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CANADA
MEDICAL & SURGICAL JOURNAL

Original Communications.

NOTES OF ABNORMALITIES,

OBSERVED IN THE DISSECTING ROOM OF McGILL UNIVERSITY

DURING THE WINTER SESSION OF 1876-77.

BY FRANCIS J. SHEPHERD, M.D., M.R.C.S., ENG.

DEMONSTRATOR OF ANATOMY.

The following notes were taken on the spot during the last winter's session from 33 bodies dissected. The record is necessarily far from complete, as many of the slighter variations altogether escape notice, or when seen are too much injured by dissection for complete notes to be taken.

Osseous System.—There is no record of any abnormality occurring in the osseous system except one case of atrophy of parietal bones in a woman. This, however, is rather pathological than anatomical.

Muscular System.—Muscles of face were normal in every subject.

Two examples of absence of the stylo-hyoid, both occurring in the same subject. Two examples of the stylo-glossus muscle passing in front of the external carotid artery, both these cases also occurred in the same subject. The anterior bellies of the

two digastrici frequently united in the middle line, and shut out the mylohyoid muscles from view.

In a muscular male subject the pectoralis minor arose by five digitations from the five upper ribs. In the same subject the pectoralis major had broad muscular attachments to the 5th, 6th, and 7th ribs near their costal cartilages. The pectoralis minor was often found to arise from the 2nd, 3rd, and 4th ribs, and the pectoralis major frequently was connected with the rectus abdominis in muscular subjects.

In six cases the biceps had an additional fleshy head, arising from a line about two inches long, between the attachments of the coraco-brachialis and the outer part of the brachialis anticus. In two subjects there was a muscular slip about 1½ inches wide, running from the latissimus dorsi muscle to be inserted in one case into the coraco-brachialis and in the other the slip was attached to the pectoralis major near its insertion. Both these muscular slips covered the brachial and axillary vessels, and brachial plexus. One example of a third head to the pronator radii teres arising from the intermuscular septum between the brachialis anticus and internal head of the triceps. This third head was about two inches broad and completely covered the brachial artery in the space at the bend of the elbow. In two cases the palmaris longus was absent, and in one subject on both sides the palmaris longus was muscular down to the annular ligament, penniform in shape, resembling the flexor pollicis of the leg. In another case it arose by a long tendon which reached to below the middle of the forearm, where it ended in a pyriform muscular belly, this again ended in a tendon which was inserted into the palmar fascia in the usual way. One example of a special extensor of the middle finger of the right hand which arose from the ulna below the extensor indicis and went through the same division (4th) in the annular ligament. In the same subject the extensor minimi digiti was inserted into the annular ligament and the extensor carpi ulnaris sent part of its tendon to the little finger. One case in which the anterior belly of the omohyoid was fused with the sterno-hyoid so as to form one broad thin muscle bounded

below by a tendinous arch. I have no record of any abnormality occurring in the muscles of the back, except that the levator anguli scapulæ is often divided into two or more slips, which often have a much more extensive origin than is usual, sometimes arising from as many as six vertebræ.

In one subject there was rather a peculiar arrangement of the flexor brevis digitorum of the foot. It was divided into two distinct parts, which crossed each other. The superficial portion arose from the great tuberosity of the os calcis and divided into two tendons, which went to the second and third toes. The deep portion arose from the tendon of the flexor longus digitorum above the insertion of the accessorius muscle, it then passed downwards and outwards and also divided into two tendons, which went to the fourth and fifth toes.

I have very frequently seen the tendon of the short flexor distributed to the fifth toe, absent, or so small as often to be overlooked by a student; when it is of small size it is seldom perforated by the long flexor. I have also several cases of the abductor ossis metatarsi quinti (Wood) recorded.

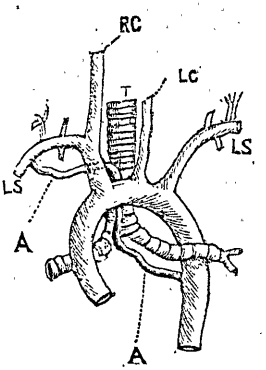
Arterial System.—Abnormalities of the arch of the aorta were few. There were two examples of the left carotid artery arising from the innominate; three examples of a middle thyroid artery being given off from the innominate. In one of these cases the middle thyroid was of very large size and anastomosed freely with the inferior thyroid.

In one subject there was rather a peculiar (and as far as I know hitherto undescribed) aberrant artery given off from the thoracic aorta opposite the upper border of the fifth dorsal vertebra, from here it proceeded upwards and towards the right side, running *over* the œsophagus and behind the arch of the aorta to the right bronchus, where it gave off two small branches to the bronchial glands, it then continued on upwards in a tortuous course to the right side of the trachea, ending finally in the lower border of the second part of the right subclavian artery. This aberrant artery was about the size of a goose quill. It is well known that the right subclavian sometimes arises from the descending aorta owing to atrophy of the 4th

right arch, and persistence of the right aortic root. (Turner Med. Chir. Rev., 1862). In this case the branches from the aortic arch were quite normal, so this aberrant artery seems to be a case of persistence of the right aortic root without atrophy of the 4th right vascular arch. The peculiarity of the vessel passing *over* the œsophagus is, however, difficult to account for.

There was one example of the right common carotid dividing above the hyoid bone. In one subject there was no thyroid axis given off from the right subclavian, each branch arose separately from the main artery.

The superior laryngeal artery was found to arise frequently directly from the external carotid.

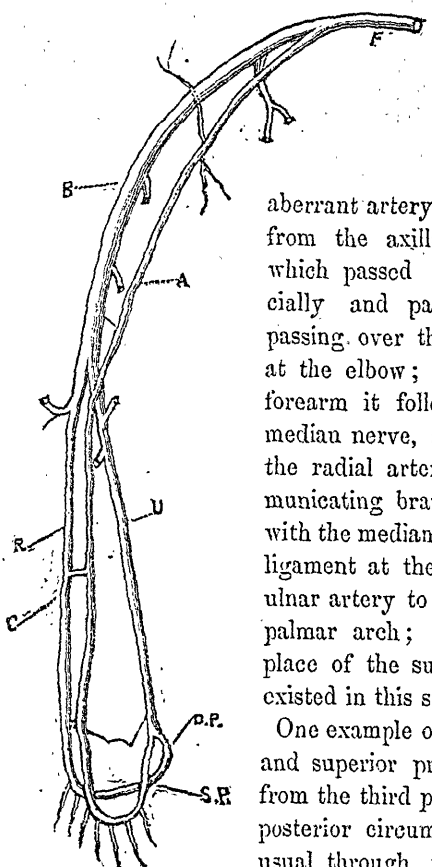


A. A. Aberrant Artery. L. S. L. S. Subclavian Arteries.
R. C. L. C. Carotid Arteries. T. Trachea.

One case of the posterior scapular artery arising from the 3rd part of subclavian, and giving off the dorsalis scapulæ. Many anomalies of the branches of the axillary artery were noted.

In one case anterior and posterior circumflex, subscapular and superior profunda, arose together. A still more rare variety is the following of which we had one example. The axillary artery gave off a large trunk nearly its own size which was embraced by the two heads of the median nerve, and divided into the anterior and posterior circumflex, subscapular, superior and inferior profunda. This variety occurred only twice in 456 subjects dissected at Guy's Hospital from 1866 to 1873. (Guy's

Hosp. Rep. vols. 14, 16 and 18.). In another case the acromio-thoracic, anterior and posterior circumflex and subscapular arose by one common trunk. In one subject there was a large trunk given off from the axillary (3rd part), which divided into the posterior circumflex, superior and inferior profunda, and an *aberrant* artery which went down the arm superficially and over the bicipital fascia; it then dipped down between the pronator radii teres and supinator longus, to join the interosseous artery.



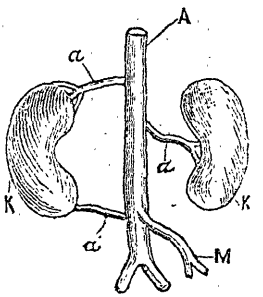
A. Abnormal Artery. F. Axillary. B. Brachial. R. Radial. U. Ulnar G. Communicating Branch between Aberrant Artery and Radial. D. P. Deep Palmar Arch. S. P. Superficial ditto.

There were several examples of the superior and inferior profunda arising by a common trunk from the axillary. In addition to the above aberrant artery, there was one given off from the axillary in another subject, which passed down the arm superficially and parallel to the brachial, passing over the intermuscular septum at the elbow; about the middle of the forearm it followed the course of the median nerve, and was connected with the radial artery by a transverse communicating branch, it then passed on with the median nerve under the annular ligament at the wrist, and joined the ulnar artery to complete the superficial palmar arch; apparently it took the place of the superficialis volæ, as none existed in this subject.

One example of the posterior circumflex and superior profunda arising together from the third part of the axillary. The posterior circumflex did not pass as is usual through the quadrilateral space,

but it passed through the triangular space below it, bounded by humerus externally, long head of triceps internally, and teres major above. The supra-scapular artery in the same subject arose on the right side from the first part of the axillary, and passed between the outer and inner cords of the brachial plexus to the supra-scapular notch. In three cases a long thoracic artery passed down on the serratus magnus with the nerve of Bell; in these cases the subscapular was of smaller size. High division of the brachial occured five times. In three cases the artery divided just below the latissimus dorsi. The ulnar artery in these cases was given off on the radial side and crossed over to the ulnar, giving off before doing so the radial recurrent. In two cases the division took place just above the bend of the elbow, and in both these cases the ulnar passed *superficially* over the muscles arising from the internal condyle. In one of these cases the interosseous supplied both recurrent ulnars and in the other only the anterior, the superior profunda from the brachial taking the place of the posterior ulnar recurrent. Two examples of large *A. comes mediani*, supplying two and a half fingers, the ulnar artery in this case only supplying the little finger and half the ring finger; in fact the distribution of the arteries exactly corresponds to that of the nerves. These cases both occurred in the same subject. In the pelvis the most important arterial abnormality is that of the obturator arising from the deep epigastric. During the past winter I have observed this in ten (10) cases, three occurring on both sides of the body. In two cases the obturator passed to the inner side of the femoral ring. Ten cases of abnormal obturator occurring in 33 subjects is not much above Quain's average which is 1 in 3½. In one case I observed the internal epigastric and internal circumflex arising by a common trunk from the femoral, about half an inch below Poupart's ligament, and in another the deep circumflex ilii arose from the femoral in common with the external circumflex one inch below Poupart's ligament. The external circumflex or some of its branches in at least a third of the cases arose from the common femoral instead of the deep.

