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Original Communications.

BRAIN LESIONS AND FUNCTIONAL RESULTS.

BY DANIEL CLARK, M.D., TORONTO.

(Read before the Canada Medical Association, at Ottawa, Sept. 1st, 1880.)

(Continued from page 4.)

It is satisfactory to see that recent investigators are paying more attention to the central organs. Their researches go to show that very important functions are likely to be found having their excito-motor centres in the internal parts of the brain. These experiments, as far as they go, point to the probabilities of my theory of localization. Richet, in speaking of cerebral excitation by means of electricity, is forced to say in explanation of certain phenomena, "Known facts demonstrate that excitation of the convolutions which surround the sigmoid gyrus act with extreme energy upon the ganglionic centres of the brain (opto-striated bodies). It is possible that such excitation culminated in the cerebral centres, and that these centres thus surcharged discharge to the muscles." Charcot says, in speaking of the lenticular nucleus of the *corpus striatum*: "These grey nuclei are possibly so many centres endowed with distinct properties and functions." This is a germ idea of the theory which I propounded several years ago in the following words: "Large portions of the cerebrum and cerebellum may be taken away from the living body without immediate danger of death; but the organs in the base of the brain, from which spring the numerous nerves so essential to life, cannot be touched in

vivisection or by disease with impunity. From this central region nerve influence radiates to every part of the body, making its connections with the depositories of nerve-power in the spinal cord and with the ganglia of the sympathetic system."—(*Vide* "An Animated Molecule," p. 38.) If Charcot had added to his hypothesis the probability that the base and central ganglia were the true and only motor centres, a solution of the difficulties which surround the Ferrier system could be arrived at without ignoring the doctrines of localization. Let the area be circumscribed to really the most vital parts of the brain, then, could all phenomena be explained. It would then become more evident why traumatic injury and destruction from pathological processes are not always followed by functional and mental unsoundness. If this explanation be accepted, it will be seen that the surfaces and upper portions of these nervous masses thus become adjuncts to vital organs in the centre and base of the brain. The former, in their analogy of structures and juxtaposition, give power but do not impart function; they are auxiliaries, but not necessities, to the ganglionic centres; they intensify energy, but do not direct; they are, as it were, additional cells to the battery, but are not its controlling agency. I repeat this view in another form to avoid ambiguity and misconception.

It is worthy of remark in this connection, as it is a matter of experiment, that such a large area as the Rolandic zone can be destroyed, and yet leave the intelligence unimpaired. A considerable portion of the frontal or even of the occipital lobes can be removed without any apparent alteration of the intellectual powers.

The corresponding lobes of either the frontal, occipital or parietal regions have been destroyed without affecting the conscious being, or those functions said to have their seat of power in these parts. It is evident then that these are not the *sole* habitations of mind or certain physical operations. The reciprocity between mind and body is strikingly seen in aphasia. There can be no aphasia without more or less impairment of the memory, judgment and imagination. Yet this functional and mental disorder can exist either with or without injury to the third frontal convolution. What basis then is there to suppose it so necessary to certain physical operations?

If it could be shown that sight, hearing, tasting, often were accomplished when the optic, auditory, and gustatory nerves and the region of their insertion, were destroyed, then would it be plain that these were not the only tracts of nerve influence for these centres of special sense to reside in, nor the avenues of each peculiar manifestation of sensation. In the same way, if we can have aphasia, paralysis of the legs, arms and face, with these so-called centres of nerve force unimpaired, or if impaired without these results, then is it beyond controversy that this doctrine of the cortical localization of specific functional energy is not proven. What may be in store in the future for these earnest and honest workers is only a matter of conjecture. As Richet pertinently says (page 115), "If the convolution which surrounds the crucial furrow is really the motor centre of the legs, then by removing both right and left convolutions the legs should become paralyzed; if not, then is it not a true motor centre. It would then be necessary to admit that there are several organs for one function, several motor centres for one limb, which is contrary to probability and to fact." He suggests as a way out of the difficulty that as the spinal cord conduction (according to Vulpian) is carried on equally by all parts of the grey matter, it is possible that the same indifference holds for the brain, though less in degree. In other words, *there are habitual roads, but no compulsory ones.* This view would be, if true, a death blow to the organic local

theory as applied to the cortex. This theory would not meet Ferrier's definition of localization, which is said by him to be "a complex arrangement of individually differentiated centres, which in associated action regulate the various muscular adjustments necessary to maintain equilibrium of the body."

It will be seen that so far the greatest interest centres round the third left frontal convolution, on account of the stress laid on the fact that aphasia is so often found as a result of its injured or diseased condition. If it can be proved that this imperfection of speech is always conjoined with an impaired condition of this locality, and *never otherwise*, then is the battle won for localization of functional power in the cortical substance, for it would be fair to infer that other centres for other functions would be found in similar parts of the same field of investigation. Unfortunately for this doctrine, the exceptions to these results are too many to be ignored, and these show that this spot is not the centre of speech, nor its injury the sole cause of aphasia. It has been found in numbers of examples that aphasia is found with this convolution intact. Not only this, but it is known that speech, in its different forms of language, such as writing, reading, singing, drawing, and imitation—in fact, aphasia in all its forms—follows lesion in the Island of Reil. (*London Lancet*, Amer. Ed., July 1880, p. 34.)

Aphasia is known to exist as the result of disease in the right hemisphere, and that not in the corresponding third frontal of that hemisphere. It cannot be supposed this reputed motive brain tissue which excites the functions of speech may be destroyed, and yet the peculiar energy which animates it can remain unabated after its obliteration has taken place, unless it is claimed that the corresponding convolution on the right, in a vicarious way, does the work of its fellow. If such were the case, then the third left frontal convolution could claim no pre-eminence as the sole seat of the faculty of articulate language. To get over this difficulty, this school of thinkers introduces what is called *the theory of supplementation.* They say some other part of the cortical substance comes to the rescue when

any centre of function is destroyed. This neighbourly assumption of peculiar and distinct labour is not found in any other part of the system, however willing the organs may be to give a helping hand to one another. We are told it may be the corresponding part of some other cortical area. This is virtually a giving up of the doctrine of these so-called "true motor centres."

Here let me say, in passing, that a fallacy in vivisection often arises in forgetting that experiments on the brains of inferior beings by the destruction of parts do not always produce analogous effects on man when corresponding parts are injured. We may remove the whole of a cerebral hemisphere of a pigeon or rabbit with the only functional result of a slight impairment in flying or jumping. No hemiplegia will follow, such as is the case with like injury to the dog or monkey. Man is much more sensitive to such lesions, only in certain parts. In fact, the whole brain may be removed in many creatures without affecting their locomotion. We know that in man disease, such as sclerosis, and softening, may cut off the spinal cord from cerebral influence, yet functional activity goes on with unabated vigour. In the same way, we find that if the base and central organs remain unimpaired, no marked symptoms arise, except by sympathetic connections with adjacent parts. This shows the fallacy of reasoning by analogy between man and animals based on experiments. There are common results and also great differences.

It is now important to say a few words about the circulation of the blood in the brain, to show how much more plentifully the centre and base are supplied with blood than are the superior parts of the cerebrum and cerebellum. *It is not to be forgotten that where the largest supply of blood is needed, there is found the greatest functional activity.* We are all well acquainted with the wonderful distribution and anastomoses of the blood in the base of the brain, both in the circle of Willis and in the cerebral arteries springing from this polygon of vessels. We are also aware of the fact that two sets of branches shoot from these main trunks in almost parallel lines. The one

class goes into the medullary and cortical substance in an outward direction from those central reservoirs, but does not reach the surface. Another class runs to the periphery and forms the *pia mater*, from which branch inwards numerous arterioles to supply the cortical and medullary parts not reached by the vessels springing from the centre. These two sources of supply are not only distinct as between each of their own vessels, but also unconnected to a great extent with one another. The anastomoses between these two sets of vessels is very slight indeed. The streamlet in each can be dried up or seriously interrupted in many ways without disturbing the neighbouring vessels to any appreciable degree. This accounts for so many circumscribed lesions in these parts, and for the little effect they produce on the adjacent tissues and circulation. I am inclined to think, that on account of this localization of circulation, and consequently a tendency to restricted areas of disease, a good many fallacies of reasoning have obtained currency in respect to centres of function. Heubner cites pathological cases which indicate that obliteration of one of the large vessels of the cortical system, or any of its branches, has during life given no pronounced symptom. (Charcot.)

Let us now turn to the arterial circulation in the *grey central ganglia*. This section includes the *thalami optici*, the *corpora striata* and their appendages. It needs only a moment's reflection of our anatomy to realize that the central ganglia are largely supplied from the Sylvian artery, as well as from the nutrient vessels, which spring in large numbers from all the cerebral arteries and from the basilar at its bifurcation. The sum total of all these shows a much greater capacity for blood supply per square inch than in any other part of the brain. Such being the case, we know this augmented normal supply means proportionally increased activity. Hence it follows as a matter of fact that any abnormal increase or decrease of blood means a greater or less physical or mental perturbation. Congestion, as well as anæmia, is followed by the same results—that is, more or less suspended sensibility and retarded voluntary action. Where the blood supply is found to be

naturally the most copious, there is greater susceptibility of this kind, and as a corollary it may be added, there is functional activity in proportion to the normal blood supply. The difference in this respect between the cortical substance and the central parts is most marked. This points to the former as being only subsidiary to the latter, taking the circulation as a physiological basis to judge from in this respect. Although the central and base ganglia are much less in bulk than is the cortical substance, yet, about one-half of the blood which enters the encephalon is distributed to the former. It would be interesting to know if this unequal supply has anything to do with the pathological fact that in hemiplegia from cortical disease we find it "limited, transient, and variable" (Charcot), but in paralysis of the body from central disease it is permanent, general and uniform. It is a pathological fact that paralysis, general or partial, can be produced by *any part* of the brain being affected with inflammation, embolus, or tumour; showing that loss of function is not consequent on degeneration or destruction of some localized spot. That part of the brain which demands the greatest amount of blood in the performance of its work must necessarily have the greatest activity.

Let me then repeat in another form that a very superficial knowledge of the brain circulation indicates how direct and ample is the blood supply to the base and central ganglia in comparison with the cortical supply. This is especially true of the arteries which run to the *corpus striatum* and *thalamus opticus*. The cortical substance is nourished in a roundabout way through the *pia mater*, but the central system is reached directly through the large central vessels springing from the circle of Willis, which furnish a perfect fountain of blood supply near at hand. So distinct and important is the circulation in this grand centre, that when obliteration of the Sylvian artery takes place, all the ganglionic centres are affected, and cerebral hemiplegia accompanied by hemianæsthesia is the result. This physiological fact alone shows the greater importance these ganglia hold—it seems to me—as functional centres in comparison to the cortex or even the

entire hemispheres. Since writing the above, I find that Prof. M. Schiff, of Florence, has caught the same idea, when he says, in his monograph on "motor centres," that "human and comparative pathology have stated with certainty that the motor centres do not extend above the base of the brain." Unless my attempt to be brief has led to ambiguity, it will be seen that among the probabilities of this obscure subject, the explanations I have given in defence of the theory enunciated are based on—

I. The radical difference found in the circulation of the blood, both as to mode of distribution and quantity, leading to the reasonable inference of greater functional activity existing in the centre than in the circumference of the brain. The more life-action in any part, the more is blood supply needed.

II. The want of uniformity in functional results, when definite and alike portions of the cortical substance are stimulated, impaired or destroyed; hence, this cannot be the seat of so-called true motor centres.

III. It would be consonant with pathological and experimental facts to locate these motor and physical centres in the base and centre ganglia; yet in sympathetic relations, being influenced, but not absolutely controlled, by the cortical substance.

IV. The want of distinctive physiological features in the different convolutions.

I will now give a few examples of brain injury, illustrative of these views. The first are culled from the surgical records of the war of the late American rebellion:

Private Hughes was wounded at the battle of Antietam. The hospital reports say that the injury was a perforation of the skull by a single conoidal musket ball entering near the inner posterior angle of the right parietal, and emerging at a higher point of the left parietal, making, after traversing a portion of the brain, a large exit wound. At the time of this extensive injury he dragged himself from the field, but *he did not lose his consciousness*. Eight days after the injury, it is reported the general condition of the patient was good; suppuration had commenced, no febrile action existed, the pulse was regular; sleep not ma-

terially disturbed, *mind clear*, and manifested no signs of compression of the brain, or inflammation of its membranes. When the swelling of the scalp subsided, a prominence of brain substance was found—one inch in height, and three inches in length—in which the pulsation of the arteries could be distinctly observed. Spiculae of bone came away from time to time, and the tumour subsided within the cranium. On December 20th, 1870, or over eight years after the injury, he was examined by two medical men. Previous to this time he had worked in an iron foundry. His memory remained quite good. He had no paralysis, and it is reported by Drs. Keen and Thomson that it is remarkable to observe the almost entire restoration of his mental faculties, especially in view of the probable deep lesion of the brain, both by the primary injury and the subsequent fungus cerebri.

It will be seen that in this case there was no functional disorder, except that, for a short time at first, "the brain functions seemed clouded." This might be expected for a time.

Private Sheridan was shot through the left temporal region. The missile lodged in the brain and was never extracted. At the close of the war he was discharged—recovered, and received no pension. No functional disturbance.

Corporal Farnum, wounded by a round ball entering the cranium and brain matter. He recovered, and was put on the Veteran Reserve Corps. He was not pensioned. He was none the worse for the wound.

Private Dillon was wounded by a bullet which entered the cranium very near the superior angle of the occipital bone, and had passed anteriorly into the substance of the brain. He lay on the field of battle two days without any attention. After being a year invalided he returned to active service, perfectly well physically, but with the intellect slightly impaired. Afterwards he was mustered out of the service perfectly well, and was not pensioned. The ball was not extracted. After the first shock there was no functional disturbance.

Private Bemis, wounded by a ball entering a little outside the left frontal pro-

tuberance, and passing backwards and outwards. It removed a piece of the squamous portion of the temporal bone, with brain substance and membranes. When the patient entered the hospital, brain matter was oozing from the wound. At first, respiration was slow; pulse 40; the right side was paralyzed, and there was total insensibility. Three days after the injury the bullet was extracted from the substance of the left hemisphere. It was a conoidal ball and badly shattered. He then rapidly recovered, and the report says that in four months and a half afterwards "the mental and the sensory faculties were unimpaired." On October 30th, 1870, he wrote: "I am still in the land of the living. My health is good, considering what I passed through. My head aches some of the time. I am married and have one child. My memory is affected, and I cannot hear as well as I could before I was wounded." These were the only results of this extensive laceration of brain matter. The slight functional disturbance did not correspond with the doctrine of cortical functional centres.

