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## Original Communications.

### THE PRESENT STATUS OF THE ELECTRICAL TREATMENT OF FIBROIDS.\*

BY A. LAPHORN SMITH, B.A., M.D.,  
*Montreal, Canada, President of the American Electro-Therapeutic Association; Fellow of the American Gynecological Society; Member of the Royal College of Surgeons, England; Surgeon in chief of the Samaritan Free Hospital for Women; Gynecologist to the Montreal Dispensary; Surgeon to the Western Hospital, etc.*

At the full flow of the tide of the most successful surgery the world has ever known, one must possess a good deal of the courage of his convictions to rise in the

\* Abstract of paper read before the Obstetrical and Gynecological Section of the American Medical Association at Baltimore, 7th May, 1895.

presence of such a distinguished audience as this, to even discuss, far less to advocate, the treatment of tumors, even the most benign ones, by any other method than the surgeon's knife.

Appearing on the programme of this meeting, surrounded as this paper and its author is by papers and surgeons advocating every kind of surgical treatment, from tying the uterine arteries to removing nearly all the pelvic contents, my position is a peculiarly difficult one, the more especially as I have been trained as a surgeon and occupy the position of surgeon in three hospitals where circumstances often compel me to treat fibroids by surgical procedure.

It is only fair that I should say at the outset, that I did not choose this topic for my discourse; it was assigned to me by our esteemed chairman, who, in order to preserve the high reputation for impartiality which should characterize the conduct of the presiding officers of all scientific meetings, and which has been possessed to an

eminent degree by the chairmen of this section of the Association in the past, no doubt wished that justice should be done to all methods of treatment at present employed.

So strong is my own personal taste for surgery, especially of the abdomen, that I might have been tempted to disobey the chairman's command, but as I reflected upon my work during the past seven years, there passed before me the image of some fifty women whom I had treated for fibroids by electricity. First, as they appeared when I saw them, with faces anxious with pain and blanched with hæmorrhage, and then after their pain had been relieved, and their bleeding had been stopped by galvanism, and their cheeks had resumed a rosy hue, these fifty women's faces encourage me to do justice, though the heavens may fall, to the treatment which has cured them.

Then there pass before me the dying faces of *ten* women, who were treated by total extirpation, at two of which operations I was the executioner, at six of which I was the first or second assistant, and at two of which I was only a spectator. True, the majority of the ten operations were performed in the pre-antiseptic days, though by a great master in this department of our art; but four of them were performed within the last few years, under the most rigorous aseptic precautions, by men who have a low mortality in general for abdominal surgery.

The memory of those fifty women who have been cured by electricity—many of whom I could find if required, and many of whom to this day stop me in the street to thank me and it for their rosy cheeks—and the memory of these ten women who are now no more, all tell me that I would be a traitor to the cause of truth if I remained silent, not only out of season, but in the very hour when it most needed to be spoken.

True, I can quiet my conscience when

circumstances compel me to operate, by the reflexion that one woman died while under electrical treatment, not through electricity, but through an error of diagnosis (in mistaking a tense impacted liquid tumor for a fibroid), which would not have been made if the abdomen had been opened, or, in other words, if the treatment had been surgical instead of electrical. This is the one and only case in which, as far as my experience goes, I have ever had to seriously regret the use of electricity. I can still further soothe my conscience when I am compelled to operate, by remembering that I have operated on ten women, seven by abdominal hysterectomy, treating the stump by having it transfixed at the lower angle of the incision, and three by removal of the appendages tying the ovarian arteries low down, and of several others treated in the latter manner, at which I was first assistant, all of whom recovered and are now in good health.

When I visit the city of Brotherly Love, where the surgeons have declared war to the *knife* upon the *electrode*, I am often placed in an awkward predicament. When I tell my friend, Dr. Jos. Price, that I am going to spend a few hours at the electrical clinic with Dr. Massey, he is "surprised that a man of my intelligence can waste his time in such fiddle-faddling nonsense," and it is useless for me to assure him that I can show him many women in Canada, from Manitoba in the West to New Brunswick in the East, who are the picture of health and who have been cured by electricity.

On the other hand, when I tell my friend Dr. Massey that I am going to spend the morning with Dr. Jos. Price, extirpating fibroids, he looks with pity on my blood-thirsty taste and misguided energy. In vain I tell him that life is too short to treat all my fibroid cases by electricity.

In this somewhat peculiar position which I occupy, I have one consolation:

and that is, or at least I hope that it will be so, that the conclusions which I shall presently lay before you are those of one who is entirely unbiassed and non-partizan, and consequently to be accepted, as far as they go, in good faith.

My own opinion on the present status of electricity in the treatment of fibroids is fully made up, and I shall now endeavor to lay it plainly and honestly before you.

During the last year especially, although it has been growing gradually for several years, the conclusion has become evident that electricity is not suitable for every kind of case nor for every kind of doctor.

It is as true to-day as it ever was, that for the cure of pain in and bleeding from the uterus, the application of the positive pole of the galvanic current, properly applied and of sufficient strength to the uterine mucous membrane, is in the majority of cases effective. The percentage of successes is greatest in those cases in which the fibroid growth is interstitial, not quite so great in the cases of submucous growths, although in several of these cases a few applications have been followed by the expulsion of the tumor from the uterine cavity. The earlier the cases come under treatment the more surely are they cured, many patients with small interstitial tumors in the anterior wall having been cured by me, and still more under the care of others. So that the plea for the early treatment of fibroid tumors by electricity is just as just a one as is the early plea for operative treatment—indeed, it is even more so. For while we can truthfully say that the electrical treatment, when undertaken early, and with a correct diagnosis, is at the present day entirely devoid of danger, no one can truthfully say the same of the treatment by operation. In fact, I am sorry to say that no one knows what the death rate of the latter treatment stands at. Three of the ten deaths which I have above men-

tioned have never been reported, and six of them were only reported at my urgent solicitation. May there not be many other similar cases?

When a woman comes to a doctor for menorrhagia, and he discovers a small fibroid, is he to urge her to submit to an operation when he knows that with the greatest skill and care she runs the risk of dying from the operation, while if let alone the death rate is not more than one per cent., while with electrical treatment the risk is absolutely nil?

When she tells me that she will not submit to operation, will I assure her that I can do nothing for her, when I carry in my pocket the record of fifty similar or worse cases which have been cured by electricity? Surely that were dishonest. And yet the temptation to operate in spite of the danger of surgical and the safety of electrical treatment is very great; too great in some cases for us to resist.

Ours is a busy life, and there is not one of us here who has not often felt that life was far too short to accomplish all the good that we would wish to do, and for the want of a few more hours in the day much work of value to our fellow-beings must go undone.

With this feeling strong within us, a poor woman applies at the out-patient department of our hospital, with a small interstitial fibroid which has, however, doubled or trebled the bleeding surface of the uterine mucous membrane. We believe that we could cure her by a long and tedious course of treatment with electricity, from ten to fifty applications, either at the hospital, or if there are no facilities at the hospital, then at our office. If at the hospital, the time required for this one case would seriously encroach upon the time allotted to our service there; if at our office, there is the same as well as other objections. And when we have made the sacrifice and cured the woman, what is our reward?

Perhaps, but not always, the woman's thanks. Our own feeling of having done well, surely. But when we turn to our brethren, whose esteem is and should be the greatest incentive that we can look for to good work well and conscientiously performed, what do they say? We have no fresh and bleeding tumor to take to the medical society,—as an Indian waves a white man's scalp,—before our admiring brethren as a trophy of our powers and our skill. I have shown the women over and over again; I have shown their clothing, which had to be taken in as much as seven inches owing to their decrease in size; the women themselves have offered to state on oath that their bleeding had been arrested and their pain removed, and their general health improved. How were these triumphs of therapeutic skill received? With loud applause, you will say. No, indeed. The praise bestowed upon the exhibitor of even an apparently healthy appendix, the removal of which was followed by the death of the patient, is received with acclamations wild in their enthusiasm when compared with the manner in which is received the report of a case of cure by electricity. Indeed, a sincere friend and admirer in our Society warned me privately that my reputation was injured every time I showed a woman who had been cured by this means, and he urged me to show no more. But I must continue to cure them by that means as far as my time limit and life limit will allow.

How different when we report an operation, whether the patient lives or dies. Everybody seems pleased, and praises us in proportion to the danger to which our patient has been exposed. But if she dies, there are two at least who must regret that it was performed: the patient and the doctor; and sometimes there are the husband and the little children who are very much concerned.

But how much easier to take the patient

into the hospital, and in a few days perform hysterectomy, which we can do in a quarter of an hour sometimes. It is, as the French say, "un mauvais quart d'heure," but it is soon over, and the patient's fate is sealed for weal or woe when we have put in the stitch which closes the peritoneal cavity. After that the house surgeon and nurses take care of her, and an average of three minutes a day for the next twenty days is the very most she requires of us. But with the electrical treatment, what with getting the patient ready, carrying out the asepsis of the vagina, and adjusting the apparatus, I have spent as much as one hundred precious hours on one single fibroid case. But the ovaries remained, and many of these ladies are now happy mothers of children, and others are happy wives though childless.

I have lately asked several well-known men, men of the highest surgical reputation,—you would be astonished if I mentioned their names,—whether they had employed the electrical treatment with good results. And when they assured me that they had, although they have never reported them, and I asked them what was the principal objection to it, they replied in confidence that it took too much of their time. And this I admit is a serious objection to it, but not an insurmountable one. There are two ways in which it may be surmounted: one is by having an assistant, whose time is less precious than our own, who has been trained to carry out the treatment with accuracy and care when we prescribe for the disease which our more experienced touch has diagnosed; and the other is by having several rooms, and a nurse to prepare the patient, including the antiseptic vaginal douche, and by devoting two afternoons a week, and having those patients come only at that hour, as many as six treatments an hour might be administered.

Never before has it been so well demonstrated as it is to-day, that by the division

and subdivision of labor the artists become more and more expert. It does not surprise me therefore that the best results of the electrical treatment of fibroids is obtained by such men as Apostoli and Massey who employ this treatment alone. They both obtain results which neither I nor any other operating gynaecologist can hope for. In every large city we should encourage some one man to establish an electro therapeutic clinic, where our poor patients at least might obtain the benefit of his skill in electrical technique after having obtained the benefit of our experienced diagnosis. In time his reputation would reach the ears of the rich, and he would then have some substantial reward.

The present status of electricity is suffering, as did the status of abdominal surgery a few years ago, because they have been tried by men without sufficient experience, and have, as a consequence, been found wanting. The electrical treatment of fibroids requires the gynaecologist's knowledge of the pelvis and its contents, as well as the electrician's knowledge of the power he is wielding.

I must trespass on your time yet a little more while I refer to two points: one, a claim which has recently been made by Apostoli for the electrical treatment, which I can heartily endorse; and the other, an objection which has been made to it, which I can as heartily deny.