In one subject on the left side there was no sciatic artery, the gluteal in this case supplied the muscular branches, and the pudic supplied the coccygeus and comes. N. ischiadici. There was one example of the deep pudic branch from the common femoral, taking the place of the dorsal artery of the penis. In three cases the kidney was supplied by two arteries, arising separately from the aorta. In one case the superior one entered the extreme upper end of the kidney, and the inferior extreme lower end, as is represented in the plate. There was



a, *a*, *a*, Renal Arteries. A. Aorta. M. Inferior Mesenteric Artery. K. K. Kidneys.

one example of absence of the dorsalis pedis artery, the anterior tibial artery terminating immediately below the annular ligament.

Nervous System.—The median nerve passed behind the brachial artery in three cases. Two examples of the musculo-cutaneous nerve of the brachial plexus after piercing the coraco-brachialis muscle and supplying the biceps, joining the median. This latter nerve gave the branch to the brachialis anticus and also the cutaneous branch to the outer side of the arm. Two examples, occurring in the same subject, of the ulnar nerve arising by two heads, one from the outer and one from the inner cord of the brachial plexus. In one subject the ulnar nerve supplied the little and *all* the ring finger. There was one case where the posterior tibial nerve at the inner ankle was anterior instead of posterior to the artery. The nerve crossed under

he artery about the middle of the leg. In one subject there was a nerve from the sacral plexus which pierced the great sacro-sciatic ligament and accompanied the coccygeal artery.

Internal Organs.—There are few abnormalities noted down Several cases of abnormally long sigmoid flexure and one case where the rectum began on the right side instead of the left, the sigmoid flexure crossing over to the right side. In one subject there was a *diverticulum* from the ileum about two feet from the ileocæcal valve. The diverticulum was about the size of a tallow candle, and three inches in length. It was unattached by peritoneum, and floated quite freely. In this same subject, the appendix vermiformis measured six and a half (6½) inches in length. There was nothing else worthy of being recorded.

TETANUS.

FOLLOWING AMPUTATION OF THE INDEX FINGER,

Treated with Chloral Hydrate.

By George C. Duncan, M.D., C.M.

Having been convinced for some time of the therapeutic value of chloral hydrate in the treatment of tetanus, I beg to bring before the notice of the profession a case which recovered, I think, chiefly owing to chloral. On account of the diversity of opinion which exists in regard to the pathology of the disease different modes of treatment necessarily have been recommended by the advocates of the different theories. As the young practitioner in such cases is very often left to his own judgment in the selection of his treatment, and as it is yet an unsettled question in medical science what is the most effectual remedy for the successful treatment of tetanus, and considering that many of the descriptions of the treatment hitherto resorted to have been, for the most part, vague and unsatisfactory, I venture to give the treatment and the following notes of a case, hoping that it may tend in time to help to arrive at some conclusion in the matter.

Dec. 9th, 1876.—Mr. T., a well developed young gentleman, of a sanguine temperament, came to me to have his index finger dressed, which he stated had been amputated a few days previous and had not been dressed for several days on account of having to leave the vicinity where he resided immediately after the operation, and, as he would be travelling for several days, his surgeon instructed him to dress it with ung. zinci. I found the finger swollen and the wound discharging very copiously. After thoroughly washing it, I dressed it with carbolic oil, 1–40. It may be well to mention here the cause of amputation; a few years previous he had the end of his finger taken off by some machinery, and the bone had been exposed ever since, so he concluded to have it amputated.

14*th.*—The wound has progressed very favorably until to-day, when it became tumid and swollen, and very painful to the touch. Pulse, 88.

15*th.*—Pulse 90. Came to me complaining of his jaws being stiff, and asked me if it was "tetanus," which I tried to laugh him out of by telling him that it was his imagination, &c., as he had assisted me the previous day in dressing a crushed arm and hand, and after that he had discussed the probability of tetanus occurring from it. Towards evening he called again, stating that he felt chilly, and that it was with difficulty that he could open his mouth. I advised him to take some whisky and hot water, which relieved him. Pulse 104. Wound healing rapidly.

16*th.*—Pulse 114.—Looks haggard and tired. He seems in good spirits and does not complain of any distinct pain. The masseters are rigid, and his mouth cannot be opened more than half an inch, and he complains of a stiff sensation of the throat. As he obtained relief last evening from whisky I resolved to try it again. Ordered whisky every two hours, alternated with beef-tea. During the day he continued very much the same, until 8.30 p.m., when a distinct spasm occurred. The features were haggard, and the forehead bathed in perspiration. Pulse, 120. Pain along spine, but especially over sacral region. No opisthotonos. Ordered chloral hydrate grs. xxx. Visited him again

at 11 p.m. He has had no return of spasm, and can open the mouth about $\frac{3}{4}$ of an inch, but says he cannot got to sleep. Pulse 114. Gave chloral grs. xxx. Temperature, 98.6°

17*th.*—Pulse, 112. Slept well during the remainder of last night. Finger looks well, but he complains of pain in it. Can't open his mouth sufficiently to allow the end of his thumb to enter. Ordered beef-tea and milk, which he seemed to swallow with difficulty. As his bowels had not moved for two days I ordered pil rhei. co. gr. iii, and chlor. hyd. gr. xx. every three hours. Was very restless all day, and very excited at times, and has had three of what he calls his stiff attacks, complained all the evening of pain in the back of his head, and at 9.30 p.m. he had a severe spasm, teeth firmly closed, slight opposthotonos. Gave chloral hydrate, and in about 15 minutes the spasm passed off, leaving him weak, and, as he expressed it sore all over. Pulse, 120. Temperature 99.4° His mouth can be opened about half an inch. Took a small quantity of soup. Suddenly he complained of the finger paining him, which was relieved after it was dressed. Gave chloral hydrate, grs xxx, at 11 p.m.

18*th.*—Pulse 100. Temperature 99°. His night attendant states that he slept very soundly shortly after midnight, but towards morning became very restless, and after a time delirious, imagining that he was being promoted in some secret order, and discussed its merits at great length. He is very weak and irritable. By using considerable force his mouth can be opened about $\frac{1}{4}$ of an inch, but as soon as the pressure is taken away it closes. He complains of pain in the back of his head, down the back and across the loins. The chloral was ordered to be continued in the same quantity as yesterday, viz. xx grs. every three hours. He says that he cannot use his throat to swallow, as it is so stiff. He was fed with a spoon about ℥ij of beef-tea, but wished to wait for a short time. Bowels moved freely. At noon he could talk quite freely and open and close his mouth about half an inch, but the movement is very slow. Seems quite delighted with the improvement and took some oysters, after which he slept for three hours, when he awoke with a sense of suffocation, severe pain in the back of the head and back. Gave

chloral grs. xx, after which the pains disappeared, and he went asleep in about half an hour afterwards, and remained so until 11 p.m., when he awoke he stared around quite bewildered, and said he had no recollection of the whole day. Feels very languid and yawns almost incessantly, and opens and shuts his mouth quite freely about half an inch. Left him with instruction to repeat the chloral in xx gr. doses during the remainder of the night if awake.

19*th*.—Pulse 88, very soft and compressible. Temperature, 98.2°. After taking two xx gr. doses of chloral last night, he fell into a sound sleep, which continued for six hours, when he awoke and felt much better as far as his throat and mouth were concerned. Can open his mouth quite freely. Pupils widely dilated, but feels very weak and tired. Took some oysters and beef-tea. Ordered ℥i whisky every two hours, alternated with beef tea and chloral grs, xxx, every six hours.

At 4 p.m. he had a slight spasm, which lasted about twenty minutes, after which xx grs. of chloral were given. Bowels moved shortly after.

20*th*.—Pulse 85, and compressible. Temperature 98°. Pale and nervous. Cannot open his mouth as wide as formerly, but attributes it to the soreness of the muscles. Complains of the back being very sore, as though it had been pounded. During the day took a considerable quantity of food and whisky. No chloral. Had no spasm during the day, was up several hours. On account of the pain in his back, and his restlessness at night, I gave him morph. sulph. gr. ¼.

21*st*.—Temperature 98.8°. Pulse 86. Says he feels much better, but this morning on attempting to get out of bed he was seized with a spasm which caused a distinct opisthotonos for about ten minutes. Ordered chloral hydrate grs. xxx. Tongue clean, but still some pain in his back. Took a good breakfast of fish and chops. Can open his mouth with ease. On account of some family business, caused by the death of his father, he had to undertake a railway journey of several hundred miles. Very reluctantly I was forced to consent, he assuming the responsibility. If the spasm returned, I instructed

him to have recourse to chloral, with which I provided him for the journey.

25*th*.—I received word from him that he had stood the journey very well, but that on the morning of the 23rd he had two very severe spasms causing him to screech with pain until he got the chloral, after which he continued quite well until the 28th.

April 24th, '77.—Patient called on me, looking very well, and states that since the date mentioned above he has had no return of the symptoms, and has enjoyed very good health.

TREATMENT OF HÆMORRHOIDS,
INJECTIONS OF CARBOLIC ACID OIL.

BY GEORGE WOOD, M.D., Faribault, Min.

The following method of treating piles has been attended with such marked relief in several cases, that I cannot resist the publication of them in your journal. The treatment adopted is simple and efficacious, and so far as my own experience goes perfectly safe. I give you a hasty account of several cases, with the results—which appeared marvellous—in as few words as possible. The method I adopted was as follows:

Draw down the piles and inject from three to fifteen drops of equal parts of carbolic acid and oil. The pile immediately whitens and feels like a piece of cheese. Give morphia, hypodermically for a day or two, and then move the bowels with the following:

℞. Powdered senna leaves; liquorice root, fennel seeds; washed sulphur aa ℥j; white sugar, ℥ij. M.