Sergeant Rotherham, wounded at Gettysburg by a musket ball, which penetrated the skull near the right frontal eminence, passed directly inwards and lodged somewhere on the membranes or in the brain substance. The opening through the bone was similar to that made by a trephine, and the track of the ball could be followed on the *dura mater* with a probe for a considerable distance, as that membrane was detached from its natural connection with the skull. The ball was not extracted. There was no perceptible loss of power, motion, or sensation on either side of the body. There was no arterial excitement. His recovery was rapid, and five weeks after the injury he was furloughed for fifteen days, at the expiration of which time he returned to duty, having suffered no inconvenience from the injury. After this several bones exfoliated, but his mind was not impaired to any perceptible degree. For some time after the wound was received, he was assigned light duty in the Veteran Reserve Corps Hospital.

Lieut. Brown, at the battle of Wilson Creek, received a penetrating gunshot wound of the

cranium and brain. The ball was not removed for seven years after the injury, but in a few days after being wounded he was fit for duty. In January, 1871, this officer was on duty as captain in the 13th Infantry.

Private Stallman, wounded at Winchester by a musket ball, which entered at the right temple and emerged at the opposite side of the head. In spite of this serious lesion of brain, in a few months he was put on light duty. He had no strabismus, and we are told that, although his mental faculties were slow and uncertain and his memory impaired, he had no hallucinations nor mental aberrations. The year following the injury he was pensioned. No functional impairment except the above mentioned.

Private Haggart was wounded by a conoidal musket ball, which struck the left side of the head, and passing through carried away a large part of the left half of the occipital bone. At first he became insensible and lost more than an ounce of cerebrum, leaving bare the meningeal artery. Seven months afterwards he was discharged from the hospital. At that time both eyes were dilated, causing dimness of vision, but his intellect was good, and he could read very coarse print. He died four years afterwards, but it is not recorded what was the cause of death. This extensive lesion only produced these slight results.

Sergeant Woodman was wounded by a gunshot missile, which entered above the left frontal eminence and emerged at a point one inch behind the upper margin of the right ear. He was unconscious for several hours. At the wound of exit eight small bones afterwards discharged. He was alive three years afterwards, and it was reported that the organs of special sense and the intellect were unimpaired.

Private Plumly was wounded by a conoidal musket ball, which entered at the inner angle of the left eye, and after passing through the brain substance it emerged behind the left ear. On March 7th, 1867, nearly three years after the wound was inflicted, he was in good health, and a pensioner. The only physical results were obscuration of the vision of the left eye for a short time, the discharge of pus from the orifice of entrance of the ball and through the right nostril and upper part of the posterior nasal cavity into the mouth.

Private Sechler was wounded by a conoidal ball, which struck the *os frontis* over the right eye and passed into the brain. He not only lived, but returned to duty six months afterwards, and was at the close of the war mustered out so well that he did not even receive a pension. The ball was not extracted. No functional results.

(To be continued.)

PLASTIC OPERATIONS ON THE EYELIDS.

BY R. A. REEVE, B.A., M.D.

Lecturer on Ophthalmology and Otology, Toronto School of Medicine, and Surgeon to Andrew Mercer Eye and Ear Infirmary.

(Read at Meeting of Canada Medical Association, Ottawa, Sept. 2, 1880.)

(Continued from page 6.)

CASE 2.—*Ectropion of Upper Lid, treated by Transplantation of Flap without Pedicle.*

Though second in order, this was the first case in which the above method was followed; and it was the fourth, so far as I was then aware, on this side of the Atlantic, the first being reported by Wadsworth, of Boston, and the second and third by Aub, of Cincinnati. The patient had psoriasis (non-specific) to such an extent that one could hardly get a patch of healthy skin large enough for a flap; and I did not wish to operate until he had fully recovered, as there was little likelihood of success; but it was (now or never) with him. When admitted, the left cornea was sloughing, owing, seemingly, to exposure of the globe from ectropion—the result of an injury received some months previously. The lower lid was drawn downwards and outwards, and everted, and all the skin of the upper lid was destroyed, except at the ciliary edge, which was adherent to the upper margin of the orbit, where slight exfoliation of bone was going on. All the surrounding tissue was cicatricial, and a flap with pedicle could not be had.

As it was too late to attempt to save the cornea, palliative treatment was used until the inflammatory action had ceased and the carious spot had healed; and on the 25th of June, 1879, the operation was done. The lower lid was first brought up into place by incisions making a triangular flap with base to free border (upwards), some burrowing and subcutaneous division of bands of adhesion, and then the sliding upwards and inwards of another flap (rectangular), with its base under the malar process.

The upper lid was freed by an incision a little above the eyelashes, and some dissection. The free edges were then made raw at four corresponding points, which were brought

together by sutures. A large piece of skin was then cut away from the arm, made as thin as possible, trimmed, fitted, and adjusted upon the upper lid, and all the parts covered with gold-beater's skin, compress and bandage.

Not to go into too many details, the transplanted skin did not unite save at one point, and had to be removed after a few days; and grafting, by means of small grafts, was afterwards done. The patient was discharged on the 22nd July, 1879, cicatrization being complete.

The lids had parted slightly, short bands having formed by traction at the points of union, the division of which was deferred.

Remarks.—It need hardly be urged that this method of blepharoplasty conveys a lesson of practical moment in general surgery. In some cases, at least, the planting of a large piece of skin on a raw (lymph-exuding) surface will be found preferable to the old plan of putting small grafts on a pus-secreting one. Much painstaking care is required in its execution, and the tendency of the flap to contract is certainly a disadvantage; but it is sometimes available when other methods are not, and its results seem to compare favourably with those of transplantation of large flaps with pedicle.

Dr. H. D. Noyes, of New York (N. Y. *Medical Record*, March 27th, 1880), after reporting some successful and unsuccessful cases of his own, and citing others, says,—“A number of cases have proved failures. In some of these instances failure is sufficiently accounted for * * *; at the same time, if out of fifteen cases ten have proved successes, it is something remarkable.”

In my own cases there were two successes and one failure, the latter being almost a foregone conclusion.

A few points should be observed, which, if not essential, are most important. 1. In contrast with other flaps, the transplanted skin should be thoroughly freed from subcutaneous connective tissue and fat, which is most easily done by means of sharp scissors. 2. It must be adjusted and the edges coapted with the greatest nicety; all oozing of blood having ceased from the raw surface, which should be quite clean; and it should be kept well covered

and undisturbed. 3. Allowance must be made for extraordinary contraction of the skin after its removal, say 35 to 50 per cent., and for further shrinkage after union. 4. The general integument and the subject should be healthy. 5. The special indication in blepharoplasty is the destruction of the skin of the lid or lids, with preservation of their free edges, so that they can be temporarily united; the tissues around the orbit being so altered or diseased as to preclude or jeopardize the proper nourishment of a flap through its pedicle. And it is to be preferred, *ceteris paribus*, when there is a likelihood of increasing the deformity by utilizing the skin of the face after the usual methods.

CASE 3.—*Epithelioma of Eyelids and Inner Canthus. Blepharoplasty by Sliding Flaps.*

Mr. M.—consulted me July 27th, '77, in regard to disease of the lower lid of the left eye, which had begun in 1862 as a large pimple on the edge of the lid near the lachrymal punctum, with ensuing excoriation, slight discharge, and scabbing. For the first twelve years the disease was confined to the inner fourth of the lower lid. It then began to creep outwards. There has been no pain from the outset. The whole ciliary border of the lid is now involved, the inner fourth presenting an ulcerated fissure, with hard, slightly-raised edges, and there is partial ectropion. The immediate removal of the diseased tissues was advised, but the case was not seen again until July, '79, when the outer canthus and also the lachrymal sac and the inner end of the upper lid had been invaded. An operation was again advised, a guarded prognosis being given.

July 21st, '79, the patient being anesthetized by Dr. Zimmerman, and Dr. Covernton, the family physician, kindly assisting, the whole of the lower lid from the ocular conjunctiva to below the edge of the orbit, the outer end of upper lid as well as its inner fourth, and the lachrymal sac with some of the orbital tissue behind it were cut away. An incision was then made down the side of the nose, and a large horizontal flap dissected back with its base on and below the malar bone. This was slid up against the globe, and its upper

edge stitched to the upper lid (to form the outer canthus) and to the ocular conjunctiva, and at its inner free end to the apposed part on the side of the nose. To restore the inner canthus and upper lid another horizontal flap was made across the root of the nose, and its free end then drawn over and carefully united to the raw vertical edge of upper lid by a twisted suture and stitches. Strips of plaster, cotton wool and bandage were then applied. Both flaps united satisfactorily. Grafting was done on the raw surface below the lower flap to lessen cicatricial contraction, and some suspicious looking tissue near the site of the sac afterwards destroyed by chromic acid.

Five weeks after the operation (Aug. 28), the new part of upper lid was well back in position, and the patient could just uncover the pupil so as to see straight forwards, and could read with facility. The eye was comfortable, though there was some epiphora. A microscopic examination by Dr. Zimmerman confirmed the diagnosis of epithelioma.

On several occasions during the year a small growth appeared about the inner canthus, yielding at once to treatment.

P.S.—Jan., '81. There has been no sign of relapse, apparently, during the last six months.

CASE 4.—*Epithelioma of Eyelids. Plastic Operation.*

T. C. D., æt. 51, was admitted into the Andrew Mercer Eye and Ear Infirmary, Dec. 19, '79. The patient ascribes his affection to a burn caused by molten lead splashing into his eye five years ago. The sore would not heal, he says, but remained as a red lump with a white top near the caruncle for one year, when it spread to the lower lid. Treatment by caustics was tried ineffectually. Eighteen months ago, epithelioma was diagnosed after a microscopic examination. One year ago the side of the nose was invaded, the ulceration creeping very slowly and painlessly.

Present condition.—The inner fourth of the upper lid, nearly to the brow, is eroded and perforated and surrounded by a hard, raised border; and there is also erosion of the inner canthus, lachrymal sac, and inner two-thirds

of the lower lid. The globe itself is intact, though the conjunctiva bulbi at the inner and lower side has a doubtful look.

On Dec. 27th the following parts were cut away: the inner three-fourths of the lower lid and inner two-fifths of the upper, all the lachrymal sac and some orbital tissue behind it, part of the ocular conjunctiva, as well as a square piece from the side of the nose down to the periosteum. A large flap was then made reaching from the side of the nose to the malar process, $3\frac{1}{2}$ inches long by $1\frac{1}{2}$ inches wide, and was slid up against the eyeball, its upper edge being stitched to the conjunctiva bulbi, and its free end in position at the root of the nose. To repair the upper lid a flap was taken from the top of the nose and the forehead, and then turned horizontally, the original lower edge being fastened to the vertical raw edge of the upper lid by a pin and three sutures after the fibres of the orbicularis muscle had been divided at the outer canthus to allow the lid to give towards the nose. The adjacent edges of the two flaps at the root of the nose were also stitched together, and the upper edge of the upper flap and the skin under the brow. A pad was put on the lower flap to keep it in contact with its bed, and supporting straps, cotton wool and bandage applied. On the third day all the dressings were removed. The flaps looked well; vaseline compress and straps re-applied. On the fourth day no pain or inflammatory reaction present; no discharge from orbit; took out pin and some threads. On the fifth day removed the rest of the stitches, putting collodion across the upper lid before all were cut out. Subsequently, put twelve grafts on the raw surface below, but with indifferent effect; also had to destroy sprouting granulations at the site of the sac. The patient was discharged January 23th, '80, the parts having healed.

On July 27th he was re-admitted, and the rest of the lower lid cut away, mainly to relieve his own anxiety. A canthotomy was also done, and division of external palpebral ligament to render upper lid lax and remove discomfort from friction.

August 20th, patient discharged. The inner canthus has cicatrized back to the plane of the right. There is some annoyance from lachrymation, for which excirpation of the lachrymal gland may hereafter be done.

P.S.—Jan., '81. Patient reports no relapse to date.

NOTES OF A CLINICAL LECTURE AT
TORONTO GENERAL HOSPITAL,
SESSION 1880-81.

CLINIC OF DR. THORBURN.

CASE I.—*Third Stage of Bright's Kidney—
Hypertrophy of Heart.*

CASE II.—*Mitral Regurgitation.*

CASE I.—*History.*—J. C., æt. 32, was admitted to the Hospital, and examined November 24th, '80. Native of Canada; has lived for last 22 years in Toronto; is brakesman G. T. R. Married two years ago; wife and child living. His previous history is moderately good; was always a strong, healthy man; good constitution, but has been in the habit of drinking heavily. Has always noticed a remarkably abundant excretion of urine, pale; but when troubled with a cold, felt pain across region of kidneys, and the urine then was high-coloured. Six years ago had severe attack of inflammatory rheumatism, which seemed to settle in right leg and left arm; he was obliged to use crutches for a while, but this attack left no permanent noticeable bad effects.

Has had two attacks of gonorrhœa—the first ten, the second seven years ago. Was slightly injured in the head about one year ago. No hereditary predisposition to disease, as far as can be ascertained.

Present disease.—About seven weeks ago felt a severe pain over the region of the heart, which continued for three weeks. His face was œdematous at night when in bed, but resumed its normal condition during the day; bowels costive; urine decreased in amount. He knows of no cause for this attack.

After three weeks of treatment went to work again, but felt poorly; worked for ten days, and one morning, after a heavy lift, found himself unable to go to work, the symptoms above given having returned in full force. Again he received treatment; but not improving, was sent to the hospital.

Present condition.—In walking, seems very weak and unsteady; in bed, he lies by preference on his back, shoulders and head elevated. If he lie for any considerable time on his side or with head low, dyspnoea supervenes. Coun-

tenance anæmic. Pulse 108, not very compressible; in fact, rather incompressible. Respirations 36, short and shallow. Extremities cold and anæmic; the lower decidedly anæsthetic. Tongue shows a coating of whitish fur. He has been troubled considerably by epistaxis for last four or five days. No appetite; can keep nothing on stomach but a little dry toast, milk or eggs; vomited his medicine while under treatment, before coming to hospital; very thirsty, but refrained from much fluid. No pain except a little in arms and shoulders. Shows general anasarca. Liver very tender; right lobe enlarged. Heart shows considerable hypertrophy on percussion; reduplication of the sounds heard best over base. Action of the organ impaired. Urine pale in colour, decreased in amount; specific gravity 1006; acid in reaction; contains large quantity of albumen; no sugar. Microscopical examination shows the presence of granular casts, mucous cells, and degenerated epithelium of both renal and cystic varieties.

