when in proper position the inner tube passes beyond the outer one by one-eighth of an inch. The gutta-percha tubes of Prof. Spence were then tried. With all the objections of the ones noted above, they have the additional one of having too small a bore compared with the diameter of the tubes.

The simplest, cleanest, and most easily worked

TABLE.

No.	Date.	Name.	Age.	Physician.	Assistant.	Why Diphtheria.	Operation.	Result.	Date.	Cause of Death.	Duration.	Tube Removed.
1	Dec. 1, '72	C. B.	20 months.	Self.	Dr. Macdonald.	On pharynx.	Low.	Fatal.	Dec. 6	Spreading downwards.	5 days.	
2	Jan. 25, '73	McK. L.	"	"	"	"	"	"	Jan. 25	"	20 hours.	
3	Mar. 24, '75	B. B.	6 years.	"	Dr. Mullin.	On tonsils.	High.	Well.	Apr. 10			12th day
4	Feb. 11, '76	S. S. J.	"	Thomas White.	Dr. White.	On pharynx.	Low.	Fatal.	Feb. 12	Spreading.	23 hours.	
5	Sept. 1, '76	W. M.	3.5 years.	Self.	Dr. Mullin.	"	Not noted.	"	Sep. 2	"	30 "	
6	" 19, '76	McL. E.	2 "	"	Dr. Macdonald.	"	Low.	"	Sep. 22	"	46 "	
7	Oct. 9, '76	S. J.	5 "	Dr. Macdonald.	"	"	Not noted.	"	Oct. 11	"	48 "	
8	May 19, '77	B. —.	18 months.	Dr. Rosebrugh.	Dr. Rosebrugh.	"	Low.	"	May 23	Attended by Dr. Rosebrugh.	93 "	
9	Sep. 21, '77	B. A.	4 years.	Dr. Miller.	Dr. Miller.	"	High.	"	Sep. 23	Attended by Dr. Miller.	32 "	
10	Dec. 15, '77	F. D.	3 "	Self.	Dr. Mullin.	"	Low.	"	Dec. 18	Pneumonia.	56 "	
11	Jan. 6, '82	T. R.	3 "	Dr. Reid.	Dr. Reid.	Membrane wound affected.	High.	Well.				62 hours.
12	Apr. 26, '82	M. W.	4 "	Self.	Dr. Mullin.	Pharyngeal.	Not noted.	Fatal.	Apr. 28	Spreading.	48 "	
13	Aug. 3, '82	H. F.	7 "	Dr. Mullin.	"	"	Low.	Well.				
14	Feb. 3, '85	C. W.	5 "	Dr. Ridley.	Dr. Ridley.	Membrane.	High.	Fatal.	Feb. 3	Heart clot.	17 "	
15	Mar. 19, '85	S. A.	7 "	Dr. Shaw.	Dr. Cochrane.	Pharyngeal.	"	"	Mar. 19		1 "	
16	Apr. 2, '86	P.	12 "	Dr. Millward.	Dr. Alway.	Membrane.	Low.	"	Apr. 4		48 "	
17	May 6, '86	M. W.	9 "	Self.	Dr. Philp.	Pharyngeal.	"	Well.	May 20			
18	Nov. 27, '86	H. C.	5.5 "	Dr. Miller.	Dr. Miller.	Membrane wound affected.	"	"	Dec. 10			9 days.
19	Dec. 13, '86	C. G.	5.75 "	"	"	Pharyngeal.	"	Fatal.	Dec. 15	Spreading.	47 "	11 "

tubes which have fallen under my observation are those of the late Dr. Foulis, of Glasgow, which I show. The curve of the tube is wide, to prevent the extremity of the tube from impinging and eroding the anterior wall of the trachea, and the inner tube is provided with a knob on each side, which strike the outer tube when in position.

In all the cases chloroform was administered, and the high or low operation performed, whichever seemed the easier after exposure of the isthmus; but the high operation seems preferable, as the trachea being here more superficial, easier access is obtained to the larynx.

The operation, with an assistant beside the chloroformist, can be almost bloodless, and is, in general, not difficult, if one just watches what is below the knife and does not cut rashly. A ligature need never be employed unless a vein crosses the line of incision. With only one person to administer the anæsthetic as well as to assist, the operation may be anything but easy, and may try the coolest operator. On one occasion, to relieve impending death, the knife has been plunged through the cricothyroid membrane to gain time for the tracheotomy which was subsequently performed.

After the operation the surgeon has, in general, no easy work before him. For days, if the case does well, he may expect to be summoned to his patient at any moment; and, perhaps, he has no sooner left the house than he is recalled.

It is to be regretted that the cause of death in the cases was not verified by *post mortem* examination, but I have never been able to get the parents' consent to one.

SUMMATION.

19 cases; 14 deaths; 5 recoveries.

11	low operations.	8	fatal.	3	recoveries.
5	high "	3	"	2	"
3	not noted.	3	"		

Gusserow (*Centralblatt für Bacteriologie*) after numerous experiments concludes that the microorganisms of erysipelas (streptococcus erysipelatis) never cause puerperal fever — while Wickel sees in the virus of erysipelas the most potent agent in the production of puerperal sepsis.

ADDRESS AT THE NINTH INTERNATIONAL MEDICAL CONGRESS.*

Delivered before the Section for Dermatology and Syphilography.

BY A. R. ROBINSON, M.B., L.R.C.P. & S. EDIN., NEW YORK,

President of the Section.

It devolves upon me, as chairman of the Section of Dermatology and Syphilography, to perform the very pleasant duty of offering on behalf of my American colleagues a most hearty welcome to our foreign co-workers who honor us with their presence, and give us such fresh proofs of their deep interest in science by travelling so far to attend this meeting and to take an active and important part in the proceedings, although from our past history they must have very slight hope of any intellectual compensation from us. And whilst we do not promise them as warm a reception from the authorities who regulate our weather conditions, as, according to rumor, the wind-organs from certain quarters promised them weeks and months ago, yet they may rest assured that we are very glad indeed to see them present, and whilst we recognize them as leaders—as representative men in our special department, the men who have done and are still doing real scientific work, and in whom we place much hope for future advancement of our knowledge of subjects, still altogether too numerous in this branch of medicine, of which we know almost nothing—we would also gladly have welcomed a greater number of their colleagues, and regret the absence of several who, from ilness or other causes, are unable to be present, although most anxious to have come.

It is fortunate that the heat will not be so great as the false prophets promised, for, knowing the effects of high temperature upon the mental powers, and the amount of raiment one can wear under great heat conditions; and that these Medical Congress meetings are partly scientific and partly social in their character, it is evident that for a successful Congress of this

*Dr. Robinson kindly furnished THE CANADIAN PRACTITIONER with the revised manuscript of his address.

kind the participants must be clothed and in their right minds. If the social part is a comparative failure, I trust that the mental food offered will be rich in valuable material. The American supply to past Congress meetings has been an unknown quantity; for this meeting we already know the quantity, and will soon know the quality.

You, as specialists, are too familiar with the dermatological literature of America, vast in yearly amount, meagre in contributions, not to wonder why, with so many writers upon the subject, with so many dermatologists animated with that peculiar American quality called "push," we have contributed so little to the recent substantial advancement in our knowledge of skin diseases. But if we consider, as we now intend to do briefly, all the conditions under which we pursue our studies in this country, it will appear strange that good work is not even rarer than it now is.

Taught in colleges, the majority of which require only a two years' course of study, the sessions of each year lasting five or six months, what inducement do such colleges hold out to their students to study medicine as it should be studied, if they are to be other than the blindest followers in the pursuit of our profession of the advice received from a few lectures or compendiums. Such a college course was, perhaps, not objectionable in colonial days, or when physicians were not a drug upon the public, as they may be said to be now, when every village is overcrowded, and continual efforts to get patients are necessary to enable the professional man to build up a practice, and, at the same time, financially to make both ends meet. It must be clear to the members of every teaching faculty in the land that a two or even a three years' course of study is quite inadequate—even if he be a student, in the best sense of the term, bright and diligent—for the responsible duties of a medical practitioner; for the faculty is the examining body, and the superficial knowledge of candidates for graduation must be painfully evident to the professors.

Lectures upon special subjects are given in the majority of the colleges, and in some of them dermatology is considered as a special subject, in which case one clinical lecture a week is usually given. As, however, no examination upon the subject is required for graduation, the majority of students absent themselves from the lectures, but afterward receive their diploma, certifying to their knowledge of medicine in all its branches, although they may not have seen a single case of cutaneous disease, and could not diagnose an ordinary syphilide from an eczema, or even an elephantiasis from a scleroderma.

Afterwards in practice, however, they treat all patients with cutaneous disease without hesitation, as a rule, and with the utmost coolness and outward appearance of confidence in their knowledge of the "rash," for to them it is a rash and nothing more. I am not blaming those general practitioners who follow this course; it is the legitimate result of the doctrine of the teaching body, for with only a two or three years' course it is not possible to devote time to subjects upon which they are not to be examined. Neither do these remarks apply to those general practitioners, of whom there is quite a number, who have devoted post-graduate time to the study of cutaneous diseases. But a yearning after practical points—what drug to give for this or that disease; what is the best prescription for an eczema, for instance—signs pathognomonic of imperfect mental training, and the lack of clinical experience, and of the information contained in good text-books upon special subjects, bring about other evils which particularly concern us as dermatologists, and to which I will directly refer.

On account of the few lectures given upon skin diseases, and the short course of study required, it is not possible to learn dermatology in this country, except under great disadvantages at least. It is true that private instruction can be obtained at some dispensaries, and that regular clinics are held at some of the post-graduate schools; but for any extended knowledge of the subject a trip to Europe has hitherto been considered necessary. Vienna has usually been the Mecca for those who wish to specially study this subject, as the magnificent material to be seen at the Hôpital St. Louis has not drawn many students to Paris, whilst in London the patients are not used specially for teaching purposes, and consequently

the advantages for studying the subject are not to be compared to those of Vienna.

How long the student, now a physician, remains abroad depends usually upon his ideas of the proper course to pursue, and the amount of money at his command. He should remain several years for the study of histology, pathology, morbid anatomy, internal medicine, bacteriology, and skin diseases, if he intends practicing afterwards as a specialist; but that is not the course usually pursued. He devotes too much time to learning the diagnosis and treatment of skin diseases—a course very proper for a general practitioner, but not for one who ever hopes to advance our present knowledge of cutaneous diseases; for who can expect to add to the descriptions of clinical symptoms as given by such acute observers as Hebra, Wilson, Tilbury Fox, etc.—observers who have devoted their lives to the subject and seen their thousands and tens of thousands of cases. I do not say that it is impossible to do so, but he has not a heavy heart or weak imagination who expects to make a reputation in that direction.

To combine, as is frequently done, the subject of cutaneous with genito-urinary diseases, instead of with internal medicine, is a serious error; for the two classes of diseases are in no way related to each other, and a knowledge of the one does not aid us in the study of the other; whilst every one must admit the close etiological relationship of many cutaneous diseases with internal pathological conditions.

Histology—normal and pathological—bacteriology, and general pathology hold the same relations to dermatology that they do to the other branches of medicine and surgery: that is, they are essential to the foundation of a broad view of the subject, and no one can fully discuss the etiology of the majority of diseases, that important branch of medical science which at the present time is studied more than any other, without some knowledge of them.

Whether the student remains abroad for a few months only, or several years, he receives the foundation of his dermatological knowledge in foreign lands, be that slight and dangerous, or broad and capable of being built upon, according to the time and brain energy spent. The majority of dermatologists at present practicing in America have obtained their schooling in dermatology in other countries, and as they continue afterward to be more or less influenced by the teaching received abroad, they may be called followers of this or that school, depending upon the country in which they studied.

A school can exist only when there is a comparatively great dermatologist in a given country, one whose views are more or less unreservedly accepted, and his teachings followed by his countrymen and pupils, or when the leading dermatologists of a country hold similar and peculiar views. As our knowledge of cutaneous diseases increases, and the number of dermatologists multiplies, there is more and more difficulty in founding a school, so at the present time we are scarcely justified in speaking of a German, French, or English school, for in all these countries eminent dermatologists, of whom there are always several in each country, hold very widely different views concerning the etiology, nature and treatment of the inflammatory affections of the skin, and it is upon the divergence of views in reference to this class of diseases particularly that schools have existed.

As there is no particular centre for dermatological study in America, as there is no comparatively great dermatologist, and, finally, as the majority of dermatologists have had their schooling abroad and hold widely different views on the inflammatory and the other cutaneous diseases, there is no such thing as an American school of dermatology, consequently also there cannot be a representative American dermatologist, for there are no special American views of dermatology to be represented.

This is specially gratifying to your chairman, for, that being true, it logically follows that it cannot be said of him for the present occasion that he is not a good representative of American dermatology. As independent workers, each of us represents but the character of our own labors, and if that is not creditable, the author is a corresponding dermatologist. If the work done by American dermatologists, as a whole, is to be represented, then the position should not be a difficult one to fill, for the average of that work is not astonishingly high,

as shown by the articles in journals and the reports of our special societies.