Dose, a teaspoofnul every six hours, until it operates, and then a teaspoonful at night, for a short time. In a week you cannot find any trace of the pile. I treated one case of 27 years' standing, and in a week the patient was entirely cured. This patient had eight large piles. And three cases of 17 years' standing, one pile as large as a hen's egg, which bled at times, so that the patient had attacks of syncope. And again in a case where there was one small pile, treated by my partner Dr. Rose, the cure was effected in a week. Another case, one pile of eight years standing was cured in three days.

Faribault, Min., May 19th, 1877.

Hospital Reports.

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

Case of Psoas Abscess following Excision of Testicle.—Under the care of Dr. GEO. E. FENWICK. Reported by Mr. D. F. SMITH.

G. S., æt. 46, blacksmith, was admitted into the Montreal General Hospital on the 13th of March, 1877, with contraction of the left thigh upon the abdomen, to an angle of about 90°, and great pain in the groin on any attempt to extend the limb. He had been in the hospital in the month of August, 1876. with enlargement and suppuration of the left testicle, which was diagnosed as tubercular in origin. The testicle was excised and found to be tubercular. His testicle had become first enlarged about three years ago, and since that time he had suffered more or less from an aching pain in the left lumbar region. At the time when the testicle was excised, the walls of the vas deferens were found to be much thickened and the canal filled with a purulent secretion. The wound healed well, and he was discharged on the 15th October, still complaining at times of pain in the left loin. From a short time after his discharge from the hospital, he began to find some difficulty in extending his leg fully, and the contraction of the thigh upon the abdomen rapidly increased. On his re-admission into hospital the contraction was as stated above. When lying on his back he had to bend his back forward in order to bring the left leg near the bed at all.

There was a fulness in the left iliac region, some tenderness on pressure here, dulness on percussion, and a sense of deep fluctuation immediately above Poupart's ligament. There was no tenderness over the vertebræ, and no suspicion of caries of them Dr. Fenwick explored with a fine exploring trocar and got pus. He then made a cut about two inches long above and parallel to Poupart's ligament, one inch from the anterior superior spine of the ilium, and dissected down carefully till he opened the sac of a large abscess, from which about a pint of healthy-looking pus escaped. For two nights his temperature

was 102°, after which it fell to normal and has remained so since that time. Two weeks after this, finding that the pus did not appear to escape sufficiently, Dr. Fenwick put the patient under chloroform for the purpose of exploring the cavity more carefully, and succeeded in bringing the point of a long probe to the surface just below the twelfth rib, about 2½ inches from the vertebral column, made an opening here and passed a drainage tube. Since then the patient's condition has rapidly improved. On the 12th of May, and now, the drainage tube still remaining in, the discharge is very slight and the patient can walk very well, being able to extend the left leg almost as well as he can the right.

Case of Lithotomy.—By GEO. E. FENWICK, M.D. Reported by Mr. D. F. SMITH.

C. D., æt. 29, wheelwright, was admitted into the Montreal General Hospital on the 28th of March, 1877. Patient had always enjoyed good health until six years ago, when he began to suffer from some renal disorder. In October, 1870, he felt a grinding pain in the left lumbar region, and suddenly on the following night a very severe paroxysm of pain over the kidney and extending down in the direction of the ureter. This attack was attended with nausea and vomiting, and a 'quivering of the muscles,' He had several such attacks during the summer of 1871, and suffered from the grinding pain in his left loin almost constantly. In the autumn of this year he had three very severe attacks of renal colic in one week, and a couple of weeks afterwards passed in micturition two calculi of the size of beans. From this time till December 9th, 1873, he had no recurrence of these attacks. At this time the old attacks returned with occasional severe paroxysms. He suffered so much that he had to keep his bed. At the end of December he had retention of urine for thirty hours when he was relieved by a catheter. On February 15th his bladder was explored with a sound and he was told that he had a stone. He then came in to the Montreal General Hospital, but no stone was detected after careful exam-

ination. In April of this year, 1874, he had some more severe attacks. After these passed off he had ease for some time, but he soon began to suffer from pain in the bladder and a difficulty in micturition, the stream stopping suddenly. These symptoms kept increasing, and he came again to the Montreal General Hospital on the 28th of March, feeling positive that there was a stone in his bladder. At this time his general health was good. He suffered a good deal of pain in the perineum when walking. No tenderness over the bladder, and very little irritability of the bladder. He could retain his water for two hours at a time. There was a good deal of mucus in the urine but no pus. He was examined by Dr. Fenwick who immediately detected the presence of a stone, apparently of moderate size. The examination was attended by a good deal of fever and the passage of blood with his urine for two days afterwards, and some pain in the left lumbar region. After this irritation had subsided attempts were made on three occasions to seize the stone with a lithotrite but unsuccessfully. Although the stone could be constantly felt with the blades of the instrument, it could not be grasped. Each attempt was followed by a rise of temperature to 103° or 104°, for one or two nights, and the passage of large quantities of blood with the urine. Feeling that some condition existed which prevented the seizure of the stone with the lithotrite, Dr. Fenwick decided to perform lithotomy. On the 24th of April he performed the lateral operation, Dr. Ross holding the staff for him. A large, irregularly-shaped calculus, weighing 1¾ ounces was removed. It was soft and phosphatic, and broke to pieces in the attempt to remove it. It appeared to be adherent to the wall of the bladder, and had to be forcibly torn away. On the night following the operation his temperature rose to 105°. pulse 108. Next morning temperature was 101°, pulse was 96. For five days temperature ranged from 100° to 101; on the night of the 5th day it was 103°, after which it fell to the normal and has remained at that ever since. The patient suffered a good deal from pain in his back, particularly on the left side. After the operation he retained his water regularly for four hours at a time. There was a good deal of

blood and mucus in the urine for a few days. The case progressed most favorably, and on the 17th day after the operation the urine ceased entirely to come through the wound, he has passed a few small fragments through the urethra. On May 12th the patient was ordered his clothes, and on the 14th was discharged. The only thing that he now complained of was a feeling of weakness in his back, and after a little fatigue a dull pain in his left loin.

Case of Unilateral Convulsions, Cheyne-Stokes Respiration. Death.—Under the care of Dr. Ross. Reported by Mr. GUERIN.

On the 23rd of April, at 9 a.m., the patient was brought to the hospital by the police. His name was unknown. He had been seized with convulsions in a drinking-place, and had been unconscious ever since, with frequent convulsive attacks. He was a stout, strong-looking man, about 40 years of age. It was found out after his death that he was a carter by occupation, and was much addicted to intemperance.

1, p.m.—Patient still unconscious. Has had seven convulsive attacks since his admission. The convulsion is confined almost entirely to the left side. The right arm and leg, move very slightly.

Pupils of natural size, not dilated. No reflex movements induced by touching cornea, or tickling sole of foot. He has evacuated his bowels and bladder involuntarily. There is no distension of the bladder. His respirations are ten in the minute, and stertorous. Some urine was drawn from the bladder and examined. Found it to be free from albumen and sugar. Specific gravity 1015. Pulse 90. He was ordered morphia gr. $\frac{1}{2}$, hypodermically.

5.30 p.m.—After the morphia the patient had no convulsions till 3 o'clock. Coma still profound. Pupils much contracted. Pulse 136, irregular and intermittent. Pulsation of heart forcible. Second sound scarcely audible. Epigastric pulsation very marked. Face and lips greatly congested. Respirations

16 in the minute, showing a peculiar irregularity in the rhythm, which the house surgeon noticed about 3 o'clock. It resembles that described as Cheyne-Stokes respiration. A distinct cessation of breathing occurs every 1¼ minute, and lasts ten seconds. Then the respirations begin gently and slowly, becoming more laborious and deeper, and gradually growing shallow again till another interruption occurs. The ascending and descending rhythm are distinct, and the period and duration of the interruption are always the same. When the breathing stops, the limbs, particularly the left arm and leg, become rigid and flexed, and again become flaccid when the breathing goes on.

12 p.m.—The patient has had four convulsions since 9 p.m. Pulse 140, irregular in rhythm and volume, not intermittent. Respirations 24 in the minute. The peculiar rhythm noticed above has ceased. Pupils more contracted. The patient has not evacuated his bowels or bladder since morning. Bladder slightly distended.

The patient died at 5 a.m., on the 24th of April. At the autopsy nothing was found to account for the condition that the patient was in before death. The brain, heart and vessels, liver and kidneys appeared to be healthy.

Correspondence.

EDINBURGH, MAY 13th, 1877.

DEAR MR. EDITOR,—As I have hardly been a week in Edinburgh, I have scarcely yet had time to collect any notes worth communicating. However, I will give you a short contribution by way of showing you that I have not forgotten my promise.

I have, of course, been following Lister very closely in his antiseptic work, and must say have been already deeply impressed in favor of his system. He is a wonderful enthusiast, and has the faculty of imparting his enthusiasm to those about him, so that his House Surgeon, dressers, and nurses vie with

each other in carrying out, to the letter, his instructions. They feel besides that any want of attention on their part is liable at any moment to be known by Lister, who himself dresses a certain number of cases indiscriminately each day, partly for the purpose of detecting any inadvertence. I am convinced that it would be worse than useless to attempt to carry out the antiseptic system without the most thorough co-operation of all those having to do with it. Lister, in fact, most emphatically asserts that the cause of the failure of antiseptic surgery in so many hospitals, and in the hands of so many private surgeons, is in main part, the want of attention and indifference of those concerned. All the other surgeons attached to the Infirmary, with the single exception of Mr. Spence, are thorough converts to the antiseptic treatment, and carry it out just as faithfully as does Lister himself. Mr. Spence advocates what he terms "common sense surgery," but it is thought not improbable that even he may, at no distant date, overcome his prejudices. Mr. Lister announced to the class, with uncontrolled pleasure the other day, that the great Langenbeck, whom he considers the Father of German surgery, was now carrying out "the antiseptic treatment" in all his cases.

