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THE

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Selections : Medicine.

PROPHYLAXIS OF HEMIPLEGIA.

BY W. H. THOMPSON, M.D.

In no class of diseases is the study of their etiology so important as in nervous affections, because the majority of them are not primarily nervous in their origin, but rather are simply nervous sequelæ of diseases occurring wholly in different structures. Their effects on the nervous system, however, are such that its symptoms completely overshadow everything else and thus lead naturally to their too exclusive consideration, especially as regards treatment. A man, for instance, who survived for a while the lodgement of a bullet in his brain, would scarcely be rated as an example of nervous disease, and yet in what respect does his case essentially differ from one of hemiplegia due to the sudden lodgement in a cerebral artery of a vegetation detached from a cardiac valve, except that in the latter the foreign body came from within rather than from without? So, also, an apoplectic clot is almost always the result, not of any nervous disorder, but of vascular disease. Apoplectic hemiplegia, therefore, requires for its proper understanding, by the practical physician at least, not so much a minute acquaintance with the localization of nerve-centres and their functions, as a knowledge of the effects, for example, of disorders of the kidneys upon the texture of the arteries. Again, in syphilitic hemiplegia, it is not the nerves, but rather the connective tissue, or else the membranes of the brain, which are involved, and from which the entire trouble proceeds, producing nervous symptoms either by exudation

or effusion. Hence, in most paralyses, the nervous lesion is secondary to primary disease elsewhere. Etiologically, therefore, we may divide the common forms of hemiplegia into three classes. 1. Embolic; 2. Syphilitic; 3. Vascular.

Embolism, producing hemiplegia, is most commonly due to one of those little wart-like formations caused by endocarditis upon a heart valve, which, after breaking its pedicle, is washed up to the circle of Willis. If the plug passes beyond the circle of Willis it is then oftenest arrested in the left middle cerebral artery, with results more disastrous than if it occluded a much larger vessel below the great arterial ring. The reason of this is, that the arteries of the brain do not anastomose above the circle of Willis, so that if one of them become closed, those parts of the brain supplied by it can get no help from their neighbours and are hence likely soon to soften.

There are necessarily no premonitory symptoms in this form of hemiplegia. It comes without giving any warning to the patient or affording to the physician any signs, other than if he knows his patient has roughened valves, he may suspect a liability to it, but no more. Nothing, therefore, can be done to prevent its occurrence. We may be tolerably assured of embolism in any given case, if there be a heart murmur, if there be a healthy radical artery, if the attack was extremely sudden, if the patient be comparatively young, and if the consciousness is intact, which is often evidently the case, though there be total aphasia. But on the other hand, the absence of these elements does not disprove it.

In striking contrast to the embolic form, syphilitic hemiplegia is almost always preceded by significant symptoms, valuable both for diagnosis and treatment. Of these the most important and constant is headache, both preceding and following the attack. It is rarely absent from one of these periods and most commonly belongs to both, though in some cases more severe before the attack, in others, afterwards. It differs from the slight temporary headaches which may presage vascular hemiplegia in being far more constant and severe, sometimes agonizingly so, continuous and generally worse at night. Another common symptom preceding this form of hemiplegia is that of slight, usually transient, local paralyzes occurring in different portions of the body. The uvula may be found out of line, or the tongue protruded to one side with a thickened articulation, or else there may be a little ptosis of one eyelid, or slight strabismus, or numbness or weakness in parts of one limb, etc. Another peculiarity of syphilitic hemiplegia is that it may develop slowly, beginning, for instance, in the morning and not becoming complete till evening; and lastly, it quite often occurs without loss of consciousness. Sometimes, however, it begins with, or is preceded by, an epileptic fit or fits. Here again headache is a valuable aid in diagnosis, for syphilitic epilepsy differs from the common form of that disease in a permanent sense of discomfort about the head during the intervals between the attacks. Like other syphilitic neuroses, hemiplegia is a late manifestation of that disease, often only after years have elapsed since the primary infection, which, moreover, may have had but slight secondary symptoms following it. But the prognosis in syphilitic hemiplegia is much better, as a rule, than in the other forms, and you may sometimes use this fact successfully to quicken the memory of a patient who has denied before that he ever put himself in the way of contracting syphilis. Iodide of potassium, of course, should be used unsparingly, from drachm doses upwards, with $\frac{1}{2}$ gr. doses of corrosive sublimat, and to sustain the patient against the iodide I would recommend,

R. Ac. phosphor. dil. ʒvi.

M. Syr. hypophosphit. ad. ʒiv.

S.—Two teaspoonfuls in water, t.i.d.

But it is especially the precursors of vascular hemiplegia, which you should learn well and carefully attend to. They are not so pronounced, and are more complex than in the syphilitic form, but nevertheless, the more important of them are rarely absent, and when recognized in time may be of unspeakable importance in leading to measures which will prevent a misfortune worse often than death itself. Vascular hemiplegia, I think, scarcely ever occurs until long after the existence of signs which are as readily appreciable, and even more indicative of danger, than cough, for example, is indicative of the approach of phthisis. As phthisis has both its rational and its physical signs connected with pulmonary organs, so the vascular disease which causes hemiplegia has its rational and its physical signs; the first consisting of nervous symptoms, the latter of structural changes in the vessels.