The following is the substance of Dr. Thorburn's remarks in reference to the diagnosis, prognosis, and treatment of the case:—

In forming our diagnosis we must take into account two factors, prominently brought out in the history just read: namely, the evident abnormal condition, first, of the heart, then of the kidneys. Some gentlemen might be disposed to ask, Why not include the anasarca as a factor for consideration? To this it may justly be answered, because the history of the case shows this plainly to be not a primary condition; not a cause, but an effect. And this effect may have been produced, is frequently produced, by abnormal conditions either of the heart or kidneys. Our present object, then, is to ascertain whether the enlargement of the heart produced the diseased kidneys, or *vice versa*, and thus to discover the cause of the condition of the system now before us.

Considering, first, the heart, we find a history of a rheumatic attack of some severity. Knowing the tendency of such attacks to involve this organ, its condition must be carefully noted. We find it to be abnormal in two respects; first, organically, it being increased

in size; in the second place, functionally, the sounds being altered.

But rheumatic attacks chiefly tend to produce valvular affections. Now, there is no evidence, after the most careful auscultation, of disease of the valves here. Neither the hypertrophy, then, nor the reduplication of the sounds can be held to point to heart disease brought on by the rheumatic attack as the prime cause of disease in this case; in fact, these conditions both help to sustain the idea that the real origin of the trouble is to be sought for in the kidneys.

What evidence can be adduced from the history or present condition of this patient to uphold this opinion?

In the first place we must remember that he is stated to have been a heavy drinker. This habit is well known to tend towards a cirrhotic condition of the kidneys, as well as other organs—a condition characterized by hyperplasia of the connective tissue of the gland, and consequent increase in size, followed by atrophy and diminished bulk, which latter state is seen in the most advanced cases of chronic Bright's disease. Now, we must remember another fact indicated by his history. For a long time previous to the present attack the urine was excessive in amount; and the kidneys were easily disordered by slight causes.

We have here sufficient data to pronounce the kidneys to have been more or less affected for a considerable period.

Might this of itself tend to produce the abnormal heart conditions previously noticed?

To answer this question we must remember, not only that in chronic Bright's disease there is a tendency to hypertrophy of the heart muscle, but that also the lumen of the smaller arteries of the body is diminished, while their coats are thickened, and become more or less rigid. To this latter fact is due the comparatively high tension of the pulse in a case of chronic Bright's disease, and also the general enlargement of the organ; caused, of course, by the extra amount of force required to send the blood through the narrower passages.

This is sufficient answer to the query, in so far as the size of the heart is concerned; and it also explains why we have, in this case,

with a comparatively weak heart action, a better state of arterial tension than might have been expected.

In regard to the reduplication of the sounds this is said to be an occasional accompaniment of Bright's disease, but you will rarely have so good an instance as the one now before us.

The history then gives us good ground for diagnosing a case of chronic Bright's disease, and this is the primary cause of the present condition. And when we take into account the present condition of the urine of the patient, its abnormal constituents, with the other symptoms, no room for doubt is left.

The stage to which the cirrhosis of the kidneys has reached is a matter of some interest. It seems highly probable that there is a certain amount of fatty degeneration present, together with a more or less granular condition of the gland. But an autopsy alone would reveal their condition positively.

The prognosis is unfavourable, as in all such cases, where we know that there is a considerable amount of organic change. The treatment is merely palliative, consisting mainly of a heart tonic and suitable diuretic. Plenty of nourishing, easily digested food is ordered, and the state of the bowels well looked after. He receives:

R Tr. Digitalis..... ʒiij.
Tr. Card. Co..... ʒjv.
Aquam ad..... ʒjv.

Sig. ʒij. every six hours.

[Subsequent to the clinic, the following notes of the case were taken:

Dec. 3rd. A condition resembling eczema has appeared on the legs, epistaxis is frequent, feels pained over the region of the kidneys, orthopnea well marked. He drinks much water; urine is more plentiful; not so much albumen present. Bowels acting well. Pulse 110.

Dec. 10th. Urine much more plentiful; acid; albumen decreased; eczema disappearing; anasarca condition not so apparent; appetite better; pulse, 104; respirations, 28.

Dec. 16th. Pulse, 100; respirations, 28; the albumen in the urine largely increased. From this time he gradually sank, the quantity of urine decreasing.

About Dec. 27th, he became helpless ; urine almost entirely suppressed ; the small amount secreted was removed by catheter ; eyes protruding ; partly delirious.

Dec. 30th. Evident uræmic poisoning ; comatose ; died in that condition, Dec. 31st.

It was the intention to have held a *post mortem* examination, but the friends claiming the body, the diagnosis unfortunately could not be thus confirmed.]

CASE II.—Dr. Thorburn also drew the attention of the class to a case of heart disease, which formed a very instructive contrast to the case detailed above.

T. S.— had also been rheumatic, and showed general anasarca. This was due, however, to the condition of the heart, which, on auscultation showed well-marked indications of valvular disease. The mitral valves were chiefly involved, the murmur being regurgitant.

EXTENSIVE VENEREAL WARTS.

BY H. T. MACHELL, M.B., L.R.C.P. EDIN., TORONTO.

On the 1st of December last a patient presented herself, saying she had "the chancres." The history of the case, however, pointed to gonorrhœa, which she said she had contracted six months ago. On making an examination, the whole circumference of the vagina, from the labia minora backwards for an inch and a half, was completely studded with venereal warts, while above these these growths were scattered here and there up to within a few lines of the cervix uteri. These vegetations so packed the anterior portion of the vagina that when the labia were separated the direction of the canal could not be made out at all, and it was with considerable difficulty that the finger could be introduced.

They varied in size from a pin's head to that of a good-sized pea, but the greater number of them were flat and smooth, and frequently three or four could be seen attached to one pedicle.

Nitric acid was applied a few times at intervals of three days ; then the remainder were clipped off with the scissors at a couple of sittings, and the acid applied to the base of the pedicles. Result good.

THE TREATMENT OF SPRAINED ANKLE.

BY R. L. MACDONNELL, B.A., M.D., M.R.C.S. ENG.,
Assistant-Demonstrator of Anatomy, McGill University,
Montreal.

According to most writers of text-books, the management of a sprained ankle is a simple affair indeed. An evaporating lotion, perhaps iced applications, a few days in the house, and the surgeon's duties are over. Some writers mention that starched bandages may be applied in very severe cases. Every one will acknowledge, I think, that a sprained ankle may turn out a very troublesome accident ; that sometimes its effects last for months, that usually the unlucky patient must stay in bed or upon the sofa for at least a week, and that upon resuming his occupations the joint will be for a long time weak, and prone to turn under, when the weight of the body is unexpectedly thrown upon it. The object of this communication is an attempt to show that all these unpleasant consequences may be in a great measure obviated by the use of some fixed apparatus, whether of plaster of Paris or of any other similar material. The application of a splint of this kind relieves pain, reduces swelling, and enables the patient not only to walk about his house soon after the application of the splint, but in those cases where the business of the patient demands his immediate presence he is enabled, with his foot encased in a hard shell, to go to his office and perform the duties required of him.

Latterly I have used these appliances with great satisfaction, and, as I relate the following cases, shall point out a few "tips" in the application and removal of the apparatus. There are many ways of using the plaster of Paris, but I think the following the most suitable plan : The limb should be encased in a large, thick, porous woollen stocking. A roller of book muslin, the coarser the better, about 2½ inches wide, should be wetted and applied around the leg in the ordinary way. There should, however, be no "reverses" made in the bandage. At every third or fourth turn, water and dry plaster should be alternately rubbed over the limb. This process is to be continued until a thick layer of bandage

and plaster envelops the limb from the toes half way up to the knee. Every now and then thin slips of wet cardboard should be inserted between the layers of bandage to strengthen weak places, such as the back and front of the joint, below the heel and the ball of the great toe. The splint completed and the plaster set, the patient may be allowed to walk in a few hours, or perhaps the next morning. In a week the splint may be removed, passive motion employed, and the shell kept at hand ready to be reapplied whenever any unusual strain is to be put upon the joint, or be used in the daytime and removed at night.

Case 1.—Mary H., *æt.* 26, a parlour-maid, slipped on the pavement on the 21st October, 1879, and sprained her left ankle. Twenty minutes afterwards there was very great swelling over the external malleolus. Intense pain. Applied with firm pressure two or three rollers of common gray cotton bandage soaked in iced water, about the ankle, so as to form a stiffish casing for it. Iced water was applied during the night. On the following morning the swelling had almost disappeared, but there was great pain on the slightest motion. The splint was applied in the manner described. As soon as the plaster had hardened, the girl was able to get up and walk about her room without pain, and on the following day was able to attend to, at least, a considerable part of her duties. In a week the apparatus was removed, and she found the ankle quite well. In the removal of a plaster splint there is usually a deal of bungling. The best plan is to divide the splint down the front with a small saw. Some pocket-knives contain a little saw useful for this purpose. The stocking used by this patient was strongly "rubbed," and made little ecchymoses on the skin.

Case 2.—George R., *æt.* 16, a schoolboy, was engaged in a football match on the 9th of October, 1880, and received some injury, he knew not how, of his ankle joint. About half an hour afterwards there was very extensive swelling all around the joint, but more especially about the external malleolus. In fact, it was impossible at the time to tell whether the fibula had escaped fracture. The limb was put up in a wooden side splint, and lead and opium

lotion applied. For two days the swelling was so very great that it did not seem desirable to apply any fixed apparatus. On the fourth day the plaster bandage was applied. Here I neglected two important points. The plaster set while the foot was not quite at right angles with the leg—consequently the toes pointed downwards slightly; moreover, I neglected to cover the heel thickly enough. As a consequence, the weight of the body was thrown too much forwards and the patient did not walk without pain. These defects were soon remedied. The boy slept well all that night, it being his first night's rest since the accident. In a few week's time he was able to walk about his house, and soon extended his promenade to the garden. Although complete recovery did not occur for some four weeks, I have no doubt but that under other plans of treatment he would have been in bed some weeks suffering pain and ennui, and have gone back to school in three months with a weakened ankle. At present he can take part in all the sports becoming his age, and I find that since the winter set in he has been skating every day.

Case 3.—A stout cook, aged 40, missed a step in coming down stairs. Twenty minutes afterwards there was a swelling the size of a very large apple over the centre of the ankle joint. I had no bandage with me but book muslin. This was wetted and applied directly to the foot with considerable pressure. This bandage being firmly impregnated with starch in drying, forms a firm light casing. She was told to remove it should there be pain during the night. Immediately after the application she felt quite free from pain, but during the night she became frightened, thinking that gangrene was setting in, being of a nervous disposition and an old maid; so she cut part of it off. The following is an extract from my case book. "Nov. 5th, 1880 (the day after the accident).—All swelling gone. Not much pain but great weakness is complained of. Complete inability to put the foot upon the ground. Encased the joint in plaster in the usual way. Nov. 7th, 1880.—Very comfortable. Able to do work and walk about the house. Complains of pain towards evening (she had previously suffered from swelling of the feet at night time). Nov.

10th.—Removed splint with saw. Patient able to walk about without splint." Thus in a week she was completely set upon her feet.

Case 4.—On the 5th November, 1880, I was called in the greatest haste to see a man whose leg was said to have been broken. I found a burly brewer's driver, about 22 years of age, surrounded by friends, and groaning with pain. He had been scuffling, half in fun, half in earnest, with a fellow-workman, and had received an injury of the right ankle joint, he did not exactly know how. A swelling as large as an orange covered the external malleolus. No fracture could be detected. Applied common rollers soaked in iced water. The next day, having forgotten my plaster, I applied a starched bandage. On the following day I found him walking about the yard, playing the trombone. On the sixth day he was back again at work. Starch does not answer well for this purpose, as it takes too long to dry.

It is obvious that great care must be taken that the joint be not kept too long fixed. After a week the splint should be removed, and applied only when the patient is obliged to undergo some extra exertion. Sir James Paget (*Clinical Lectures and Essays*, p. 96) states that too long rest is by far the most frequent cause of delayed recovery after injury of joints in nearly all persons who are not of a scrofulous constitution. Mere long rest, he says; stiffens them and makes them over-sensitive, cold douches and elastic restraints and pressures make them worse; and nothing remedies them but movement, forced or voluntary. He tells us, too, that such are the cases successfully treated by bone-setters, who get a joint that has been sprained and kept too long at rest; then, pretending or believing that it has been dislocated, wrench it, and tell the patient that it has been put in, and that now he may use it.

I have no doubt but that many of those who take the trouble to read this communication will say that I am deceiving myself by the *post hoc* argument. These cases were all severe ones. I have treated cases by the older methods, and have reason to know how long such cases last. I have seen a patient, a strong young man, lame for upwards of six months from the

effects of a simple sprain. I may here throw out a suggestion that practitioners will find, in many instances, that book-muslin is a great improvement on gray cotton as a bandage for common use. Some weeks ago I used it on a Colles' fracture. It is well starched, and, when applied wet, sticks firmly to adjacent parts, making a stiff, firm covering. It cannot stretch or get pulled out of place, is porous, light and comfortable, and is not more expensive than the common article.

1433 St. Catherine Street, Montreal,
January 14th, 1881.

FRACTURE OF THE SKULL, WITH A COMPLICATED FRACTURE OF THE LEFT FORE-ARM—RECOVERY WITH UNAVOIDABLE RESULTS.

BY C. FREEMAN, M.D., MILTON.

The case which I am about to report is intensely interesting to the profession in two particulars: firstly, its being of extremely rare occurrence; and secondly, from its having formed the subject matter of a supposed case of malpraxis.

ACCIDENT.