By-the-way, I understand that the Kings College Hospital authorities are still making overtures to Lister, and the Edinburgh men express a fear that they may yet lose him. He went up to London yesterday to attend a meeting of the Medical Council so that it is within the bounds of possibility that he may be induced to reconsider his adverse decision, made with such emphasis a few weeks ago. Notwithstanding his love for Edinburgh, with its cherished memories of Syme, he feels, I believe, that here his sphere of usefulness is limited, while in London he would have a grand centre for the dissemination of his antiseptic doctrines. He would be much missed here for he is a great favorite both with his brother surgeons and the students of the University; and besides, being a man of means and independent of practice, he can devote a large share of his time to hospital work.

Among the patients in the Infirmary that have interested me

most since my arrival are undoubtedly three cases of *nerve stretching for sciatica*. One of the cases was operated on by Mr. Lister, the others by Dr. Chiene, one of the assistant surgeons, who always takes charge of Lister's wards during the absence of the latter from the city. The patients were all men, aged about thirty, and had suffered from the disease for many months—in fact one of the patients had not been free from sciatica for nearly five years. The ordinary treatment recommended for this disease had in all the cases been faithfully carried out, such as the application of Corrigan's hammer, acupuncture, hypodermic injections, blistering, purging, &c., but in none were these measures of any avail. The symptoms were mainly great pain, feeling of numbness, and loss of power of the limb. In the operation the directions laid down by Nussbaum were carried out, viz., after exposing the nerve immediately below the gluteal fold, powerful traction was made on it first from below, then from above, and lastly at right angles to the body,—with such force in the latter direction as to raise the body of the patient off the table. The relief was instantaneous so that on the day following the operation each man was found perfectly free from pain, and with considerable power in the limb. The recovery in all three cases has been uninterrupted. Of course too short a time has yet elapsed to allow one to judge of the permanent nature of the cure, but to have given relief to pain and to have restored power to a limb for even a few weeks, is certainly a sufficient justification of the operation. The *modus operandi* of nerve-stretching in sciatica is a subject of very great interest, and will no doubt receive the early attention of pathologists.

I have been struck more than once with the amount of original thought that is being developed by the few here who earnestly believe in the antiseptic system. The most unheard of expedients are devised, and the ordinary surgical rules set at defiance when the desire is to treat a case antiseptically. To give you an illustration,—a few days since a lad about twelve years of age presented himself to Dr. Chiene suffering from post pharyngeal abscess the result of disease of the cervical

vertebræ. He at once asked the question, "How can I prevent this pus from becoming putrescent; how can I treat this case antiseptically? It certainly cannot be done by following the ordinary practice of opening the abscess through the mouth with a guarded bistoury. I must get at the pus by some other route. I will endeavour to reach it under the spray, *behind the sterno-mastoid muscle.*" After a careful dissection he did reach it and drew off about eight ounces of pus, and the case has done admirably well ever since.

I am watching a number of very interesting cases, which I may make the subject of another letter before I go down to London next month.

Yours, very truly,

T. G. R.

Reviews and Notices of Books.

Cyclopædia of the Practice of Medicine. Edited by Dr. H. von Ziemssen, Vol. VII.—Diseases of the Chylopoetic System, together with Chapters on Diseases of the Naso-Pharyngeal Cavity and Pharynx, Laryngitis Phlegmonosa, Perichondritis Laryngea, Ulcerations and Tumours and Neurosis of the Larynx. By Prof. H. Wendt, Prof. W. Leube, Dr. O. Leichtenstern, Prof. A. Heller, Prof. H. von Ziemssen and Dr. A. Steffen. Translated by Dr. Macan, Dr. Schauffler, Dr. Ball, Dr. Stimson, J. Solis Cohen, M.D., and A. von Harlinger, M.D., Albert H. Burk, M.D., of New York, editor of American edition. 8 vo. pp. 1046. New York: William Wood & Co., 27 Great Jones street, 1876.

We received quite recently volumes vii. and xii. of this valuable work, although we believe that volume vii. has been before the public for several months. This volume treats of diseases of the chylopoietic viscera, beginning at the upper alimentary passage.

The first article is from the pen of the late Dr. Herman

Wendt, who died in October, 1875, at the early age of thirty-seven years and seven months. From the biographical sketch of his life it would appear that he was an indefatigable worker; indeed, his continuous mental labour brought on an obstinate attack of insomnia, which terminated in cerebral disease, from which he sank. His researches were chiefly in the field of pathological anatomy and histology, and his productions are described as very extraordinary. Many of his researches were on the middle ear, its anatomy both physological and pathological. The article here reproduced is on the diseases of the naso-pharyngeal cavity and their influence on the organs of hearing, of speech, of breathing and of swallowing. The anatomical alterations of the mucous membrane is considered, such as anæmia and hyperæmia, hemorrhage, œdema, parenchymatous swelling and increased and altered secretions. The author then discusses acute and chronic retro-nasal catarrh, the same of the lower pharynx, phlegmon, abscess, croupous and diphtheritic inflammation, tuberculosis of these parts, the condition in syphilis, dry catarrh, morbid growths, neuroses and foreign bodies in the nasal and naso pharyngeal cavities.

The next article is written by Prof. Leube, on diseases of the stomach and intestines. He begins by giving a few preliminary remarks on the position of the stomach, its structure, and then passes on to the physiology of digestion. The author points out the necessity of an acquaintance with the anatomy and physiology of these organs before a thorough conception of their diseases can be obtained. He then passes on to consider acute gastritis, sporadic cholera, gastritis phlegmonosa, diphtheritic gastritis and chronic gastritis. Ulcer of the stomach is the next subject taken up, and then he passes on to other conditions of the stomach, such as tumours, cancer, softening, hemorrhage, neuroses of the stomach, dilatation, contraction, anomalies in shape and position of the stomach and rupture of the organ. The remaining portion of this paper is devoted to affections of the intestines other than the stomach, and the diseases are taken up in the same order.

Leichtenstern is the writer of the next article, which is de-

voted to constrictions, occlusions and displacements of the intestines. There is a very full account, well illustrated with wood engravings of various forms of knotting, twisting and strangulation of the intestines. Referring to treatment, the author shows the advantages of operative interference in suitable cases, puncturing the intestines when much distended with gas, using for that purpose a fine exploring trocar well disinfected, and he holds that this can be done "quite without danger." The relief given to the patient is immense and sometimes permanent. Puncture of the intestines and evacuation of the flatus not only relieves the distressing distension and oppression of the respiratory organs and heart, but occasionally the very condition of obstruction is maintained by the pressure of gas from above on a twisted intestine. "Consequently the direct result of puncture in such cases might possibly be to overcome the strangulation."

The operation of laparotomy is discussed and certainly the statistical account is far from reassuring. The danger and risks of the operation are fairly laid before the reader and fully discussed. So also is colotomy both Littre's and Amussat's operation.

The next paper by Heller is on intestinal parisites. These he divides into four groups; I. infusoria, II. tape worms, of which he describes no less than nine varieties, III. leech tribe, and IV. round worms, of which seven distinct varieties are given. This paper is amply illustrated, and is a most valuable contribution to the subject of intestinal parasites.

Von Ziemssen writes the next paper on laryngitis phlegmonosa, perichondritis laryngea, ulcerations and tumours and neuroses of the larynx. The author adopts the designation of laryngitis phlegmonosa after Bouillaud for that form which runs its course in the submucous connective tissue, without however being confined thereto. He then discusses perichondric inflammation and its results. He then passes on to ulceration and tumours of the larynx, describing some special forms of disease such as lupus, lepra or elephantiasis græcorum, glanders, and syphilitic disease of the larynx. These are all destructive

ulcerative affections. And subsequently he passes on to neoplasms within the larynx, connective tissue growths such as papillomata, fibromata, mucous polypi, cysts and lipomata. Malignant disease of the larynx is then touched upon and he mentions the various methods adopted by the surgeon for the removal of these growths, mentioning also the cases in which extirpation of the larynx has been practised. The author is of opinion that this operation has a future before it, as without doubt it is justifiable under circumstances in which the patient is doomed to death, and he adheres to the opinion that the operation should be conducted at the earliest possible stage, "as soon as the diagnosis is fully established, because thereby the prospect of avoiding relapses will of course be improved." This article closes with an account of the neuroses of the larynx. This part of the paper is fully illustrated by many excellent and clear engravings on wood. Some of these are from Braune's Atlas of Topographical Anatomy. The last article in this volume is by Dr. Steffen on spasm of the glottis. We observe that this volume is printed on lighter paper than those that have already appeared, and consequently contains a larger amount of reading matter in a volume of the same size as the others. The type is all that can be desired, and the execution of the work both in a literary sense and as a work of art is in no way inferior to any of the series. As the work advances to completion its indispensable qualities as a book of reference become more and more apparent. We advise all who have not already availed themselves of the opportunity offered by the publishers to possess a cyclopedia so essential to the real student of the science of medicine, to do so without further delay.

Therapeutic use of Faradaic and Galvanic Currents in the Electro-Thermal Bath, with history of cases. By JUSTIN HAYES, M.D. 8vo. pp. 112. Chicago: Jansen, McClurg & Co., 1877.

"During my investigation of its use, *I am confident that, as an auxiliary to the treatment of the diseases of women it is a boon of greater value to her than has been discovered during*

the last fifty years." Such is the language of the author in his preface, with reference to the use of the electro-thermal bath.

From the list of diseases treated successfully by this method we concluded that all that is claimed for it in the treatment of diseases of woman must apply to the treatment of all other diseases. The following is a list of cases which he gives:

General debility, intra-mural fibrous tumour, subperitoneal fibroid tumour of the uterus, abdominal tumour with symptoms of cerebral apoplexy, epithelioma of the cervix uteri, glaucoma and premonitory symptoms of *apoplexy cerebri*, weak eyes, strabismus, anteversion with ulceration of os uteri, spinal weakness, obstructive dysmenorrhœa, progressive locomotor ataxia, acute rheumatism, sciatica, articular rheumatism, gout, areolar hyperplasia of the uterus, multilocular sero-cystic ovarian tumour, over-wrought brain, sterility.