Returning from his European travels—"speaking a foreign language just as well as his mother tongue"—the would-be specialist is beset by temptations to which he too frequently falls a victim. With more medical journals in the land than are necessary for the publication of papers that repay one for their perusal, there is, on the one hand, a demand for an article on some subject—it matters not what it be—by the editor; and, on the other hand, a desire to publish a paper by the specialist anxious for reputation and notoriety. The medical world at least must know that he is devoting special attention to a particular branch of medical science, and what plan so good as to write an article for a journal and, by means of reprints scattered broadcast, let the world know your specialty, name, and address. A few repetitions of this procedure will, without fail, bring patients to the office, and reputation among the mass of general practitioners. Why this latter is a result is not difficult to understand. As already mentioned the college graduates usually have no knowledge of the so-called special branches, consequently any reprint, although it be only a compilation of previous articles by real workers—and very often they are even very poor compilations—appears to the busy practitioner to contain valuable information, and the author thereof as one having special knowledge of his subject.

This mode of action is a very serious evil, and must and does bring discredit upon the specialists in that branch as a body. It is to be hoped that the protest I now enter against this evil will not be in vain, and that in the future only such articles will be published as represent real contributions to the existing knowledge of the subject discussed. We still have so little real knowledge of diseases of the skin that there is a wide field for future observation, and the energy wasted in the compilation of these papers should be devoted to original and more creditable work. Let us show that American dermatologists have the spirit and ability to do their share of work for the advancement of our knowledge in their special branch of medical science. I do not wish to be considered as maintaining in this address that no good work has ever been done in this country, for that would not be correct; but it has borne no proper proportion to the number of articles which have been published, for too often the leading of a paper as a "contribution" to our existing knowledge of this or that disease has scarcely been justified by the contents.

As we learn most from a contemplation of our errors, I have endeavored to draw attention, as regards dermatology in America, to the faults of the colleges with reference to this branch, and the errors of action which we as specialists are liable to commit for our personal advancement, and have pointed out the way by which creditable reputation, if not pecuniary success, can always be attained.

Finally, in view of past events I desire to express the hope that another International Medical Congress will not be held in America until the profession in this country have shown by their actions a change of heart; that they are prepared to subject the desire for personal gain to the proper, nobler, and more honorable feeling for the advancement of medical science and consequent relief of human suffering.

CASE OF FRACTURE OF THE LARYNX.

BY A. B. ATHERTON, M.D., L.R.C.P. & S. EDIN., TORONTO.

A. S., male; age, 38; generally healthy, and of a strong muscular frame.

On July 25th, 1879, I received a hasty summons to visit a patient at Marysville, a village about three miles across the river from Fredericton, N.B., where I was then practising. The messenger informed me that the man had been struck by a slab somewhere about the neck; but he couldn't say where. He also told me the ferry-boat was waiting at the shore for me, and urged me to go at once without any delay. Thus entreated, I did not return to my house for any instruments, but started off with what I had with me, which were contained in a small pocket-case three and a half inches long. About half a mile from the village, I was met by a second messenger, who implored me to push on as the patient seemed to be dying.

On my arrival, I found the sufferer sitting out on the doorsteps of his dwelling, surrounded by a crowd of anxious relations and neighbours. They told me that he had rushed out into the open air, in a paroxysm of dyspnæa a few minutes before. He was breathing with much difficulty, and complained very much of distress and pain beneath sternum and in region of the diaphragm. His face, neck, and chest were enormously swollen, the swollen parts crepitating on pressure. The eyes were completely closed. The surface of body was everywhere colder than natural, and the skin was of a livid hue. The pulse beat slowly and feebly.

A superficial wound about half an inch long, was observed to the left of the nodian line over the lower end of the larynx. This, I was now informed, was caused by a blow from the spiked end of a peevy, which had been caught and flung from his hand by the saw-gang of the mill where he was engaged in rolling the logs into position for sawing. The condition of the patient was so critical that without further examination I then and there proceeded to open the windpipe, in order to relieve the breathing, and put a stop to the increasing emphysema. This was rather difficult, because of his sitting posture; but after cutting through an inch or more of swollen tissue, I could feel the trachea, and soon had an opening in it. In order to keep the wound freely patent for the passage of air, I introduced the artery forceps of my small pocket-case well into the trachea and held it there with its two arms wide apart.

The patient bore the operation without the least manifestation of pain, and in a few minutes expressed himself as greatly relieved. On more closely examining him, I found that the emphysema was confined to the upper half of the body, the waist-band of his trousers below, apparently, limiting by its tightness its further extension in that direction. In about an hour and a half, the tracheotomy tube for which I had sent was brought, and after withdrawal of the forceps it was secured in its place. I then for the first time allowed patient to walk into the house, and had him put to bed.

July 26th.—Rested fairly well without any opiate. Emphysema somewhat less. Some clotted blood cleared out of inner tube.

July 28th.—Doing well; swelling continues to diminish, also soreness in chest is less. Tracheotomy tube removed, and as respiration was easy I left it out.

August 2nd.—Emphysema nearly all gone. Patient feels very well, may go out of doors when weather is fine.

August 10th.—Wound in neck almost healed.

Remarks.—I am uncertain as to the exact site of the fracture in the case reported, but suppose it must have been in the left lower wing of the thyroid cartilage, or in the left of the cricoid. I did not at the time of the operation notice any fracture, but such might very readily have escaped detection in the swollen condition of the soft parts. After recovery there was no marked irregularity of either cartilage to indicate the line of fracture.

In the article on injuries of the neck in "Holmes' Surgery," Mr. Arthur E. Durham gives a table of sixty-nine cases of fracture of the larynx, fifty-three of which proved fatal. It is, therefore, evident that such injuries are among the most dangerous of those with which the surgeon has to deal. I suppose that my patient's speedy recovery is to be attributed in great measure to the absence of any marked displacement of the broken cartilage, which permitted the respiration to be freely restored as soon as the emphysema and other swelling was reduced.

The rapidity with which the air can infiltrate the cellular tissue in such injuries is well exemplified in this case. It could only have been about two hours after the accident when I first saw the patient, and one would think the laceration of the mucous membrane must have been considerable in order to allow of so extensive emphysema in that time.

ANTIPYRINE IN CHOREA MINOR.—Dr. Wollner (*Münchner Med. Woch*) treated successfully with antipyrine a chlorotic girl sixteen years of age, who suffered from chorea minor after an attack of acute rheumatism without cardiac affection. Complete recovery took place in twelve days. The dose administered was 15 grains three times a day.

OPHTHALMIC MEMORANDA.

BY R. A. REEVE, B.A., M.D.,
Professo of Ophthalmalogy and Otology, University of Toronto.

THE NEW LOCAL ANÆSTHETIC, GLEDITSCHINE (SO-CALLED, STENOCARPINE).

With W. Goodman, V.S., U.S., rests the honor of discovering the anæsthetic properties of the leaves of a certain tree in Louisiana; Dr. Seward, of New Jersey, has the credit of first isolating an alkaloid from them and proving its local anæsthetic power; and to Dr. J. H. Claiborne, jr., New York, we are indebted for the first account of its distinctive local effects,* and for identifying the tree as the *gleditschia triacanthos*, or thorny locust.†

Prof. H. Knapp, of New York, first showed ‡ the toxic qualities of the drug, and urged the need of care in applying it to open wounds and under the skin. He found the symptoms of poisoning in rabbits to be like those from strychnine.

Gleditschine—2 per cent. solution—like cocaine anæsthetizes the corneæ and conjunctiva in five minutes or less, but it affects the pupil and the accommodation much more than does cocaine, the mydriasis being at least as prompt and marked as that by atropine—full dilatation in twenty minutes and lasting three or four days. It paralyzes the ciliary muscle in from thirty minutes to three hours, according to circumstances, as age, dosage, etc., and the accommodation is regained in from two to four days; in atropinization, in from six to eight days. Should diminished tension, noted by Dr. Claiborne, prove to be one of its regular effects, the value of this useful agent will be enhanced. In a case of the writer's, of iritis with glaucomatous tension, necessitating paracentesis corneæ, this property seemed to be of special value. At anyrate, atropine which tended to heighten tension was exchanged for gleditschine, and and mydriasis was kept up without further plus tension, and also with marked relief of pain.

* *N. Y. Medical Record*, July 30, 1887.

† "Rich in woods from Pennsylvania to Virginia, Illinois and South-westward. Common in cultivation as an ornamental tree, and for hedges."—*Gray's Botany.*

‡ *N. Y. Medical Record*, August 13, 1887.

During the past month, or more, the writer has used gleditschine, two per cent. solution, in various operations upon the eye, removal of foreign bodies, in ulcers etc., of cornea, and in paralyzing the accommodation; and also to anæsthetize the nasal mucous membrane before using the galvano-cautery. As a local anæsthetic for operative purposes cocaine is preferable to gleditschine owing to its transient effect on the pupil and ciliary muscle; and the toxic properties of the latter will preclude its free use hypodermatically. Professor H. Knapp considers gr. $\frac{1}{6}$ the largest safe dose of gleditschine with the needle, and even this is unsafe in vascular tissues. Whereas the writer has used about two grains of cocaine salt with impunity in enucleating the eye without general anæsthesia. In congestion and inflammation of the iris, simple, or complicated with tendency to glaucoma, or secondary to keratitis, trauma, etc., gleditschine—alone or combined with atropine, *p. r. n.*—will prove superior to cocaine. Where mydriasis is indicated in subjects of fifty and upwards, in whom atropine sometimes induces glaucoma, gleditschine will be safer than atropine.* And it will largely supplant the latter for paralyzing the ciliary muscle in testing refraction; though homatropine hydrobromate will often be better than either, for a 1 to 2 per cent. solution of it instilled from four to six times at intervals of fifteen minutes, will frequently paralyze the accommodation in an hour, ability to read ordinary print returning in from twelve to twenty-four hours.

Experience proves that it is desirable to use both cocaine and gleditschine with some caution, and the least quantity likely to be effective should be used in each instance. Much less cocaine and weaker solutions, are utilized in ophthalmic surgery than formerly, a 1 or 2 per cent. solution being often made to do duty in lieu of a 4 per cent. Unpleasant systemic effects, as faintness, dizziness, nausea, etc., are thus best averted, and also necrosis of corneal epithelium and, indeed, of cornea itself, which have been occasionally reported.

*Solution Atropiæ Sulph. gr. $\frac{1}{2}$ ad. one ounce Aq. dest. suffices for ophthalmoscopy, and does not affect the accommodation.

HYDROGEN DI-OXIDE (PEROXIDE).

This agent, which Fownes tells us, "is an exceedingly interesting substance, but very difficult of preparation," now takes front rank as a bactericide and disinfectant, and is furnished to the profession in 5 to 15 volume aqueous solutions. The latter contains about 3 per cent. of the pure $H_2 O_2$, and forms a clear, colorless, inodorous fluid which is unstable above 65° Fah., and, yielding oxygen readily in the nascent state, acts strongly as an oxidising and bleaching agent. Miguel's tests shew the hydrogen di-oxide solution to be many times as powerful as carbolic and salicylic acids as an antiseptic and disinfectant. The writer was led to try its efficacy by a remark of a savant at the British Science Association meeting in Montreal, to wit, that $H_2 O_2$ was the most potent bactericide known. Its power to destroy pus and arrest fetor was first seen in aural practice; as long as there was any pus in the ear the characteristic frothing process would continue in the meatus with a seething or crepitant sound. It has been an admirable cleanser in purulent catarrh of the lachrymal sac, as it is in case of all pus-secreting surfaces, and has proved of special service as a collyrium in purulent conjunctivitis. When a one per cent. solution is instilled under the lids the pus is quickly destroyed and ulcers are cleansed. It may be applied alone or after irrigation by sol. acid boracic and use of cocaine, and if the solution be not acid the injection is non-irritant. It is, of course, more active than acid boracic, and is free from the offensiveness of carbolic acid. From its marked effects upon croupous and diphtheritic membranes, it will prove valuable in these varieties of conjunctivites, though happily the diphtheritic is rare in this country. Acid solutions of $H_2 O_2$ are too irritating, and should be treated with Ba. cl. and filtered. It would be out of place here to dwell upon the general application of $H_2 O_2$ in medicine and surgery. Its value is, unfortunately, impaired by the difficulty of making and keeping it.

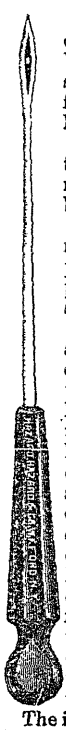
Glycozone, or ozonized glycerine, yields oxygen less rapidly than hydrogen di-oxide solution, and, therefore, as it acts more slowly but persistently than the latter, will have its special uses. Ozonized ether and the "Sanitas" preparations are other forms in which $H_2 O_2$ is utilized with advantage.

THE ACTUAL CAUTERY IN CORNEAL ULCERS.