Duncan Tost, æt. 14, carpenter, while assisting his father in the erection of the new Town-hall at Georgetown, fell, on the morning of the 17th of August, 1878, about 22 feet, with a pair of rafters in his hands, on the hard floor, his head striking against a scantling. The results were fracture of his skull above the left orbit (with both concussion and compression of the brain), also fracture of the radius and ulna in their lower third, with rupture of three of the tendons of the flexor sublimis digitorum at their attachment to the muscle, and severe contusion of the other flexors. There were no abrasions of the skin at the seat of either fracture. Drs. Wm. Freeman, Standish, Starr and Raunay were summoned immediately, and found the patient apparently lifeless, with little or no prospect of recovery. After the free use of salts of ammonia and other stimulants, Dr. Freeman reduced the fracture of the arm and applied Day's splints. He then cut down and elevated the depressed bone of the skull with the assistance of the medical gentle-

men present. The patient was seen three times the day of the accident, and the arm was dressed during the evening. The boy was in a semi-comatose state for a few days, and required the use of the catheter. The arm and head were dressed daily, and the patient was visited twice and thrice daily for two weeks, and afterwards once a day until the 7th Oct. Drs. Rannay, McGarvin, and C. Freeman saw the boy in consultation at different periods within ten or twelve days of the receipt of the accident, and corroborated the defendant's testimony at the trial, that at no time was there a solitary condition present to indicate gangrene from too tight bandaging, but the deep-seated suppurative inflammation arose from rupture and contusion of the tendons from the severity of the accident. About the beginning of the second week a fistulous opening made its appearance over the seat of fracture, and gradually enlarged upwards until three of the tendons dropped down and were removed about the third week, when Dr. McGarvin saw the patient again with the attending surgeon. About the time the suppurative inflammation commenced, the anterior splint was removed and never used again, the bandage having been applied around the palm of the hand and up the arm, leaving an interspace of about four inches for local applications over the seat of fracture. After the *debris* was removed, it healed kindly, with the following results: a perfectly straight fore-arm, with partial contraction of the fingers, caused more particularly by the adhesions and contraction of the profundus digitorum. The patient was requested to persevere with passive motion, which pained him so much that he could not do so. At one time the parents desired Dr. Freeman to remove the hand, which he declined to do stating that it would be impaired, but would be better than an artificial one. No dissatisfaction was expressed until after the doctor had sent his bill, when the ungrateful father manifested his admiration of the doctor's skill and attentive kindness by instituting a vexatious suit at the Milton Assize Court for \$5,050, in September last, for negligence and want of skill during the treatment of his son. In consequence of the delay in obtaining the

preliminary examination of the patient before His Honour Judge Miller, of Halton, Chief Justice Wilson granted the application for changing the venue to the city of Hamilton Assizes on the 25th of October. Notice was given for trial and expenses again incurred, and then it was countermanded. The gist of the boy's evidence before Judge Miller was, that he was faithfully attended by Dr. Freeman; his hand and fingers were never swollen, benumbed or discoloured; and that his fingernails were natural, and did not come off. He wanted money for the partial loss of his hand. The trial finally took place on the 5th and 6th of January, 1881, at the city of Hamilton, before Mr. Justice Galt. The chief contention on the part of the plaintiff's counsel, Messrs. Hagel and Schoff, was that the arm was not dressed for eight days, and that the deep-seated suppurative inflammation arose solely from the splints and too tight bandages, through the culpable negligence and want of skill of the defendant. This was very inadequately supported by the lay testimony of the Tost family and friends, with the professional evidence of Drs. Standish, Starr, DeLa Haye, Bennett and Hagel; while, on the other hand, the defendant's counsel, Messrs. Goodwillie, Laidlaw, and Osler, contended that there was neither neglect nor want of skill in the treatment of the patient, which was clearly and conclusively established not only by a number of disinterested and respectable lay witnesses, but was further ably and unanimously confirmed by Drs. Canniff of Toronto, Ridley, Billings, Miller, Mackelcan of Hamilton, McMahon of Dundas, Buck of Palermo, McGarvin of Acton, and C. Freeman of Milton. The judge's patience was sorely tried and almost exhausted by the hesitancy and delay on the part of many of the medical witnesses for the prosecution, when he put this important question to them: "Would not deep-seated suppurative inflammation which lasted for months be more likely to occur in a broken limb from internal injury or contusion than from any subsequent bandaging or splints?" His Lordship, after passing a very high encomium on the medical profession and its advantages to the public, animadverted in the strongest terms on the great ingratitude of the plaintiff, and the vexatious injustice and great expense sustained by the defendant in consequence of the suit.

PECULIAR CASE OF CHANCROID.

BY GEO. WRIGHT, A.M., M.D., TORONTO.

The following case of chancroid, that came under my notice, possesses one or two points of interest, and I have thought it proper to communicate it to your Journal.

Thomas O——, age 13 years, came to my office with his father on the night of the 18th of November. The father informed me that his son had fallen on the wheel of an express waggon and received an injury, about which he desired to consult me. From previous intimations I had received in another place, I was not altogether unprepared for another illustration of those cartwheel cases, which have become somewhat traditional, and in which the member next most unruly to the tongue was possibly implicated. I at once suggested to the youth that he should "*show up*." In consequence of his tender years, I avoided any expression of my apprehensions to the boy, until quite satisfied that, in challenging him with indiscretion, I would be doing him no injustice. And here I venture to make a suggestion, without desiring to read a lecture to my professional brethren. My experience with all such cases of youthful depravity has been, that the slightest levity in the presence of those concerned has a demoralizing influence, by encouraging them to think that, after all, their case is not so shocking.

I found, on examination, a chancroid involving the whole point of the *glans penis*, being about the size of a five-cent piece, and situated more to the left of the *meatus*, but still covering it. There had been considerable swelling and pain of the right inguinal glands, which had partially subsided before I saw him.

On inquiry as to the origin of the trouble, the boy stoutly protested, at first, his innocence of any indiscretion. But, after a good deal of beating about, until he found that any further attempt at concealment of the facts might be a serious impediment to his recovery, I elicited the following facts. This boy, with four others of about the same age, were out together in the evening about a fortnight before I saw him; and on one of the leading streets of the city they came in contact with four little girls

of ages from eleven to thirteen. He represented that he and his companions had been seduced by those little girls, and that they retired to a vacant lot in the neighbourhood, where they had a short season of mutual intercourse, and finally separated. The boy declares that his little paramour was not more than twelve years of age, and that he must have contracted the disease from this mere child. I am told that such cases are not at all uncommon in this city; but I am happy to say that, in my thirteen years' experience, I never before met with one in whom this or any other form of venereal disease was developed at so early an age.

A noteworthy feature of this case was the fact that the threatened lymphatic glandular trouble was on the side most remote from the chancroid.

The case improved rapidly under local treatment, consisting of carbolic acid lotion, one in thirty-two, with the observance of scrupulous cleanliness; and in ten days the sore was entirely healed.

TRIPOLITH DRESSINGS.—A new compound material (preparation secret) whose main ingredients are calcium, silicium and protoxide of iron (*International Medical and Surgical Journal*), has been introduced by V. Langenbeck of Berlin, as a substitute for plaster of paris, which it resembles in appearance and weight but, is smoother and softer. It is used in exactly the same way, and the advantages claimed for it are: that it absorbs less moisture from the air, and consequently keeps better; dressings made with it are lighter; they harden more rapidly, and once hardened take up no more water; it costs a trifle less than plaster of paris. The name proposed for it is tripolith (or triple stone), from its great hardness. It is shipped from Hamburg.

THE EDINBURGH COLLEGES.—A movement is again on foot in Edinburgh to wipe out a disgraceful blot in the constitution of both the Royal College of Physicians and the Royal College of Surgeons, and to put an end to the admission of members and fellows except upon due examination. The agitation has, however, we believe, excited much opposition.

Selections: *Medicine.*

CASE OF PYOPNEUMOTHORAX SUB-PHRENICUS.

Prof. Gardner, McGill University, reported an interesting case of sub-diaphragmatic abscess and pyopneumothorax (so called) before the Medico-Chirurgical Society of Montreal.

A young man, *æt.* 28, of rather delicate health, had an attack of perityphlitis which developed into general peritonitis with very alarming symptoms. Contrary to expectation, he rallied, and most of the abdominal symptoms disappeared, with the exception of tenderness in the right iliac and lumbar regions. No distinct swelling could, however, be detected. In a few days he felt pain in right side of chest, involving lateral and front parts up to fourth rib: no dulness on percussion, no pleuritic friction sounds, but weak respiration sounds over anterior and lateral parts of the right lung. Temperature occasionally rose—sometimes diarrhoea.

Suddenly, in seventh week of his illness, and two weeks before he died, he was seized with sharp pain in his side, and began to cough up pus, which was soon replaced by a brownish fluid having all the characters of thin *fæces*. Semi-collapse followed, and on physical examination of the chest a remarkable change was found to have taken place. The physical signs of air and fluid in the right thorax had developed themselves, in, however, a somewhat modified form. As the patient lay on his back, percussion of the right side gave forth, from the third interspace downwards, to the lower edges of the ribs in front, and at the side, a clear tympanitic note. Above the third interspace the note approached in character the ordinary healthy note. At the dependent part of the chest, as he lay on his back, the note was perfectly dull. By turning the patient on his left side, the limit of tympanitic note on percussion was altered. All the parts of the right chest now uppermost were tympanitic when percussed, showing the presence of air and a liquid. Nowhere, in any position, could the liver dulness be discovered; neither could the liver be felt by palpation. On auscultation,

weak, amphoric respiration was present from the third interspace downwards; on coughing, splashing sounds. Above third interspace the respiratory sounds approached in character the vesicular murmur of health. There was considerably diminished mobility of the right chest wall, which was quite sensitive to the pressure of the stethoscope. A normal condition of the intercostals obtained. Seen at various times in consultation by Drs. Fenwick, Buller and Ross. Diagnosis: perityphlitic abscess communicating with the bowel, creeping up behind the peritoneum and perforating the diaphragm, and thus gaining access to the cavity of the chest, and subsequently perforating the lung. During the last fortnight that he lived the patient coughed up at intervals pus, and the thin, brown, stinking fluid above described. There was great debility and frequent diarrhoea. Died in a paroxysm of coughing.

Autopsy, fifteen hours after death, by Dr. Rich. MacDonnell. Emaciation extreme: on opening the abdominal cavity, the first thing noticed was the absence of the liver from its natural position. It was pushed upwards, backwards and inwards towards the spinal column, completely away from the right lateral and anterior chest wall, thus explaining the impossibility of either feeling or discovering it by percussion. To the outside and behind the cœcum an abscess cavity was discovered, having on its inner wall the appendix vermiformis, containing a number of masses of inspissated, quite hard, fecal matter. Two or three openings existed between the cœcum and this cavity, one of them being large enough to admit the little finger. This cavity communicated by a narrow neck-like prolongation, extending upwards behind the peritoneum, with a very large cavity, probably as large as a child's head, bounded above by the diaphragm pushed up to the level of the third interspace; externally and anteriorly by the ribs, as far as their free edges; below and on the inner side by the right lobe of the liver, whose upper surface and free edge, compressed, flattened, and rendered quite obtuse, formed part of the wall of the abscess cavity. The contents of this cavity were not pus, but a thin, brown-colored, stinking fluid,

containing flakes of curd of milk, and gas or air. The stomach was somewhat pushed over to the left. The transverse colon was somewhat displaced downwards. The right lung was much compressed, its lower lobe collapsed and closely adherent to the diaphragm; a series of perforations existed, extending through the lung substance to the bronchi. There was no effusion in the right pleural cavity. The left lung was healthy; the heart healthy, a little displaced to the left.—*Synopsised from Canada Medical and Surgical Journal.*

Surgery.

FRACTURES OF THE INFERIOR EXTREMITY OF THE RADIUS.

M. DUPLAY.

Fractures of the inferior extremity of the radius are easily recognized and are generally produced by a fall on the palm of the hand. The physiological signs are an impotence of the limb and a violent pain at the wrist. The physical signs are of much greater importance and are truly pathognomonic. They are characterized by a deformity of the wrist, easily produced on the cadaver, and by a vicious attitude of the hand.

The dorsal deformity gives to the wrist the aspect of a fork handle, as Velpeau described it, or of a Z. On the palmar aspect the deformity is in an inverse direction; on the lateral parts the styloid apophysis of the ulna is sometimes broken off. It makes a more considerable protuberance than in the normal state on account of the displacement *en masse* of the hand. The styloid apophysis of the radius is shoved upwards, and is found on the same plane as the styloid apophysis of the ulna; while in the normal condition it is situated lower, and beneath this last.

Lastly, the vicious attitude of the hand is such that the entire hand is pushed from the ulnar towards the radial border; and the prolonged axis of the forearm, in place of being normally continuous with the axis of the middle finger, passes, on the contrary, into the axis of the ring finger.

These different deformities that we have just indicated, as well as the vicious attitude of the hand, caused the belief for a long while, even for some hundreds of years, in a luxation from before backwards of the hand, and from behind forwards of both bones of the forearm. It was only at the beginning of this century that the error was recognized.

Luxation of the hand is, moreover, very rare and its diagnosis easy. The protuberance backwards is altogether different from that which is produced by fracture of the radius. It takes on the rounded form of the carpal bones, very distinct from the irregular surface formed by the fractured extremity, dentated and unequal. Further, in fractures of the radius, the styloid apophysis is displaced from its relations, whilst in luxation its relations are the same. Its diagnosis is then, I repeat, very easy; and further, this luxation is so rare, that hardly one example of it is observed, against five hundred fractures of the inferior extremity of the radius.

Now there are cases in which fracture of the radius is not accompanied with displacement, or where this is so feeble that it is scarcely perceptible; further, an error is committed even in these days, the pain and impotence of the limb causing the supposition of a sprain of the wrist. The diagnosis between sprain and fracture is sometimes more difficult than between luxation and fracture without displacement. This diagnosis rests upon three symptoms which we might call fundamental. The first is the seat of pain on pressure, which in a sprain is found at the level of the radio-carpal articulation and of all the carpal articulations, or a little beneath this interline; whilst in fracture it is situated a little higher, above the line of articulation, and the pain is less intense at the level of the carpus.

The second sign is furnished by the relations of the styloid apophyses of the radius and ulna to one another, which are no longer the same as in the normal condition, even when the fracture is accompanied by no displacement. The third sign is the mobility of the fragments, slight as the displacement may be, when in cases of fracture antero-posterior movements are instituted.

Thus, then, the seat of the pain, abnormal mobility and change of relation between the two bones of the forearm : such are the distinctive characters of fracture of the inferior extremity of the radius.

The inferior fragment of the fractured radius is generally very short, and the seat of the fracture is most often found at a centimetre and a half above the articular interline. The direction of the fracture is nearly transverse ; and the extremity of the superior fragment, pointed, frequently penetrates the extremity of the inferior fragment, which it sometimes splits, producing secondary fragments. It is when the carpus is displaced with the inferior fragment of the radius, the hand being carried towards the dorsal face of the forearm, whilst the superior fragment protrudes on the palmar face, that results the fork-handle of which I spoke in the beginning.