On the use of the method which the author calls the "vitalized treatment," the following is an example of it:

"His feet were placed in a footbath at 98° Fahr. and gradually raised to 100°, (not his feet), with the negative electrode in the water, the positive electrode in a soft sponge and placed by the operator over the region of the liver, with an intensity current appreciable to the patient—from here it was passed over the right pectoralis major muscle, across the chest to the left pectoralis major muscle, down the side over the spleen to the left iliac fossa, across the lower part of the abdomen to the right iliac fossa, up the ascending colon and over the transverse, finishing the circuit over the small intestines. This was repeated twice, then the sponge was grasped in the left hand of the operator, the right hand carried slowly over the chest and abdomen, following the same course as the sponge for four or five times. Then the sponge with the positive electrode was placed on the nape of the neck, one side of the spine, and was carried down the whole length of the spine, alternating twice from side to side. This was followed by using the hand for an electrode, as in treating the chest and abdomen, carrying the hand over the spine, as well as at each side. The treatment was concluded by the patient holding the sponge with the positive

electrode for three minutes—time of treatment being twelve minutes."

Now, we would dispense with the classically derived word 'vitalized' in characterizing this treatment, and call the treatment *lively*. As an illustration of the style of composition of which Dr. Hayes is capable we quote the following euphemistic description of the fall of a medical man into an indecent style of practice: "The doctor, after receiving his M.D. in our noble profession, like the animal whose pedigree ends in its race, applied his heels to those who gave him the honourable degree, and diving down into the cess-pool of vice and indiscriminate licentiousness, 'brought up drowned honor by the lock,' wrote a book to make licentiousness more licentious, and deal death to generative molecular life—by which means he had sold his character to gain notoriety and filthy lucre."

There is an absence of scientific tone, and a carelessness in the use of medical terms in this book which, we think, will not recommend it as an introduction to the profession of a new method of treatment.

The Microscopist, a Manual of Microscopy and Compendium of the Microscopic Sciences. Third edition, re-written and enlarged. By J. H. WYTHE, A.M., M.D., Professor of Microscopy and Biology in the Medical College of the Pacific, San Francisco. 205 illustrations, pp. 260: Philadelphia, Lindsay & Blakiston, 1877.

The first edition of this work was well known to us ten years ago, when beginning our microscopical studies; and as the author states in the preface, "the progress of microscopic science may be well illustrated by a comparison between the present and former editions." The comparison reflects credit upon both author and publisher, and shows us with what rapid strides the investigation of the minute structure of animals and plants has advanced in the last decade.

The work professes to be a compendium of the microscopic sciences, micro-mineralogy, micro-chemistry, biology, histology,

and pathological histology; and, considering that these extensive subjects, to each of which a separate treatise might well be devoted, are treated of in 260 pages, we do not expect any great minuteness in detail.

The first three chapters of the work deal with the microscope as an instrument, its history, construction, and the various mechanical accessories in use with it. No preference is expressed for any special form of microscope, nor do we find any precautions suggested in the choice of an instrument. A more extended reference to the student's microscopes of Hartnack, Swift, and others, which combine in a marked degree excellence and cheapness, would have been well; considering how generally they are in use, even on this side the Atlantic. The sections on the microscope in geology, and mineralogy and in chemistry are well prepared, and contain much information of value to the general student. Chapter ix gives a very good *resumé* of the structure and functions of cells; from the phraseology employed we perceive that the author is a follower of Dr. Beale.

Vegetable histology is dealt with in 30 pages, which, while they contain much that is useful, ought to have furnished much more. Thus, only three-fourths of a page is devoted to the general structure and life history of the diatomaceæ, and ten pages to a classification of them which can be of no special service to the ordinary student.

The wide field of invertebrate zoology is treated in the same superficial manner, and valuable space occupied with classification, out of place in a manual of microscopy.

The final chapters (xii and xiii) on animal histology, and the microscope in practical medicine, may be regarded as a strong extract obtained after boiling down the modern works on the subject, and as such would be of use to the medical student.

Twenty-seven tinted plates, the execution of which is good, embellish the work. It is stated in the preface that "*many* of the figures illustrating the lower forms of life, and normal and pathological histology have been drawn from the works of Carpenter, and others." It would have been more correct to say *almost all*, for we have looked in vain for original figures in

these sections. The habit of copying wholesale the illustrations of others is one we strongly deprecate, and all the more when they are not acknowledged. If an illustration is worth having it is worth acknowledging, if for nothing else, as an act of courtesy to the author.

To the numerous *dilettante* microscopists this work will be of real service; to real workers its superficiality in many important matters diminishes greatly its value.

Extracts from British and Foreign Journals.

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

An Emetic for Croup.—It may be well therefore to consider in detail the properties which such an emetic should possess—properties almost a matter of inference, the indications for use being known. First of all it should be one upon which we can rely; it must always act and not fail. Secondly, it should, if obtainable, be of such character that if a greater or overdose be given no harm would result. This has always been a great point in favor of ipecacuanha, over dosage with which when given as an emetic is unimportant; and a serious objection to the use of antimony, which cannot be so administered with impunity. Beck narrates a case in which "The 1-30 of a grain given to a child a year old labouring under croup, induced such severe and protracted vomiting, together with general prostration, as to require stimulants to save life." Thirdly, its systematic effects should not be too prolonged and depressing. From the general feebleness of their organization, children cannot sustain the effects of those emetics which profoundly depress the system. "On this account antimonial emetics are frequently hazardous to young children." Fourthly, it should act promptly. The element of time in these cases is all important, and such emetics as act speedily, the effects otherwise being alike,

are greatly to be preferred. Fifthly, it should be one that can be given with as little trouble and as little repugnance on the part of the patient as possible. All crying and struggling or resistance not only entails delay, but aggravates the condition of the little one by the general excitation consequent therefrom, as also by the local strain upon the parts. Such an emetic we have in the Hydrag. Sulphas Flava, a remedy long known, but much less used by the profession than its merits warrant. Baker says, "My reasons for preferring this to all other emetics in croup are the following: It acts much more promptly and efficiently than ipecacuanha or alum; it is tasteless, and much more easily administered than either; it does not exhaust and depress the vital power like antimony. It depletes the mucous membrane by an abundant secretion of mucus, which is thrown up; it removes from the larynx, by the forced expiration which it causes, any albuminous or fibrinous exudation, which may be there in a diffluent state, and which by remaining may become subsequently pseudo-membrane; it acts as a powerful revulsive, and thus diminishes the capillary circulation in the trachea and the larynx." These results he considers that the active emesis from the Turpeth mineral (Hydrag, Sulphas Flava) accomplishes much more speedily and effectually than any other agent. Its properties are here clearly and concisely set forth, and a long and successful, and in every way satisfactory experience with it, causes me to endorse it as the emetic *par excellence* for croup. The average dose for children of from one to three years of age is three grains. For infants of much less than one year it is two grains, although even to them three grains can also be given without hesitation. For children over three years of age four to five grains. If not acting in fifteen minutes, is to be repeated. Although, as with all remedies, the adjustment of dose to age should herewith be likewise observed, still the extreme care that ought not never be wanting in the use of tartar emetic is not equally demanded in the employment of the Hyd. Sulphas Flava.

As previously noted, a variety of opinions exist in reference

to the frequency with which emetics should be administered during the course of the disease, or in other words, to the advisability of their repetition. Some instruct that they should be given over and over again during the disease, evidently placing their greatest reliance upon such remedy. Others say that, emesis having been once produced, their use should then be discontinued. I think neither are right. To keep a patient constantly under the influence of an emetic would beget a depression and exhaustion in no way agreeing with the general indications, viz., a sufficient but not sthenic support of the system. To be satisfied with a single primary emisis would be to forego the invaluable effects which by the operation of emetics we are enabled to obtain. *Medio tutissimus ibis* is here to be born in mind, and an occasional emetic of the Hyd. Sulphus, Flava (say once in six or eight hours, but dependent upon the case and the grade of its symptoms) will give us the benefit arising from its mechanical action in clearing out the air passage from the abnormal secretion or exudation that has taken place, and at the sametime re-impress upon the system the beneficial effects known as systemic.—*The Practitioner.*

Massage, and its value.—Massage and its value to the physician—By a jump or misstep a man suddenly experiences a violent pain in one or both ankles; he limps home with difficulty. Arrived there he finds around one or both malleoli marked swelling and pain; it is no longer possible for him to walk. Here then, we have to deal with a superficial capsule or ligament rupture with moderate effusion of blood. If one is called at this time, before the effusion of blood has added to it serous effusion, the prognosis is extremely favorable.

After oiling the limb, attempt by stroking with both hands in a centripetal direction to empty the superficial veins and lymphatics so as to make more space in them for carrying off the effusion below. Then with gentle rubbing continue to approach the injured parts. These at first are somewhat pain-

ful, but stronger pressure can gradually be made upon them. Circular rubbing should then be added, while simultaneously with the other hand the vessels above should be emptied. When the centripetal and circular rubbing have been continued for about a quarter of an hour passive motion is then added, and finally the patient is told to move the foot. The sufferer is usually astonished to find how little pain is left, and how well he can move the joint; he thinks he can at once go about upon it again. It is well now to apply a bandage, and change it every four or five hours. I do not permit such of my patients as can to walk upon the injured limb, as most of the operators with massage do, for I believe that in severe cases it is expecting too much of torn ligaments infiltrated with blood. In two cases which I treated, one kept the horizontal position to begin with, and recovered speedily and favorably: the other, contrary to my wishes, walked about after the first manipulation, in consequence of which a considerable effusion into the joint followed. In the latter case there was probably a partial or entire rupture of a small capsular artery. When possible, the massage should be applied twice daily, as by so doing a more speedy cure will be obtained. A few days generally suffice in light sprains to restore the joint to its normal condition.—*Boston Medical and Surgical Journal.*

Amenorrhœa.—Application of Electrical Current; Recovery.—Hattie W., aged eighteen; single; occupation, tailoress. The catemenia, which first appeared at fifteen, were always somewhat irregular, the periods varying from four to six weeks. The general condition had always been excellent, and the patient presented the appearance of robust health. She was sent to the hospital by O. G. Cilley, M. D., who had treated her for effects caused by the ingestion of about two drachms of oil of cedar, administered by herself. As she had already undergone sufficiently active treatment, merely general treatment was adopted, and in two or three days she

recovered perfectly. As a reason for taking the drug, she stated that the catamenia had not appeared for sixteen months, and she hoped by this means to cause their return. Five days after admittance a gentle secondary current was applied to the fundus uteri in the following way: one of the terminal wires from a small battery was bound firmly to a uterine sound, and the sound passed into the uterus to the fundus. The other pole of the battery was then applied to the abdomen, just above the pubes. A mild current was then passed for a few minutes, the sound being moved freely about the fundus. On the following day the catamenia appeared, and continued for four days.