Since it became known that the conjunctiva was the habitat of microbes, some of which were pathogenic and the cause of suppuration, treatment of certain lesions has become less empirical, and eye operations have proved more generally satisfactory than formerly. It is well known that many ulcers are quite tractable, and that others tend to progress steadily in spite of careful local and general treatment. One example of the latter is the so-called creeping ulcer of the cornea, which new tissue becomes infiltrated and necrotic from day to day. That there was need of a better remedy than any in hand was proved by the readiness of specialists a few years ago to adopt the method of Sæmisch, and make a section of the cornea across the side of the ulcer, re-opening the wound daily so as to evacuate the anterior chamber. This plan doubtless saved eyes otherwise doomed, but was ineffective in too many instances; and the neglect to destroy the pyogenic fungi present in this and other infected ulcers, furnishes a good reason for its failure. To kill the infesting microbes and keep the conjunctival sac as aseptic as possible is, of course, the desideratum. For the latter purpose frequent irrigations with sol. acid carbolic, acid boracic, or the use of pulv. iodoform, etc., and more recently sol. hydrogen di-oxide are practised. And to attain the former end the application of iodoform, or iodol, or pure carbolic acid, or the cautery, prove generally satisfactory. Dr. Williams, of Cincinnati, has used carbolic acid for a number of years with seeming satisfaction. The writer's experience during several years past with the actual cautery has led him to regard it as a safe and reliable method of treating corneal ulcers, and since cocaine came in it has been used the oftener, though it caused but little pain. The galvano-cautery, warmly advocated by some, has been rarely used; but, as a rule, a short piece of platinum wire, held in a small bone handle, as of crochet needle, has been brought to a white heat in the flame of a small spirit lamp, and quickly and lightly applied to the

surface and infiltrated edges of the ulcer. Generally one application suffices, but at times several have been required in order to arrest the morbid process and secure healing. And where Sæmisch's incision has seemed necessary, prior cauterization has been done. In a few instances, depending possibly on mal-nutrition, etc., the ulceration has progressed. The writer has not found leucoma or decided opacity to follow the use of the cautery, and this result complained of, has probably been due to the too free application of the galvano-cautery point. In using carbolic acid, a silver probe should be merely moistened by dipping, but not have a drop hanging from the point; or a very small tuft, wound on the end of a probe, answers well; and this, rather than the actual cautery, will likely be found the most convenient mode by the general practitioner. In pustular ophthalmia, and some cases of the phlyctenular variety, in which, by the way, a microbe has been found, the cautery will be of service.

The writer has never found inflammatory reaction of any moment follow the use of the actual cautery, even when passing the glowing wire into stophylomata. Cocaine and cold water dressings are occasionally necessary.



MITCHELL'S VARICOCELE NEEDLE.—Dr. Mitchell, in writing to the *N. Y. Record*, says:—While there are other needles already in use similar to this, yet this possesses some new features, and decided advantages over any that have so far come under my notice.

By the aid of this little instrument, the operation for the subcutaneous ligation of the spermatic veins is extremely simple, and may briefly be described as follows:

The hair on the affected side of the scrotum may be shaved off front and back and the parts perfectly cleansed. A few minims of cocaine 4 per cent. sol. are injected under the skin at the seat of the operation.

The operator now isolates the vas deferens, and holds it with his left hand to the inner side of the scrotum. With his right hand he takes the needle threaded with a sufficiently long silk ligature (previously boiled to make it antiseptic), the two ends of which he holds firmly with the handle. Holding the flattened point perpendicularly he plunges it quickly through the scrotum, the point with the ligature sticking out behind. He can now let go the vas deferens, and draw one end of the ligature out of the orifice of exit, and out of the eye of the needle. He now withdraws the needle, *back to, but not out of, the orifice of entrance.* The point of the needle is now carried *subcutaneously* around the veins, and made to emerge *exactly* at the orifice of exit. Here the ligature is quickly and easily threaded into the *large eye*, and both withdrawn through the orifice of entrance.

The instrument is manufactured by Messrs. Hazard, Hazard & Co., corner 5th Ave. and 24th St., N.Y.

Selected Communications.

THE CARDIAC RELATIONS OF CHOREA.*

BY WILLIAM OSLER, M.D.,

Professor of Clinical Medicine in the University of Pennsylvania
Physician to the University Hospital.

The heart symptoms of chorea demand special consideration as among the most important and peculiar features of the disease. Chorea is rarely a fatal disease in children, and hundreds of cases may be treated without a death. By far the most serious fact in the clinical history of the disease is the occurrence of endocarditis; but here the danger is remote, not immediate, and lies in the changes which an acute valvulitis may initiate.

A satisfactory study of the cardiac relations of chorea must embrace the condition during the attack, and the subsequent heart history after a period of years. The first question has engaged the attention of many workers, and an attempt is here made to work out the second on a scale not hitherto attempted.

I. CONDITION OF THE HEART DURING THE ATTACK.

Oftentimes the extreme jactitation renders the examination of a choreic child difficult or even impossible. I make it a rule to examine the bare chest. Auscultation through the clothing is not trustworthy, as soft murmurs, readily audible with the stethoscope, may easily escape detection. It is a good plan to let the child lie quietly on a lounge for some time, and make the first examination in the recumbent position when the heart's action is less rapid. Subsequently the effect of exercise and of the erect posture may be tested.

In chorea, as in rheumatism, the evidences of cardiac disease must be sought for, as it is rare to hear complaints of either palpitation, pain, other symptoms which would direct attention to the heart.

The cardiac disturbance is indicated by the presence of murmurs, alteration in the rate or rhythm of the heart's action, and by pain.

*Abstract of paper to have been read at the meeting of the Canadian Medical Association, and published in the *American Journal of the Medical Sciences.*

A murmur at one or other of the cardiac areas is by far the most common sign, and is present in a considerable number of all cases. Of 410 cases in the records of the Infirmary for Nervous Diseases, there were 120 which presented a heart murmur at the time of examination. In at least 40 cases there was either no note or an imperfect one, and in very many the exigencies of out-patient work prevented a very thorough examination. It can safely be said that in over one-third of the cases a heart murmur was detected, and I have no doubt that this number would have been much increased had each child been stripped and special attention given to the auscultation of the heart.

Of the 120 cases, 113 presented the apex systolic or mitral murmur, in 7 a basic, and in 3 both apex and basic. In 15 cases the heart's action was noted as rapid, and in as irregular. Pain was not a frequent complaint, and was noted in only 6 or 7 cases.

It is common experience that the special indication of heart trouble in chorea is the presence of a soft systolic bruit, heard best at the apex or over the body of the ventricles, and not often propagated to or beyond the mid-axilla. Basic systolic murmurs are usually associated with anæmia or debility. Diastolic and presystolic murmurs rarely, if ever, occur in acute chorea.

Much has been written in explanation of the heart murmur of chorea; an idea of how much may be gathered from the fact that a discussion of the theories which have been advanced occupies twelve pages in Hayden's work on "Diseases of the Heart." We are concerned chiefly with the apex systolic murmur, universally recognized as the most frequent and characteristic sign of implication of the heart in chorea. Speaking generally, we meet with such a murmur in mitral endocarditis, or in relaxation of the ventricular walls, such as occurs in anæmia and fevers, and it is attributed to regurgitation through the mitral orifice, owing either to absolute insufficiency, in consequence of the endocarditis, or to relative insufficiency when the normal valves are unable to close an orifice enlarged as a result of relaxation of the heart muscle. In chorea a special theory of musculo-papillary spasm has been advanced to account for the mitral murmur.

I am strongly of the opinion that the apex systolic bruit of chorea is, in at least nine out of ten cases, associated with endocarditis:

1. The extraordinary frequency with which mitral valvulitis is met with in fatal cases. There is no known disease in which endocarditis is so constantly found, *post-mortem*, as chorea. As the figures above quoted show, it is exceptional to find the heart healthy. I do not know of statistics of any very large number of fatal cases of acute articular rheumatism to place besides these figures, but I doubt if even this disease, so prone to endocardial complication, can be compared with chorea in this respect. Dickinson has raised the question whether these beads of fibrin are not rather the consequence than the cause of the valvular defect, and Sturges holds that this appearance does not represent a true inflammation of the endocardium. Whether a true inflammation or not, I think it must be conceded that the lesion is identical, microscopically as well as macroscopically, with simple or warty endocarditis as we see it in other diseases.

2. The character and location of the murmur are such as experience in other affections has taught us are associated with inflammation of the mitral segments. I speak of the apex bellows-murmur. Why this should be so generally associated with the presence of a row of small warty vegetations just within the auricular margins of the curtains, not, one would think, seriously interfering with their functions, is a problem to be solved. The condition certainly does not necessitate regurgitation, and the bruit may perhaps, as has been suggested, be due to friction of the roughened faces of the segments.

3. The inconstancy of the murmur and its disappearance on the subsidence of the chorea have been urged against this view. Now we must acknowledge that the bruit may be variable and, indeed, does not necessarily accompany mitral endocarditis. Kirkes, years ago, insisted upon this, and there have been two autopsies in carefully studied cases of chorea in which the vegetations were found *post-mortem*, and careful examination failed to reveal a murmur.

The facts which I shall subsequently give suggest that we may during the attack have an endocarditis, not manifest even by a murmur, but which has laid the foundation of future trouble. The disappearance of the apex murmur of chorea —and of rheumatism too—has been repeatedly followed, and if caused by the small vegetations, this is a natural sequence of the changes which go on in them. At first a soft granulation tissue, they become in time firmer, smaller, and ultimately smooth flat elevations mark the spots. It is not improbable that if we could follow accurately the auscultatory history of a valve affected with acute endocarditis, we should find in many cases that the murmur of the fresh attack disappeared, to reappear when the changes, which it is the misfortune of the acute disease to initiate, have reached a point of interfering with the competency of the valve.

4. In its sequel the cardiac affection of chorea has been supposed to differ from that of other diseases, "as none of the injurious after-consequences which attend endocarditis in its other relations . . . are found to ensue here" (Sturges). A study of any large number of choreics some years subsequent to the disease tells, as I shall show, a sad tale to the contrary and proves that the primary heart trouble is, in a majority of cases, at least, endocarditis.

II. THE CONDITION OF THE HEART IN CHOREIC PATIENTS SOME YEARS AFTER THE ATTACK.

Owing, doubtless, to the difficulties inherent to such an investigation, this line of inquiry has not be followed by many workers. Indeed, so far as I know, Dr. Stephen Mackenzie's paper, at the London International Congress, is the only one which has dealt with the subject, and he has examined 33 patients at periods from one to five years subsequent to the attack. Postal cards were sent to all the choreic patients, in sets of twenty-five, who had been in attendance at the Infirmary since 1876, asking them to return for the purpose of having the heart examined. One hundred and ten came back, a number much exceeding our expectations. All the more recent cases in attendance at the clinics have been excluded —all, endeed, after March, 1885, so that the study is based upon 110 cases in which the examination was made *more than two* years subsequent to the attack of chorea. In each case, as it came, reference was made to the original notes, questions asked concerning subsequent attacks, and rheumatism, and the heart examined in the recumbent and erect postures at rest, and after exertion.

The results summarized, are as follows: In 43 cases the heart was normal, in 54 there were signs of organic disease, and in 13 there was functional disturbance.

Of the 43 cases in which the heart was found normal, 12 had had three or more attacks, 8 had had two, and 23 a single attack. There was a history of rheumatism in 8—*i.e.*, 18.6 per cent. In six of these cases the rheumatism was acute. In only two cases had there been a murmer noted at the time of the original attack.

From the cases presenting abnormal physical signs, 13 may be separated as examples of functional trouble. They are cases without signs of enlargement of the heart, and with localized or variable murmurs. Ten presented soft apex systolic bruits not propagated, in three variable with position. In most of these there was accentuation of the second left pulmonary sound, but I do not think much stress is to be placed upon this sign in young persons, as it is by no means uncommon in normal hearts. Particular attention was paid to this point in the examination of all the cases and comparison made between the sounds in the second right and second left spaces. There were 10 normal cases in which the pulmonary sound was distinctly louder than the aortic, and in some instances reduplicated. No note was taken of the murmurs, so often developed in the region of the pulmonary artery during respiration and which are extremely common in thin-chested children. In two cases the sounds in this region were clear in the erect posture, but in the recumbent position systolic bruits developed; in both the second sound was accentuated, and in one the area of pulsation somewhat increased. In the third case there was a soft systolic murmur in the second and third spaces in the recumbent position only, with accentuation of the pulmonary sound and the apex beat outside the nipple line. In some of these there may

have been organic changes in the valves, but I deemed it best to exclude all doubtful cases.

There remain for consideration 54 cases with signs of valve disease. In 21 cases there had been three or more attacks of chorea.

The facts regarding rheumatism are interesting. In 22 cases, 40.7 per cent., there was a distinct history of articular trouble, sometimes with the chorea, but in 6 cases from one to five years after the attacks. Comparing the frequeney of rheumatic affection in this group, 40.7 per cent., with that in the total number of cases, 15 per cent., or with the group of 43 normal cases, 18.6 per cent., we see the influence this disease exercises in producing the heart lesions. We have, however, the larger proportion 59.3 per cent., of the cases without any history of rheumatic trouble. Of the 21 cases which had had three or more attacks of chorea, only seven had rheumatism.