Apostoli has discovered that the very failures of electricity can be turned to advantage in the following manner: It has been found that in those cases where the electrical treatment has been badly borne, and has been followed by febrile reaction, so that the patients have been turned over to the surgeon for operation, the presence of pus tubes and pelvic peritonitis has been discovered. Apostoli has pointed out that electricity may be employed as a diagnostic agent for the purpose of detecting diseased appendages. A remarkable instance

of this came under my notice a little over a year ago. A young woman, who had been employed in a restaurant in a New England town, gradually lost her health with pain and hemorrhage. She suffered agony with her periods, which came too often and lasted long, so that her face was blanched and haggard. There was no difficulty about the diagnosis, as the tumor was large, round, symmetrical and in the median line, extending up to the umbilicus, and could be easily seen and felt bulging up the abdominal wall. Several physicians in the United States, her family physicians in Montreal, as well as myself, all agreed that it was a fibroid. One of them had tried electricity several times, but always with bad results, and so did I. As she was laid up in bed for several days each time, I concluded that the appendages were diseased, and after three applications I decided to stop and to perform cœliotomy. On opening the abdomen the tumor was at once seen surrounded by adherent intestines, but it still appeared a symmetrically pear-shaped fibroid. I could not, however, detect the ovaries and tubes, and while digging around for them I made a line of cleavage, which being followed up I was able to dissect out a portion of the tumor, which proved to be a sausage-shaped pus tube, which was delivered intact, tied and cut off. Then followed a large cystic ovary, then the other tube which broke and inundated the field with pus, and then the other ovary, by which time the supposed fibroid was gone and only a moderate sized uterus remained. The pelvis was carefully washed out and drained, the patient made a rapid recovery, and is now at work and enjoying perfect health. So that in this case Apostoli's doctrine, that when the application of his method causes febrile reaction the tubes are badly diseased, was fully borne out. Now, the objection to electricity which has so often been made to it, especially by one of my most

esteemed friends in Philadelphia, that it causes adhesions, is not true. I maintain that one has no right to bring that charge : 1st, if fibroids which have *never* been treated with electricity do have adhesions; and 2nd, if fibroids which *have* been treated with electricity can be proved not to have become adherent.

Now, I am in a position to prove both of these facts. When in Baltimore I saw the abdomen opened for fibroid, but it was so adherent to everything, intestines and abdominal walls, that the operator, one of the ablest in the world, did not consider it possible even to get the ovaries out, and the abdomen was sewed up. Now, this case, the most covered with adhesions I have ever seen, you will say, had received many applications of electricity, and so I thought, judging from these statements, must have been the case. But careful enquiry elicited the fact that she had never received a single application of electricity. But that is only negative evidence. Let us see about some positive evidence.

Three or four years ago I treated a lady, head mistress of a large public school a thousand miles away, for hemorrhage and pain, by means of intra-uterine positive galvanism. She had received one year's leave of absence from her important duties, and the commissioners had advanced her a year's salary in order to regain her health, she being utterly incapacitated for work. You may imagine that she was peculiarly anxious to get well, and therefore submitted to a very rigorous application of the treatment three times a week with great fortitude, as high as 200 milliamperes being frequently given at a time. And this was not for once or a dozen applications, but for one hundred times. By this time the bleeding and pain were nearly, if not entirely, arrested, and I advised her to complete the cure by a few months rest at her old home down by the sea in New Brunswick. This she did, and came back

to me in July with rosy cheeks and sparkling eyes. She and I would have been perfectly satisfied with the result, and I should have reported her among my cures, had it not been for one thing, and that was that she asked me the question : "Can you promise me that the awful hemorrhages will not return after I have gone to my far away home in the West?" This I could not answer her affirmatively.

Her next question was : "Is there any other treatment by which you could guarantee that result?" My reply was : "Yes, one only, and that is hysterectomy."

Although the operation was not required by her then present condition, yet owing to her financial situation, which would preclude her ever coming to Montreal again, at her urgent request I removed her uterus.

Now, if the charges against electricity have a vestige of truth in them, I must have found the tumor covered with adhesions, in fact, the tumor and intestines and appendages must have been one agglutinated mass, requiring some hours of patient toil to detach them, and for this I was prepared. But what was my astonishment on opening the abdomen and screwing a corkscrew into the tumor, to be able to lift it out smooth and shining as the top of a bald man's head; the transfixing of it with pins and circling it with the serrenœud was the work of a few moments, and in a minute more the tumor was off. She ran her five or ten per cent. of risk of death safely, and made a splendid recovery, and was at the head of her school once more on the 1st of September.

One such case carries more weight than a thousand assertions that electricity causes adhesions.

But I can duplicate it. A young lady, who is now a trusted nurse in a New York hospital, came to me, the first year I used this treatment, for hemorrhage and pressure symptoms caused by a large fibroid. She improved so much, that I decided that

she might go home by the time she had received fifty applications. But after the last application she began to flow before her time, and I asked her to wait until it stopped. It lasted 17 days, a steady little stream of dark blood. I became momentarily discouraged, and advised operation, which was accepted, and I handed her over to a more experienced operator than I was at that time, but assisted at the operation. The tumor came out without the slightest difficulty, and was removed in the same way as the one mentioned above. I examined it most carefully, and the only trace of an adhesion to be found was a spot about the size of a silver five cent piece where the tumor had rubbed upon the brim of the pelvis on the right side, and where she had often complained of pain before coming to me. But there was not a sign of adhesion in the track of the electric current, nor anywhere else, except at this one spot. The hemorrhage was due to a tiny opening in a uterine sinus caused by the end of the electrode.

I dislike electricity personally, because it takes up my precious time; but I want it to get fair play, and not to be blamed for sins that are not its own.

There is one charge, however, which was frequently brought against the electrical treatment of fibroids, or rather against a method of applying it, in the past, and which was well deserved, but which is no longer applicable, because no longer employed—I refer to the method by galvano puncture.

The greatest claim for the electrical treatment of fibroids that can be made for it is that it has no mortality, that it is absolutely safe. If it is not more safe than any other treatment, or in fact unless it is absolutely free from danger, there remains only one advantage in its favor, namely, the saving of the ovaries. But galvano puncture, no matter how performed, whether by the vagina or through the abdominal wall,

must ever be a procedure fraught with danger, and is to-day practically abandoned. If anyone still uses it, in the cause of the electrical treatment of fibroids, I beseech him to use it no more. The positive pole of the galvanic current gently introduced into the uterus will accomplish our object by unseen but no less certain means. It dries up the juicy bleeding mucous membrane, and by its tonic action upon the muscular tissue through which must pass the vessels carrying nourishment to the tumor, its blood supply is cut off just as surely as though we tied the ovarian arteries which supply the body of the uterus.

The action of the electric current as applied to fibroids is threefold. The first is not mysterious; it is but the arrest of circulation in dilated capillaries by an electro-chemical cauterization. The second is no more difficult to understand than the action of ergot or strychnine; it not only tones up the vaso-motor system, making the calibre of the arteries less, but it calls into play the special and remarkable power which the uterus possesses of controlling its own circulation when it has the strength to contract.

The third effect of the current, its electrolytic action, is, I admit, as mysterious as it has ever been, but not more so than the invariable absorption of syphilitic gummatous deposits following the administration of iodide of potassium. Whether what we call electrolysis means the actual breaking up of an organic tissue into inorganic atoms, or whether it means, as seems more likely to me, that the growth deprived of its blood supply undergoes fatty degeneration, and is partly eaten up by phagocytosis stimulated to greater activity by the trophic nerves, no one with a large experience with this subtle fluid can deny that a uterus infiltrated with and enlarged by the deposit of fibrous tissue, whether localized in the form of fibroids or dif-



fused as in areolar hyperplasia, so that the sound will enter four or five inches, will invariably diminish in depth by means of electrical treatment.

Then again, what is the enormously enlarged uterus after delivery but a bleeding myoma? Does it not stop bleeding when the arteries which supply it with blood are squeezed by its contracting walls? Does it not rapidly get smaller when, for the want of blood and exercise, that immense mass of muscular tissue silently undergoes fatty degeneration and returns to the blood from whence it came?

Wonderful and almost incredible as the total disappearance of a fibroid or myoma may seem to some, it is no more mysterious than this wonderful process of nature which we call involution.

Have those who doubt, and even worse, deny the power of electricity to work a change in fibroids, never reduced the size and weight of a uterus which nature had failed to involute? Has Emmett never reduced its size by repairing a lacerated cervix? Have Churchill and Athill and ten thousand others with honored names never reduced the quantity of tissue in the uterus by the application of iodine? Have not a hundred thousand others never reduced the weight of blood and muscle and areolar tissue in the heavy uterus by means of glycerine and hot water and other therapeutic measures? Then why, in the name of reason and justice, will you deny that an agent, which we can see blanching tissues before our eyes, and making muscles of every kind contract, why will you deny, I say, that it can diminish the blood supply to and favor the fatty degeneration and absorption of the fibrous or myomatous uterus?

Gentlemen, the electrical treatment of fibroids, reduced to the above simple equation, and stripped of all the extravagant claims which were at first made for it, in darkness, but in good faith, stands to-day

upon a foundation so strong and true, that it will find an honored place in the treatment of fibroids as long as women shall dread to die by the surgeon's knife, which I think will be as long as the world shall last.

### INDICATIONS FOR TOTAL HYSTERECTOMY.

*An abstract of a Paper read in the Section of Obstetrics and Diseases of Women at the Forty-sixth Annual Meeting of the American Medical Association held in Baltimore, Maryland, May 8, 1895. By AUGUSTUS P. CLARKE, A.M., M.D., of Cambridge, Mass., U.S.A., Dean, and Professor of Gynæcology and Abdominal Surgery of the College of Physicians and Surgeons, Boston, Mass.*

The author, after making some introductory remarks in reference to his interest in the work of total hysterectomy, speaks of a new method of operating by a vagino-abdominal incision. He says, by the advantages that may be gained by this method of operating it is not unsafe to say that total hysterectomy is indicated in cases in which the uterus may be in a position opposite to that of prolapse, and in such a state of immobility, superinduced by previous inflammatory processes affecting the appendages, as to necessitate for relief operative interference. By the facility with which the whole organ can be removed by the operator's adopting the improved method of technique, the danger usually attendant on the carrying out of such radical measures will be greatly lessened. Total hysterectomy should be had recourse to in cases of rapidly growing interstitial fibroids, or in cases of large subperitoneal growths developing from a broad sessile base.

The operation is indicated not only from the hæmorrhage which they occasion, but also from the pressure which may take place upon the surrounding parts. Fibroids

have a tendency to take on malignant degenerative changes.