CASE II. *Amenorrhœa: Electrical current; Recovery.*—Annie D., aged twenty-two; single; domestic; general appearance that of perfect health. Catamenia appeared at eighteen, and were regular until three months ago, when, from exposure to wet and cold during menstruation, they ceased, and did not again appear. On vaginal examination the uterus was found to be perfectly normal in size and position, with cervix congested, and dark purplish-red in color. The vaginal walls were also congested. The hot vaginal douche was used twice daily, and the fluid extract of gossypium, one drachm three times a day. As the desired effect was not produced, the electric current was applied fourteen days after entrance. Catamenia appeared two days after the use of the battery, and continued five days.

The above cases are interesting on account of the patients presenting the appearance of robust health, and from the fact of the affection in both cases having resisted the action of various remedies prescribed before their entrance. By the hospital records we find cases similar to the above discharged not relieved or only partially so after long courses of tonics. It would seem also that if possible the current should be applied directly to the fundus uteri, as good results are gained in this way in cases which were not affected by a current passing from the pubes to the sacrum. Various authorities, as Althaus,

Beard and Rockwell, Thomas, Golding Bird, and others, recommend the electrical current in cases of this nature; and certainly in otherwise healthy patients, where the disorder is not caused by structural disease or mechanical displacement, it seems capable of giving the best results.—*Boston Medical and Surgical Journal.*

Incipient Phthisis.—The attack began in this case, that of a sailor, twenty-four years of age, with a slight, dry, hacking cough, some two years and a half ago. Six months after that date, when at work on shore, he had a severe hemorrhage and lost a pint of blood. The hemorrhage was followed by fever and an increase of the cough, which however soon subsided, and he returned to his work. Six months later he had another hemorrhage larger than the first. Again the same improvement occurred, to be again followed, after another six months, by a third hemorrhage. One month ago he had a fourth hemorrhage, and later still he has had two or three slighter ones. *Throughout these two years and a half the mucous secretion has been scanty and the cough dry.* There has been but little loss of flesh. Epistaxis has occurred several times. The patient exhibits no cardiac, or gastric symptoms. The pulse is 96 and the temperature normal, with the daily fluctuation of half a degree. There is thick, tenacious mucus on the posterior wall of the pharynx, the mucous membrane is congested and the tonsils enlarged. Physical examination shows a symmetrical, non-phthisical chest, with good expansion, though there is a little less motion at the left apex than at the right. There is no contraction and no increased vocal fremitus. Percussion is healthy on both sides, with the exception of a very slight elevation of pitch and a little less volume at the left apex. Auscultation shows a slightly weaker expiratory murmur, with prolongation of expiration at the left apex. There is evidently a disposition to hemorrhage from the mucous surface. It is impossible that such large hemorrhages as he has had should have come from the fauces or larynx. They may

however, have come from the bronchial mucous membrane, and have been due to acute congestion of the left apex.

The diagnosis must be considered finally, not only as regards the preexistence of local lesions, but also as regards vital tendencies and the significance of such lesions. In this aspect we may conclude that our patient has a very slight degree of condensation of a portion of the left apex, due to repeated congestions, and some degree of subacute inflammatory action, but without true tubercular formation as yet. It is in just such cases as this that exact diagnosis is of vital importance although it is attended with difficulties that are absent when the disease has advanced to the later and less curable stages.

There is no doubt that even large hemorrhages may occur from the mucous membrane of the bronchial tubes, without pre-existence of any disease of the lung tissue. In some cases, too, it appears that the occurrence of such a hemorrhage seems to excite an irritative process in the lungs, which in subjects who are predisposed to phthisis, may result in chronic destructive lung disease. In such instances, of course, the initial symptom would be the hemorrhage taking place, perhaps accidentally, in the midst of ordinary health. That there is needed a constitutional or local predisposition to disease, in addition to the hemorrhage, may be learned from the numerous cases where even large and repeated hemorrhages occur without the supervention of phthisis. Thus I believe that the importance of hemorrhage as a cause of phthisis is much exaggerated by a certain class of pathologists. On the other hand, with the existence of even a very small amount of lung disease, hemorrhages are very apt to occur, probably as the result of severe congestion. Thus, in the present case, it is for us to consider whether there has been a small amount of subacute local disease all along, and that the hemorrhages have occurred from temporary broncho-pulmonary hemorrhages, or whether the hemorrhage was its first phenomenon, and the local disease was induced by it, and has been increased by each subsequent hemorrhage. In view of the history of dry cough, preceding the first hemorrhage for six months, and of the rapid return to the previous

condition which followed each hemorrhage, I am inclined to take the former view. In like manner, cough deserves careful study, as an early symptom of phthisis, although, owing to the frequency with which chronic cough is due to fancied laryngeal or bronchial irritation, much care is needed to determine its true significance. The cough in incipient phthisis is usually short, hacking and painful, and is at first dry, and continues thus without expectoration, for a variable time, weeks or even months. Expectoration, when it begins, is apt to be at first of glairy mucus, later of whitish and thicker mucus, and then of whitish, yellow, muco-purulent matter. True, solid, purulent sputa rather belong to a later stage. These symptoms we have thus alluded to, and even the detection of physical signs of slight localized change at one apex, can only have their true value given them, when viewed in connection with the general constitutional symptoms. In the present case, both the local and general symptoms are exceedingly slight.

The local signs are usually found at the upper part of one lung. They depend on the development of little centres of disease—tubercles, a peculiar type of lymphoid tissue—growing from either the connective tissue elements or the alveolar epithelium of the minute bronchioles. Each tubercle cuts off partially the supply of air from a colony of air vesicles, and thus impairs expansion. On auscultation this same cutting off of air makes the inspiration feeble. The inspiration may be not only weak, but also jerky. The air has the same difficulty in getting out, so expiration is more prolonged. Percussion ought to show less resonance over the affected spot, but this frequently amounts only to a slight elevation of pitch and loss of volume, which, when at the left apex, as in this case, are with difficulty appreciated, on account of the slight natural difference between the right and left apex.

Among general constitutional symptoms which afford means of diagnosis may be mentioned loss of flesh, debility, increase in rapidity of pulse, and elevation of temperature. Marked general emaciation always means that something serious is the matter. It may be the result of impaired digestion, but if the

patient eats heartily and still loses flesh, there is something vitally wrong going on. If flesh keeps up, even when other decided symptoms show themselves, there is more reason to hope that the local lesion may not be of truly tubercular nature. Loss of muscular strength, unless it be very marked, is not so important as a symptom, as loss of weight, for muscular weakness may come on from temporary causes. Getting out of breath easily may be merely a symptom of debility, or a symptom of organic lung trouble. Rapidity of pulse is exceedingly valuable as a rational sign. The normal pulse is 72, but it may vary from 54 to 86 with perfect health. Persistent and sustained increase in pulse rate, however, without cardiac disease, is apt to indicate serious constitutional irritation due to some local lesion. Elevation of temperature always means increased tissue change. It may, in the earliest stage, not be greater than half a degree. There is no more important symptom than this last, and it usually sets in long before the physical signs become evident. Temperature differs much in different people with the same amount of lung disease. We must, therefore, always take into consideration the individual idiosyncrasies of the case under treatment, before reaching a final conclusion.

The treatment of such cases as the one now under consideration, where there is slight impairment of one apex, and an accompanying liability to chronic, but not tubercular, phthisis, may be entered into, and carried on, with great hopes of permanent cure. Among the most important hygienic measures, are good food, healthful out door exercise, which will expand fully the chest, and an equable climate, such as may be found in the south of California, New Mexico, or the southern and Western slopes of Colorado. Sea voyages, such as a cruise to some tropical ocean, and not sailing about in some inclement climate, as many consider the term to mean, are often most plainly beneficial. If these ways of regaining lost health be out of the question, and the patient be compelled to stay at home, inhalation of compressed air may be tried with success; counter-irritation may be applied over the seat of disease, and cod liver oil, the syrup of

the iodide of iron, arsenic, and the hypophosphites of lime, soda and iron administered internally.—*Medical and Surgical Reporter.*

Fractures of the Lower Extremities.—To recapitulate.—You must have the whitest, finest, cleanest cotton batting, the smoothest and freshest plaster-of-Paris, and a lot of roller bandages made of the cheapest and flimsiest cotton cloth, such as is used for lining comforts or covering cheese. After getting the cloth have it well washed and dried. Tear it then into strips of two and a half or three inches in width and into two different lengths. One should be nine or twelve yards long. The remainder should be but three yards long. Lay these latter on a kitchen-table or board, and have the dry plaster well rubbed into the cloth. Roll them now as evenly as you can. Have an ordinary wash-basin, one-third full of water a little warm. Put into this two heaping tablespoonsful of powdered alum. Have the whites of half a dozen fresh eggs beaten into a froth. Open out the batting carefully, that it may be in a sheet rather than a roll. Envelope the broken limb in this. Be particular that the bony prominences are well covered. Secure the cotton with your long roller, into which, you will remark, that you have rubbed no plaster. Put your plaster rollers into the basin of water. Squeeze and press them with your hand, that they may be well wetted. Apply these to the limb one after another, until you think you have made the dressing sufficiently firm. I think you will find three layers usually sufficient. You may apply the fourth immediately over the seat of the fracture. As you proceed you may put the rollers on longitudinally instead of circularly. You observe we make "no reverse" turns of the bandage. They are unnecessary; indeed they give the dressing a clumsier appearance than it otherwise would have, and are in that at least objectionable. As you apply each layer of bandage smooth it nicely with your hand. It will add to the firmness of the dresssing and make it dry more quickly. Having put on as many rollers as you care

to, and smoothed them well, wait a few moments for the plaster to dry. The alum you have added to the water will greatly facilitate this. When comparatively dry apply the whites of the eggs over the plaster. Now apply a roller without plaster over this; or if you prefer cut the roller into strips, and lay them along the length of the limb. The purpose of the egg is to prevent the plaster from chipping. The purpose of the additional roller is to assist in this, and to give to the dressing a finish which it does not otherwise have. Besides this the whites of the eggs will be a great convenience to you in enabling you to cleanse your hands of the plaster. They are better than any soap or any amount of water. Indeed they are the only substance I know of which, if you work much in plaster, will prevent your hands from chapping and becoming harsh and rough.—Dr. YANDELL.—*Louisville Medical News.*