A study of the cases justifies, I think, the following conclusions:

1. That in a considerable proportion of cases of chorea—much larger than has hitherto been supposed—the complicating endocarditis lays the foundation of organic heart disease.

2. In a majority of the cases the cardiac affection is independent of rheumatism, and cannot be regarded as in any way associated with it; unless, indeed, we hold with Bouillaud, that in the disease "chez les jeunes sujets le cœur se comporte comme une articulation."

3. As the presence of an apex systolic murmur in chorea is usually an indication of the existence of mitral valvulitis, as much care should be exercised in this condition as in the acute endocarditis of rheumatism. Rest, avoidance of excitement, and care in convalescence may do much to limit a valvulitis, and obviate, possibly, the liability to those chronic nutritional changes in the valves wherein lies, after all, the main danger.

PUERPERAL SEPTICÆMIA.—Dr. Archibald D. Macdonald, of Liverpool, England, dislikes the term puerperal septicæmia, and prefers to call it puerperal micro-organismexcrementæmia. There is much to be said about anything that looks so well on paper, but we are not certain that it will come into general use.

ON HEPATIC CIRRHOSIS IN CHILDREN.

BY R. PALMER HOWARD, M.D., L.R.C.S. ED., LL.D.,

Professor of Medicine in McGill University, Montreal.

Having met with two cases of that rare affection in children, cirrhosis of the liver, I venture to make them the subject of a few observations; not that I hope to remove the obscurity which surrounds the subject, but rather to add to the few examples already recorded two more, in which neither the use of alcohol nor the virus of syphilis can be assigned as the cause of the hepatic cirrhosis.

The infequency of cirrhosis of the liver in children may be substantiated by a few quotations. Thierfelder speaks "of the absolute rarity of the affection as regards children." Henoch admits that he never found the disease "fully developed in children." Dr. Charles West states that "an experience of 70,000 cases of children's disease had yielded him but four examples of hepatic cirrhosis." The late lamented Flint, in a private letter to me respecting one of the cases about to be reported, dated December, 1884, remarks that "in so young a subject the disease is exceedingly rare." And Neureuter estimates its ratio to other diseases admitted into the Franz Joseph Hospital for children at one-tenth of 1 per cent.

The known conditions in the human subject under which interstitial hepatitis occurs are somewhat numerous and may be thus classified or grouped:

1. Toxic or irritating substances entering the blood; (*a*) especially alcohol, (*b*) syphilitic virus, (*c*) malaria, (*d*) probably, but rarely, lithic acid when productive of the lithic acid or gouty dyscrasia, (*e*) blood pigment in diabetes.

2. Chronic congestion of the hepatic vein, as in valvular and pulmonary diseases, and in those rare affections of which I have seen examples, obstruction or obliteration of the hepatic veins, or of the inferior vena cava above entrance of the hepatic vein.

3. Adhesive inflammation of the portal vein (pylephlebitis), especially the syphilitic variety, three cases of which I have found reported.

4. Extension of inflammation to the inter-

stitial tissue of the liver in chronic peritonitis, and in perihepatitis.

5. Obstruction of bile ducts, whether from congenital defects (absence of common duct) or from post-congenital disease (tumors, gall-stones, or experiment ligatures).

6. In association with tubercular disease, more especially of the lungs.

7. As a part of a general tendency to new formation or hypertrophy of connective tissue in the system, the so-called fibroid diathesis.

I have not had time or opportunity to institute a very extensive search into the literature of the subject, but have collected 61 cases of cirrhosis of the liver in children up to the age of puberty, which, with 2 personal cases, give an aggregate of 63.

The symptoms of hepatic cirrhosis in children are identically those of the disease in the adult. I shall speak very briefly upon a few of them. In the two examples seen by the writer, there were present on the face stigmata composed of collections of dilated minute venules. Although they have been spoken of by some few authors, they are rarely alluded to in systematic descriptions of cirrhosis, and are mentioned but once in the records of the other cases, 61 in number, which I have collected and studied. Their presence should suggest an examination of the liver with special reference to the probable existence of cirrhosis.

The opinion commonly held by the profession is that cirrhosis of the liver is a non-febrile disease, yet in 10 out of 52 cases, uncomplicated by other affections that might produce pyrexia, cirrhosis was associated with fever; that is, in 19.2 per centum. The same association obtained in 5 other instances in which either simple or tuberculous inflammation complicated the cirrhosis and may have produced the pyrexia. Dr. R. E. Carrington, who has recently drawn attention to this circumstance, found an irregular febrile temperature present in 18 out of 44 cases of cirrhosis, or in 43 per cent. (This includes seven children's cases.) It would not, however, be safe to conclude from these figures that cirrhosis is less frequently associated with a febrile temperature in children than in adults; for the records of many of these are altogether devoid of details on this point. Of these 10 febrile cases of uncomplicated cirrhosis, 4 presented the hypertrophic form, 4 the atrophic, and 2 had normal sized livers.

In the 56 cases of non-syphilitic cirrhosis, ascites existed in 34; it was absent in 8, and it was not mentioned in 14. It is interesting to note that in the 13 instances of hypertrophic cirrhosis ascites was absent but twice, not mentioned twice, and present, contrary to the opinions of some authors, 9 times. On the other hand, abdominal dropsy was absent in 4 out of 19 instances of atrophic cirrhosis, in which it is thought to be rarely wanting, present in 14, and not mentioned in 5 cases.

Icterus, more or less deep, was present in 23 cases, absent in 12, and not mentioned in 21 of the non-syphilitic group. These cases do not confirm Fagge's statement that where cirrhosis is associated with jaundice the liver is not contracted, as a rule, but is increased in size. For in the 13 hypertrophic examples jaundice was present 7 times, absent 3 times, and not mentioned 3 times; while in the 19 atrophic examples it was present 10 times, absent 4 times, and not mentioned 5 times. In other words, icterus coexisted with the hypertrophic form in 70 per cent., and with the atrophic in 71.4 per cent.

The fatal issue of hepatic cirrhosis in children is brought about in many different ways; but there are three especially frequent, viz, by toxemia, or certain disturbances of the nervous system, by peritonitis, and by asthenia, in the production of which hemorrhage plays an important *rôle*. These three modes of termination obtained respectively in 12, 9, and 8 instances. Pneumonia seems to have been the immediate cause in 3 instances. The following affections held the same relation respectively in one instance: pleuritis, pulmonary congestion, tuberculous meningitis, ulceration of the entire colon, and "diarrhœa, with fits."

The toxæmic symptoms in these children, the subjects of hepatic cirrhosis, have been more especially violent fits of crying, and frequently of screaming, delirium, dilated pupils, stupor, tremor, twitchings, clonic or tetanic convulsions, rigidity, coma and hemorrhages from stomach, nose, intestines, or kidneys.

In conclusion, it results from this analysis of these 63 cases of hepatic cirrhosis in children—

1st. That most of the established causes of the disease in adults obtain also in children, more especially the use of alcohol, present in 15.8 per cent. of the whole number; syphilis, chiefly hereditary syphilis, present in 11 per cent.; tuberculous disease of other organs than the liver, in 11 per cent.; also, but much less frequently than these, venous congestion of the liver, peritonitis, and a general tendency to connective tissue formation in the system.

2nd. That syphilis occasionally tends to a diffuse interstitial hepatitis or cirrhosis, by first inducing an adhesive inflammation of the portal vein.

3rd. That a general arterio-capillary fibrosis is not proved by these cases to be the usual, and probably not even a frequent, cause of hepatic cirrhosis in childhood.

4th. That more than half of the cases of hepatic cirrhosis in children do not appear to be produced by the above-mentioned well-established causes of that affection.

5th. That there is some evidence that cirrhosis of the liver may be very exceptionally induced by the acute infectious diseases—cholera, typhoid fever, measles, scarlatina, but that proof of this is wanting.

6th. That the habitual use of a stimulating diet, or the absorption of the products of faulty digestion, are probably fruitful sources of hepatic cirrhosis in children.

7th. That it is in harmony with what is known of the causes of hepatic cirrhosis to believe that the bodies known as ptomaines may be capable of exciting a cirrhotic condition, and that investigation of this subject deserves attention.

8th. That the period of childhood most liable to cirrhosis of the liver is from the ninth to the fifteenth year inclusive, but that it may be congenital and may occur at any age after birth.

9th. That it is twice as frequent in male children as in female.

10th. That its symptoms are essentially the same in childhood as adult life.

11th. That it is frequently accompanied by pyrexia.

12th. That ascites or icterus, and frequently both together, are of common occurrence in the atrophic and the hypertrophic forms.

13th. That the group of symptoms which have been referred to cholæmia or to cholesteræmia or to acholia, and even sometimes to uræmia, frequently ushers in the fatal issue of hepatic cirrhosis in children.—*American Jour. of the Med. Sciences.*

DYSPNŒA IN LEUCÆMIA.

CLINIC BY PROFESSOR VON BAMBERGER,

Professor of Medicine in the Vienna University.

(Translated for the CANADIAN PRACTITIONER.)

Patients frequently present themselves here suffering from a marked anæmia of the skin and mucous membranes, and a peculiar firm elastic œdema of the surface of the body and lower extremities. They have also a very striking inspiratory dyspnœa and a considerable enlargement of the spleen and liver. The most striking symptom, however, is evidently the dyspnœa. Now, what is its origin? One's first thought on seeing such a serious case of dyspnœa, apart from any obstruction in the larynx, is an affection of the lungs. An examination of the lungs, however, will show nothing which could give rise to such a condition, for percussion and auscultations sounds are normal, unless for some slight crepitation. There is certainly no change in the lungs which could explain such extreme dyspnœa. Then it might arise from heart trouble: either from hypertrophy and dilatation of the right ventricle, and consequent permanent congestion of the pulmonary vessels, or more frequently from disease of the left auricle and ventricle, complicated with weakness so that the heart does not contract in the ordinary manner, and the blood becomes dammed up in the pulmonary veins. Serious forms of dyspnœa may also occur from valvular incompetency, from diseases of the muscular tissue of the heart, fatty degeneration, sclerosis of the coronary arteries, etc., whereby it may happen that a partial paralysis of the left heart may result, and incomplete emptying of the pulmonary veins may take place.

An examination of the heart, however, proves no abnormal condition. It is normal in size,

the sounds are clear and without any murmur, somewhat weak, perhaps, because the whole system is weak, but not to such a degree as will explain the dyspnœa. Evidently the dyspnœa does not depend on this cause. But there are other conditions which may give rise to it: for instance, though it cannot be demonstrated with certainty, some disorganization of the respiratory centre in the medulla oblongata may produce great dyspnœa, and it may also arise from various changes in the blood mixture.

This latter may happen in various ways. Certain changes may cause an abnormal excitation of the respiratory centre, probably owing to a lack of oxygen in the blood, so also may different other substances of a poisonous nature. In this class we have uræmic dyspnœa where, through retention in the blood of those constituents which should be excreted with the urine, whether urea or the change-products of it, severe dyspnœa occcurs merely through the abnormal excitation caused by the same in the respiratory centre. All cases of dyspnœa from kidney disease, however, are not of this nature. In Bright's disease, in stone formation, in hydronephrosis, we find dyspnœa occurring, which is anatomically the result of intercurring œdema of the lungs. This condition is, moreover, very easily recognized, because œdema of the lungs gives positive symptoms. We find the tympanitic percussion sound and, perhaps, moist sonorous or sibilant râles in greater or less extent. Kidney disease may also produce other conditions which lead to dyspnœa, such as pleuritic exudation, pneumonic exudation, or lobular masses, forms which are readily to be distinguished from those produced by pure uræmia. Similar results occur also in diabetes, in which peculiar infection of the blood we have probably a like connection with the sugar or the products of change from it—whether it is the acetic acid or acetone is not yet certainly known. Also in *coma diabeticum* occur grave forms of dyspnœa. Having found, then, the lungs and heart healthy, and nothing abnormal present in the abdominal cavity which, through pressure on the diaphragm, could explain the dyspnœa, we can at once come to the conclusion that there must be some abnormal excitation of the respiratory centre; we might suspect a disease of the kidneys, but an examination of the urine shows nothing which could support that view. We find it rich in urates, uric acid, and uric salts, a trace only of albumen, and extremely few casts. Single cylinder casts are almost always present when there is albumen, showing that a direct connection must exist between them, but on such slight evidence one must not diagnose kidney disease. On the other hand, the high degree of anæmia demands that a closer examination of the blood be made. The examination of a drop of blood under the microscope shows in these cases a great diminution of the red corpuscles; they are widely separated from one another and form rouleau only in a few places, and among them are a large number of colorless elements, from thirty to forty in one field. If a higher power be used, one observes granular cells without nuclei, four or five of them running together and considerably larger than the colored corpuscles. Examined by Fleischl's Hæmometer, we find the hæmoglobin much below normal—about forty per cent.