The removal of a fibroid should not be deferred because it appears, or is first observed, at or near the menopause, for it is not infrequent for such a tumor to continue to develop long after the occurrence of that period, and it may assume all the phases and present all the untoward results that are attendant on one that has had an earlier beginning. A nodular fibroid of a slower growth should not be regarded with unconcern, for the pressure that may be exerted on the uterus or other parts may be productive of most serious results. Uterine myomata in all their various stages call for removal; this should be effected as early as possible.

In certain cases the curette can be advantageously employed; if this mode of treatment proves unsuccessful, total hysterectomy should be the next surgical expedient. The author makes mention of a case of multilocular fibroid which was not cured until hysterectomy was tried, though Hegar's method for removal of the uterine appendages had been resorted to. Total hysterectomy offers the best advantage for the permanent relief of uterine adenoma. The malignant nature and unfavorable tendencies of uterine sarcoma are unquestioned. The presence of such a growth calls for speedy action.

As in the early stages of cancerous disease, before the para-metrian tissue has become involved, so in sarcomatous developments partial removal of the organ by a supra vaginal method will prove inadequate; nothing less than total ablation of the uterine tissue will be sufficient for a cure. Carcinomata and sarcomata in all of their various forms call for immediate and thorough removal; this should be done as soon as the diagnosis of the condition can be made. Total hysterectomy is absolutely necessary for uncontrollable prolapse after anterior and posterior colporrhaphy and

other plastic operations have been repeatedly tried but have failed to produce permanent relief. In such cases the vaginal method is the operation to be preferred. Total hysterectomy is the only safe surgical expedient to be adopted in cases of hæmorrhagic polypi, which present suspicious microscopic appearances after removal, and which leave as a result an enlarged uterus, as may be determined by palpation or by the sound.

Total hysterectomy is called for in ectopic pregnancy; in such cases the hæmorrhage can be more safely controlled, and the patient is enabled to make a more rapid recovery than when other methods of procedure have been adopted. This method of treatment should be undertaken in ovarian abscess, in pyosalpinx, in old inflammation of the appendages, in a post-clinical severed uterus which has been productive of pain, and has been a source of disablement. The operation should be resorted to in all suspicious diseases of the adnexa, and in cases of large cysts as well as in papillomatous developments, in otherwise irremovable cysts, and in intra-ligamentous fibroids and tumors of the broad ligament. Late experiences show that total hysterectomy can be accomplished with as little danger as may be attendant on many other important surgical measures. When properly performed, there is often but little ~~wonder~~ <sup>hesitation</sup> left about the vicinity of the broad ligaments. When done in ectopic pregnancy, in ovarian abscess, in pyosalpinx and in purulent liquifaction of a uterine fibroid, better drainage can be established. On the other hand, when the uterus or a portion of it is left, the condition resulting is liable to be followed with many complications,—with uterine catarrh, malignant degeneration, certain neuroses, and with other sequelæ of a painful or of a clinically depressing nature. Another advantage total hysterectomy insures is that the posterior and anterior folds of the

pelvic tissue can be brought together and united by suturing, so as to secure better results than when other surgical methods are employed. In bringing together the folds after the uterus has been totally removed, their margins can be turned outward and downward; this arrangement of the parts will thus practically invest the operation with all the advantages that can be secured by the choice of the extra-peritoneal method.

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## Society Proceedings.

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### MONTREAL MEDICO-CHIRURGICAL SOCIETY.

*Stated Meeting Nov. 30, 1894.*

G. P. GIRDWOOD, M.D., PRESIDENT, IN THE CHAIR.

Dr. LAPHORN SMITH strongly advocated the use of anæsthetics, and employed the A. C. E. mixture, giving the bottle to the patient, and instructing her to sprinkle a few drops on a handkerchief and inhale it as she required it. In this way the patient never became entirely unconscious, and the employment of the anæsthetic did not necessitate calling in another physician. He admitted that it prolonged labor and increased the tendency to postpartum hæmorrhage, but he felt no anxiety on this score, while he possessed the fluid extract of ergot, which he administered in hot water immediately after the birth of the child, to prevent it. He also believed strongly in quinine and strychnia for increasing and maintaining the tonicity of the uterus. The latter he gave, where possible, for a month previous to labor.

Dr. PROUDFOOT referred to the use of laudanum in labor, it diminished pain, acted as a strong tonic and prevented post-partum hæmorrhage.

Dr. ENGLAND endorsed Dr. G. A. Brown's method of giving ergot. He thought that in some cases the drug was not absorbed by the stomach, and therefore dependence should not be placed solely upon it. Chloroform, in his experience, in suitable cases accelerated rather than delayed delivery. He differed from Dr. A. A. Browne in his method of detaching a retained placenta, keeping the pulp of his fingers towards the uterine wall, because he believed there was less danger of damaging it thus. As a styptic he considered the hand in the uterine cavity the best means of bringing about contractions, and after this injections of hot water.

Dr. A. A. BROWNE, replying to Drs. England and Campbell, said that if an adherent placenta

were detached from above, their method would be most convenient. He, however, spoke of detaching from below and working upwards, in which case he believed the best way was to have the back of the fingers towards the uterine wall and the pulp towards substance of the placenta, which was separated by a to and fro movement.

Dr. J. C. CAMERON, in closing the discussion, explained that in making the arrangements for dealing with the subject, different parts had been allotted to different speakers, and those to whose lot it had fallen to treat of the nervous aspect of the subject had been unable to attend. He had no hesitation in putting himself on record as favoring the use of anæsthetics in the latter part of the second stage when the head was down on, and bulging, the perineum. It then not only relieved the pain, but rendered laceration less likely. He, however, would only use it to the obstetrical degree. Speaking of the employment of ergot, he said his own custom was to give it after the birth of the placenta; but he saw no very great objection to giving it earlier in some cases (that is, after the birth of the child), especially when absorption is thought to be slow. It is a good rule not to give ergot until the uterus is empty, or can certainly be emptied in half an hour. In regard to this slowness of absorption, he thought we would not hear so much about the worthlessness of ergot, if more care were to be taken to keep the patient's stomach reasonably empty. It is not at all hard to understand why the drug has no effect in some cases, when we consider the mass of stuff, in the way of food and drink, with which some patients load themselves during labor. As a prophylactic against post-partum hæmorrhage, there were two classes of cases in which ergot should always be given: (1) in *precipitate* labor, where the uterus acts in an hysterical sort of way, the uterine muscle not having attained its rhythmic power, and where relaxation and flooding are apt to set in as suddenly and acutely as the contractions did previously; (2) *prolonged* labor, when the uterine muscle is apt to become exhausted, and the relaxation results from weakness. If you wish to be sure of getting the full effect of ergot, it should be given hypodermically, because when given by the mouth its action is apt to be slow. Speaking of the spontaneous delivery of the placenta, he thought some seeming contradictions which had arisen during the discussion might be easily explained by a consideration of a few of the factors which play a part in the act. When the placenta is in the upper part of the uterus, the uterine muscle or the hand of the operator may serve to force it downwards; but directly it reaches the lower uterine segment, the action of these forces is much lessened. Its further progress depends then upon gravity, supplemented by the contraction of the

voluntary abdominal muscles. It was through the action of these last that the cough, so favorably mentioned by Dr. F. W. Campbell, obtained its potency. So also the abdominal binder, by strengthening the lax abdominal wall, steadied the uterus, and allowed it to act in a direct line, hence increasing its expulsive powers. A uterus wabbling about in a lax abdomen could not be acted on so effectually by the abdominal muscles, as one that is steadied and kept in its proper place. Referring to traction on the cord, he said, of course, when we are positive the placenta is in the vagina, no possible harm could arise from gentle traction on the cord; but it is the possibility of making a mistake in this regard that is dangerous, and he believed that a placenta which was still in the uterine cavity might sometimes be erroneously thought to be in the vagina, and the traction upon the cord would be a mischievous practice. Of the danger of drawing on the cord while the placenta was still attached to the uterine wall, he need not speak; and in no case should any but the gentlest traction ever be employed. As to cases of retained placenta, he believed that most of our cases of retention occurred in the early days of our practice; and as experience ripens, they become rarer. Retention is very often caused by undue haste in trying to expel the placenta, or to improper manipulation. Referring to the method of dissecting off the placenta, it seemed to him that the one mentioned by Dr. A. A. Browne was the right one. A careful dissector always dissected towards the debris, and from the tissue he wished to save, in like manner a careful obstetrician should work from the uterine wall which he wants to save towards the placenta which he does not care to save. Then as to the difficulty experienced in separating and removing the placenta, he believed it was due to the fact that the operator did not commence his work in the right place. He should remember that the line of cleavage is in the decidual plane, and to reach this it is necessary to get down to the uterine muscle. Most men commence the operation of digital separation by following the cord. This brought them, of course, in contact with the foetal surface of the placenta, and the only way to separate it easily from this point was to push the fingers right through it until the uterine wall itself was reached, and then commence the "peeling off" process. It would be better to begin at the edge of the placenta rather than at the attachment of the cord, or better still, to follow up the membranes, which, it will be remembered, were separated from the lower uterine segment during the first stage of labor. By passing the finger beneath them, the edge (not the centre, as in the case of following the cord) of the placenta may be reached in the plane of natural cleavage, and then the process of peeling off will be

comparatively easy. If these points were kept in mind, he believed the breaking up of the placenta into pieces during its removal, with the consequent danger of leaving some bits behind, would not so often occur. Coming then to the expression of the placenta, and the question of how long should we wait before doing so? It should be remembered *why* we wait. We wait to give the uterus time to separate the placenta. To do this requires pains; and the number will depend on their strength. A man's clinical experience, therefore, upon feeling the uterus, should always inform him where the placenta is, and when and how he should interfere. Above all, manipulation should not be applied to "separate" the placenta, but to expel it, unless the uterus is incapable, or the placenta abnormally adherent. A little thought, and a thorough knowledge of what we are doing, was all the speaker believed necessary to guide one in such cases. As to the position of the patient in expelling the placenta, he preferred the dorsal; the lateral allowed the uterus to topple to one side, and pressure cannot be applied so correctly in the axis of the pelvis. The Crede method of manipulation is by all means the best method; but it is not so generally practised as one would think; many only imagine they are using it, while only the few really fulfill all its conditions. The fingers should be got well behind and thumbs in front of the uterus, grasping and compressing the fundus before downward pressure is made. If you simply press upon the organ, as a whole, without compressing the fundus, you will only flatten out the fundus and fail to move the placenta. Speaking then more particularly of the membranes, he remarked that if they are ruptured too early, separation from the lower uterine segment does not wholly take place, owing to the dilatation of the cervix being completed by the head of the child; they are then likely to remain attached even after the delivery of the placenta. In such a case the fingers should be passed up, to separate them from around the internal os, taking care that all are removed. In closing, Dr. Cameron made an appeal for gentle manipulation of the uterus during the third stage, saying it was one thing to support, another to injure the fundus; and that a great deal of harm was often done by rough handling of the uterus and its peritoneal covering.