Gastrotomy.—Dr. Lannelongue read the notes of a case of gastrotomy before the Academy of Medicine. The following is a résumé of the paper. A man 59 years of age, without hereditary antecedents, and up to this time in the enjoyment of good health, was seized suddenly with pain in deglutition, which progressively increased, till on his entrance into the hospital, six months after the beginning of the affection a few spoonsful of milk could scarcely be swallowed. A very resistant and absolutely inseparable obstacle was made out about the middle of the thoracic portion of the œsophagus. The emaciation was extreme, but there was no cachectic taint; all the other organs were healthy. There only remained, as a last resort, to prevent the patient dying of inanition, the operation of gastrotomy. It was performed with all the precautions recommended by Professor Verneuil, in his interesting communication to the Academy of Medicine, on the 31st of October, 1876.

The operation was followed by neither pains nor inflammatory accidents. The feeding was done regularly through the fistula, which, however, allowed a considerable quantity of liquids to escape, when some thoracic accidents supervened which carried off the patient on the 26th day after the operation.

At the autopsy, it was found that the primary lesion of the œsophagus (epithelioma), had determined a bronchial perforation, from which had resulted the asphyxial phenomena which had led to death. But the stomach was firmly adherent to the abdominal wall. The gastric fistula was well formed. The success of the operation was complete. M. Lannelongue concluded this interesting communication by the following reflections:

(1). Gastrotomy is a rational operation founded on the history of gastric wounds and fistulas made experimentally in animals or produced accidentally in man.

(2). It is indicated at all times that aphagia renders death imminent by inanition.

(3). The operative details should conform exactly to the rules indicated by Prof. Verneuil. One of the principal points of which consists in only opening the stomach after having firmly fixed it to the abdominal wall by the minute application of numerous points of suture, in order to avoid all immediate or consecutive escape of fluid, into the peritoneal cavity.

Some modifications of detail might be added as follows:

(4). In the incision of the integuments not to pass downwards beyond the inferior border of the left eighth costal cartilage, in order to arrive more directly on the anterior wall of the stomach, which is always shrunken and drawn up, against the diaphragm, in consequence of a long abstinence, in cases in which gastrotomy is called for.

(5). To open the anterior wall in the neighborhood of the short curvature, in order that the liquids secreted or injected, finding in a dependent part a sufficient space in which to accumulate, may not escape by the opening.

(6). Not to apply to the edges of the gastric aperture, either hemostatic forceps, or threads to pin the sound left in the opening. Such measures expose to tearing and to mortification, whence results an ulterior enlargement of the fistula which facilitates the escape of liquids. — *Gazette Hebdomadaire*, 13th April, 1877.

Two Cases of Menstruation during Infancy.—The first occurred at the age of three years, in a child born of healthy parents.

At the age of two years and seven months menstruation first made its appearance and recurred every three or four weeks, lasting three or four days each time. The infant appeared in all other respects to be in the enjoyment of perfect health, and is now three years and six months old, well developed with well formed breasts, and a slight development of hair on the pubes. Its mental development about equal to that of ordinary children of a similar age

Menstruation præcox is of rare occurrence if we may be allowed to judge from the literature of the subject. It would also appear to happen more frequently between the ages of one and seven years than during the few years immediately preceding puberty. No satisfactory explanation of the phenomenon has as yet been given, and there are many inaccuracies in the statement which have been made from time to time concerning it. The second case reported by Bouchut occurred in the fourth child born of healthy parents. The family consisted of six children, all of whom were unusually strong and well developed from the very day of birth.

Menstruation first appeared at the age of two months, and has continued regularly ever since every four weeks, lasting two to four days each time. When it is about to come the child experiences some discomfort, and the strongly developed breasts undergo considerable enlargement; she presents the appearanee in miniature, of a woman of perfect sexual development, is of unusually grave deportment, and in playing with other children usually takes a motherly part. Bouchut calls attention to the rarity of these cases, and is of the opinion that ovulation does not take place; he thinks with G. William, that the menstruation is due to simple uterine congestion.

O. Wachs notices a case of premature menstruation in a child of three years of age.

Bouchut on "Puberté precoce et Menstruation régulière" in an infant aged 22 months. Quoted in the *Centralblat f. Med-Wissenschaften*, No. 10. March 10th, 1877.

How to prevent Hæmorrhage.—(How to prevent hæmorrhage after the removal of Esmarch's Bandage. Dr. RIEDINGER.—*Deutsche Zeitschrift fur Chirurgie*, XXVI., 5 and 6.

The greatest disadvantage attached to the use of Esmarch's bandage, is the profuse hæmorrhage following the removal of the elastic band. The hæmorrhage in profuseness depends upon the force of constriction, and the length of time which it is allowed to remain. The amount of blood lost in many cases is often more than that following digital compression.

Esmarch himself admits that there is considerable capillary hæmorrhage after the removal of his bandage, but thinks that it is easily stopped and of no long duration.

The author mentions the names of many eminent surgeons, who have seen the most profuse hæmorrhage after severe operations, particularly after amputations: the blood pouring out of the wounded surfaces as if from a sponge.

Various surgeons of England, France and Germany are mentioned, all of whom have had unpleasant experiences with this secondary hæmorrhage.

The author believes that hæmorrhage is caused through paralysis of the vaso-motor nerves; further, that through the constriction, the blood being forced entirely from the part operated, upon no coagulation of the blood takes place.

Various means have been tried to check this hæmorrhage, but they have, as a rule, not been very successful, *e. g.*, cold applications, ice, ice-water; but the hæmorrhage persists in spite of these applications often fifteen minutes, and sometimes one-half to one hour.

Esmarch recommends the ligation of every blood vessel, veins as well as arteries.

P. Bruns has ligated as many as thirty-six vessels, and still had hæmorrhage. Bardeleben has ligated all arteries mentioned in anatomy, and those vessels presenting themselves to the eye, arteries and veins, and still had considerable hæmorrhage.

The author has performed experiments on animals to see whether the sensibility of the nerves was entirely overcome by

the constriction of bandage. The reaction upon applying electricity was quite apparent, and from this he was led to apply electricity to the nerves which supply the vessels of the part operated on; his results were quite satisfactory, so much so that he recommends the application of electricity before the removal of the bandage. He uses the induced current. The poles to terminate in sponges; one pole to be placed on the wounded part the other electrode to be passed over the nerve or nerves which distribute branches in the bandaged part, he has succeeded in reducing the hæmorrhage to a great extent.—*Chicago Med. Journal.*

Extirpation of Bronchocele. — Bruberger records a case of total enucleation of a hyperplastic thyroid gland, weighing 375 grms. (11.7 oz.) in a man 18 years of age. The enlarged organ had compressed the trachea on both sides, causing intense dyspnœa. The operation was rendered difficult inasmuch as the patient had to sit up and could only take chloroform at intervals. The hæmorrhage was slight, and under antiseptic treatment the large wound was in a few days healed, a small fistulous opening only remaining, and the patient got up on the 6th day.

Statistics are given of all cases hitherto published, from which we learn that of 82, in which the whole tumour was removed—but probably not the whole thyroid; 28 died; of 17 cases in which the total extirpation was certain, 2 died; 25 partial excisions, 5 died. The entire mortality amounts to 27 per cent. and it appears that the removal of the entire thyroid, if more difficult was not more dangerous than partial excision. The latter operation should always be undertaken when only a single lobe of the gland is affected. The etiology of the partial degenerations of this gland is still unknown. In unsuccessful cases the fatal result is due to excessive loss of blood during the operation, or to subsequent inflammation and suppuration. The use of antiseptic treatment is beneficial.

Symptoms of pressure on neighboring organs form the chief indication for operation, and even the large size, broad base,

and deep position about the jugulars of the tumour, advanced by Lücke as contra-indications, are not so in in reality, for the impending suffocation will itself necessitate an operation, not without danger.—*Deutsche Militärarztt. Zeitcher.*—Quoted in *Clbt. f. d. Med. Wissen*, No. 2, 1877.

Jaborandi in Bright's Disease.—BRUEN. (*Philadelphia Medical Times*, April, 1877).—Jaborandi as a remedy in Brights' disease, has found great favor with Dr. B., who reports seven cases successfully treated with the drug. He found prompt relief following the administration of an infusion of ℥ii to ℥ii of water, the entire quantity given in one or two hours. About one hour after taking the tea, patient is usnally bathed in perspiration, dyspnœa if any present caused by fluid in the pleural cavity, is relieved, and the general condition of patient much improved. So thoroughly convinced is the author of the value of this remedy in dropsies, that he urges the profession to make use of it in private practice.—(W. F. L.)—*Chicago Medical Journal.*

Pulsatilla.—(WENZEL. — *Louisville Medical News*, March, 1877.)—There are two preparations of this drug, the German tincture, and the American Fluid extract. The tincture is chiefly used, and in ten-drop doses three times daily for several days, will produce the same results as small doses of hasheesh. In increased doses it causes frequent micturition and hœmaturia. Forty-drop doses of the tincture will cause violent headache, nervous excitement and bloody stools. Severe headaches that have resisted all other remedies, will, the author says, receive benefit by from three to ten drop doses of the tincture three times daily for one or two weeks. He believes it acts directly on the nerve centres, and principally on the cerebrum. Great care shonld be exercised in administering pulsatilla, because of its poisonous qualities. Dr. W. claims that wherever a nerve-sedative is required, no remedy is equal to it.—W. F. L.) *Chicago Medical News.*

CANADA

Medical and Surgical Journal.