The first effects of the fracture—especially in the case of penetration of the bones—are a shortening of the radius, an ascensional movement of its styloid apophysis, the apparent protrusion of the styloid apophysis of the ulna, and the deviation of the hand on the radial border of the forearm. There exists little or no crepitation of the bony fragments.

Fracture of the inferior extremity of the radius is produced almost always in the same conditions by a fall forwards on the palm of the hand, the heel of which supports the wrist. Its mechanism, which no author has been able, until lately, to give very clearly, and which I confess I had never, so to speak, understood before becoming a surgeon of the hospitals, is the following :—

The individual falls from a height more or less great, or from his own height, and the fracture is produced by pulling, the anterior radio-carpal ligament being forcibly stretched by an exaggerated extension. This ligament is inserted fifteen millimètres above the articular interline ; and it is nearly at its level, or a few millimètres above, that the fracture is produced, and its form corresponds to that of the inferior insertion of that ligament. A *memoire* of Dr. LeBon especially suggested this mechanism, which is to-day absolutely demonstrated.

It is then always by pulling that this fracture is produced. If it took place in an inverse sense it is still by the same process, by the pulling of the posterior ligament, which pulls in its turn the portion of the radius to which it is inserted. This mechanism is most important to comprehend perfectly, in order to prepare for the deformities which the fracture brings with it and the accidents which may follow it.

As to the displacement, it varies according to the age of the subjects. It is much rarer after fifty years than under that age, for a reason easy to understand.

At that age, in fact, the bones have undergone modifications of structure characterized in the inferior extremity of the radius, as in the neck of the femur, for example, by a superabundance of spongy tissue : consequently, it is sufficient then for a slight fall upon the palm of the hand to produce a fracture of the radius. If the violence is slight, the displacement is nothing as well as the deformity. On the contrary, in young people and children, the fracture exacting a certain amount of violence for its production, necessarily carries in its train a deformity of the limb and a displacement proportional to the violence which caused the fracture.

Fractures of the inferior extremity of the radius easily recover without accident unless, unrecognised, they also are badly treated, and a vicious consolidation allows a deformity to persist, which is shameful, not only in an æsthetic view, but also because by it the limb loses its strength and the hand its skill.

If there exists no displacement, any retentive apparatus is good, and consolidation is effected in twenty-five days. I generally apply a plaster splint, which I take away the twenty-fifth day, after which I begin to make some motions of the limb.

If, on the contrary, the fracture is accompanied by displacement, it is very necessary to proceed to its reduction. Chloroform is rarely necessary, unless the patients are extremely nervous, pusillanimous, or of an exaggerated sensibility. Reduction being obtained, the fracture is placed in a plaster apparatus, of which the splint will encroach a little on the external lateral face of the forearm and the hand, which will be left pendant. As to the consecutive articular stiffness, it generally disappears in less than a month by massage and douches.—*Gaz. des Hôp.*

Midwifery.

PUERPERAL ECLAMPSIA.

BY WM. H. WATHEN, M.D.,

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Medicine, Louisville, Ky.

(REPORTED BY A. H. KELCH, M.D.)

There is a great variety of opinion in regard to the treatment of puerperal eclampsia, and you can see at once why this should be so, because there is no settled opinion in regard to its cause. You know the scientific treatment of disease is to first discover its cause, and then remove that cause, if possible; and where that cannot be determined, we must simply use those remedies which, in the hands of the most experienced physicians, have yielded the most successful results.

In studying the statistics of all the past cases that were available, it was discovered that about thirty-two per cent. of those cases that occurred subsequently to labour ended fatally; but in the examination of cases that have occurred since the subject has been more thoroughly studied and the treatment more successfully adapted to the case, we find the mortality has very materially lessened, and that it does not exceed fourteen per cent. in scientific hands; and I predict that in a very short time it will not exceed ten per cent. in all cases.

Now, one of the old remedies, one that was for some time discontinued in this country, but which has to some extent been reintroduced and recommended, is venesection as soon as the attack is discovered.

Venesection is unquestionably a decided benefit at the beginning of and during an attack, when the symptoms are violent, and the face and brain much congested. This is demonstrated by clinical experience, for we frequently find the attack thus cut short, and no recurrence of it for a considerable time.

Granting that the blood is in a hydræmic condition, still there is an excessive vascular tension; and we can readily comprehend how venesection should be immediately productive of happy results, preventing serious lesion of the brain and kidneys by relieving vascular tension; and we can at the same time understand how excessive venesection, or venesection

practised indiscriminately, could be productive of evil results; for when you remove the blood, you remove not only the watery elements, but, simultaneously, a proportionate amount of the blood corpuscles that are necessary to the sustenance of the patient; so that, while you relieve that excessively vascular condition, while you remove the immediate danger of structural lesion of the brain and kidneys, you leave the system in a condition that is less favourable to recovery than it would otherwise have been; and it often does not afford permanent relief to the vascular tension, because the blood has the power to absorb from the tissues the watery elements, and thus produce the same amount that existed previous to the venesection. So, when you bleed, do not practise it to excess. Venesection may produce permanent good results, or be of temporary benefit that will enable you to avail yourselves of other treatment, by which you may bring about rapid and favourable results.

When you have controlled the immediate convulsion, then you may resort at once to other treatment to prevent a recurrence, and the best of all remedies is chloroform. It gives the best results, and having put your patient at once under its influence, you can administer it during the convulsion, and during the coma at any time that it is indicated.

There is no necessity for thoroughly anæsthetizing your patient, but give enough to control the convulsion, and when it begins to reappear, increase the amount until it is controlled. It must be watched closely and continued for a long time. It is well, when you have once commenced it, that you should administer some remedy that is more pleasing and lasting in its effects, and nothing more fully meets this double indication than full doses of hydrate of chloral.

You may combine large doses of bromide of potassium with it.

Dr. Barker has not experienced the happy results from chloral which have been met with by a great many celebrated authorities upon this subject, and he advises, in its stead, large doses of morphia hypodermically. The chloral may also be administered in this way, giving from four to eight grains in one drachm of water as often as may be indicated.

After the convulsions are brought under control, a brisk cathartic should be given, that will, as soon as possible, clean out the bowels and cause a watery discharge; because in this way you deplete, by relieving the vascular tension without removing the blood elements.

Accepting the theory of the hydræmic condition of the blood, we would naturally expect to have happy results from those remedies that produce profuse diaphoresis. But we find the results have not been in accordance with this theory, and we have, by the use of pilocarpine administered hypodermically, unfavourable reports—indeed, quite a number of fatal results, and it has been determined that under the use of pilocarpine, where salivation has been produced, the success has been less encouraging than where we have resorted to the other means of treatment I have suggested.—*Phil. Med. and Surg. Reporter.*

Translations.

It suffices, says M. Lépine, to vary the degree of acidity of the urine examined, in order to obtain at will retractile or non-retractile albumen.—*Le Prog. Méd.*

CUTANEOUS HYPERÆSTHESIA DUE TO DYSPEPSIA.

M. Leven has studied the influence of dyspepsia upon the sensitive nervous system and upon the motor nervous system. All the classical treatises repeat, on the word of M. Briquet, that hyperæsthesia of one-half the body is a frequent complication of hysteria, and that in hystericals the hyperæsthesia occupies by preference the left side. M. Leven believes that this phenomenon depends rather upon stomachal troubles. In fact, hyperæsthesia is met with eight times out of nine in dyspeptics, as well in men as in women. The degree of hyperæsthesia is more over in proportion to the intensity of the disease of the stomach. Hysteria develops not hyperæsthesia but anæsthesia. This is so true, M. Leven declares, that the coincidence of hyperæsthesia of one side and of anæsthesia of the other side in the same patient indicates at once dyspepsia and hysteria.—*Le Prog. Méd.*

LOCALIZATION OF PAIN IN HEPATIC COLIC.

BY J. CORNILLON.

1st. *Cystic Point.*—Anatomically, it corresponds to the place where the gall stone leaves the gall bladder to pass the cystic duct and become engaged in the choledoch canal. According as the calculus approaches the duodenum and the *ampulla* of Vater this painful point is extended, and soon ends by becoming confounded with the epigastric point.

Nearly constant, it is wanting however in some fine attacks of hepatic colic with icterus and issue of biliary gravel; or it is so slight as to pass unperceived both by the patient and the physician. It is very difficult to determine the sensations to which it gives rise, its forms are so varied. Sometimes it is acute and tearing, and produces cries and tears; sometimes it is comparable to a heavy body which compresses the right hypochondrium. Its intensity depends neither upon the length nor the brevity of the attack. I have seen it very acute in short crises, and slight in crises of long duration: in other cases, I have remarked that the expulsion of large biliary calculi gave rise to supportable cystic pains, whilst small concretions occasioned horrible sufferings. It is a matter of idiosyncrasy.

The cystic point is direct; its position at the beginning is very nearly fixed. When I have investigated it, I have seen that it corresponded, most often, with the inferior border of the great lobe of the liver, below and to the right of the xiphoid appendix, at about ten centimetres from the point of that bone. By sliding the pulp of the index finger between the border of the costal cartilages of the right side and the anterior abdominal wall, we may proceed to determine it with most exactness. In certain cases the cystic point is displaced: it is found in the seventh or the eighth right intercostal space, on a line which leaving the right nipple would follow a direction parallel to the median division of the body. Finally, in some circumstances, it is a little outside of this line, four or five centimetres at the most.

This painful point, even when it is slight, is always accompanied by trouble in the

respiratory functions—the patient suffocates. This dyspnoea, which might cause us to look for an unexpected complication of the pleura, or of the lung, or of cardiac troubles, is nothing but natural. Physiology explains it to us. When the diaphragm contracts in inspiration, the liver is slightly lowered, to be raised again in expiration. The movements of ascension and descent of this organ necessarily exaggerate the cystic pain. Instinctively then the patient abstains from breathing. That is the whole secret of this dyspnoea.

The cystic point announces the near apparition of an hepatic colic, sometimes twenty-four hours before the appearance of the other accidents. It is then a sign of a certain value. Not always disappearing with the end of the attack, its persistence for days and even for some weeks, indicates either the return of the colic in a short while, or the existence of a cholecystitis. These indications are precious, as well for the prognosis as for the treatment of the principal affection.

Pointed out for the first time by Fleming, this painful point is not admitted by all authors, and notably by M. Charcot. In my opinion he is wrong.

2nd. *Epigastric Point*.—This is never wanting, so that all the authors who have in any degree whatever busied themselves with the biliary lithiasis, describe it. Pemberton and M. Sénac (of Vichy) speak of it in their writings. Purely reflex in nature, it appears after the beginning of the morbid accidents, and although the stomach may be struck only by *contre coup*, it makes itself felt the most acutely and attracts the attention of the physician the most. Sometimes it consists of a sense of dilatation and distension of the stomach, in a cramp, sometimes in a bar which extends from the border of the left false ribs as far as that of the ribs of the opposite side, thus dividing the stomach into two equal parts. Sometimes this bar has a direction diametrically opposite; it starts from the xiphoid appendix and ends at the umbilical ring. Here, it is a weight which compresses the epigastric region; there, it is a sensation of scalding and of a dragging at the level of the stomach.

These varieties of pain, so dissimilar in appearance, have however one common point, which is, that their maximum point is found quite exactly in the median line of the body, and at one or two finger's breadths beneath the xiphoid appendix. The epigastric point is accentuated according as the attack augments, so that at the moment of its paroxysm, it occupies the whole region of the stomach and seems to be confounded with the cystic point. Until then, pressure upon the epigastrium was possible; but at this moment epigastralgia supervenes, and palpation even is no longer practicable without causing the patient to utter sharp cries. The unfortunate ones cannot bear the slightest touch in this place. They throw off their covering and avoid even the contact of their shirt. If they are in bed they assume the position most suitable to alleviate their sufferings. This position is essentially variable according to the case. When they make a movement they execute it, as it were, all of a piece. If they are up, they bend themselves forwards with the hand in front of their epigastrium, as if to sustain it and protect it from external objects. Others, on the contrary, experience relief by compressing the stomach with the fist, or by applying warm bodies on the painful spot.

At the moment when the cardialgia appears, nausea supervenes with emission of fetid gas, and soon after the desires to vomit emesis occurs ordinarily. In the beginning it takes place without effort: the patients reject their aliments without experiencing very great suffering; some even imagining that they have an indigestion (which often happens with those who are taken for the first time with similar accidents), thrust their finger down their throat or swallow some tepid water to aid the vomiting.

Once the stomach is emptied, there is a slight relief; but it is of short duration, for the vomitings soon recommence. They are no longer executed as before, without pain and without fatigue; often, in fact, they are accompanied with anguish, with lipothymia and even with syncope. The matters rejected are bilious, mingled with glairy mucus and with the débris

of food which had resisted the previous evacuations.

As soon as the crisis diminishes in intensity, the violence of the epigastric pain is less, and often even it ceases with the end of the access, unless a local or general peritonitis should intervene. However, there exist numerous cases in which, in spite of the cessation of the hepatic colic, and without any phlegmasia whatever being declared, the cardialgia is renewed for many days after the patient takes a little nourishment. This persistence can be explained only by the continuation of the reflex action which has been exerted upon the stomach.

3rd. *Dorsal Point*. — Its existence was pointed out for the first time by M. Vidal, in a communication to the Society of Biology. He calls it point of correspondence, and places it over the spinous apophysis of the fourth dorsal vertebra.

Upon many occasions it has been permitted me to point out the dorsal painful spot. Generally, I have found it comprised between the spinous apophysis of the seventh dorsal vertebra and that of the tenth; very exceptionally, it is higher or lower. It corresponds exactly to the epigastric point in such a manner that, if we were to introduce a needle at the latter point, making it to follow a horizontal direction, the spinous apophysis where it emerged would be found to be the maximum of the painful dorsal point.

It is at the very beginning of the hepatic colic that it appears with the cardialgia and the gastric troubles, and it ceases with the end of the principal lithiasic accidents. It is rarely wanting even in the slightest cases. It acquires sometimes such intensity that the patients are obliged to bend themselves forwards to lessen its violence. The pain is spontaneous, as in the cystic and epigastric points, but it is exaggerated by pressure; and when we lean upon the spinous apophysis, it causes a sharp crushing feeling, accompanied by cries and propulsion of the body forwards.

The dorsal painful point ought not to be confounded with the general feverishness which follows hepatic colic; it is due to the osseous system and not to the muscles. A little

attention will always suffice to prevent a mistake.