The red corpuscles number about 2,529,000 in the cubic millimeter, or less than half what they ought to be; accordingly we find a striking condition of the blood, changes in the number of the red corpuscles whilst the white corpuscles are largely increased. Evidently these alterations belong to a series of leucæmic changes. Then the examination of the internal organs proves a marked enlargement of the liver and spleen, especially the former. We shall find changes also frequently in other organs, such as alterations in the retina, as infiltrations, hemorrhages, etc.; accumulations of leucocyptres takes place also in the marrow of the bones, causing pain and swelling from pressure. The swelling of the glands, however, does not present itself so manifestly. Having then such a marked enlargement of the spleen and liver whereby such alterations exist in the blood as we find in leucæmia, increase of the white and decrease of the red corpuscles to so great an extent, we can immediately declare that there is predominant at the root of the evil a hepatic form of leucæmia, whilst the gland changes are manifestly secondary. Varying somewhat from the usual in this form of leucæmia is the

case when the spleen is immensely enlarged so that it reaches even down into the pelvis; the liver being at the same time greatly increased, but not to the same extent. The enlargement of both organs springs from the same origin—the accumulation in such abundance of the white elements of the blood forcing themselves into the parenchyma of the spleen and into the periphery of the hepatic lobules, following the course of the vessels, and forming whitish grey masses around the lobules. In the vessels themselves one finds sometimes an accumulation of these colorless bodies in some places so that single vessels occasionally become plugged up. Why it is in these cases the changes in the liver are so much greater in proportion is difficult to say. Possibly some pathological condition may have existed there previously; a diffuse cirrhotic degeneration is unlikely, but there might easily have been a mild form of fatty degeneration. In other respects the condition presents a typical form of leucæmia, and especially is the dyspnœa characteristic. The dyspnœa you will recognise as long as there remains any leucæmia, although the former is not necessarily present in every case. It does not stand in direct relation to the colorless elements. We have frequently observed leucæmic cases of this kind (in which the changes in the blood were still more marked) and yet no dyspnœa, or, at the most, it was noticeable only on considerable bodily exertion. As far, then, as the origin of it is concerned we can certainly regard it as nervous, that an abnormal excitation has taken place in the respiratory centre, in what manner it is difficult to say. The decrease of the red corpuscles and of the hæmoglobin is probably not the cause, because no direct relation exists between the dyspnœa and the increase of the colorless elements. There are probably other conditions than a mere lack of oxygen in the blood, which cause irritation of the respiratory centre, most probably some chemical substance which is formed in the blood.—*Wiener Medizin Zeitung.*

(*To be continued in our next number.*)

Mr. Richard Quain left over three hundred thousand dollars to the University of London.

Selections.

☞ *We are indebted to* DR. NEVITT *for the translations from the Italian and to* DR. ZIMMERMAN *for the French.*

ACTION OF STROPHANTHUS.

Prof. Drasche, in a paper which he read before the Imperial Royal Society of Physicians of Vienna, communicated the results of his experiments with the tincture of strophanthus. He had used the strophanthus for three months in the General Hospital, and administered twice a day twenty drops of an alcoholic tincture with an equal quantity of laurel water. After the administration of the drug in this dose (half the maximum dose of Fraser), he observed a constant decrease in the frequency of the pulsations; a few minutes after the administration, there was sometimes a decrease in the number of the pulsations from eight to twelve in the minute; in other cases this effect was not produced till half an hour after the drug had been administered. This slowing of the pulse lasted for some hours. Professor Drasche had tried strophanthus in various febrile diseases, such as pneumonia, typhoid fever, acute phthisis, and so on, and had always observed a retardation of the pulse-beats as well as a slight fall of the temperature, which, however, rapidly rose again. In the case of a woman suffering from nervous palpitations, he gave from 10 to 20 drops daily for three weeks (the number of the pulsations was from 150 to 190 in the minute) without noticing a cumulative effect. The number of pulse-beats, nevertheless, increased until twenty drops were administered twice a day, when the number of the pulsations was diminished by twenty beats, and the action of the heart became quiet. This effect was constant, and in spite of six weeks' administration, no disturbance of digestion occurred. In a case of Basedow's disease with tumultuous action of the heart, he succeeded, by giving 20 drops of the tincture of the seeds of strophanthus, in obtaining a retardation of the pulsations as well as an improvement in the regularity of the pulse. Professor Drasche, moreover, had tried the tincture of strophanthus in thirty cases of failure of the heart with serious dis-

turbance of compensation, and in that case also with a proportionately good effect. The palpitations and the feeling of anxiety very quickly disappeared; the accelerated action of the heart decreased more rapidly than after the use of digitalis or adonis, so that the patients always asked for the strophanthus tincture. Professor Drasche finally also stated that similar experiments had been made with success in Professor von Bamberger's *clinique*: the latter gave from ten to twenty drops daily.—*Brit. Med. Journal.*

A New Treatment for Erysipelas.—Prof. V. Nussbaum has frequently treated erysipelas in the following manner: In case of solution of continuity on an erysipelatous surface, he would first, after carefully disinfecting the wound, cover it with small iodoform gauze compresses; then cover the whole surface, where the erysipelatous inflammation was on the increase, with ichthyol salve, consisting of equal parts of ichthyol and vaseline. This he then covered with salicylated cotton and applied a loose bandage. The following day he found that not only did the erysipelas extend no farther, but the surface already involved had improved in appearance. The pain which had existed the day before upon touching, had entirely disappeared, instead of which a slight numbness of the parts was experienced. In fact, all inflammatory symptoms had disappeared, nor did they return although the application was repeated but three times. A further continuation of the treatment would not have been advisable, as the ichthyol was beginning to affect the skin disagreeably. Nussbaum applied this treatment in five cases of erysipelas of the extremities with surprisingly good results. In cases of facial erysipelas he considers an ichthyol collodium more applicable, and where the scalp is affected, he advises the use of ichthyol soap, although he has himself not as yet had an opportunity of testing its merit. In regard to the healing properties of ichthyol, it would be well to add that it possesses no antiseptic qualities, and therefore could not destroy the micrococci of erysipelas. Nussbaum supposes on this account that the alternative effect of the agent so reduces the soil of the cocci that it becomes unfit for their further development upon it.—*Weekly Med. Review.*

Meigs' Listerian Lecture.—The best Listerian lecture I ever heard was delivered by the late Professor Charles D. Meigs in 1859, when I was a student at the Jefferson Medical College. It was on the conduct of a labor. Preliminary to the lecture the janitor brought in a conspicuous array of soap, water and clean towels. Then followed the Professor, and he was received, as he always was, with hearty applause. First bowing right and left in acknowledgment he pulled off his coat, removed his cuffs, rolled his shirt sleeves up, and soaping his hands and arms above the elbows, washed them, and then rinsed them in clean water, and finally dried them carefully and, taking a bottle of cologne, applied some of it freely to his hands. Then turning to the class he said slowly: "In the conduct of every labor the first essential thing demanded alike by safety and decency is to wash your hands. Wash your hands first! Wash them clean! Wash them always; don't forget it. How are you to tell; how am I to know that my servant who handles my reins hasn't got the gonorrhœa?" Many regarded all that as excessive mannerism and affectation. It was the very best kind of teaching. I have known and heard very many public teachers, some good, some bad, some indifferent, some very few great ones; the greatest of all was Professor Meigs. That typical hand washing has been throughout my professional life a guiding star.—Dr. Ellzey, in *The Journal of the American Medical Association.*

Large Fees.—In the recently issued Autobiography of the late Professor S. D. Gross we find the following interesting extract from a letter written to him by the late Dr. J. Marion Sims: "No man in our country, 'solitary and alone,' ever made as much money as I have by my profession, except, perhaps, Dr. H., and yet I am comparatively poor and must work for my daily bread. I am not extravagant, and never gambled. I have lived well and have educated a large family of children, and I have only found out lately that my agent who managed my business for the last fourteen years stole from me not less than $100,000. To justify myself for remaining abroad let me show you what I have done since I saw you: I went to

Rome January 1, and remained there unti April 1. Of course people could not find out I was there until about the middle of February. From that time until the close of March, a period of six weeks, I made 52,000 francs. Since coming to Paris the following items show the work done and soon to be done: April 22, operation, 25,000 francs; April 28, operation, 1,500 francs; April 29, operation, 15,000 francs; April 30, operation, 20,000 francs; May 3, operation, 5,000 francs. Total 65,500 francs. In addition to these I am to operate in the next ten days as follows: First case, 10,000 francs; second case, 10,000 francs; third case, 5,000 francs; fourth case, 15,000 francs. Total, 40,000 francs. This makes the incredible sum of nearly $22,000, all compressed within about one month; but many of these cases followed me from Italy, and you must not think this an average showing. It is an accidental *blocking*. But if I were to settle down here anywhere in a great, ample centre, I am sure I could make with ease $50,000 a year; so you will see that my self-expatriation for health is justifiable."—*College and Clinical Record.*

Professional Secrecy.—The sacredness of the confidential relations between physicians and their patients has lately received fresh recognition in Belgium. According to a brief account given of the affair in the *Union Médicale*, a physician was prosecuted and convicted, and the conviction was affirmed at a second trial, for having refused to reveal the mother's name in a birth certificate. What we interpret as a recognition of the inviolability of the confidence given by patients to their medical advisers is the reply made by the Minister of Justice to a question raised by the occurrence in the Chamber of Deputies, to the effect that there was no legal means of compelling a physician to betray his patient's secrets. It is said that the Belgian Society of Medicine has determined to make a thorough study of the whole question, which is one that is continually coming up in one shape or another. It is easy to see how private grief and humiliation may be greatly intensified by the public record of the parentage of an illegitimate child, and we think it is very much to be questioned if the assumed advantage to the community is great enough to warrant the infliction of such an amount of pain.—*N. Y. Med. Journal.*

A Prince of Quacks.—The audacity of quack doctors is their chief stock-in-trade. Judging from what a Parisian correspondent states, it is very evident that charlatanism is carried on in Paris in a much more pretentious style than is attempted in this country. Some weeks ago a quack opened a splendid suite of rooms in a building on the Grand Boulevard. He had footmen in plush and pages in livery, distributed handbills by the million, and announced that he had an infallible method of curing hoarseness and diseases of the throat by inhalation. This prince of quacks did not purchase a degree, like many of his compeers, but had himself heralded on bills and in the newspapers as Dr. Pitchitchine, Beloochistan, Member of the Academies. The big, foreign-sounding name, which the doctor had culled at random from an atlas, and the style of his rooms, are said to have produced a great impression on the minds of those unsophisticated people who, despite the enlightenment of the age, still abound, even in the great centres of civilization; and among those was an actress, who sought this pseudo-throat-healer for hoarseness from which she was suffering. The patient, we are told, went to Pitchitchine's magnificent establishment on the Boulevards. The folding doors were thrown open by a gorgeous flunkey, and the great quack was discovered dressed in Oriental garb. The actress's head was first enveloped in a cloud of cashmere, and she was told to inhale the contents of a tube. She did so, and in a moment fainted away, being nearly suffocated. The quack became alarmed, and had to send for a *bona fide* medical man, who revived the victim. The actress went home in a cab, and found that, besides being incapacitated from singing, she was hardly able to speak, and had to cancel her engagement. She has consequently brought an action against the pseudo-native of Beloochistan, who had simply made her inhale a concoction which contained a large quantity of chloroform. Sahib Pitchitchine is also to be proceeded against by the *Parquet* for the illegal practice of medicine, and

for having worn dazzling decorations to which he had no right.—*Brit. Med. Jour.*

ANOTHER TRIBUTE TO BRITISH SURGERY.—Last spring Dr. Bantock, surgeon to the Samaritan Hospital, was invited by the American Gynæcological Society to read a paper at one of its meetings. This invitation was accepted, and not only was the paper read, but Dr. Bantock was called upon to operate at several hospitals in the States, chiefly with a view to illustrate his manner of performing hysterectomy for the removal of uterine fibroids. At Philadelphia, he performed the operation on a patient of Dr. Joseph Price, in a private hospital, and on a young negress, a patient of Dr. Bromall, in the Women's Hospital, where Dr Bantock also removed the appendages for hydrosalpinx. At the Women's Hospital, New York, he performed hysterectomy on a patient of Dr. Hunter, and on another under Dr. Caroll Lee's charge; he further did an exploratory operation in a case of malignant disease at the Bellevue Hospital; lastly, at Chicago, Dr. Bantock did a double ovariotomy at St. Luke's Hospital, and another ovariotomy in private, the cases being under the care of Dr. Dudley. All these operations were performed without antiseptics. When we bear in mind the reception of Sir Joseph Lister at Buda-Pesth, a few years ago, and the yet more practical compliment recently paid to Sir Spencer Wells in Austria, and to Dr. Bantock across the Atlantic, we must feel how strongly the influence of British surgery is felt, and the merits of our surgeons recognized, beyond the dominions of Queen Victoria. —*Brit. Med. Jour.*