*Stated Meeting, December 28th, 1894.*

G. P. GIRDWOOD, M.D., PRESIDENT, IN THE CHAIR.

Dr. A. G. Morphy was elected an ordinary member.

*Tubercular Ulceration of the Stomach.*—Dr. ADAMI exhibited this specimen taken from a child of ten, born in Montreal, who, until within three months of her admission to the Royal Victoria Hospital, was in one of the charitable homes in the city.

At the beginning of October she began to be depressed, and suffered from a violent attack of abdominal pain, with frequent vomiting after meals. The attack passed off, to recur again a fortnight later; there was a third attack the next week, and since then there have been several others. A fortnight before admission, the seizures became very frequent and violent, two or three daily. The vomiting did not recur after the first attack.

During the last two months the emaciation had been most rapid, until upon admission, on December 7th, the little patient was little more than skin and bone. The abdomen was full and slightly distended and painless upon entrance into hospital, later there was diffuse tenderness upon palpation. The bowels were regular, but slightly loose.

A diagnosis was made of tubercular peritonitis. It was worthy of note that the family history in this case was good. The father had died of a "tumor in the neck," the mother and three children were alive and healthy. While in hospital the child stated that a cow at the house had become sick some few months before, and at last ceased to give milk.

The child became weaker and yet more emaciated, and died upon the 22nd instant.

At the autopsy, the body presented the most extreme emaciation, with a petechial eruption upon the lower part of the thorax and upper half of the abdomen, and upon examination presented advanced tuberculosis. Upon opening the abdomen there were abundant signs of dry tubercular peritonitis. The omentum was adherent in several places to the walls. Scattered through it were several small hæmorrhagic spots and occasional large tubercles. In the centre of the hæmorrhagic spots miliary tubercles could frequently be detected. The coils of the small intestines were dotted over with similar petechiæ. In the serous coat of the stomach also were at least four whitish tubercular masses. In the small intestines were typical transverse tubercular ulcers which had broken down, exposing irregularly the muscular coat. The mesenteric glands were enlarged and caseous, as were also the retroperitoneal glands.

Before passing to the consideration of the state of the stomach, Dr. Adami concluded, describing the general post-mortem appearance.

Dissecting out the thoracic duct, a tubercular mass was found in its walls opposite to the body of the sixth dorsal vertebra.

The bronchial glands were found enlarged, and some of them entirely caseous. There were small cavities, the largest the size of a brown bean, in the upper lobes of both lungs, with tubercular broncho-pneumonia, and further a condition of fairly recent dry tubercular pleurisy, the membranous adhesions being not

pale and bloodless, but of a reddish color, and removable with moderate ease. Tubercles were present in both visceral and parietal pleuræ.

There was then a condition of advanced and very generalized tuberculosis, which, from the extremely caseous state of the mesenteric glands, he was inclined to regard as having first manifested itself in connection with the alimentary tract, although it would certainly be possible to urge that the disease began in the lungs. It was easier to explain intestinal tuberculosis succeeding pulmonary than *vice versa*. It must, however, be remembered that in this case the earliest symptoms were abdominal.

The petechial eruption and hæmorrhagic condition of the omentum and the serosa of the small intestines gained an explanation by the discovery of growths of the pyococcus aureus in cultures, made from the spleen and other organs. There had been secondary infection on the day immediately preceding death.

Turning to the stomach, this was found fairly full of curdled, milky matter, and upon examination of the walls there was found, as shown by the specimen, a certain amount of post-mortem digestion, so that in one place the wall was almost eroded through. In addition, in the centre of the great curvature was an ulcer 13 mm. in diameter, with raised and irregularly thickened edges, and with a comparatively smooth base, formed of the muscular coat of the viscus. The smoothness of the base might have caused doubt as to the tubercular nature of the ulcer, but that this was truly tubercular was shown by the fact that corresponding to it in position upon the serous coat was an area of confluent tubercles.

Tuberculosis of the inner coats of the stomach was a rare condition. Why this should be when the affection was so common in the intestines it was difficult to explain, unless it was that the acid excretion of the cells of the mucosa hindered the proliferation of the tubercle bacilli, just as acids are known to hinder the growth of the microbes outside the body. This theory would help to explain the rarity of tuberculosis within the brain substance and in muscle-tissues, which also are characterized by their active development of acid substances. That there was no great lack of production of acid on the part of the gastric mucosa, as a whole, in this case was evidenced by the post-mortem digestion.

*Multiple Intestinal Anastomosis of Tubercular Origin.*—The same case exhibited no less than four fistulous communications between different portions of the gut. The uppermost of these was in the lower part of the jejunum where the opening passed between the floors of two ulcers at points distant, the one four

inches lower down the gut than the other; the lowest was between the lower end of the ileum and the first inch of the ascending colon. The fistulæ had occurred at regions where the serous surfaces of ulcerated areas had come into apposition, and where the extension of the inflammatory process on to the serosa had apparently resulted in the formation of adhesions anterior to perforation.

*Tuberculosis of One Suprarenal.*—Dr. ADAMI exhibited this case of chronic tuberculosis affecting the left suprarenal, the right being normal. The affected organ presented a mass 2.5 c.m., or roughly an inch in diameter, showing on microscopical examination a central very chronic and fibroid tubercular growth with areas of caseation and frequent giant cells.

The specimen was from a case from Dr. Stewart's wards at the Royal Victoria Hospital, of mixed syphilis and tuberculosis in an elderly woman, the latter manifesting itself also in the lungs, where evidently it was of old standing, and in the pleura where it was of relatively recent advance.

Within the last eighteen months there had been a short discussion at one of the meetings of this Society concerning Addison's disease, associated with affection of one suprarenal. In the present case, as is most usual, unilateral disease of the organ was associated with no bronzing of the skin, vomiting, and progressive loss of mental and bodily vigor.

*Generalized Tuberculosis with Affections of Back of Tongue, Soft Palate, Pharynx, and first two inches of Œsophagus.*—The last specimens were from a case of extremely widespread tuberculosis in a man of 22 years of age, who died in Dr. Stewart's ward of the Royal Victoria Hospital. The larynx, trachæa, pleuræ, pericardium, large and small intestines, peritoneum, liver and kidneys, all showed signs of the disease, and with this was extensive ulceration of characteristically tubercular nature in the above more unusual positions.

*Two Complicated Breech Cases of Labor.*—Dr. G. A. BROWN read a paper on this subject, as follows:

Two difficult breech cases of labor having occurred in my practice within a short space of time, and having the same complication, I thought I would report them, and at the same time say something of the method of treating the complication.

Case 1.—Mrs. B., aged 32, medium-sized woman; has been fairly healthy; has had two children, the first was an eight months' child, and the second went to full term. During all the time that she carried her children she complained of persistent vomiting, and when pregnant five years ago the vomiting was so severe that artificial abortion was performed for her relief. When she became pregnant

this last time I put her on small doses of chloral and bromide, which controlled her vomiting, and she had good health after the third month. About one month before labor she fell down stairs, which might account for the complication present during labor. Her labor began Wednesday, October 3rd, at 2 p.m.; pains were strong and frequent; membranes ruptured at 4. At 5 o'clock I saw patient and made an examination, and found the breech presenting in the left dorso-anterior position and well down, almost touching the perineum. Fœtal heart was strong. From 5 to 9 o'clock there was no change in the position of the breech, although the pains were very strong and frequent. At 9 o'clock the pains began to grow weaker, and as there had been no advance of the fœtus, I decided to give chloroform. After the patient was anesthetized I made an examination, and found the legs were extended, forming a wedge with the arms and head. The forceps were applied to the breech several times without moving it to any extent, and always ending in slipping. Traction by means of a finger in each groin was made without any result. I then succeeded in introducing my hand in utero, and seized the foot of the anterior limb by the instep, flexed the left leg on the thigh by sweeping it across to the right side of the child's chest, and at the same time rotating the knee outwards and everting the thigh. The limb was delivered by internal rotation of the thigh and extension of the leg. The fœtus having turned cynotic at this time I endeavored to deliver it hurriedly, but it seemed to be still further arrested, and on examination the arms were found to be extended. The posterior arm was easily delivered, but on making traction on the fœtus the anterior arm became locked between the head and the symphysis pubis. As the child was dead and the arm could not be dislodged, I severed it from the chest wall, and delivered by tying a noose around it. The head became extended during my manipulations, and I had difficulty in causing flexion before delivering the child. The time for these manipulations was about one hour and a quarter. The patient made a good recovery. Her temperature rose to 100° F. on the third day and fell to normal on the sixth.

Case 2.—Mrs. F., primipara, age 44, is a large, well developed woman; has been fairly healthy, no illness of any extent; has been married twenty years; family history tubercular, one brother and sister having died of phthisis. Patient came to me in August complaining of an abdominal tumor, which on examination proved to be pregnancy. Her last menstrual period was January 20th, and vomiting did not set in until the end of March. Felt life about the end of June. On October 18th I made an examination of the patient, as

she was complaining of severe pains in the abdomen. The breech was found presenting in the left dorso-anterior position. At this time no abnormality was discovered. Pains having ceased I did not see patient until November 29th. She had complained of œdema of the legs and frequent micturition during the intervening time, and two days previous to her labor had severe pains off and on. Labor began at 2 a.m. Thursday. The pains were good and strong up to 6 a.m., when I saw the patient and made an examination; found the os dilated to about the size of a fifty-cent piece and the breech presenting in the left dorso-anterior position. Fœtal heart normal. Pains continued strong and frequent up to 11, when they began to grow weaker and less often. On examination the os remained about the same, and there was no advance in the breech. Patient was feeling pretty well played out, and complained of severe headache. I decided to give her chloroform and deliver the breech. Patient being anesthetized, on examination there was found extension of the legs forming a wedge with the head and arms. As in the former case, I decided to introduce my hand and break up the wedge. The os being dilated manually, the hand was with difficulty introduced, and the instep of the anterior limb seized and the leg delivered as before. After this the arms were delivered before traction was made on the fœtus, thus avoiding the accident which occurred in the previous case. After delivery of the arms, traction was made without result, as the foetal head was arrested at the brim. I attempted to apply forceps, but failed, and on bimanual examination the head was found very large and fluctuating, and the diagnosis of hydrocephalus was made. I then severed the vertebral column in the dorsal region, and passed up a gum-elastic catheter to the cranial cavity, and drew off one gallon of fluid. The foetal head was then easily delivered by traction on the body. Time for manipulations was about thirty minutes.