MONTREAL, JUNE, 1877.

REGISTRATION OF FOREIGN AND COLONIAL DEGREES.

The general Medical Council of Education and Registration of Great Britain opened its annual session in London on the 10th May, ult. The inaugural address was delivered by Dr. Acland, F.R.S., the President of the Council, and amongst other topics of interest he touched upon the relations of the Board of trade to Canadian surgeons serving on ships sailing to and from Canadian Ports. Indeed it would appear that the subject of the recognition of Colonial degrees has occupied the attention of the Council at successive meetings of that body ever since the year 1861, and the secretaries of state in successive governments have pressed upon the Council the necessity of dispensing with, or greatly relaxing its regulations in reference to persons holding Colonial diplomas or degrees. And it was added that this condition appeared to be a *sine qua non* to the consent of the Government to the introduction of any bill of amendment to the Medical Act. This statement by the President of the Council is very satisfactory, and we trust that the matter will be arranged on an equitable basis.

The condition of Colonial institutions appears to be indifferently understood. It does seem an anomaly that institutions working under Royal charter should be denied privileges of such vital importance to them as the recognition of their degrees. Their graduates hitherto have been simply ignored, or rather outlawed so far as the mother country is concerned. Surely there is no fear on the part of the Colleges and Universities of

Great Britain, that their effulgence would in any way be dimmed by the bright scintillation of a Colonial school. Therefore, we say why not register Colonial degrees? Let the graduates appear as hailing from such or such a colonial university or college. If the Colonies were manufacturing doctors by the cord then, indeed, might the medical defence association take alarm and fear that their very existence was threatened. It has just occurred to us that this method of enumerating quantity may not be understood by our English friends, and we would in explanation remark, that in this wooden country of ours we purchase wood by measurement, and what constitutes a cord of wood with us is a pile 8 feet long by 4 feet high of the full length of the stick as it is cut from the tree.—But, to be serious, as this is a matter which is somewhat above levity.—There are in Canada but two institutions whose qualifications entitle a man to practice his profession legally in this country, and as the yearly number of men licensed by each board is on an average about 40, it cannot, therefore, be said that Canada is flooding the country with indifferently qualified men.

In Ontario the College of Physicians and Surgeons of that Province is exclusively an examining body. They admit no man's degree or qualification before he has satisfied the board by actual examination that he is qualified to enter the profession. Of course a regular curriculum is demanded, and also evidence of having passed an examination on preliminary education before entering on his medical studies. These alone form the qualifications which entitle the candidate to examination, and after having passed that examination he is entitled to register all the degrees or diplomas of which he may be possessed. In Ontario they possess a single door of entrance to the profession through which all must enter; all qualifications are regarded as mere evidence that the candidate has in a *bona-fide* manner passed through a regular course of study, but the fact of his being a graduate of Toronto or McGill, or Laval or any other university or college does not exempt him from examination touching his professional knowledge.

Dr. Acland in his address states: "I am informed that

English practitioners are re-examined in Canada prior to their legal registration in the Dominion." In this he is right so far as the Province of Ontario is concerned, although we believe that the action of the Ontario board will be modified, and that Ontario is ready to admit to registration the holders of British diplomas, so soon as members of their college are admitted to registration in Great Britain.

In the Province of Quebec we are under a totally different regime. The profession is incorporated under the name and style of the College of Physicians and Surgeons of the Province of Quebec. Every third year the college meets and elects 40 governors, who are by the terms of the act constituted the Provincial Medical Board. The license of this board alone qualifies a man to practice his profession. At the time of the issuing of the license, the candidate has to enter his name, age, residence, and his qualifications, in the register of the college.

The candidate must be possessed of a degree or diploma from any one of the universities or colleges mentioned in clause IV of the Act, to wit: The University of Laval, the University of McGill, the University of Bishop's College, and the Incorporated School of Medicine and Surgery of Montreal in affiliation with the University of Victoria College; furthermore, "The Provincial Medical Board shall have the power or option of extending the same privilege to holders of Medical degrees or diplomas from other British and Colonial universities or colleges." This act is a local act operative only in the Province of Quebec; and the four teaching bodies above named are subject to visitation by assessors appointed by the Provincial Medical Board, whose duty is to attend all professional examinations, and report on the character of those examinations, and should such report at any time be adverse to any of those universities or colleges then shall the Provincial Medical Board refuse to issue its license to holders of a diploma or degree from such university or college so reported upon, until the character of the examination is changed. We may remark that this system has prevailed in the Province of Quebec ever since the year 1847, if we except the right of visitation which has only recently been obtained, and we may

state furthermore, that British graduates have always been admitted to registration by the Provincial Medical Board of this Province, without any question of examination, on presentation of a diploma from a recognized university or college in Her Majesty's Dominions. Such has been the invariable custom, and such good honest custom will, we hope, be continued. We are sorry to observe that the Medical Council of Education and Registration of Great Britain has apparently been forced into the position by their Government. Allowing a large margin for British apathy and conservatism, we do think that sixteen years is possibly a long period for such a question to be an annual and apparently unpalatable refreshment. Let us hope that it will be gulped down now, and duly digested, in fact, we can announce that the following resolution was passed on the 17th ultimo, prior to the adjournment of the Council. "That the Medical qualifications granted under legal authority in any part of Her Majesty's dominions outside the United Kingdom, and entitling to practice in such parts, should be registrable within the United Kingdom on the same terms as qualifications which are granted in the United Kingdom, but in a separate and alphabetically arranged section of the register." This we suppose is the recommendation of the Council to the Parliamentary Committee, if such exists, to whom the Medical Amendment Bill has been referred. This is as it should be, Science is cosmopolitan. The science of medicine and surgery in its application knows no country or creed. It is a Royal Priesthood, having for its sacrifice that of self to the necessity of fellow mortals.

MR. LISTER AND KING'S COLLEGE.

We have received a note from a friend in Edinburgh, who announces that it is definitely settled that Prof. Lister takes the chair at King's College Hospital, London, rendered vacant by the death of Sir W. Fergusson. The authorities of King's College had made overtures to Prof. Lister to induce him to accept the position, which he had declined. Lister being a member of the General Council of Medical Education and Registration of Great Britain, the recent meeting in London

called for his presence in the metropolis, and it was on this occasion that overtures were received and we suppose accepted.

We certainly think that it is very desirable to secure the services of a man with the originality of Lister in the metropolis. But furthermore, he will have greater scope and many more opportunities of spreading his antiseptic doctrines in London than in Edinburgh. So that this may be regarded as an important gain to the antiseptic practice of surgery not alone in London but throughout the world. London is the centre of surgical as well as other learning, and Lister in London will do far more good and be of far greater benefit to the human race than he would have been in his dearly-loved Edinburgh. Should this change be in verity carried out a vacancy will be created in Edinburgh, over which there will be a struggle. The candidature, we have heard will rest between Mr. Annandale, Joseph Bell, Watson, and Chiene, all attached to the Edinburgh Royal Infirmary, and in all likelihood Buchanan of Glasgow. We also learn that it it definitely settled that Dr. Fraser will be appointed to fill the chair vacated by the resignation of Sir Robert Christison.

McGILL UNIVERSITY.

The following changes have been made in the curriculum of the Faculty of Medicine:

(1). A practical examination in anatomy will form part of the Primary Examination.

(2). Medical and Surgical Anatomy will form part of the practical examination by the Clinical Professors.

(3.) The attendance upon the lectures in Hygiene is compulsory.

(4). Students may present themselves for examination in Materia Medica at the end of the second year.

(5). The section in clause 9 of the Qualifications for the Degree in Medicine relating to the Thesis or Inaugural Dissertation is cancelled.

(6). Eighteen months' Hospital attendance is required instead of twelve.

(7). A certificate of having compounded Medicines for six months' is necessary to qualify for the Degree.

PRESENTATION TO DR. CHAMBERLIN

OF FRELIGHSBURG.

A most pleasant incident transpired at the semi-annual meeting of the College of Physicians and Surgeons of the Province of Quebec, held on Wednesday, the 9th, ult. It appeared that that day was the 50th anniversary of the admission to the practice of medicine of Dr. Joshua Chamberlin of Frelighsburg, who is still a member of the Governing Board of the College, and who had served as President of the College during the term from 1865 to 1868. Dr. Chamberlin has been one of the most active members of the Board, and has served as a Governor of the College since its first inception in 1847. But more than this he is a general favorite amongst his younger brethren, and highly respected by all who know him. It was therefore a matter of no surprise, but was hailed with satisfaction by all when it became known that this fitting occasion was to be made use of by the Governors of the College to present to the worthy Doctor a series of congratulatory resolutions,—these we give below for the benefit of our readers, and we most heartily endorse the sentiments expressed

Moved by Hon. Dr. CHURCH, M.P.P., seconded by R. P. HOWARD, M.D., &c., Vice-President of the College, that

Whereas, Dr. Joshua Chamberlin, one of the original members of the College of Physicians and Surgeons of Lower Canada, and President of the College during the term from July, 1865 to July, 1868, has this day reached the fiftieth year of his admission to the practice of his profession: be it therefore

Resolved,—That this College begs to tender to him its earnest congratulations on the occasion.

Resolved,—That Dr. Chamberlin, from the inception of this college in the year 1847, has always manifested a zeal in its welfare, which has largely contributed to its success. That his example for courtesy, efficiency and integrity will ever remain a model worthy of imitation.

Resolved,—That the College wishes him length of years to enjoy the close of a long and honorable career.

Resolved,—That these resolutions be entered in the minutes of this day's proceedings, and that a suitably engrossed and authenticated copy be presented to Dr. Chamberlin by the President.