PAPAINE IN SYPHILITIC ULCERS OF THE TONGUE.—Mr. Henry Fenwick strongly recommends papaine in syphilitic ulcers of the tongue and throat, especially when mixed with cocaine. The surface of the ulcers and the white patches in secondary syphilis, rapidly clean and begin to skin over. He has used it in lozenges (papaine, $\frac{1}{8}$gr.; cocaine, $\frac{1}{8}$gr.; potass. bicarb., $\frac{1}{4}$gr). He has also used it in the following way: Mix papaine with a small quantity of glycerine and water, so as to form a thin paste; add a little bicarbonate of potash, and brush ulcers with the same thrice daily. Papaine is coming into use in the treatment of the dyspepsia in infancy and childhood associated with diarrhœa, with stools containing imperfectly digested food. It would seem that Finkler's preparation is best adapted for this purpose.—*Medical Times.*

LACTIC ACID IN CHRONIC PURULENT INFLAMMATION OF THE MIDDLE EAR.—Lange (*Monatshf. f. Ohrenkrkh,*) recommends lactic acid in the above named affection. He commences, as a rule, with a 15 per cent. solution, which is dropped in once daily, or which is applied with cotton pledgets on the diseased mucous membrane. After this treatment has been continued for some days without having caused reactive symptoms, Lange makes use of stronger solutions in those cases in which the mucous membrane is considerably thickened or granulating; he, however, rarely used a stronger solution than 30 per cent. The first symptoms which are noticed after using the lactic acid are decreased secretion and early disappearance of the frequently existing fœtor. Small granulations usually get covered with a white, necrosed scab, and then shrink rapidly. The acid is apparently ineffectual against coarser vegetations. Neither does it seem applicable for acute ear inflammations. More concentrated solutions cause pain, but the latter usually passes off rapidly. Steel instruments are attacked by the lactic acid.—*Therapeutische Monatshefte—Medical Chronicle.*

LAFAYETTE MIXTURE.—A modification of the the mixture of copaiba, liquor potassæ, sweet spirits of nitre, and mucilage of gum arabic, known as the Lafayette mixture, was proposed by Bumstead, and is now generally employed in place of the original:—

℞ Copaibæ,
Spirit. ætheris nitrosi, āā.. f ℥ j
Liquor potassæ..... f ℥ ij
Extract. glycyrrhizæ .... ℥ ss.
M. et adde
Ol. gaultheriæ ..... gtt. xvj.
Syrup. acaciæ ..... f ℥ vj. M.

DOSE.—A teaspoonful after meals.

—*College and Clinical Record.*

Prof. Woodbury at the Medico-Chirurgical recommends Ferrier's snuff in coryza:

℞ Morphinæ sulphatis ..... gr. v.
Pulveris acaciæ ..... gr. x.
Bismuthi subnitratis ..... gr. l. M

For a mild and sure cathartic divide a seidlitz powder into four parts and give one double part every fifteen minutes.—*Coll. and Clin. Record.*

THE

Canadian Practitioner.

(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.

TORONTO, NOVEMBER, 1887.

☞**We again furnish our friends with several pages of additional reading matter, and would kindly request them to consult the label on their journals, and send amount of subscription due.**

MEDICAL FACULTY OF THE UNIVERSITY OF TORONTO.

At the commencement of this year few would have supposed it possible that before the expiration of the same a Medical Teaching Faculty of the University of Toronto would be in existence, fully organized in all respects, with an attendance of two hundred and fifty students. Yet such is the fact, and we hope the feeling will be almost universal in the Province that the existence of the new Faculty will be in the interests of higher medical education.

To Professor Ramsay Wright was assigned, by common consent, the honor of delivering the opening lecture, which we are pleased to publish in this issue. The assemblage of guests, who met in the university at the inauguration of the medical Faculty, was one of the most distinguished and representative that has ever been seen in the convocation hall. A very full report having appeared in the Toronto daily papers, we need not here enter minutely into details. We cannot, however, omit to mention the gratification of the chief promoters of the scheme caused by the presence of so large a number of physicians from differents parts of the Province.

The establishment of this Faculty has involved an immense amount of work on the part of its chief promoters. The members of the Senate, the Minister of Education, the President and Professors of the University, and the staff of the Toronto School of Medicine all worked together with a determination to overcome all obstacles and arrange all details in time for the opening of the regular session in due season. Special credit is due to Professor Ramsay Wright and his coadjutors in the university professoriate who rendered such valuable assistance in perfecting a scheme which means for them extra work and increased responsibility without any prospect, so far as we know, of additional remuneration for their services.

Where there were so many willing workers it is hard to particularize, but we cannot refrain from referring especially to the Vice-Chancellor of the University, who was early and late indefatigable in his efforts from the inception of the scheme until its final consummation. Fortunately he continues to take as deep an interest in the routine work of the teaching faculty as he did in its inauguration. In the future history of this faculty, we trust the name of William Mulock will ever be remembered in connection with his invaluable services in adding this strong arm to our national university.

Upon the teaching staff is imposed the responsibility of making the college a success. Its prospects now are bright in every respect. The profession and general public are evidently in sympathy with its aims and efforts. No amount of paraphernalia or complete equipments will attract students without enthusiasm and love of the work on the part of the teachers. We believe these essential qualities do exist in the present staff, and feel confident that the results will show that we are not mistaken.

THE WOMEN'S HOSPITAL, TORONTO.

It affords us a great deal of satisfaction to note the success attending the Hospital for Women under the management of the Sisters of St. John the Divine. This hospital, which is situated on the corner of Euclid Avenue and Robinson St., was established by the Mother Superior of the Order residing in Toronto a little more than a year ago. The idea of starting such an institution was entirely her own, and aided by her efficient staff of sisters, who, we may mention, are all members of this sisterhood, which is an order belonging to the Church of England, she has brought the hospital in a few short months to a degree of excellence which could hardly have been anticipated by the most sanguine.

The building is capable of receiving ten patients for treatment at one time, and of that number of beds at her disposal, three are for the exclusive use of women who cannot afford to pay for maintainance and treatment. The remainder are for patients who are in better circumstances, and the rooms are graded in price according to size and situation. In connection with the hospital is a free dispensary for women, where at a certain hour each day advice and medicine are given gratis.

For the purpose of assisting the ladies in their laudable undertaking to attend the poor in the hospital and dispensary, the Mother Superior has surrounded herself with a consulting and acting staff of physicians. The consultants are Drs. U. Ogden, Temple, Burns, and Johnson. The acting physicians are Drs. Machell, A. Davidson, Cameron, Atherton, and J. F. W. Ross.

One feature possessed by this hospital, which will be readily recognized as important by the profession, is that any registered physician has the privilege of securing admission for suitable patients to the pay wards, and there continue his attendance upon them. The demand for rooms has been so increasingly great that it is determined to erect an hospital which will accommodate at least twenty-five patients at one time; for which purpose an eligible site has been purchased on Major St., a short distance above College St., and we learn that building operations will be commenced at once. The work done already in the way of surgical operations in this hospital is very creditable; comprising a large number of abdominal sections, uterine, and breast treatments, etc., and the success has been equally great.

We wish a hearty God-speed to the new undertaking, and confidently recommend the institution to the favorable consideration of the profession and the public.

SIR SPENCER WELLS IN VIENNA.

In the *Wiener Med. Blätter* there appears an account of the magnificent banquet which was given to Sir Spencer Wells by the surgeons and gynæcologists of Vienna. Other guests present were Prof. Welponer, of Trieste, Prof. Konrad, of Grosswardein, and Prof. Lobmeyer, of Agram. Prof. Breisky sat on the right and Prof. Karl Braun v. Fernwald on the left of the celebrated ovariotomist. In reply to the toast of Prof. Breisky, Sir Spencer said: "Nearly thirty-five years ago—in 1853—when I was a young naval surgeon, I passed a few weeks in Vienna. There were giants here in those days—Rokitansky, Skoda, Schuh, Oppolzer, Hebra, Sigmund—I have always valued the many lessons I learned from these great teachers, and have never forgotten their great kindness to me. But if any one had prophesied that I should be received here as I have been to-night—by their successors, by the men I see around me now; men who have not only maintained the reputation of the Old Vienna School, but have advanced it, and continue to advance it—I should have received his prophecy with absolute incredulity. And even now I am almost as much surprised as I am thankful for your most gratifying kindness. During the last few days I have seen operations performed here by some of the surgeons now present, which never would have been thought of in 1853, or if they had been suggested, would have been regarded, if not as the ravings of a lunatic, certainly as the dreams of an enthusiast. And I need not say what pleasure it has given me to be frequently reminded that the influence of modern British surgery—especially in the abdominal and antiseptic surgery, and in gynæcology—has been generously acknowledged as a good

and useful influence. And it is equally agreeable to me to recognize that in many directions the men of Vienna are turning *good* into *better*, and are taking a formost place, among powerful rivals, in the generous race towards perfection, and the struggle of who can do most for the good of mankind.

HOSPITAL FOR SICK CHILDREN.

The plans for a new and complete Hospital for Sick Children have just been finished, and the work is to be begun at once. The old site has been adhered to. The building, having a frontage of 150 feet, will face on College Street, one wing extending down Elizabeth Street 100 feet, and another down Emma Street the same distance.

It is in the Romanesque style of architecture, three stories high, of red brick on Credit Valley stone foundation. While the exterior is solid and comparatively unpretentious, no pains have been spared to make the interior the most convenient, perfect, and complete Children's Hospital on this continent. It will accommodate 120 patients comfortably, and it is expected to coast something like $75,000.

In addition to the ordinary medical and surgical wards, provision has been made for emergency, ophthalmic and contagious cases, for a few private patients, for a training school for nurses, for a home for nurses out of employment or between engagements, for a mortuary and post mortem room, for a crematory, for a disinfectant room, for a dispensary for out-door patients, and for a neat little chapel for the weekly devotional services of those ladies who give so much of their time, and who have so successfully managed this most necessary public charity.

The plans, prepared by Messrs. Darling & Currie, are a modification of those by a celebrated Glasgow architect—Mr. Jas. Sellers—and which Mr. J. Ross Robertson had prepared for the hospital when in Scotland last winter.

A sanitary convention will be held at Albion, Mich., under the auspices of the State Board of Health, on Tuesday and Wednesday, Dec. 6th and 7th.

OUR MEDICAL SCHOOLS.

Another year has passed, and we are now at a period interesting to our medical students, who form rather a vast army in this healthy country of ours. The public look on with considerable interest, mixed with a certain amount of dread, arising perhaps from the feeling that they will be expected to furnish the ailments upon which these embryo doctors must, in the near future, subsist.

The session of 1887-8 has opened; the freshmen are enrolled, and are acting circumspectly under the wise supervision of the sophomores and seniors. Report says the Schools in Ontario, and McGill, of Montreal, are all full. The prospects for a survival of the race of doctors are excellent so long as there is any pabulum left for them to feed upon.

As far as Toronto is concerned we believe its schools are in a better position to-day than have ever been in the past. The numbers are at least as large as before, and what is of far more importance, we believe the character of the teaching, as a whole, in both schools is the best ever known in their history.

We offer our congratulations to the faculties in the prosperity of these worthy institutions; and extend our usual cordial welcome to the students.

BILLROTH'S OPENING LECTURE.

Billroth, when he appeared in his lecture-room on the 10th of October, after his severe illness, was received in "stormy sympathy" by his students, and in reply to an address from a delegation (*Wiener Med. Blätter*) said: My dear friends—It is exactly twenty years to-day since I first stood here as the successor of Professor Schuh. Rokitanksy, Oppolzer, Skoda, Arlt, Dumreicher and others were my colleagues—truly a cultured band! A melancholy poet calls life a funeral march, to which the heart beats time. But it must not be a continual funeral march; it can also be a merry, fresh march which the heart makes joyous. I thank you from a full heart for your courteously kind words. In the darkest days of my illness I took leave of this place and of you, my friends, but fate decided other-

wise. My truly self-sacrificing friends dragged me from the entrance to the Shades, and to-day I am heartily glad to greet you once more. . . I find no other form in which to express my thanks than to say, so far as my strength permits, I shall work for the weal of suffering man, for the renown of the university, and for the welfare of Austrians. (Loud and long-continued applause.) But while to-day is one so full of joy to me it is also one of mourning. In all hours of happiness I have thought, and still think with thankful heart of my master and teacher, of my fatherly friend, Langenbeck, who always entertained towards me the warmest feelings. His name is written in the history of surgery in golden letters. . . . After this, Billroth sat down and delivered an address on the life and works of Langenbeck.

THE WOMAN'S MEDICAL COLLEGE.

The Woman's Medical College participates in the increasing renown of Toronto as a centre of education. The large number of new students has made it incumbent upon the Faculty to make such alterations in the building as to give two lecture rooms, thus increasing the teaching facilities and materially adding to the comfort and convenience of both teachers and students.

The students met at the President's house and organized a Clinical Society, to meet on alternate Friday nights for the purpose of the reading of clinical reports and discussions thereon. The members of the society are enthusiastic in the pursuit of knowledge, and have taken the best means of attaining their ends.

SIR JAMES GRANT.