The measurements of the foetal head were as follows:—Occipito-parietal  $20\frac{1}{2}$  inches, bregmatic 21 inches, occipito-mental  $21\frac{3}{4}$  inches. The placenta was about  $3\frac{1}{2}$  by  $4\frac{1}{2}$  inches, and was very soft and friable. About two hours after labor, patient had post-puerperal convulsions, which were very severe and which lasted for three hours and were controlled by chloroform, chloral, bromide and a purge of hydrarg. subchlor. with pulv. jalap co. The urine contained 2 per cent. of albumen. Patient made a good recovery. Lactation was established on the fifth day, and with it a little rise of temperature, which fell to normal on the following morning. Albumen disappeared on the sixth day.

As will be seen by the method adopted in the second case, I profited by the experience gained by the first. Had I followed this method in the first case, I am sure I could have delivered a living child. There are several methods of dealing with this complication: First, forceps; second, soft fillet or hook; third, introduction of the hand up to the fundus, seizing a foot and delivering it, thereby breaking up the wedge by causing extension of the vertebral column.

Forceps are recommended by many good authorities, as Tarnier, Lusk, etc.; but I think that it is a waste of time to apply them, as they are fitted to the thin end of the wedge, and in nine cases out of ten are bound to slip and cause a great deal of damage to the maternal tissues. Besides, traction cannot be made in the right direction, that is, usually to the right or left side, in order to change the flexion of the vertebral column to extension, which is a most important thing in breaking up the wedge. Another danger of repeated application of forceps is perhaps to stimulate the child to breathe and cause its death in utero.

The soft fillet is still recommended by different authorities, but there is often great difficulty in applying it, and it takes a great deal of time, and even then one is not always successful. There is also danger of lacerating the child's tissues and fracturing the femur. The third method seems to me to be the most scientific, and is therefore the best, as it breaks up the wedge, is quickly performed, and causes less damage to the fœtus and maternal soft parts. If one should fail to introduce his hand owing to contraction of the pelvis or tetanic spasm of the lower uterine segment, I think that the soft fillet would be the best and surest method of delivery.

The second case having had a complication of hydrocephalus, the cause of which is obscure, I would suggest a possible explanation of this case, and be glad to have an expression on this subject from the members.

We had here disease of the mother's kidneys and of the placenta, which performs the same function in the child. Why should not local dropsy occur in the cranial cavity in the child, just as ascites occurs without general œdema in the adult? The fact that the head receives the freest circulation in the fœtus would determine the site of the fluid effusion.

#### AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

THE TREATMENT OF GOITRE. — Dr. Chas. H. Dickson, of Toronto, stated that in the early stages of simple hypertrophy, a current of 100 to 150 milliampères should be given for ten minutes at a time, a clay electrode being applied over the goitre, and a large wire-

gauze electrode between the shoulders. When puncture is resorted to, one should not be content with a current of less than 50 milliamperes applied for eight or ten minutes, and care should be taken to observe antiseptic precautions, and to see that the portion of the needle outside of the capsule is thoroughly insulated. In his experience, pure cystic goitres had proved to be the most amenable to treatment. His method was to aspirate the contents of the cyst, inject a hot solution of chloride of sodium (1 drachm to the ounce—4 to 31 cubic centimetres), apply through a trocar a current of from 50 to 100 milliamperes for ten minutes, and then withdraw the salt solution. It should be remembered that puncture alone involves some risk, and that change of residence and attention to hygiene are important adjuncts to all forms of treatment.

Dr. Robert Newman, of New York, referred to a method of treatment employed by Dr Watkins, of New York City, with good results. A needle was connected with each pole of the battery, and currents of only from  $\frac{1}{4}$  to  $\frac{1}{2}$  a milliampere were found to answer.

Dr. Rockwell objected to the strong currents advised by Dr. Dickson.

Dr. Morton said the object of using these strong currents was to secure adhesion of the cyst-walls, but the same object could be attained with a current of only 5 or 10 milliamperes by calling to our aid metallic electrolysis.—*Universal Medical Journal*.

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## Progress of Science.

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### THE TREATMENT OF SCIATICA.

Græme Hammond, in discussing the treatment of sciatica in the *Post-Graduate* for September, 1894, states that the pain of sciatica varies in accordance with the severity of the disease. In mild cases, from 10 to 15 grains of phenacetin will afford prompt relief, but in the majority of cases the anæsthetic properties of this drug fall far below what the patient requires. If the pain is moderately severe or intense, it is better to inject morphine. Enough morphine should be given in one dose, if possible, to thoroughly arrest the pain. It has been claimed that the morphine should be injected directly into the sciatic nerve, because it not only relieves pain, but also exerts a beneficial effect upon the inflammatory process. There is no proof that morphine possesses any such power. The writer has injected it repeatedly into the sciatic nerve in many cases, but never observed that it had any antiphlogistic properties. Puncturing the sheath of the nerve

in a number of places by piercing it with a needle has in some instances afforded relief. This is accomplished by permitting the serum which is poured out between the sheath and the nerve to escape through the puncture made by the needle, thus relieving the pressure and consequently the pain.

Having made the patient comfortable, the neuritis is best treated in the following manner: Absolute rest of the afflicted leg cannot be too strongly advocated. Mild cases of sciatica sometimes get well in spite of this rule being flagrantly violated, but the course of every case will be shortened, and, in many instances, the disease will be prevented from becoming chronic by the rule of absolute rest being strictly enforced. The patient should not only be confined to bed, but the leg must be made almost immovable by being confined in a splint. The author prefers the old-fashioned hip splint, as recommended by Weir Mitchell. A piece of board about three inches wide, and long enough to reach from the axilla to the sole of the foot, should be properly covered, and then applied by attaching it to the body by a few turns of a bandage, and in the same manner to the leg from the knee to the foot and from the knee to the hip.

Having thus secured almost perfect rest for the inflamed nerve, the next most important feature of the treatment is the application of heat. The most common seat of the neuritis is in the upper part of the nerve, from its exit from the pelvis to the middle third of the thigh. Hot-water bags should, therefore, be placed under the back of the thigh and kept there continuously until all signs of inflammation have ceased; the constant electric current is also very serviceable in relieving pain. In almost all cases patients will speak of the improvement they feel after each application. A large electrode, fully the size of the foot, should be fastened to the sole of the foot by straps or elastic bands. Another large electrode, fully six inches square, should be placed under the hip while the patient is reclining. This electrode should be connected with the positive pole, the one on the foot with the negative pole, and the current should then be gradually turned on, being careful not to break the circuit until the patient is receiving enough to give rise to a moderate sensation of burning. The current may then be allowed to flow uninterrupted for about five minutes, and should be gradually diminished until it is taken off entirely. This ought to be repeated daily, and in severe cases it can be used advantageously twice a day. By these three methods—absolute rest, continuous application of heat, and daily applications of galvanism—the most severe acute cases will promptly yield, the average cases not lasting longer than seven or eight days. At the end of that time treatment can be discontinued,



but the patient should remain in bed two or three days longer. If, in that time, he can move the leg without pain, he may then be allowed to walk a little and to gradually increase the distance until further restriction becomes unnecessary.—*Therap. Gazette.*

### THE STOMACH-TUBE IN GASTRIC AFFECTIONS.

In discussing the question as to what can be done without the use of the stomach-tube in the diagnosis and treatment of gastric diseases, A. L. Benedict, of Buffalo, pronounces the tube as practically useless for determining the motion as well as the sensation and absorption of the stomach, except that the chemical examination of the stomach-contents assists in determining the motor and absorptive power. It is in investigating the secretions and the course of digestion that the tube becomes important, being the least distasteful and most practical of any method suggested. Still, in weak patients with irritable stomachs, who vomit frequently, the stomach-contents accidentally furnished may be made use of and the tube avoided. The question as to whether the fats and carbohydrates are innocuous or whether they are fermenting is answered unfavorably by finding bacteria and yeasts microscopically, and butyric and acetic acids chemically, in the stomach-contents. But, knowing that fatty and starchy substances have been taken, that certain foods of these classes habitually cause trouble, finding the stomach tympanitic with gas, and noting the eructation of sour gas or liquid, in which we may smell butyric and acetic acids, the diagnosis of fermentation is quite as well established.

The change of cooked starch into sugar is not in itself an important one. If the pancreas can provide for any reasonable quantity of raw starch, it will probably not be overtaxed if the salivary function also devolve upon it. If the saliva is suspected of being at fault (which is rarely the case), let the patient chew a bit of raw potato and spit into a test-tube, in which, after a few minutes, the ordinary sugar-test will show whether or not enough ptyalin is secreted.

It has been shown that the presence or absence of pepsin and rennet has not much practical importance, a little of either seeming to act as well as a good deal. The author protests against the indiscriminate use of pepsin, and believes that, as Ewald says, it should be restricted to cases of advanced mucous catarrh and atrophy. The most important fact to be determined is the quantity of hydrochloric acid. Gastritis of all grades, carcinoma, and usually dilatation are marked by a downward tendency in the secretion of this acid; ulcers, by a marked increase. So far as gastritis is concerned, the stomach-tube is clearly contra-indicated.

Subacute gastritis can scarcely ever require the tube, either for diagnosis or treatment, unless it is excited by foul, fermenting, soft masses. Chronic gastritis can usually be diagnosed from the state of the circulation and the history of the case; still, the tube is desirable in order to verify the diagnosis, and is invaluable for treatment. Copious hot alkaline drinks taken before meals are of some service in stimulating the sluggish circulation and washing away the tenacious mucus which dams up the feeble secretion of the glands, but one experience with lavage will teach us that the stomach must be filled and emptied several times before it is properly cleansed.

Dilatation of the stomach can be diagnosed without the aid of the tube, although the alternation of tympany and flatness and the metallic tinkle of bubbles bursting in the half-filled stomach are valuable tests, possibly only when the tube is used. In the treatment, the tube is almost indispensable to relieve the concomitant catarrh and to remove undigested remnants of food. Still, much good may be accomplished by giving predigested foods and antiseptics.

In cancer, the continued absence of hydrochloric acid, as determined from the analysis of the gastric contents, is diagnostic but not pathognomonic, as was at first claimed. Few cases of cancer fail to present other indications of their nature, and, without confirmatory evidence, the non-acidity would scarcely warrant a positive diagnosis. There are cases, however, in which every hint as to the true condition must be eagerly sought. All treatment, except possibly operative, is palliative, yet the tube is useful for the treatment of the accompanying catarrh and fermentation. However, there comes a time when any mechanical interference is dangerous.