4th. *Scapular Point*. — This is far from being as constant as the preceding; in fact, we meet with it only in about one-fifth of the cases. To Budd belongs the honour of its discovery. Generally it is at the inferior angle of the scapula that the pain is felt most sharply. At times also it is localized in the acromion or in the spine of the scapula, in such a manner that its seat is not absolutely fixed and constant. This point is very painful. It is exaggerated by pressure upon the osseous surfaces and by the movements of the shoulder. It is accompanied at times by strange troubles, tinglings in the ends of the fingers of the right hand, by sensitiveness of the bones of the elbow, and notably in the epitrochlea. These last phenomena may even be manifest in its absence.

The scapular point is a manifestation of hepatic disease, so when it exists it is a valuable semeiological sign. It permits, in fact, a strict and precise diagnosis in all cases in which there is hesitation between the biliary and renal lithiasis.

5th. *Painful Point of the Left Hypochondrium*. — Of all those which we have just pointed out, this is by far the rarest. Denied by M. Sénac, it is admitted by MM. Durand-Fardel and Willemin, who have observed a certain number of cases of it. It is found situated a little below the border of the left false ribs, below and outside of the xiphoid appendix, at about twelve centimetres from that bone.

Does this painful point proceed from a congestion of the liver or of the spleen? M. Willemin reports a case of sharp suffering localized in the left hypochondrium, in which the middle lobe of the liver and the spleen were engorged. Twice only have I met with this painful point, and in both cases the spleen was appreciably congested. I will even add that it was at its level that the maximum of suffering was found, so that I have asked myself if the painful point of the left hypochondrium was not rather a splenic than an hepatic point.

In acuteness it differs in no way from the cystic point. Like it, it forces cries from the

patient; like it, it sends painful irradiations to the epigastrium. When it exists, the attention of the physician ought to be awakened; for its proximity to the renal region and its extension into the left flank exposes to the commission of very prejudicial errors of diagnosis. They are even inevitable unless we can seize the *corpus delicti*.

Nota.—Sometimes the painful localizations of the epigastrium, of the back, and of the hypochondria are replaced by a cincture which enlaces the base of the thorax and constrains it. It is then impossible to establish any maximum whatever.—*Le Progrès Médical*.

RETRACTILE ALBUMEN.

The *Lyon Médical* publishes some remarks of MM. Cazeneuve and Lépine upon retractile albumen. These gentlemen consider that the retractility or non-retractility of albumen, in albuminous urine or other fluid, is of little pathological significance, and that it is dependent upon the chemical constitution of the fluid. Urine is said to contain retractile albumen when, upon the application of heat, the albumen separates in flocculi which contract, allowing the clear urine to be seen between and around the coagula; non-retractile, when only a turbidity or lactescence results. Both forms are frequently present at the same time, and may be separated by filtration. The addition of acetic acid, sufficient to saturate the alkalinity of the fluid, will cause the turbidity to disappear and the retractile form to appear—a little liquor potassæ or sodæ added to the albumen thus coagulated will cause the lactescence and turbidity to reappear. They explain this by the fact that the albuminous fluids of the body, in addition to free albumen, contain albumen combined with a base (potash or soda). These albuminates coagulate badly or not at all with heat, and hold in suspension the coagulated albumen; hence the turbidity. The acetic acid attacks the base, frees the albumen and allows it to contract; hence the retractility. Too much acid must not be added, as it has a tendency to re-dissolve the coagula.

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TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, FEBRUARY, 1881.

ANTISEPTIC OVARIOTOMY.

Heretical opinion is undoubtedly contagious. When, therefore, a few months ago, Mr. Lawson Tait, of Birmingham, had the hardihood to appear in the midst of the Royal Medical and Chirurgical Society in London and denounce the practice of Listerism in ovariectomy as not only useless but injurious, we were not slow to foresee—notwithstanding the fact that not a single ally raised his voice in his support—that this seed of truth (as we believe) would not fail to fructify, even in uncongenial soil. Accordingly, we were not at all surprised to find Dr. George Granville Bantock, of the Samaritan Hospital, reading a paper at a late meeting of the Royal Medical and Chirurgical Society on “Hyperpyrexia after Listerian Ovariectomy.” This, with other symptoms of carbolic acid poisoning, appeared to be the main evil charged against the acid; and as one of its chief claims has always been the avoidance of pyrexia, the *tu quoque* retaliation was received with redoubled force. In the author's experience 36 Listerian cases and 36 non-Listerian, gave a difference in temperature in favour of the former of but 0.4°; and the lowest temperature occurred after a non-Listerian case. Volkman admitted a condition of phenic acid poisoning, and termed it “aseptic fever.” Thiersch had encountered great irritation from its use, and substituted salicylic acid. Keith found very little difference in the temperature in a series of cases under the old and the new methods. In three Listerian cases the temperatures were the

highest he (the author) had ever seen. Before adopting antiseptics he had never found the ice-cap necessary for subduing pyrexia. The experience of Mr. Spencer Wells and Mr. Knowsley Thornton was, however, contrary. The author described at length two cases of poisoning from prolonged action of carbolic spray in complicated ovariectomies. He had observed albuminuria and temporary suppression of the sulphates in the urine of a young girl after antiseptic ovariectomy. Sonnenburg, Lightfoot, and others had had similar experiences. The poisoning was not always indicated by discoloration of urine.

Mr. Thornton regarded the kidneys themselves as at fault in these cases, and strongly upheld antiseptics. In his last 100 cases he had had a mortality of 7 per cent. in hospital practice, and in private practice he had only lost 1 case out of 27. Without Listerism, the mortality in ovariectomy might be reduced to 10 per cent., but not lower.

Mr. Lawson Tait thought it impossible for anyone to understand the theory and practice of Listerism. He had used solutions of carbolic acid, gradually reducing the strength, till at last he used simple water, and had found that his results were equally satisfactory under the simple dressing. Moreover, under the latter, the wounds healed more satisfactorily; a fact which Dr. Savage, his colleague and a strong Listerite, felt constrained to admit. In one of his cases (double) the temperature rose to 112°, and remained so nearly 50 hours. He attributed this to the use of carbolic acid.

Mr. Spencer Wells said that since adopting the antiseptic method in 1878, he had had 131 cases with 13 deaths, or 10 per cent., the death-rate being exactly the same as in his last two years' of hospital practice without special antiseptic measures. Before, the results of the intra-peritoneal method had been less favourable than those of the extra-peritoneal; the reverse was now the case. He had never seen a remarkable rise of temperature after antiseptic ovariectomy; it rarely rose above 100°

Mr. Holmes thought the statistics showed no decided difference in favour of Lister's method in ovariectomy. He had long ago tried,

without success, to master the details of the method, when they were more simple than at present; and he doubted whether anyone understood it in its present form.

Dr. Bantock, in reply, said his results had been as follows:—With 1 in 50 solution, 41 cases with 3 deaths; with 1 in 60, 10 cases and 1 death; with 1 in 80, 8 cases and 2 deaths; with 1 in 100, 19 cases and 1 death. In Italy, in the first 100 cases of ovariectomy (4 of which were done antiseptically) there were 37 deaths; in the second 100, done antiseptically, the mortality was 36. He had not been able to desist from the use of the ice-cap till he had reduced the carbolic solution to 1 in 80.

In an article in the *Berlin Klinisch. Wochenschr.*, 1880, 43, Prof. V. v. Bruns, of Tuebingen, following v. Naegeli, exclaims, "Away with the spray! not only unnecessary and superfluous, but also a disagreeable and annoying addition."

In the course of the debate at the Royal Medical and Chirurgical Society, Mr. Savory suggested that diminution of mortality in a surgeon's practice might be due, in great measure, to increased experience. And Mr. Lawson Tait regarded Mr. Thornton's great success as being attributable to the fact of his having been brought up under the master's eye during his long service with Mr. Spencer Wells. That this is the probable solution of all these differences receives strong confirmation from Mr. Tait's own record, seeing that he witnessed 19 deaths in his first 50 cases, and only 3 in his last 91. In the New York State Women's Hospital a death from ovariectomy is very exceptional, and yet, we believe, they are not Listerites there.

Mr. W. G. Falconbridge, M.A., has resigned his position as Registrar of Toronto University. Messrs. W. H. Vandersmissen, M.A., Alfred Baker, M.A., and E. B. Brown, M.A., are, we believe, candidates for the office.

Dr. Grant has been elected President of the Medical Society of Ottawa, and is spoken of for the vacancy in the Senate.

ANÆSTHETICS.

The Report of the sub-Committee on Anæsthetics (composed of Prof. McKendrick, Dr. Coates, Dr. Ramsay, and Mr. Newman, of Glasgow) to the Scientific Grants Committee of the British Medical Association, published in the *British Medical Journal* for 18th Dec., 1880, affords the material, as well as a fitting opportunity, for the consideration of the merits as well as the demerits of the chief anæsthetic agents now in use. The effects of these were determined clinically by the committee in the wards of the Western Infirmary, Glasgow, and experimentally upon animals, for the most part frogs, dogs, and rabbits. As a result of their experimentation it became evident that chloroform exercised an injurious influence upon the respiratory centres as well as upon the heart, "while ether has no baneful influence" upon the cardiac contractions. The tardiness of the action of ether is, however, a great disadvantage; comparative experiments with rabbits showing that complete anæsthesia was induced with chloroform in about three minutes, while with ether 15 to 20 minutes were required, although the cloth was kept constantly saturated. Accordingly a trial of some dozen different agents was instituted with a view to discovering some anæsthetic possessing the advantages of both chloroform and ether with the disadvantages of neither. After a laborious and difficult investigation the committee reached the conclusion that the dichloride ($C_2H_4Cl_2$) of ethidene—recommended in 1858 by Snow—possessed these qualifications in the highest degree. This substance, it appears, was used by Liebreich and by Langenbeck in 1870; Sauer also has recorded its use in 33 cases (two vomited, two suffered from headache, and one died from heart disease). Steffen has published the details of 20 cases with satisfactory results; and Mr. Clover records (*British Medical Journal*, 29th May, 1880) his experience of it in 1877 cases, with one death due to a fatty heart in which nitrous oxide had been previously administered. With reference to the comparative effects of ethidene and of chloroform in the human subject, the following facts are stated:—The average dose of ethidene is 40.3c.c.; or in other

words 1.8c.c. for each minute the patient is under the anæsthetic; whereas in the case of chloroform it is 31.8c.c., or 1.7c.c. per minute. Further, the time required to anæsthetise with chloroform is greater by 1.1 minute (5.4—4.3) than with ethidene. Again, recovery from chloroform anæsthesia occupies on the average 4.8 minutes; with ethidene only 4.4 minutes. Sickness during administration occurred more frequently with chloroform than with ethidene. The effects on the pulse respiration ratio are also tabulated. It appears hence that with chloroform there frequently occurs a rise in the respirations and a fall in the pulse below the normal line—these two phenomena being concomitant; moreover, dicrotism in the pulse and low arterial tension are not unfrequently observed. With ethidene on the other hand, there is but little disturbance of this kind; and in only one case did the pulse become dicrotic. The influence of these two agents upon the blood-pressure, and the effects of anæsthetics on the pulmonary circulation, are then dealt with by the committee; but of this portion of the report, and the ingenuity, patience, and labour expended therein, we can afford our readers no adequate conception, but beg to refer those interested to the No. of the *British Medical Journal* (18th December, 1880), in which it is contained. Suffice it to say, that in nearly all these respects, ethidene occupies a position midway between chloroform and ether. The recommendation of ethidene by the committee is so strong that we are greatly encouraged to urge upon members of the profession the propriety of subjecting this anæsthetic to the crucial test of daily practical experience. And we doubt not that if its administration be scientifically watched, and its failures and successes impartially recorded, we shall ere long accumulate sufficient evidence to determine definitely whether this new beacon of progress be an *ignis fatuus* or the veritable thrice-prayed-for banisher of pain, whose effects shall be manifested *cito, tuto, atque jucunde*.

Drs. Canniff, of Toronto, and Beatty, of Cobourg, have been appointed Census Commissioners for Ontario.

ONTARIO MEDICAL ASSOCIATION.

We understand that the Committee appointed in this city to confer with the members of the profession throughout the country concerning this subject have decided to call a meeting soon for the purpose of organizing a Medical Association for this Province. As far as we can learn from various sources, medical men west and north of Toronto, and east, as far as Kingston, are unanimously in favour of the scheme—in fact, the greater proportion of them have been for some time. We regret that the Ottawa Medical Society considers its establishment “inexpedient at the present time.” We understand that Dr. Grant, whose opinion is entitled to the highest respect on account of the untiring zeal and energy which he has always shown in advancing the best interests of the profession, considers the undertaking undesirable at present, but thinks that we should rather endeavour, for a few years at least, to throw all the life-blood possible into the Dominion Association. We cordially sympathize with the opinion here expressed, but at the same time feel certain that the organization of a Provincial Society in this, any, or all the provinces, will not in any way weaken the Dominion Association, but will rather tend to strengthen it.

There appears to be a certainty that the Ontario Association will be established under the most favourable auspices, and we wish it all success. We will not undertake to discuss details, but leave these for the consideration of the Society or the Committee before referred to. One question has, however, been brought forward frequently—should its meetings be held always in one place, or should they take place successively in several different cities? Much might be said on both sides of this question; but we must say, we incline to the view that it would be much better not to limit the place of meeting to one locality, nor prescribe any fixed rule for the present, but rather leave this, with other questions, to be decided by the Association after it is properly organized. The 10th of March has been mentioned as the day for the preliminary Convention.

The Obstetrical Journal of Great Britain and Ireland has suspended publication.

MALPRACTICE.

At the Hamilton Winter Assizes, the case of *Tost vs. Freeman*, referred to in a previous issue, was tried and disposed of, resulting in the entry of a non-suit. We offer our hearty congratulations to Dr. Freeman upon this happy termination of a most vexatious and unrighteous prosecution. The particulars of the case are published in another column. At the conclusion of the trial, the presiding Judge, Mr. Justice Galt, gave expression to some pertinent and too oft-forgotten truths concerning the arduous nature and precarious character of professional services. For this timely recognition, in high places, of the difficulties and dangers of medical practice, we thank him in the name of a profession too obnoxious to malicious prosecution, and too little accustomed to a grateful appreciation of duty faithfully and painfully discharged.