A complimentary dinner was given to Sir James Grant at the St. James' Club, Montreal, by the Medical Faculty of McGill University, on the evening of Monday, October 3rd, in recognition of the honor of knighthood recently conferred on him by Her Majesty.

The medical practitioners of the city of Ottawa and district gave him a banquet in the Russell House on the evening of October 13th. Dr. Sweetland, who occupied the chair, read a very flattering congratulatory address on behalf of the profession of Ottawa. Sir James, in his reply, returned his warmest thanks for the honor shown him by his colleagues. He referred to his work of over a quarter of a century in the city of Ottawa, and many of the pleasant features of his association with his professional brethren.

The banquet was a marked success in every respect, and expressions of good will and kindly feeling towards the distinguished Knight, from those who have known him longest and best, must have been highly gratifying to him. That Sir James may live long to enjoy the many honors he has won is, we feel assured, the earnest wish of his numerous friends in all parts of the Dominion.

UNIVERSITY COLLEGE CONVOCATION.

It was generally remarked by those in attendance at the last College Convocation, that the conduct of the students was very objectionable. Those present would not as a rule object to a little fun, or an occasional *snatch* of a college song, but such rudeness as interrupting the speakers, or firing "darts" so promiscuously as to annoy the ladies in the audience, is simply intolerable, and should be stopped by the authorities of the college if certain students have lost all sense of shame and decency.

It is, fortunately, quite probable that the new order of things will make a vast improvement in the morals and manners of the Arts students. The establishment of a Medical Faculty in the University will, of course, introduce new blood, and it is expected that the refining effect of a more intimate contact with medical students will soon be shown by a thorough renovation of the whole establishment.

THE MEDICAL LIBRARY ASSOCIATION OF ONTARIO.—Prof. Osler, of Philadelphia, has been instrumental in securing from Dr. H. C. Wood, as a donation to the above Association, a large number of valuable works from that gentleman's library, and Dr. Hodge, of Mitchell, also has generously given the entire medical library of the late Dr. Rolph to the same Association.

CLINICAL INSTRUCTION IN THE TORONTO GENERAL HOSPITAL.

Still greater improvements have this year been made in the course of clinical instruction given in the Toronto General Hospital. Some idea of the character and amount of the work done may be obtained from the following schedule:—From 1.30 to 2.30 p.m. the out-door patients are prescribed for in the theatre. The cases of general disease and special cases are allotted to the different rooms set apart for them.

From 2.30 to 3.30 the regular clinical lectures are delivered. These are equally divided between medicine and surgery. The principal part of the course, however, bed-side clinics, are given between 3.30 and 4.30. Four members of the teaching faculties, two physicians and two surgeons, take fifteen students each, and give an hour's instruction at the bedside of the patients, and in this way sixty students are drilled each day in practical medicine and surgery. A large number of clinical clerks and surgical dressers have been appointed, who, during the forenoon, write up histories of cases, and prepare material for the afternoon clinics. We are not aware that a more thorough course of clinical instruction is given in any hospital on this Continent.

NOTES.

The following statistics will give a fair idea of the growing popularity and the efficiency of the work done in this institution. The total number of patients admitted for the year ending September 30th was 2,477, viz., 1,119 Canadians, 660 English, 390 Irish, 129 Scotch, 89 Americans, and 90 from other countries. The number of patients in the Burnside (lying-in) for the year was 187, and the number in the eye and ear department 224. The mortality is low, only 162 deaths having occurred.

The number of patients admitted during the month of September is the largest yet recorded, being no less than 412.

Two hundred and twenty-five final students have registered for clinical instruction, and one hundred and fifty-two first and second year men have placed their names on the roll.

We also note with pleasure the progressive action of the hospital authorities in their worthy endeavor to make this institution a perfect mine for medical instruction, and while attending to the afflicted they have not failed to cater, when at all feasible, to the aspirations of those eager to ascertain the seat and cause of the *exitus letalis*.

NOTES.

Ivanoff (*Med. Chirurg. Rundshau*) reports a case of sudden death following a blow upon the scrotum.

A mixture of quinine with glycerine is now highly recommended as an injection in gonorrhœa.

To ease pains after burns, Dubois (*Medical Chronicle*) recommends pouring seltzer water over the affected parts.

Baron von Langenbeck, the great Berlin surgeon, died on the 29th of September, in his seventy-seventh year.

Twenty-eight of the passengers on the steamship *Alesia* have succumbed to cholera since the vessel arrived in New York.

He evidently was a lover of all mankind who regretted to announce that Samuel Christian Frederick Hahnemann was born in 1755, and continued his false and downward passage till 1843.

Change in the Color of the Hair after Erysipelas. — Dr. Manolaki (*Med. Chirurg. Rundschau*) mentions the case of a priest, 70 years of age, with white hair and beard, who lost the entire epidermis in consequence of erysipelas. On his recovery the hair which grew was a perfect black.

Cervix-carcinoma in a virgin nineteen years of age is reported by Eckhardt, of Breslau, (*Med. Chirurg. Rundshau*). The case is one of great rarity, up to the present, but two others have been recorded, one by Glatter and the other by Beigel; the ages of the patients were 17 and 19.

We are always pleased to see extracts from the pages of the PRACTITIONER in contemporary journals, but we certainly think the PRACTITIONER should receive credit for the same, and express the hope that these small courtesies of journalism may not be in the future so fully disregarded.

The Pharmaceutical Era, edited by Dr. A. B. Lyons, and published by D. O. Haynes & Co., Detroit, offers a prize of fifty dollars in gold for the best essay on the subject, "The Mutual Relations of Physician and Pharmacist." Any one may compete. The essay must not exceed 2,000 words in length, and must be sent in before the first of January.

A rare case of death from rupture of the liver is mentioned by Hugo Heinzelmann (*Rundschau*). The patient had recovered from an attack of pluero-pneumonia and pericarditis, and had been out of bed twelve days when he received a slight blow over the region of the liver, which caused its rupture, probably owing to cloudy swelling and fatty degeneration of its tissue, it was eminently friable.

Senger having made a series of experiments on the influence of iodoform on anthrax bacilli, finds that it does not prevent the liquefaction of gelatine, but changes are produced in the bacillary growth, so that their virulency and their infective properties are diminished; and the *Medical Chronicle* thinks that iodoform does not exert an energetic action on these bacteria, but only affects them after some time, and whilst it may exercise an antiseptic power locally, it has no influence on bacilli within the body.

The *Centralblatt für Therapie* states that amylenhydrat is a desirable hypnotic and recommends the following formula:

℞	Amylenhydrat	7.0
	Aqu destill	60.0
	Extr. liquir	10.0

Take half of the mixture before retiring.

The *Toronto World* says:—"That London West minister who refused to visit and baptize an infant dying of diphtheria, has mistaken his calling.

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

STATED MEETING, SEPT. 29th.

OVARIAN CYST.

Dr. Temple showed a large multilocular cystic tumour. The remarkable feature of the case was the obscurity in the diagnosis. The patient had been examined by various physicians since the discovery of the presence of the tumour seven months ago, and in no case was the growth supposed to be ovarian. The mass of the tumor lay to the rear of the fundus uteri, so tightly packed into Douglas cul-de-sac as to prevent fluctuation being perceptible through the vagina. Both ovaries were involved—the right chiefly. Several cysts were attached to the fimbriated extremities of the tubes. No antiseptic was used, but great attention was paid to cleanliness, and boiled water was employed for the instruments and dressings. The case did well.

ETIOLOGY OF DIPHTHERIA.

Dr. Ross drew the attention of the Society to a point in the etiology of diphtheria. A case might retain its power to infect others much longer than was generally supposed. Infected children should not be allowed to mingle with others till at least five weeks after all traces of the disease have disappeared. A case had lately come under his notice in which a child had communicated this dread disease to other children, whom it met for the first time a month after its apparent recovery.

Dr. Bryce had also met with several cases bearing out this point.

STATED MEETING, Oct. 6th.

EPITHELIOMA.

Dr. Nevitt presented a woman who, 29 years ago, had received a severe injury to the head from machinery—a portion of the scalp, the size of the palm, having been torn off from behind the right temple. A sore the size of a silver dollar had always remained. During the last three years this had been growing larger; granulations appeared and large nodular swel-

lings behind the ear. A nævus over the right temple had lately become involved. The patient had sought relief for the intense pain. No dead bone had been seen or detected by the probe. Topical treatment gave no relief. The opinion of the society was asked as to the possibility of the lesion having become epitheliomatous.

Dr. Atherton thought it had the appearance of keloid. The pain was doubtless due to the constant traction on the surrounding skin.

Dr. W. H. B. Aikins inclined to believe it epithelioma.

Dr. Davidson expressed the opinion that, in either case, the treatment of fine parallel incisions, as advised by Dr. Fox, of New York, might be effectual.

STENOCARPINE.

Dr. R. A. Reeve made some interesting remarks about the new local anæsthetic, stenocarpine. (See page 357.)

FRACTURE OF LARYNX.

Dr. Atherton read a paper on a case of probable fracture of the larynx. (This appears on page 355). In the discussion which followed, Dr. McPhedran stated that laceration in the mucous membrane seldom occurs without concomitant fracture of the larynx. A small opening in the membrane would suffice to account for the great emphysema, if there were obstruction above the seat of the fracture.

Dr. Nevitt related a case in which a young lady had twisted her neck in falling. There was sudden severe pain, tenderness down the left side of the larynx, and persistent attempts at swallowing.

CEREBRO-INFANTILE PARALYSIS.

Dr. McPhedran reported a case of cerebro-infantile paralysis. The history had been that of ordinary infantile paralysis. Hemiplegia was complete on the right side. The power to articulate was absent. Sensation was normal —an unusual thing. There was no hereditary tendency. The paralysis is passing away rapidly. Authorities state that in these cases the prognosis for complete recovery is unfavorable.

STATED MEETING, Oct. 13th.

UN-UNITED FRACTURE.

Dr. G. B. Smith showed a case of un-united fracture of both bones in the leg of a child of three years. The lesion had occurred when the boy was six weeks old. He had moved about for a time by means of short co-aptation splints. There was ligamentous union; the bones being much smaller than those of the sound limb, while there was about three inches of shortening.

There was a short discussion as to treatment, and as to the exact cause of the atrophy in both fragments.

SCARLATINO-DIPHTHERIA.

Dr. Graham reported a case of diphtheria in which, on the fifth day, the punctiform rash of scarlatina had developed. The history of diphtheritic infection was clear, while the rash was unmistakable. It appeared first upon the chest and covered the entire body. The throat presented the diffuse redness incident to scarlet-fever. He believed this to be a case in which the two diseases were combined. The patient had died.

Drs. Carson and McPhedran had seen similar cases.

CASE IN PRACTICE.

Dr. Hamilton showed a patient, a portion of the side of whose thumb had been split off with an axe, exposing the bone. Although the piece, two inches long, was entirely severed and had remained so for some minutes, union had been secured by first intention, without sutures.

PLASTIC OPERATION.

Dr. Carveth showed a section of the nose, with the cartilage attached, and a photograph of the recovered patient. Excellent results had been secured by skin-grafting and a plastic operation.

Dr. McPhedran then gave the history of

A CASE OF EPILEPSY AND THE POST-MORTEM NOTES.

M. C., aged 76, of good family history. As a boy he was apprenticed to a farmer who used him cruelly, striking him, on one occasion, a severe blow on the vertex. As a young man he displayed more than ordinary ability, and was energetic in his business. Forty-one years

ago, after great exertion at a fire, he had an epileptic fit, and since then fits have recurred with greater or less frequency, being very frequent of late, always one and often several in one day. He always complained of great abdominal pain, sometimes before but usually after the fit, lasting often for an hour or so. The convulsion began on some occasions on one side and on some on the other side, while in many both sides were equally convulsed. The direction of his falling was equally varied, both sides were convulsed usually when he fell on his back. For many years back he has been insane after many of the convulsions, often running into the street in his night-shirt, but never threatening to injure any one. His mental faculties have grown less keen. His health in other respects was good; he took large quantities of food. The bowels were fairly regular, never very constipated. Two days before his death he had a severe convulsion, after which pain in abdomen became severe. Vomiting set in, and became grumous. Abdomen very tender, and temperature slightly elevated.

Post-mortem examination showed skull somewhat thickened, the hemispheres considerably atrophied, and slight increase in cerebro-spinal fluid. The stomach and intestines much dilated, except the lower five feet of the ileum, which was extremely small. Many loops of the small intestines were adherent to each other; two or three were congested, and the adhesions soft, as if of recent occurrence. Along the attachment to the mesentery were many small sacular protuberances of the bowel, as if the mucous coat had been forced through the muscular. The left renal vein was greatly dilated. There was nothing else worthy of note.

No conclusions other than speculative can be drawn from the post-mortem conditions found. The abdominal pain was due, probably, to the adhesive inflammation that occurred from time to time, and, perhaps, bore a causative relation to the epilepsy. The pain may have been due sometimes to colic arising from the impediment offered to the passage of intestinal contents through the contracted portion of the ileum.

D. J. GIBB-WISHART, M. D.,
Secretary.

Correspondence.