As regards subacidity or, occasionally, non-acidity, loosely termed atonic dyspepsia, it must be borne in mind that, although 80 or 90 per cent. of the cases will be relieved by the administration of hydrochloric acid, there is danger, in the 10 or 20 per cent. of cases remaining, of giving inappropriate treatment unless the stomach-contents be examined. Acid neurosis, or supersecretion of hydrochloric acid, may be suspected from the occurrence of dyspepsia in a neurotic individual, from the account of sharp gastric pain temporarily relieved by taking food, from highly-acid eructations, and from the general characteristics of a state of over-excitement rather than depression of an organ. Still, the diagnosis needs the confirmation of chemical examination. The same neurosis culminates in peptic ulcer. The occurrence of a large hæmorrhage scarcely needs the assistance of the tube to establish the diagnosis, and the treatment both of the neurosis and of the organic lesion consists of physiological rest of the stomach and remedies to calm the overwrought secretory

nerves. Ewald refrains from introducing the tube in all cases of ulcer in which the diagnosis can be made in another way, the more so since in these cases the examination of the stomach-contents does not establish the diagnosis nor aid in the treatment.—*Therapeutic Gazette*, September 15, 1894.

#### A CASE OF AGGRESSIVE SURGERY.

A most interesting case of abdominal section for multiple gunshot wound of the intestines, with recovery, is described by Dr. M. L. Bennett, of Watkins, N.Y., in the *N. Y. Medical Journal* of Jan. 19. This case goes to show that surgical triumphs are by no means the exclusive prerogative of surgeons living in the great centres of population and surrounded by all the facilities which the presence of highly trained assistants, a full armamentarium, and nursing of a high order place at their disposal. The aggressive courage of a trained surgeon may develop wonders, whatever the surroundings may be, and the man who keeps in touch with the progress, with the surgical advance and the methods of the age, is at a much smaller disadvantage than is generally thought, even when he exercises his profession in villages and smaller towns. The case we refer to was that of an Italian laborer, suffering from a bullet wound an inch and a half to the right and a little below the umbilicus, and found by the surgeon lying on the grass, with a distended abdomen, a quick and feeble pulse, and a respiration of 40. The patient was sent home, a mile and a half, and preparations were made to operate without loss of time. As soon as all aseptic arrangements had been made, and assistants procured, the operation was begun. Between two and three pints of clotted blood were turned out of the abdominal cavity. Beginning at the descending colon, the intestines were methodically examined. Sixteen wounds of the intestines, located in the cæcum, ileum and jejunum, were found and closed with Lembert stitches. The peritoneal cavity was then carefully washed out. The wound was closed, leaving at the lower end an iodoform gauze drain. The patient quickly rallied, and improved every day. Twenty days after the operation a pain in the left sacral region revealed the presence of the bullet, which could be felt beneath the tissues, and was removed. A month and a half after the accident the patient was able to resume his occupation as a section hand upon a railway,—a rather extraordinarily short time after such an extensive operation.—*International Jour. of Surg.*

#### THE TREATMENT OF VOMITING IN CHILDREN.

The *Journal de Clinique et de Thérapeutique Infantiles* publishes the following directions and formulas to be used in the treatment of vomiting in children; Very young children

should be made to swallow small pieces of ice before nursing; milk, diluted with a little Vals or d'Alet water, should also be given. Before the child is nursed, 3 grains of bismuth subnitrate should be put on its tongue. The diet should be restricted, the milk sterilized, and the time of nursing properly regulated. For older children, iced drinks, ice, and effervescent waters are recommended. A teaspoonful of each of the following mixtures is to be mixed and swallowed while effervescing: 1. Potassium bicarbonate, 30 grains; syrup, 4 drachms; water, 1½ ounces. 2. Citric acid, 30 grains; syrup of citric acid, 4 drachms; water, 1½ ounces.

Fonssagrives recommends the following: Essence of cajuput, from 6 to 12 drops; sugar, 30 grains. When this is thoroughly mixed, add an ounce of syrup of Tolu and 3 ounces of Melissa water. From a teaspoonful to a tablespoonful of this is to be taken every hour. Huchard prescribed 75 drops of tincture of iodine and 4 drachms of saturated chloroform water, of which from 2 to 6 drops are to be taken in a little sweetened water.

For nervous children over twelve years old, Ewald prescribes cherry-laurel water, 2 drachms; tincture of belladonna, 75 drops; cocaine hydrochlorate, 4½ grains; morphine hydrochlorate, 3 grains. From 5 to 10 drops are to be taken every hour. The following formula is recommended by Guibourt: syrup of lemon, 6 drachms; lemon-juice, and orange-flower water, each 4 drachms; linden water, 2 ounces; Sydenham's laudanum, 9 drops; sulphuric ether, 15 drops; potassium bicarbonate, 30 grains. The bottle should be corked immediately, and from a quarter to a third of the mixture is to be taken at once. Le Bariller advises the use of the ether spray over the epigastrium; also blisters or the actual cautery over the same part.—*New York Medical Journal*, September 15, 1894.

Preferable to any of these we have found the following mixture, which has proved efficacious in vomiting of nearly every variety, including vomiting of pregnancy:

Cocaine Hydrochlor ..... gr i

Aquæ cinnamomi ..... ʒ ij

Sig.—One teaspoonful every half hour until vomiting is stopped.—(Ed. *Can. Med. Record*.)

#### TREATMENT OF PLACENTA PRÆVIA.

In an interesting article by Temple in the *International Medical Magazine* for September, 1894, the following conclusions are reached: In treating a case of placenta prævia, the very first question that forces itself upon us is to decide as to the advisability or otherwise of endeavoring to prolong gestation. Undoubtedly, in all cases of labor it is the duty of the accoucheur to endeavor, if possible, not only to save the mother's life, but also to give

every chance to the child. In all cases where both the mother's and child's life are in danger, the author gives the greatest chance to the mother, as her life is of far more importance than that of the unborn child. The question is one of the greatest importance, and one that deserves the most careful consideration at the hands of the attending physician. The line of treatment best to be adopted is not altogether a settled one; there are some who advise the immediate termination of the gestation on account of the real risk to the mother's life, and there are others who advise temporizing in the interests of the child.

No absolute hard-and-fast rule can be laid down; each case may possibly present some peculiar feature, calling for some special line of treatment. At the same time the weight of evidence is in favor of the termination of the gestation when the first attack of hemorrhage, especially if it be a severe one, occurs before the seventh month, for the following reasons:

1. The supposition is in favor of the placenta being centrally transplanted when the first attack of flooding is severe and prior to the seventh month.

2. The tendency of all such cases is of themselves to end in abortion and consequent death of the child.

3. When the hemorrhage occurs, even in the latter half of gestation, the tendency is towards abortion. It is estimated that only one-third of all such cases reach the end of gestation.

4. The liability to a recurrence of the hemorrhage at any moment is very great; consequently the woman's life is hourly in danger.

These are all weighty arguments against prolongation of the gestation. The great fatality from placenta prævia is in the occurrence of sudden severe hemorrhage in the absence of the physician. The first attack is usually slight, but it should be taken as a serious warning to us of the possibility of the next attack being very severe, if not fatal, before assistance can be got. The occurrence of hemorrhage in the early months of gestation so reduces the chances of saving the child's life that its welfare ought not to be considered at all alongside that of the mother. The wisdom of prolongation of gestation is open to serious question. Should the first attack of hemorrhage occur after the viable period of the child, then there should be no hesitation in the mind of the physician as to what he should do for his patient, as he should without doubt terminate the gestation as soon as possible. By so doing, the child and mother both have a much better chance of ultimate recovery. To delay is to increase both maternal and foetal mortality. On this point the words of Robert Barnes are worth quoting: "If the pregnancy have advanced beyond the seventh month, it will, as a general rule, I think, be wise to proceed to de-

livery, for the next hemorrhage may be fatal. We cannot tell the time or extent of its occurrence, and when it occurs, all, perhaps, that we shall have the opportunity of doing will be to regret that we did not act when we had the chance."

These are very significant words from a man of vast and varied experience. The few cases where it may be deemed advisable to prolong gestation in the interests of the child should present some, if not all, of the following features:

1. That the woman be very near the seventh month of pregnancy.

2. That the first attack of hemorrhage be but a slight one.

3. That the placenta be but laterally implanted.

4. That the woman be within easy reach of medical assistance.

Under such conditions the patient should be put to bed, kept absolutely quiet, free from all surrounding excitement, and possibly given an occasional dose of opium.

There is no virtue in the so-called astringents, such as acetate of lead, gallic acid, etc. The writer's own practice is not, even under such circumstances, to advise the attempted prolongation of pregnancy; the risks to the mother are too great and the chances of saving the child's life too small. Presuming the case to be one occurring after the seventh month, the attack of hemorrhage to be a severe one, and the cervix undilated, delivery should be accomplished as soon as possible. For this purpose he would advise that the membranes be ruptured; this allows the uterus to contract, and will of itself frequently be sufficient to check further loss of blood. The objections raised against this plan of treatment are that the normal means for dilating the cervix is removed, and that the chances against the child's living are increased. Still, it is the quickest way of securing rapid contraction, and thus stopping further loss of blood. If the flooding continues and the os is not sufficiently dilated to admit of version readily, and especially if the patient is much exhausted and not in a fit state to admit of version, the next best step is to separate the placenta by the finger from around the cervix as far as the finger will reach, as recommended by Robert Barnes. This, as a rule, answers promptly. It checks the flooding and it, also, favors dilatation of the cervix, for so long as the placenta retains its attachments to the lower zone of the uterus the cervix will not readily dilate. The internal administration of ergot may be resorted to from the first.

In the event of these means failing, and if the flooding still continues, while the cervix is still not dilated so as to admit of version, plugging the vagina firmly with antiseptic tampons should be resorted to. Before plugging, the vagina should be carefully syringed out with an

antiseptic lotion; this method, if properly applied, is very efficient. The plugs, however, must be carefully inserted, one after another; the first one should be placed within the cervix itself, and then the others in rotation till the vagina is perfectly full. The plugs may be made of clean strips of cotton or wool, previously soaked in some antiseptic solution. On no occasion should a sponge be used which has been in use in the house for other purposes. After the vagina has been carefully packed, a firm pad should be placed over the uterus, and the whole kept in position by a carefully applied bandage. The tampons should not be left in longer than six or eight hours, and when removed the vagina should again be syringed out.

Lastly, if on removal of the plugs the os be found sufficiently dilated to perform version, and the woman herself be in a fit state for the operation, it should be done. The bipolar method being used, if possible, the leg of the child when brought down will both form an efficient plug and further assist in dilating the cervix. The operation of version by the bipolar method may be undertaken at any time in the course of the treatment whenever the cervix will permit of it.