NEW PRIVATE HOSPITAL FOR WOMEN.—We are glad to be able to inform our readers that a new hospital of this kind has been just opened in New York city, at the corner of Lexington Avenue and 52nd Street, by the world-renowned T. Gaillard Thomas and another distinguished surgeon of the New York State Woman's Hospital, Dr. Jas. B. Hunter, President N. Y. Obstetrical Society, whose mother and immediate relations are residents of this city. We hear so frequently of Canadian women resorting to the great American Metropolis for special advice and treatment that we are sure this announcement will be read with great satisfaction in all parts of the Province. We by no means encourage an exodus to Gotham while we have very excellent gynecologists at home, but we trust that when occasion really arises, these latter will bear the existence of this new institution in mind, and direct their patients accordingly. Rooms, we suppose, can be secured by application to either of the medical officers.

See among advertisements an excellent opening for a medical man in a flourishing town; also, an assistantcy wanted.

At a meeting of the Senate of Toronto University, convened for the purpose of choosing a Vice-Chancellor to fill the place of the late Chief Justice Moss, Mr. Wm. Mulock, M.A., was elected to the office. Mr. Mulock was among the first members of the Senate elected by Convocation, and since that time has always been one of the most diligent and prominent among them. He is thoroughly conversant with all University matters, and takes a keen interest in everything pertaining to her welfare. He possesses tact, energy and ability, and being a University man of the right sort, is, in our opinion, well fitted for the position.

The American Medical Bi-Weekly (formerly published in Louisville, Ky., and for a time suspended owing to the illness of its editor, Dr. E. S. Gaillard) has resumed publication in New York, whither the editor has removed. No. I. of Volume 12 has been received. Subscription price \$1 per annum.

In the Circuit Court at Fredericton, N.B., an action is now pending to recover \$10,000 damages for loss of eyesight. The plaintiff, who is stone blind, is one Robert Dippin; the defendant, Dr. Dow.

We are pleased to announce, but regret to take our information from a lay source (*The Globe*), that Dr. G. S. Ryerson, of this city, has been elected a member of the Ophthalmological Society of Great Britain.

Dr. Mostyn, of Almonte, has been elected President of the Agricultural Society for the North Riding of Lanark.

APPOINTMENTS.

Dr. F. W. Strange to be surgeon Queen's Own Battalion, vice Surgeon Major Thorburn, who retires, retaining his rank.

Drs. J. H. McCollum and G. S. Ryerson to be Surgeon and Assistant Surgeon of new 10th Royals.

Drs. McPhedran and Jehu Ogden have been appointed Surgeons to the Toronto Dispensary.

Obituaries.

CHIEF JUSTICE MOSS.

In the death of this learned and upright judge the medical profession, no less than our brethren of the bar and the public generally, finds great occasion to mourn the common loss. We therefore feel it to be at once our pleasure and our pain to recall the salient incidents of his bright career, and to record the melancholy circumstances of its too early termination. Born in Cobourg, in 1836, his early education was acquired at Upper Canada College, where the budding genius of the boy gave ample promise of that so rich fruit which ere long characterized the man, and made the giant tree, known of all, the admiration and ensample of the saplings growing up around him far and near. In graduating at the University of Toronto in 1858, he gained the remarkable distinction of a triple first (in classics, mathematics, and modern languages). Passing then into the wider sphere of active life, he soon acquired a pre-eminent position at the Equity Bar, and at the early age of forty-one became Chief Justice of Ontario and President of the Court of Appeal. The bare narrative of this career, and the recollection of the vital strain and unintermitting nervous tension necessary for its accomplishment, cannot be devoid of interest and instruction to us who are sent to preach the gospel of physiology and obedience to natural laws. When we find one of his brother judges (Mr. Justice Burton) averring that even after his accession to the Bench "the rising sun occasionally found him still engaged in examining and verifying the authorities," all wonder dies that the age of forty-three brought with it an exhausted store of reserve energy and vital resistance totally unequal to the tolerance, much less the repulsion, of any serious pathological invasion. *Gito rumpes arcum, semper si tensum habueris.*

It is, however, as one of the foremost friends of liberal and scientific education in this country that the medical profession will most deeply feel his loss. Soon after graduation he was appointed Registrar of the University of Toronto; and in this position probably acquired

a closer insight into the requirements, capabilities and defects of University education in this country than anyone else possessed. Subsequently called, some seven years ago, to fill the most important executive office of Vice-Chancellor, his past experience and extended influence soon made him the well-spring of all University reform; and, to refer only to the Faculty of Medicine, we owe him a large debt of gratitude for the new medical curriculum and all the benefits which must flow therefrom.

Some four or five years ago, the late Chief Justice passed through an attack of whooping-cough, and subsequently suffered occasionally from acute hepatic congestion. Early in 1880, epistaxis, with evidences of hyperæmia of the mucous membranes generally, occurred, followed in March by copious hæmatemesis and unmistakable evidences of cirrhosis. His strength was at this time much reduced, but subsequently improved. During a summer sojourn in Muskoka chills occurred, again followed by improvement; but in October last the hepatic symptoms recurred, accompanied this time by dropsy. Absolute abandonment of work was now insisted upon, and in order that this advice might have the weight of the highest authority he was advised to consult Prof. Alonzo Clark. From a letter addressed to the Registrar of the University (Nov. 1), tendering his resignation of the Vice-Chancellorship, we find that he was at length convinced of the necessity of rest—too long deferred! "The state of my health," he writes, "is such as to render absolute freedom from mental effort, care, and responsibility essential. Without this, the probabilities of a restoration to health are much diminished, and other remedial agents of comparatively little avail. This was the opinion of Dr. Thorburn, my regular physician; and its correctness has been amply confirmed by the distinguished New York doctors whom I have recently consulted. Indeed it is very probable that I shall be compelled to winter in some milder climate." In pursuance of this view he proceeded to Nice, where he unfortunately succumbed on the 4th ultimo.

Eminent jurist, accomplished man, and perfect gentleman; genial companion, fond father, and faithful friend; eloquent of speech, affable in demeanour, sympathetic in difficulty or distress, the chief *presidium et dulce decus* of *Alma Mater*, the pride of relatives and friends—take him for all in all, he was a man whose like, we fear, we shall not look upon again.

Book Notices.

Cases Treated by the Lister Method, reported to the Portland Clinical Society. By FREDERIC H. GERRISH, M.D., Portland.

On Heredity in Progressive Muscular Atrophy Illustrated in the Farr Family of Vermont. By PROF. WM. OSLER, M.D., M.R.C.P. London.

The Surgical Treatment of Cancer of the Rectum. By CHARLES B. KELSEY, M.D. (Reprint from *American Journal Medical Science*, Oct. 1880.)

Ninety-eighth Annual Catalogue of the Medical School (Boston) of Harvard University (1880-81) Cambridge. Published by W. SEVER, 1880.

Proceedings of the Louisiana State Medical Association, third meeting, New Orleans, March 31st to April 2nd, 1880. J. S. Rivers, 74 Camp Street, New Orleans.

Scarlatina. A Lecture delivered in the Jefferson Medical College. By WM. B. ATKINSON, A.M., M.D. (Reprint from *Med. and Surg. Reporter*.)

Case of Pyo-Pneumothorax Subphrenicus (Leyden). By WM. GARDNER, M.D., Prof. Med. Jurisprudence and Hygiene, McGill University.

Phthisis Pulmonalis, and its Treatment with Hypophosphites. By L. DEBREMONT, M.D., Paris. New York: John Newton, Publisher, 33 Beekman St., 1880.

Report of the Board of Health of the State of Louisiana for the year 1880. By JOSEPH JONES, M.D., President. New Orleans: J. S. Rivers, Stationer and Printer, 74 Camp St.

The Surgical Treatment of Intestinal Obstruction. By W. T. BRIGGS, M.D., Prof. Surgery in University of Nashville. (Reprint from *Nashville Journal Medicine and Surgery*.)

Soluble Compressed Pellets. A New Form of Remedies for Hypodermic Use. By H. AUGUSTUS WILSON, M.D. Reprint from *Philadelphia Medical Times*. L. Wolff, M.D., Pharmaceutical Chemist, N. W. cor. Chestnut and 12th Streets, Philadelphia.

Physician's Visiting List. Lindsay & Blakiston, Philadelphia.

This well-known List appears this year as usual, with its many commendable qualities. We regret that excess of matter crowded mention of it out last month, but doubtless the majority of our readers have already secured this indispensable *vade mecum*.

How Persons Afflicted with Bright's Disease Ought to Live. By JOSEPH F. EDWARDS, M.D.

This is a little work in primer form, and containing some eighty odd pages of reading matter. The plan of the work indicates that the aim of the author has been, not so much to throw additional light upon the subject in hand, as to present in a readable form, some practical suggestions to those of the public who may be suffering from Bright's disease in any form. Viewed in this light, the work is entitled to be considered as fairly accomplishing the aims of the author.

Atlas of Skin Diseases. By LOUIS A. DUHRING, M.D. Part VIII. Philadelphia: J. B. Lippincott & Co.

Such high encomiums have, on all hands, greeted the appearance of successive numbers of these plates that the fullest meed of praise which can be accorded to Part VIII. is to say that it is worthy to succeed its predecessors in the series. The affections figured with much faithfulness and skill are Erythema Multiforme (Papulosum), Psoriasis, Syphiloderma (Tuberculosum), and Tinea Trichophytina (Circinata et Tonsurans). We trust that no one who can afford to buy the work will be content to remain without such a valuable addition to his library, and such an efficient aid to the recognition of the too often neglected diseases of the skin. The letterpress is a model of conciseness, but all too brief.

Diagnosis and Treatment of Ear Diseases. By ALBERT H. BUCK, M.D. New York: William Wood & Co. 1880.

This work forms one of Wood's Library, and will therefore serve to impress a large circle of practitioners, who otherwise might not be reached, with the fact that diseases of the ear always merit attention and very often demand treatment. The statement that "a localized meningitis may be assumed to exist in every severe case of acute purulent inflammation of the middle ear," conveys a moral which is too seldom heeded. The author's "aim has been to present, in text-book form, a picture of diseases of the ear as they have appeared in private and hospital practice," and he has admirably succeeded. His book abounds in practical lessons based on original research and a large experience; and the modesty, candour, and conservatism of the author enhance the value of his teachings.

Treatise on Therapeutics. By A. TROUSSEAU and H. PIDOUX. Translated by D. F. Lincoln, M.D. Ninth Edition. Vols. II. and III. New York: Wm. Wood & Co.

The opening article of Vol. II. is an exposition of the great question of antiphlogistic treatment. Blood-letting is now on the wane, but the arguments of its partisans are put fairly, though Bouillaud's "intemperate and ambitious antiphlogistic treatment" are spoken of, and Lordat is quoted as saying—"Bleeding to pallor is the knout of therapeutists. It puts those whom it does not kill in a state where for some time they cannot exhibit symptoms." Evacuants are divided into emetics and cathartics, and Ipecac. and Tartar Emetic receive considerable notice. Strychnia and Ergot of Rye are the selected examples of excito-motors. A chapter on Narcotics concludes this volume.

Vol. III. begins with a chapter on Anæsthetics; passes on to Antispasmodics, and Nervous Tonic, under which he discusses cinchona and the treatment of intermittents. The power of quinine in lowering the temperature does not appear to be noticed; though later on, this power is ascribed to digitalis, through its action on the pulse. Under the head of Excitants he places Diuretics, and discusses at some length the opposing doctrines of Brown

and Broussais. Chapters on Sedatives and Anthelmintics close the volume.

The treatise abounds in details of treatment, and is interspersed with keen clinical observations, while the free and flowing style render it easy of perusal. Although, in comparison with Ringer, Fothergill, &c., some of the ideas may appear old-fashioned if not obsolete, we are pleased that the work is placed within the reach of the profession.

The Venereal Diseases, including Stricture of the Male Urethra. By E. L. KEYES, A.M., M.D. New York: Wm. Wood & Co., 27 Great Jones' Street. 1880.

It is not our intention to review this book, since the space at our disposal would be quite inadequate to do so justly. We do not hesitate to say, however, that we know of no book of its kind that we like so well; none that contains a similar amount of thorough, practical information in the same space. Written by a master of the subject, as well as of his mother tongue, it presents in a clear, forcible, judicial, fluent, and pleasant style, totally devoid of dogmatism, the well-digested pabulum of a wide practical experience and thorough acquaintance with an almost limitless range of literature. No better man could have been selected to perform the task; none could have accomplished it more satisfactorily. Evidences of clerical haste alone mar the text. Part I. treats of Chancroid which is disposed of in four chapters. Part II. deals with Syphilis, to which some fifteen chapters are devoted, wherein the subject is philosophically considered in all its aspects. It will be remembered that our author is the originator of the "tonic treatment of syphilis." We are pleased to find that he is thoroughly in accord with the best French authorities as to the necessary duration of treatment, and selects three years as an appropriate term. We do not think that the necessity for this long-protracted medication is as yet sufficiently recognized by the profession in general. Part III. disposes of Gonorrhoea (in both sexes) and its complications, in seven chapters, with equal intelligence, lucidity and skill. Surely we cannot commend the book more highly to our readers. We trust all will read it, and we know of none in this Dominion who will not rise from its perusal a better practitioner—a wiser man. The one drawback about it is its publication only in a series—Wood's Library for 1880.

How to Use the Forceps; with an Introductory Account of the Female Pelvis and of the Mechanism of Delivery. By HENRY G. LANDIS, A.M., M.D., Prof. of Obstetrics and Diseases of Women and Children in Starling Medical College. Illustrated. New York: E. B. Treat, publisher, 757 Broadway. 1880.

This little 12mo. volume of 168 pages is really a very valuable addition to obstetric literature and practice, and very cogently inculcates certain by no means universally accepted views, which we believe to be pre-eminently sound. The work is divided into two parts: the former treating of the Mechanism of Labour, the latter of the Forceps. The account of the anatomy of the pelvis is remarkable for its lucidity (illustrated by diagrams), conciseness and intelligence; and, to compare the less labour with the greater, exhibits as elegant an illustration of the teleological argument as did Charles Bell's great essay on the Human Hand. In this chapter, two errors sanctioned by high authority, and perpetuated by slavish imitation, have been corrected. The first is Hodge's definition of the plane of the superior strait, which our author shows to be absurd, since "as a matter of fact the circumference of the inlet bounds two distinct planes whose inclination to one another is about at an angle of 150°. The second error confuted is the supposition that the uterus, during labour, is placed directly in the median line. In the section on the propelling forces of labour, we are glad to find our author a disciple of Poppel and Matthews Duncan. In the description of the child's head we note an error, on page 40, where "bregma" is given as a synonym of the posterior, instead of the anterior, fontanelle. The Mechanism of Delivery in the four vertical and four facial presentations is then admirably described, and the inaccuracy of Hodge's description fully demonstrated.