To the Editors of the CANADIAN PRACTITIONER.

TREATMENT OF COMEDONES.

Comedones, or grubs, are the ordinary black specks seen on the face of adolescents, and are due to the retention of sebaceous matter. After I had administered ether to a patient who was greatly affected with comedones, I noticed that they were easily pressed out, due, perhaps, to the solvent properties of ether on these greasy concretions. I resolved to give the ether treatment a fair trial. I used the following on several cases with gratifying results:

℞. Æther sulphuris.....℥i.
Ammoniæ carbonatis.....℥i.
Acidi boraci.....grs. xx.
Aquæ ad.....℥ii.

Sig.—Apply twice a day. The carbonate of ammonia with the grease forms a soap. The boracic acid acts as an antiseptic and the ether as a solvent.

Yours, etc.,
J. H. MCCASEY, M.D.

CONCORDIA, Kansas.

Book Notices.

Monatlicher Anzeiger über novitaten und Naturwissenschaft. JOSEF SAFAR. Wien. viii. Schlössel Gasse 24.

Katalog des Antiquarischen Bucherlagers, von Josef Safar. Medicinesche Buchhandlung, Wien. viii. Schlössel Gasse 24. Price, 1fl.

Pathology. Diagnosis and Treatment of Perforation of the Appendix Vermiformis. By J. McF. GASTON, M.D. (Reprint).

Surgical Relations of the Ileo-Cæcal Region. By J. McF. GUSTON, M.D., of Atlanta, Ga. (Reprint).

Announcement of American Public Health Association, 1887. Fifteenth Annual Meeting, Memphis, Tenn., to be held Nov. 8th, 9th, 10th and 11th.

On the Necessity for a Modification of Certain Physiological Doctrines regarding the Interrelation of Nerve and Muscle. By T. W. POOLE, M.D., Lindsay.

The Radical Cure of Retro-Displacements of the Uterus and Procedentia by Alexander's Operative and Median Colporrhaphy. By J. H. KELLOG, M.D., Battle Creek, Mich. (Reprint).

Ovarian Tumors, and Remarks on Abdominal Surgery, with the result of 50 cases. By EDWARD BORCK, A.M., M.D., St. Louis, Mo. 1887. (Reprint).

The Action and Uses of Digitalis and its substitutes, with special reference to Strophanthus. By T. R. FRASER, M.D., F.R.S., F.R.C.P. Edin. (Reprint from *British Medical*).

Hay Fever. The First Prize Essay of the United States Hay Fever Association for 1887. By SETH S. BISHOP, M.D. Chicago: (Reprint.)

On the Treatment of Felon without Incision. By L. DUNCAN BULKLEY, A.M., M.D., Attending Physician to the New York Skin and Cancer Hospital. (Reprint.)

A Practical Treatise on the Diseases of the Hair and Scalp. By GEORGE THOMAS JACKSON, M.D., Instructor in Dermatology in the New York Polyclinic. New York: E. B. Treat, 771 Broadway, 1887. Price $2.75.

Transactions of the American Otological Society. Twentieth Annual Meeting. Pequot House, New London, Conn. Vol. IV., Part I. Published by the Society. New Bedford, Mass., 1887.

Forty fifth Report of the Legislature of Massachusetts, relating to the Registry and Returns of Births, Marriages and Deaths, in the Commonwealth, for the year ending Dec. 31st, 1886. Editorial remarks by S. W. Abbott, M.D., Boston, 1887.

Insanity; its Classification, Diagnosis, and Treatment. A Manual for Students and Practitioners of Medicine. By E. C. SPITZKA, M.D., President of the New York Neurological Society, etc., etc. New York: E. B. Treat, 771 Broadway, 1887. Price, $2.75.

Outlines for the Management of Diet. By EDWARD TUNIS BRUEN, M.D. Philadelphia: J. B. Lippincott & Co.

This manual should be of use to nurses and to practitioners. In the management of the sick there is nothing of which there is such universal ignorance as the *why* of any given diet.

The principles underlying diet are outlined, and applied concisely yet lucidly to special diseases. Price, $1.25.

The Physician's Visiting List. Thirty-seventh year, 1851–1888, with many improvements. Philadelphia: P. Blakiston, Son & Co., publishers, 1012 Walnut St. Toronto: Williamson & Co., 5 King St. West.

This admirable visiting list has had many admirers in the last thirty-six years, and this year some new features of attraction have been added. The contents are well arranged, and its size and weight recommend it. Its binding is strong, with gilt edges. For 1,300 names, interleaved, with tucks, pocket and pencil, price $1.25. Buy one!

Lessons in Gynæcology. By WILLIAM GOODELL, A.M., M.D., Professor of Clinical Gynæcology in the University of Pennsylvania. Third edition, with one hundred and twelve illustrations. Philadelphia: D. G. Brinton.

There is probably no more charming clinical teacher of Gynæcology than Dr. Goodell, of Philadelphia. The author disclaims the idea that this is a complete treatise on the diseases of women; but states that it is mainly the outcome of clinical and didactic lectures delivered to his students for many years. This edition contains much new matter which will be found in the various chapters, and six new lessons with twenty additional illustrations. No more interesting book on Gynæcology has ever been written, and it is as useful as it is interesting.

Illustrated London News (American Edition). Potter Building, New York.

An examination of the *Illustrated London News* (American reprint) for October 22nd, will show the English view of the trial yacht race, illustrations in connection with the state of Ireland, Our Homeless Poor in St. James Park at Mid Day, the British Mission to Morocco, and Sketches on the River Congo. A Sleeping Beauty represents a handsome tiger at rest, while Christening Sunday represents infancy surrounded by admirers. The price of the number being only ten cents places it within the reach of all. Every newsdealer has it. The

office of publication is in the Potter Building, New York City. It makes a capital illustrated newspaper for the table of the physician's waiting room.

Practical Urine Testing. A guide to office and bedside urine analysis. By CHARLES GODWIN JENNINGS, M.D, Professor of Chemistry and of Diseases of Children, Detroit College of Medicine, etc. Detroit: D. O. Haynes & Co., 1887.

As stated in the preface, it is the aim of this little volume (124 pages) to give concise directions for office and bedside testing, embodying as it does all the latest advances that have proved to be of value. Particular attention has been given to the qualitative and quantitive tests, which from their cleanliness and ease of application, and the simplicity of apparatus required, commend themselves to the practising physician. The book is divided into two parts, the first being devoted to a brief consideration of the chemistry of the urine in health and disease, and the second presents a systematic scheme for urine analysis and microscopical examination.

A Manual of the Physical Diagnosis of Thoracic Diseases. By E. DARWIN HUDSON, Jr., A.M., M.D., late Professor of General Medicine and Diseases of the Chest in the New York Polyclinic; Physician to Bellevue Hospital, etc. One volume. Octavo. 162 pages. Nearly 100 illustrations. Muslin. Price, $1.50. New York: William Wood & Co.

This work is an enlarged edition of a previous book entitled "Essentials of the Physical Diagnosis of Thoracic Diseases," which Dr. Hudson published for the use of the Class on Diagnosis. The present volume is about the right size for a work of its kind. It is convenient, can easily be referred to, and is in every way quite up to the time. Dr. Hudson was a careful, painstaking physician, and it is greatly to be regretted that he did not live to enjoy the brilliant success which he certainly would have achieved. The synopses of the various diseases of the thoracic viscera, which are given in the latter part of the book, are of especial value. A great number of facts are tabulated in such a concise manner that one can at a glance refresh his memory about the principal features of the diseases dealt with. We can confidently recommend the work both to the student and practitioner.

A Handbook of General and Operative Gynæcology. By DR. A. HEGAR, of the University of Freiburg, and Dr. R. KATTENBACH, of the University of Giessen. Volume II. New York: William Wood & Co.

This is volume seven of *Wood's Cyclopædia of Obstetrics and Gynæcology*, issued monthly during 1887 (12 Vol., Price $16.50). It describes the operations in the Fallopian Tubes, Uterus, Broad Ligaments, Round Ligaments and Vagina, Urinary Fistulæ, Vulva and Perinæum.

We have also volume IX., which treats of *Diseases of the Female Mammary Glands,* by Th. Billroth, M.D., Professor of Surgery at Royal University, Vienna; *and New Growths of the Uterus,* by A. Gusserow, Professor of Obstetrics and Gynæcology at the University of Berlin.

An examination of these volumes more than confirms the high opinions we had already formed, and expressed in previous issues of our Journal, respecting this great Cyclopædia. It well exemplifies the privileges the profession now enjoy, both in a scientific and economic point of view, when Messrs. Wood & Co. can publish such a valuable series in so short a time, at such a price as one dollar and thirty-seven and a half cents a volume.

The Pathology and Treatment of Gonorrhœa and Spermatorrhœa. By J. L. MILTON, Senior Surgeon, St. John's Hospital for Diseases of the Skin, London. New York: William Wood & Co.,

This is a work on an important subject, which should be carefully read by every practitioner who has aught to do with the treatment of venereal troubles. The English authors in general are slow to accept the germ theory of disease, and Milton is no exception. We are somewhat surprised in this case, however, because it has been so abundantly proven that neissers gonococci are always present in gonorrhœa. On page 48, he says: "Tested by the result of practice, the theory breaks down as antiseptics have no particular control over

the disease." He is surely mistaken in this point, for even cleanliness is *antisepsis*. On page 74, he speaks of the hydrarg per. chlor. injection as one that must be shunned on account of its strong and *irritating qualities*: here is the secret—do not prescribe strong and irritating injections, for the weaker are efficient. Nor can we agree with the author in one other point, namely, that the nitrate of silver is the *only* treatment for gonorrhœa, from its most simple to its most complicated form. However, the work is a careful and elaborate production, and, as a book of reference, will be most useful.

Personal.

Drs. J. S. King and Elliott have dissolved partnership.

Dr. Sweetnam is now in Philadelphia attending Goodell's clinic.

Dr. Thistle, having returned from England, will practise on Broadview Avenue.

Dr. F. Beemer has been appointed resident physician to the Hamilton Hospital.

Dr. Olmstead, late of the hospital in Hamilton, has taken a position in the German Hospital, Philadelphia.

Dr. W. P. Manton has opened a Private Home for the treatment of medical and surgical diseases of women, at 543 Second Ave., Detroit.

Dr. Stevenson, of Strathroy, having spent a year in the medical clinics of New York, has removed to this city, and entered into partnership with Dr. Burns, College Avenue.

Miscellaneous.

Mr. William Nye says that although not belonging to the Knickerbocker family he was on one occasion so deeply incensed that his breath came in short pants.—*Medical Age.*

The Doctor's Ironing-Board.—A writer in the *Boston Transcript* says: "In a good old western Massachusetts town lives a doctor who has buried four wives. When number four was a bride of a few days she went with her oldest step daughter into the attic to find an ironing-board. Seeing a board that she thought would answer her purpose nicely, she was about to take it, when the daughter exclaimed: 'Oh, don't take that, for that is what father uses to lay out his wives on!'"—*N. Y. Med. Journal.*

Births, Marriages, and Deaths.

BIRTH.

Bates—At Burlington, October 17th, the wife of Frank D. W. Bates, M.D., of Hamilton, of a son.

MARRIAGE.

Wishart—Gunther—On the 4th August, at Charles Street Presbyterian Church, by the Rev. D. Wishart, of Madoc, assisted by the Rev. J. Neil, Dr. D. J. Gibb Wishart, to Sarah Staunton, eldest daughter of E. Gunther, Esq., Bellevue, Toronto.

Wyld-Wyld—At the house of his father, 529 Sherbourne St., Toronto, by the Rev. Hugh Johnston, M.A., B.D., on the 7th Oct, George Wyld, M.D., of Port Elgin, to Norah Pauline, eldest daughter of J. W. Verner, Esq., of Windsor, and widow of the late James Wyld, formerly of Detroit.

Appelbe-Land—On Wednesday, the 12th Oct., at St. Peter's Church, Carlton St., by the Ven. Archdeacon Boddy, Dr. Appelbe, of Parry Sound, to Mary E. Land, of Toronto.

Hay-Ogden—At Arbor Vitæ, the residence of the bride's father, on Wednesday, Oct. 12th, by the Rev. B. Longley, M.A., assisted by Rev. T. W. Jeffery, Stephen Moffatt Hay, M.D., C.M., L.S.A., London, Eng., to Carrie, daughter of Dr. W. W. Ogden, Prof. of Medical Jurisprudence, Toronto University.

Bell-Brown—At the residence of the bride's father, "Hillside," Eglinton, by the Rev. C. E. Freeman, of Deer Park Presbyterian Church, J. F. Bell, M.B., L.R.C.P. Lond., of Toronto, to Jessie, eldest daughter of Alex. Brown, Esq.

DEATHS.

Clarke—Dr. Clarke, formerly of Palmerston, who has been a resident of Guelph for about a year, on Oct. 7th, aged 74.

Howard—At his residence, 96 University St., Montreal, on October 12th, Henry Howard, M.D., M.R.C.S. London, Eng., in the 72nd year of his age.