In Berlin it is claimed that by this method of treatment the mortality has been reduced to four and one-half per cent. of women and sixty per cent. of children,—a marvellous reduction as compared with what it used to be.—*Ther. Gazette.*

#### SKIN-GRAFTING OF STUMP AFTER AMPUTATION.

By CHARLES MCBURNEY, M.D., *Professor of Surgery at the College of Physicians and Surgeons.*

The case upon which I will operate is one that requires skin-grafting in order to cover a large, granulating surface on the arm. It is an interesting one, because it illustrates the best method of treatment in a good many cases of traumatic surgery. By means of it we can often save large portions of tissue, which, treated according to ordinary principles, would surely be sacrificed. Take, for instance, a case of compound fracture of the thigh, with extensive laceration of the bone and soft parts. The injury was inflicted perhaps in a railroad accident, or by heavy machinery; the wound is filled with coal dust or filth, and the patient is brought to the hospital in a state of profound shock. Formerly, the approved method of treating such a case was to get rid of all the septic material by performing an immediate amputation above the wound. One serious objection to this is that, as these patients are usually suffering from shock and hemorrhage, an immediate and prolonged operation often proves fatal. The way in which we have treated quite a number of such cases here,

among them the one upon which I am about to perform skin-grafting, is as follows: If there are any bleeding vessels, they should be secured at once; then, with the scissors, any shreds about the stump are snipped off, and the whole area cleansed as thoroughly as possible. The wound is left wide open—not a single stitch being put in—and dressed with sterile gauze, just as though you were dealing with a clean wound and expected primary union. All this can be done within ten or fifteen minutes, and without the aid of an anæsthetic. These wounds, no matter how dirty they are, if thoroughly cleansed and kept wide open, do very well indeed. Perhaps, at the end of a month or two—or as soon as the patient has recovered from the effects of the injury—an amputation can be performed, if necessary.

This patient, about six weeks ago, had his left arm caught in a cog-wheel, producing great destruction of the tissues, and almost severing the forearm about three inches below the elbow joint. The wound was treated very much in accordance with the principles above laid down, and we now have, as you see, a fairly good stump, with an extensive granulating surface extending almost up to the elbow joint. The question now arises whether it is better to remove this stump, or make an attempt to preserve it by skin-grafting. Even such a small portion of the forearm as this is of enormous value, while if we amputate at or above the elbow, the left arm will be practically useless. The best method of skin-grafting is that of Thiersch, which I have shown you here a number of times. One point in connection with this operation is the absolute necessity of complete asepsis. Both the wound for which the grafts are intended, and the surface from which they are taken, should be carefully prepared; in cleansing these surfaces, we employ warm normal salt solution, not strong antiseptics, which are apt to produce necrosis of the tissues and prevent healing. When we have a granulating surface to deal with, the question comes up, shall we put the grafts directly on the granulations, or first produce a raw surface with the knife or curette? The latter plan, I think, gives the best results, and in granulating ulcers of long standing it is advisable to first excise the ulcer, making an entirely fresh surface.

Before scraping this wound with the curette, I shall apply the Esmarch bandage. The statement has been made that in making skin-grafts on the extremities, the use of the Esmarch is contra-indicated, the writer claiming that it cuts off the blood supply from the surface, and thus interferes with the growth of the grafts. I do not agree with this statement. We have tried both methods here, and I do not think that the use of the bandage interferes at all

with the grafts. On the contrary, if they are applied to a fresh surface from which the blood supply is not cut off, the accumulation of blood underneath the grafts may lift them, and cause them to necrose. The grafts in this case I shall take from the patient's thigh. Two parallel incisions, about five or six inches long, are made through the skin, the tissues are then put on the stretch, and the grafts cut off with a razor and immediately transferred to the arm. This is repeated until the entire wound is covered. This newly grafted surface should be kept moist, and for this purpose we cover it with thin rubber tissues, which in turn is covered with compresses moistened in salt solution. This dressing is removed in 48 hours, and a similar one applied. This is repeated every two or three days for about two weeks, when a dry dressing with gauze will usually suffice. The Esmarch is left on for about half an hour. The process of dressing the wound on the thigh, from which the grafts were taken, is very simple. It is covered with a layer of rubber tissue and dry gauze, and the bandage is left undisturbed for seven or eight days, by which time the entire surface is usually covered with epithelium.—*The Intern. Jour. of Surg.*

#### CATHETERIZATION OF THE STOMACH AND OESOPHAGUS.

In his recent work on gastric diseases, Dr. Bouvret, of Lyons, gives a careful study of catheterization of the stomach, and we are indebted to *L'Union Médicale du Canada* for the following interesting particulars:

The author advises the use of the soft instruments, made like the familiar Nélaton catheter, but quite long, and, of course, of a much larger calibre. The olivary bougies with a flexible stem are also of use, but the soft instruments are preferable in most cases, as they allow of the injection of alimentary liquids, when a stricture has been overcome. A calibre of 12 millimeters is the most generally useful, although it is well to have several sizes on hand. It is an error to think that the smallest sizes are most easily introduced. These instruments must be kept aseptic. Before being used, they are dipped in a solution of boric acid, and are then placed in warm water for a few minutes. In cases of syphilis, tuberculosis and cancer, a special instrument should be kept for the exclusive use of the patient. The indications for catheterization are: Symptoms indicating a possible stricture or the existence of oesophageal diverticula; dyspeptic phenomena requiring investigation of the chemical condition of ingesta, and symptoms showing the necessity of washing out the stomach, either in poisoning or for the usual therapeutical purpose. The author gives a long list

of contra-indications to gastric catheterization; these consist in senility, pronounced cachexias, pregnancy, various cardiac and arterial diseases, pulmonary conditions associated with dyspnoea and an enfeebled heart's actions. Disturbances of the cerebral circulation and recent hemorrhages, especially from the brain, the stomach and the respiratory system, are of great importance in this respect. While patients seldom refuse to lend themselves to this procedure, there are a certain number who will not consent. The longer the duration of the disease, and the more unsuccessful previous treatment has proved, the more readily will patients consent. It is rather important to succeed at the first attempt, as a failure to pass the tube discourages the patient, and causes him to refuse any further trial. The heart should be auscultated before practising this proceeding, as well as the lungs and aorta. An aneurism of the latter may be the cause of a stricture. All artificial teeth should be removed, unless firmly attached. The author describes the procedure to his patients before introducing the tube for the first time. He tells them that notwithstanding a temporary sense of constriction in the throat, they will be able to breathe quite well, since the tube does not go into the wind-pipe. When beginning the operation, the patient is told to breathe quietly and rather deeply, and to look at the operator, who himself begins to breathe in this manner. The suggestive effect of this causes the patient to do the same, and is of material benefit. The patient's head must not be thrown back, for this position does not facilitate the introduction and disturbs the cerebral circulation. The author has never found it necessary to anaesthetize the pharynx, which may be done by spraying or swabbing with cocaine solution.

With a soft instrument it is unnecessary to introduce the finger into the patient's mouth. The tube is placed upon the tongue and gently pushed backward. The upper orifice of the oesophagus is the difficult place to pass. The patient must be told to swallow. If he fails to perform this act, the physician waits, exerting meanwhile a gentle pressure, and soon an involuntary movement of deglutition takes place. The tube then penetrates, and is gently and steadily pushed home. The possible accidents due to this procedure have been much exaggerated. They arise from inattention to the contra-indications that have been mentioned, from the rupture of a diseased oesophagus, or from passage of the tube into the larynx,—a rather inexcusable accident. In some cases the instrument produces sharp, gastric pain. This is always due to the existence of a local gastric lesion, ulcer, cancer, or the pressure on an adjoining diseased organ.—*International Jour. of Surg.*

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MONTREAL, MAY, 1895.

**SIR WILLIAM H. HINGSTON.**

During the past year the CANADA MEDICAL RECORD has on several occasions in its editorial columns drawn the attention of the Government to the fact that the Medical Profession of Canada was not receiving its fair share of imperial honors ; that while there were a dozen of political knighthoods and half a dozen legal ones, this honor had so far been conferred upon only one medical man. We are glad to be able to announce that the Government of Canada, recognizing the justice of our claim, pressed it firmly upon the British Government, with the result that one of the most distinguished members of the Profession in Canada was selected and recommended to Her Majesty ; on the 24th of May, the Queen's birthday, the honor of knighthood was conferred upon Dr. Wm. H. Hingston. We are in a position to state that this action of the British and Canadian Governments has given the greatest possible satisfaction, not only to the profession of Montreal, but of the whole of Canada, and indeed wherever Sir William H. Hingston's noble and gentle qualities are known. He had already received the highest honor which his brethren could confer upon him when they elected him many years ago President of the Canadian Medical Association. A similar honor had also been conferred upon him by the Medico-Chirurgical Society and the Union Médicale of Montreal, while the citizens of Montreal testified their esteem by electing

him their Chief Magistrate or Mayor. But this last honor which has fallen to his lot, coming as it does from the hands of our beloved Sovereign, not only honors the individual but honors the whole noble profession to which he belongs. There is an old French saying, *Noblesse oblige* ; let this honor which has come to our profession be an incentive to the rank and file of us to elevate and uphold its nobility by burying the few petty jealousies and differences which may exist among us. It has often been claimed, and, we believe, justly, that nowhere on the continent of America is there a more honorable feeling governing the relations of medical men to their brethren and the public than in Montreal, where the loyal observance of the golden rule of doing to others as we would have others do to us has almost done away with the necessity of a code of ethics. For this happy state of affairs we are largely indebted to the precept and example of our elder brethren, and to none more so than to Sir Wm. H. Hingston. That he may long be spared to enjoy the honor which he so well deserves is the CANADA MEDICAL RECORD's most earnest wish.

**THE AMERICAN MEDICAL ASSOCIATION.**

The recent meeting of the above Association was one of the most successful in its history. The papers and discussions in the sections were of a high order of merit, and many mooted points in practice were fairly well decided upon as a result. Work began punctually each morning and afternoon at the appointed hour, and the proceedings were never allowed to drag for one moment until the hour for adjournment came. So keen was their thirst for knowledge, that several hundred members each day devoted the lunch hour to attending operations at the Johns Hopkins and other hospitals, where, especially at the former, every facility that art could suggest and wealth could procure have been placed at the disposal of the operators. The general sessions were presided over in a courteous and, we might almost say, elegant manner by Dr. Donald McLean of Detroit, whose Presidential address was a gem of Medical literature which we have since read over several times without its losing any of its interest. Although we attended the meeting

as an American, we could not suppress a little feeling of Canadian pride when we remembered that Dr. McLean was for many years a professor in a Canadian college. It was a matter of gratification for all connected with the Association to see so many members present from the most distant cities of the Continent, Portland, Ore., Portland, Me., Los Angeles, Atlanta and San Francisco, one member from which last city, Dr. Beverly Cole, having attended nearly thirty meetings, and after having travelled on many occasions twelve thousand miles by sea to do so, was fittingly rewarded for his devotion by being elected president for the coming year. Dr. Beverly Cole is a courtly old gentleman of fine address, and will doubtless fill the exalted position with credit when the Association meets at Atlanta next year. There was a notice of motion to throw the membership open to Canadians on the programme; but owing to the absence of the mover, Dr. Reed of Cincinnati, it was left over till next year. In the meantime, the few Canadians who were present were received with that generous hospitality for which our brethren in the United States have obtained a world-wide reputation. The social features of the meeting were not the least successful ones. The leading officials were the recipients of much private hospitality, while the members generally and their wives were lavishly entertained by the profession of Baltimore at their homes, and also at a banquet and concert in the largest music hall of the city. Dr. Rohe's banquet to the Gynæcological section at the Maryland Insane Asylum was one of the most enjoyable ones we have ever attended, and will long be remembered. What with listening to papers, attending operations, renewing charming acquaintances with the members and their wives, and attending entertainments, the general opinion, which we heard expressed on every hand was that it would be difficult or impossible to surpass the 1895 meeting in the city of Baltimore.