The forceps are then described, and our author is a warm advocate of the Davis forceps in all respects—blades, lock and handles. He prefers a wide blade with a large fenestrum (or fenestra, as we would prefer to write it); and approves of the secondary head curve (from above downwards) of the Davis instrument, as diminishing the liability to slip. A considerable pelvic curve is regarded as a desideratum.

In the matter of locks, preference is given, and with apparent justness, to what is known as the flat-button lock—another feature of the Davis forceps. In the application of the forceps the position on the back is recommended, and, we think, with every show of reason. The application to the sides of the child's head is cogently urged, and very excellent directions accompany this injunction. He condemns the passage of the instrument in the *pelvic curve in toto*, and crosses swords at once with Baudelocque, Levret, Cazeaux and Schroeder, Leishman, Barnes and Fauntleroy. While we cannot but admit the force of his arguments, yet our own experience inclines us to believe that the procedure which he deprecates is oftentimes the easier and more practicable one; and, moreover, in this benighted country, where malpractice suits are not yet unknown, it will perhaps continue to be "enough to satisfy the ambition of a private man" to act upon the principle, "*Malo errare cum Platone quam cum aliis sentire verum*," as being at once both prudent, and dictated by "the first law of nature." In speaking of traction, the author describes a method of effecting this when the forceps are applied at the inlet, which we ourselves have frequently practised, as have others to whom we have spoken about it. For a description of it, want of space compels us to refer our readers to the book itself. With reference to the amount of force to be employed, we are persuaded that the author is right in stating that *great* force can never be required, and, moreover, "cannot be applied in the right direction." Pendulum leverage is discarded as useless and injurious, and we think rightly so in view of Smith's able demonstration of its effects; and our author has little to say in favour of "rotation" by means of the forceps, an instrument capable of little good and much evil in this regard.

We regret that want of space prevents us from discussing many interesting and instructive points considered in the text; but we are persuaded that we cannot do our readers a greater service than advise each of them to buy and criticize this little volume for himself. We know of no way in which a dollar and a half of money and two hours and a half of time could be more profitably invested.

Lessons in Gynecology. By WM. GOODELL, A.M., M.D., Professor of Clinical Gynecology in the University of Pennsylvania, etc. Second Edition. Philadelphia: D. G. Brinton.

Dr. Goodell has been known for some time as one of the best clinical teachers on the Continent, and the publication of his "Lessons" was looked for with much interest. So popular was his work that the first edition, although a large one, was exhausted in a few months. We have now before us the second edition, which we have perused with much interest. The author aims at no great elegance of diction, and yet the style is attractive. Any one, who commences to read it, is not apt to be satisfied until he has reached the last page. In this edition the whole matter has been revised, and four new lessons added, together with twelve new illustrations.

After a description of instruments and modes of examination, he treats of affections of urethra, bladder, and vulva. We endorse everything he says in the main, but would suggest caution in the use of "large doses of quina" in cystitis, as, according to Milner Fothergill, and Stillé, this medicine is apt to produce irritability in a healthy bladder, especially in elderly people. It has appeared to us at times to produce this effect in people who could hardly be called elderly. Lessons ix. and x., on laceration of female perineum, with treatment, are especially good, although, we think, he is rather hard on the forceps. A word of caution in the use of this valuable instrument may, however, become necessary in this fast age, when the tendency is to rush through everything at railroad speed.

In treating acute and chronic metritis, and endo-metritis, the author uses the more ordinary terms, and does not adopt Thomas's term, areolar hyperplasia for chronic metritis. He makes no effort to draw those nice distinctions between inflammations of the neck and body of uterus respectively which are often more perplexing than useful. His account of the various mal-positions of the uterus is clear, and his description of different kinds of pessaries, and mode of using them, is in the main correct, though, we think, he rather

favours Hodge, or Albert Smith's modification of it, at the expense of the elastic spiral ring, which is, in our opinion, one of the best and safest pessaries now made. With reference to the intra-uterine stem-pessary, our author's opinions appear to have undergone various changes, but now he is convinced that it is very useful in many cases both of anteflexion and retroflexion. Again we venture to recommend caution, as we entertain a strong prejudice against these rather innocent looking little machines, which are capable, however, of exciting very serious mischief, especially when used by any but the most skilled hands.

The chapters on lacerations of the cervix, the significance of which was first pointed out by Emmet, are all that could be desired. For the treatment of vegetations of the endometrium, which he divides into three kinds, he depends mostly on the curette, generally using Thomas's blunt, but Sim's sharp when necessary. He discusses fully the nature and treatment of benign and malignant tumours of uterus and ovaries, including the comparatively new operation for the extirpation of the latter.

One of the best chapters in the book is that on "nerve-tire, and womb-ills; or, the relation of the nerves to diseases of the womb." This "lesson" shows very clearly that many of the disorders of the uterus, which accompany neurasthenia or hysteria, are merely local manifestations of the general neurosis. Nothing more useful could be written for some of those enthusiastic, but half-educated specialists, who at once rush to the womb to search for the causes of all the aches and pains which can be found between the scalp and the toe nails. The last chapter, on "the sexual relations as causes of uterine disorders," including conjugal onanism and kindred sins, has excited much attention and some unfavourable comment. After all, these evils exist to an alarming extent, and every one knows the facts; why then should physicians close their eyes, and ignore them entirely, through any childish ideas of delicacy?

Throughout the whole work there runs a vein of sound common sense and practical wisdom. As a book of the kind—and the kind is a good one for the general practitioner—we know of none better. Get it as soon as possible, and we feel sure you will read it.

Meetings of Medical Societies.

HURON MEDICAL ASSOCIATION.

The regular annual meeting of the Huron Medical Association was held in Clinton on Tuesday, January 11th; Dr. Sloan, vice-president, in the chair. The following members were present: Drs. Sloan, Hyndman, Worthington, Holmes, Williams, Campbell, Young, Hurlburt and Stewart.

The following were elected officers for the ensuing year: Dr. Sloan, of Blyth, President; Dr. Holmes, of Brussels, Vice-President; Dr. Stewart, of Brucefield, Secretary.

Dr. Worthington exhibited a man, aged 20, who eight years ago received a depressed fracture of the skull. The fracture involved the lower and anterior part of the right parietal bone. There was loss of consciousness and complete paralysis of the left arm and leg.

The patient regained consciousness in about seven days, but the paralysis of the extremities has persisted. Half an ounce of brain matter was lost. At present there is to be detected loss of bone in a region 2x2in., extending in an antero-posterior direction from the posterior border of the coronal suture to an imaginary line drawn from the squamous suture vertically upwards through the parietal eminence; and in a vertical direction from the upper fourth of the squamosa-temporal area to a space midway between the coronal suture and the most prominent part of the parietal eminence. This region is the seat of pulsation. The left arm is perfectly powerless, cold and atrophied. The left leg is smaller and shorter than its fellow of the opposite side, and there is considerable loss of motion in it. The tendon reflex is exaggerated. Both the left extremities have a considerable degree of "late rigidity."

The patient is not nearly so intelligent as he was previous to the accident. His memory is considerably affected, but there is no loss of speech. There is a slight divergent squint of the right eye, but with this exception the functions of all the cranial nerves are normally performed.

Dr. Sloan, of Blyth, showed a boy, aged 17, who received seven years ago a kick from a

horse, which caused a depressed fracture of the posterior part of the right parietal bone. This was followed by stupor and dilatation of the left pupil. At no time was there any absolute loss of consciousness. The depressed bone was removed. Two tablespoonfuls of brain matter came away. He made a good recovery.

The following is his present state: There is complete loss of bone in a region which is normally occupied by the posterior and inferior part of the right parietal bone. This region is the seat of pulsation.

He is as intelligent as he was previous to the accident. Functions of all the cranial nerves normal. There is no paralysis of motion or sensation. The dilatation of the pupil which was present at first disappeared in a week, and at the present time there is to be detected no difference in the size of the pupils.

[These two cases are, exclusive of their great surgical interest, of great importance from the fact of their being a contribution to the literature of cerebral localization. Two boys about the same age receive injuries by which they both lose about two square inches of skull on the right side, and nearly in the same situation, and both lose about the same quantity of brain matter. The result in one case is complete paralysis of the left arm, complete paralysis of the left leg, and greatly diminished intelligence. The result in the other case is complete retention of intelligence, sensation, motion, and the special senses. In the former case (Dr. Worthington's), the loss of brain substance has taken place from the regions corresponding to the lower antero-parietal area and the lower part of the upper antero-parietal area. The convolutions that correspond to these areas are the ascending frontal and parietal, and the posterior part of the three frontals; and as the former are the seat of motion for the opposite extremities; and the latter the seat of intelligence, the explanation of the effects of the injury are evident.

In the second case (Dr. Sloan's), the loss of brain has occurred principally in the lower postero-parietal area, only a small portion of the part corresponding to the posterior part of the lower antero-parietal area being involved. These regions correspond to the upper tempo-

sphenoidal convolution and the gyrus supra-marginalis, destruction of which has no effect on either intelligence or motion. Irritation of the superior temporo-sphenoidal convolution causes dilatation of the pupil of the opposite eye and a turning of the head and eyes to the opposite side. The dilatation of the opposite pupil was present for a period of a week in this case, but there is no record whether there was any deviation of the eyes or not. It is not known whether the patient was able to see with his left eye or not.—[Note by Secretary.]

Dr. Campbell, of Seaforth, showed a woman, aged 58, affected with paralysis agitans of the right extremities. Last August she felt her right hand becoming weak, and two months afterwards the thumb and forefinger of the same hand commenced to tremble. The tremor then gradually extended to the whole of the right side, and she can only prevent it by grasping firmly some object. At first the tremor ceased during sleep, but it is now continuous except when she puts the muscles into use.

On two occasions lately she has had attacks apparently of an apoplectiform character. During one of these seizures there was loss of speech and difficulty in swallowing. Both sensation and motion are depressed in the right extremities; the former markedly so, the latter but slightly. Patient walks with a shuffling gait, and is inclined to run forwards.

Drs. Stewart and Hurlburt showed a case of exophthalmic goitre in a woman aged 32. The first symptoms made their appearance very suddenly nine months ago. At present there is marked enlargement of the thyroid, protrusion of the eyeballs, and palpitation of the heart. She has been taking *jiss.* of the Fl. Ext. Ergot daily for three weeks, but as yet with no results.

Dr. Worthington showed a boy, aged 14, who is wearing a "Wyeth's Extension Jacket" for disease of the fourth and fifth dorsal vertebrae.

Dr. Hyndman showed a case of necrosis of the lower jaw.

It is proposed to call a meeting of the Profession in the city shortly, to arrange a general meeting anent the formation of the Ontario Medical Association.

TORONTO MEDICAL SOCIETY.

December 16th, 1880.—The Society met at 8 p.m., the Vice-President, Dr. George Wright, in the chair. The minutes of the previous meeting were read and confirmed.

Dr. Canniff asked the indulgence of the Society while he exhibited a patient upon whom he had operated, excising the elbow joint, for extensive articular disease. The biceps tendon being partly destroyed, rendered the restoration of motion imperfect. Motion was now very fair.

Dr. Bertram Spencer was nominated to the membership of the Society.

Drs. T. S. Covernton and J. Lesslie were duly elected members of the Society, and Dr. R. Lesslie a corresponding member.

Dr. Cameron exhibited some specimens from a case of phlegmonous enteritis with volvulus; the small intestine was distended to twice or three times the size of the large intestine. The mesenteric glands were enlarged.

Dr. Geo. Wright exhibited a fœtus and appendages of apparently four months. He also read a paper upon malignant disease (will be published).

Dr. Graham related two cases of malignant disease, in which the early symptoms were not distinctive, and where the cachexy set in late. One case simulated renal calculus, and had been under observation for 7½ years. In the diagnosis he remarked that in renal calculus you had the pain, &c., for a long while without emaciation and failure of the health, but in cancer these showed themselves comparatively early.

Dr. Oldright considered cancer as a local manifestation of a constitutional taint, this lying dormant until called into action by some local stimulus. He disagreed with the reader of the paper in his view of the use of the knife. He thought the difficulty was in not operating soon enough.

Dr. Rosebrugh spoke in favour of early removal, relating cases in support of his opinion, and advised a healthy zone of tissue to be removed with the diseased mass, and the wound to be raked with the electric harrow.

Other members also took part in the discussion.

Dr. Reeve then exhibited a burr or drill which he used for boring into the mastoid cell, and said that in cases where there was persistent pain over the mastoid, simply boring into the cells often relieved the pain, even when no pus was found.

Dr. Geo. Wright gave the details of the case from which the fœtus had come which he had exhibited earlier in the evening. Mrs. Y. menstruated last while nursing on the 15th of May; she believed herself pregnant; in October she began losing again; and on Dec. 3, after a long walk, gave birth to the fœtus, which was dead; it was apparently only at the end of the fourth month; there was no offensive smell. Dr. Oldright mentioned a case of dislocation of the head of the fibula backwards. (Will be published.)

After some discussion, the Society resolved to adjourn until the second Thursday of January, 1881.

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SUPRAPUBIC LUXATION OF FEMUR.—P. Wm. Stokes, of Dublin, records (*British Medical Journal*) a case of iliopubic luxation of femur in which the head of the bone lay above the pubis and within the pelvis. This could not be reduced by flexing the leg on the thigh, passing the left arm beneath the knee, and using the leg as a lever, lifting the head of the bone from the pelvis. Abduction and rotation inwards then brought the head of the bone through the thyroid foramen, whence rotation outwards carried it into the acetabulum.

Births, Marriages, and Deaths

BIRTH.

At "St. Leonard's," Peterboro', the wife of H. C. Burritt, of a daughter.

MARRIAGES.

On the 12th inst., at All Saints' church, Toronto, by the Rev. Arthur Baldwin, Christopher Outbaines, to Mary Louise Covernton, youngest daughter of Dr. Covernton, Toronto.

On Dec. 30th, at the Manse, Ancaster, by J. H. Ratcliffe, brother-in-law of the bride, assisted by Rev. Prof. Gregg, D.D., and Rev. J. M. M.A., Toronto, Alexander McPhedran, M.D., Jeanie, youngest daughter of Hugh R. Flett Esq., both of Toronto.