#### THE KINGSTON MEETING OF THE CANADA MEDICAL ASSOCIATION.

The life of every physician is a particularly anxious one, and one which is unusually wearing. Not only working often as many as sixteen hours a day, but from the very nature of his work, dealing as he does from day to day with questions of life and death, the doctor

more than any other working man especially needs a holiday. When and where to take it is a good deal a matter of taste. It is said that a New York street car driver, when given a week's holidays, spent it in riding up and down on the street cars with another driver who was on duty; some physicians feel that they are benefited in body and mind by visiting their brethren in other cities and watching them at work. Others derive most recreation by a week or two communing with nature by forest, lake or stream. This being a complete change probably does the most good. But the wisest way of all is a combination of these two methods, an opportunity for which is afforded by the meeting of the Canada Medical Association in Convocation Hall, Queen's University, Kingston, on the 28th, 29th and 30th of August, which promises to be one of the most successful meetings in the history of the Association. The place of meeting is about the centre of Canada, and the time the most convenient possible. The meeting will be presided over by Dr. William Bayard, a hale and hearty doctor over eighty years of age. It is expected also that Sir Charles Tupper, M.D., the first president of the Association, will also be present. The programme will also be of exceptional interest, so that what one learns at such a meeting repays him many times for the time and expense. Kingston is the centre of tourist trips, so that before or after the meeting one can retire to some secluded spot, or take a series of trips on the rivers and lakes in the vicinity, until a good stock of health has been laid in to meet the demands of the hard winter's work. For those who take an interest in electricity, which is now assuming so much importance in the treatment of nervous and female diseases, a hearty invitation is extended to attend the meetings of the American Electro-Therapeutic Association which meets in Toronto on the first three days of September. If for no other reason, finally at least from motives of patriotism, let each individual member of the Canadian medical profession feel that the success of our national organization depends upon our presence there. Out of six thousand physicians in Canada there should at least be six hundred present. The railway and steamboat companies will allow the usual rates of one fare and a third for the return ticket.

## THE BUFFALO MEDICAL AND SURGICAL JOURNAL.

There are very few medical journals in this new country that have lived to reach the age of fifty years. Those which have done so have been founded well and been ably managed, for only the fittest can survive. This is no exception to the rule. No one can have read the above journal regularly for the last ten years as the writer has done, without having felt that a man of more than usual energy and ability was at the head of it, while all who know Dr. William Warren Potter will recognize at once that he is just such a man as could bring these results about. We congratulate the *Journal* on its jubilee, and we wish for the *Buffalo Medical & Surgical Journal* at least another fifty years of such prosperity as it has had in the past, and we trust that its editor may long be spared to direct its usefulness. Its reading pages will, we are informed, be largely increased, and other improvements will be made which will greatly increase its value to its readers.

## BOOK NOTICES.

**INDEX OF MEDICINE.** By Seymour Taylor, M.D., Member Royal College of Physicians, Senior Assistant Physician to the West London Hospital. In one large 12mo. volume of 801 pages, with 35 engravings. Cloth, \$3.75. Philadelphia: Lea Brothers & Co.

The author has prepared a work of great value alike to physicians and students. In a certain sense the name "Index" is a misnomer, for the volume is in fact a concise "Practice of Medicine," the diseases being grouped systematically in order to secure for the reader the many advantages resulting from rational arrangement. After valuable chapters on "Disease," "General Pathology," "General Diseases," "Specific Infectious Diseases," and "Specific Fevers" the various organs and systems of the body are considered, and the cause, symptoms, pathology, treatment and prognosis of each affection are succinctly stated. Numerous illustrations, together with tabulations of differential diagnosis, tests, etc., elucidate the text and condense a great amount of necessary knowledge in the clearest manner. The work is one which merits and will doubtless obtain a wide popularity.

The author enjoyed during many years the privilege of listening to the lectures of Peacock, Bristowe, Ord and Shand-Smith, and he states in his preface that his work is largely prepared from his own notes taken at their didactic and clinical lectures. This has given to it a decidedly practical aspect, and we cannot read even the first chapter without being charmed with the clearness and conciseness of the author's style.

**A BOOK OF DETACHABLE DIET LISTS.** For albuminuria, anæmia and debility, constipation, diabetes, diarrhoea, dyspepsia, fevers, gout or uric acid diathesis, obesity, tuberculosis, and a sick-room dietary. Compiled by Jerome B. Thomas, A.B., M.D., Visiting Physician to the Home for Friendless Women and Children and to the Newsboys' Home; Assistant Visiting Physician to the Kings County Hospital; Assistant Bacteriologist Brooklyn Health Department. Published by W. B. Saunders, 925 Walnut Street, Philadelphia, Pa. 1895. Price \$1.50.

With this book on his desk, all that the physician has to do is to tear out a list, check off the food prescribed, and hand the list to the patient. Many a time the physician feels that it would be much better for the patient if he had his dietary written out; but being pressed for time, he is often reluctantly compelled to leave his orders in a verbal manner. This book of detachable leaves meets this difficulty. No one could think of all the suitable and unsuitable articles of diet for a given case on the spur of the moment; but everything will be found in these complete lists. The lists are numbered, and the key to the numbers is reserved for the physician. They will be found exceedingly handy.

**THE TREATMENT OF WOUNDS, ULCERS AND ABSCESSSES.** By W. Watson Cheyne, M.B., F.R.S., F.R.C.S., Professor of Surgery in King's College, London. In one 12mo. volume of 207 pages. Cloth, \$1.25. Philadelphia: Lea Brothers & Co., 1895.

This little work owes its brevity and its widespread usefulness to the fact that it is devoted wholly to the treatment of affections which, though nominally surgical, are yet so common as to form part of the daily work of every practitioner. Antiseptic methods have revolutionized surgical procedures and have added vastly to their successes. Moreover, by throwing light upon formerly unexplained failures, they have increased not only the knowledge but also the confidence of the surgeon, an element which must be recognized as having an important influence upon results. Professor Cheyne has long been known as one of the foremost of London surgeons, and as a critical student of antiseptic procedures in their practical bearings. In this volume he has described the methods of treatment which he



employs, and which he knows "to be efficient and to be the simplest consistent with certainty in results."

THE YEAR BOOK OF TREATMENT FOR 1895. A comprehensive and critical review for practitioners of Medicine and Surgery. In one 12mo volume of 501 pages. Cloth, \$1.50. Philadelphia: Lea Brothers & Co., 1895.

The eleventh consecutive issue of this annual summary of medical progress will interest the wide circle of readers who have learned its substantial value. To have the real advances in treatment in all departments of medical practice culled by recognized specialists from the immense mass of medical literature, and presented with critical remarks in a classified form for immediate use, is assuredly a help towards success which busy practitioners will not neglect, and which other practitioners will consult for the soundest of business reasons. The reader interested in a special subject can quickly post himself on whatever is new and good in treatment by a perusal of the chapter devoted to it, and the general practitioner can with facility turn to any topic by a glance at the index. Those desiring to read up the literature of any subject can find no more convenient guide than the selected list of new books, new editions and translations. The volume is exceedingly cheap in proportion to intrinsic value and serviceableness.

#### CLASS-ROOM NOTES.

Prof. Keen says warty tumors are best removed by the application of a caustic, such as sulphuric acid or nitric acid; and if removed by mechanical means their bases should invariably be touched by a strong caustic.

In cases of rheumatic fever, Prof. Wilson says the heart may become affected in all kinds of cases. The mildest cases suffer as well as the severest. The heart may also become affected at any stage of the disease, but very seldom during the earlier stages of an attack.

### PUBLISHERS DEPARTMENT.

#### MALARIAL CONDITIONS.

For all malarial conditions quinine is the best remedy we have. But associated with this condition there is always more or less pain, which often renders the life of the individual uncomfortable, if not positively miserable. Antikamnia will remove these unpleasant symptoms, and place the system in the best condition for the quinine to

do its work. There are a number of ailments, not closely defined, which are due to the presence of the malarial poison. All such conditions are greatly benefited by the use of antikamnia and quinine. In headache (hemikrania), in the neuralgias occurring in anæmic patients who have malarial cachexia, and in a large number of affections more or less dependent upon this cachectic condition, the regular administration of this combination will produce the most happy results. In cases of malarial fever it should be given as a prophylactic and curative.

"Antikamnia and Quinine" are put up in tablet form, each tablet containing two and one-half grains of antikamnia and two and one-half grains of quinine, and is the most satisfactory mode of exhibition.

#### A NEW ART EDITOR.

WILLIAM MARTIN JOHNSON, who illustrated the "Garfield" edition of "Ben Hur" for the Harpers, and also their editions of "The Cloister and the Hearth" and "Hypatia," becomes the art editor of the *The Ladies' Home Journal* on June 1st, leaving New York to reside permanently in Philadelphia. Mr. Barton Cheyney, a clever newspaper man, who has been attached to the press of Delaware and Pennsylvania, is also added to the *Journal's* editorial staff as one of Mr. Bok's principal associates.

#### JULIA MAGRUDER'S NEW NOVEL.

Miss JULIA MAGRUDER, whose story of "The Princess Sonia," in the *Century*, is attracting such favorable comment, has given her new novel to *The Ladies' Home Journal*. It is called "The Violet," and deals with the question of second marriage. Mr. C. D. Gibson, the illustrator, is making a series of pictures for the novel.

While at this time other magazines are pressing their claims to the favor of the intelligent public, those of *Littell's Living Age* are not likely to be forgotten by those who know what its services have been in the spread of the best periodical literature throughout this continent.

The price of the magazine, \$8.00 a year, is small in view of the vast quantity and high quality of its contents, a year's numbers forming four large octavo volumes of 824 pages each. As a special inducement, to any who desire to make a trial subscription, the twenty-six numbers, forming the first half of the year 1895 (January to June inclusive), will be sent for \$3.00. To anyone remitting \$6.00 in payment for the nine months, April to December inclusive, the thirteen numbers forming the first quarterly volume of 1894 will be sent free.

Perhaps no better exhibit could be found of the progress and expansion of thought in the different fields of literature, politics and science during the last half century than a complete set of *Littell's Living Age* would present. Each volume is a mirror reflecting the living literature of the month it covers.

Published by Littell & Co., Boston.