Of the rational or nervous symptoms you will have first vertigo. This is usually slight, not often with reeling, coming on suddenly; not, like other kinds, oftenest on first rising, but more commonly some time during the day, not long after a meal. But I must tell you that vertigo is an exceedingly intricate symptom, too much so for us to complete the topic now. But before you set down vertigo as threatening apoplexy, examine the ears. Some of the worst cases which I have seen have been caused by plugs of hardened wax, and so may any pressure transmitted to, or arising within, the labyrinth, make walking extremely unsteady from dizziness. Some disorders of the ocular muscles cause vertigo also, while the giddiness caused by fermentation in the alimentary canal, or "biliousness," as the patients term it, is easily distinguished by the presence of other gastric symptoms, such as flatulence, acidity, qualmishness, etc.

Another much more constant symptom is early waking in the morning, with slight headache, which passes off after rising. When a patient finds that he awakes earlier than usual, and finds it hard to sleep again, that this from being occasional is becoming habitual, and that his head feels uncomfortable until he gets up, weakening of the cerebral arteries may be suspected.

Cramps in the calves of the legs, occurring generally in the morning, but also at other times, are of even more serious import than the preceding, especially if these are also present. A dread of descending stairs is common also, but is rather a sign of senility than of hemiplegia.

Of mental symptoms, the most characteristic are sudden loss of memory, sudden confusion of ideas, and sudden loss of words. When the memory is at fault, it is not that of old, but of recent impressions, exemplified in telling a story or relating an event twice over, surprising friends by not recalling what happened a few days before, and then having it suddenly recur to him, etc. Confusion of ideas, the patient of course is himself aware of, and on account of its strangeness he is apt to be much alarmed by it. The loss of words is also of a special kind, not at all like the common experience of momentarily being at a loss for the right word, when we send the mind hunting one up, but the patient feels that some very ordinary word has suddenly escaped him, and with it also the idea he had and was about to express, so that he asks, what was I saying? All these mental derangements are palpable to the patient himself, and often lead to a too well-grounded foreboding of impending misfortune, but as they may also occur at any time of life from temporary states of cerebral anæmia or exhaustion, they are not conclusive by themselves, any more than cough is conclusive of phthisis, but still they are to be carefully noted. Mental strain, impoverished blood, or great loss of it, etc., produce just such symptoms, the result to the nerve-centres being the same, only that in the vascular disease, which threatens apoplexy, we have a more permanent cause of anæmia of those centres from narrowing or occlusion of great numbers of the blood vessels.

You may then begin the examination for the physical signs of the vascular disease by inspection of the circulation of the skin; the back of the hands affording the most convenient locality. The most common as well as significant appearance is a mottled skin, composed of larger spaces of a marked unnatural whiteness, interspaced with smaller ones pigmented brown or olive-coloured. Should you

rub the hand smartly, you can produce little more than an evanescent blush in the whitened portions, its quick fading indicating the paucity of permeable capillaries. For the same reason, the skin, where it is not exposed, is nevertheless altogether too white and scurfy. This state of affairs readily affords the explanation of the characteristic pulse, which you will soon have to examine.

You cannot now be too particular in the investigation of the state of the arteries any more than you can be too particular when you are testing a lung. Just as you should complete percussion before you begin auscultation, so the first thing to do with the radial is to feel it, without allowing your attention to be drawn off to the pulse-beat. If the radial artery is healthy, you can scarcely feel it at all; I mean distinguish it in its bed from the surrounding structures, and you judge of its presence there almost wholly from the throb of the pulse. But I doubt if such an artery as that existed in the body of a patient with vascular hemiplegia for years before his accident. Instead of that, the coats of his radial gradually lost their pliability, then become more and more thickened, growing harder all the time, until a year or so before the "stroke," that artery could have been felt more like a strong pulsating cord which you could roll over in its bed, perhaps giving to your fingers the impression of a wire under the skin. If now you note for a moment how far along the forearm you can trace the vessel, you may find it distinguishable half way up, and by the pulse-beat, even two-thirds the way to the elbow. What a departure this is from the healthy state, you can learn by the first examination you make of a person with healthy arteries, when the vessel becomes indistinguishable within an inch from the wrist. The next point to note, whether besides being hard, the artery is uniform in its calibre, or the reverse. In many cases of arterial disease, and especially in old persons, it may be very irregular, even to the extent of resembling a string of beads rather than like a smooth cylinder. This is due to atheromatous or calcareous patches of degeneration in its course, and as just stated, they are particularly frequent in the aged; but I believe that in the majority of

cases of dangerous arteries you will find nothing of the sort in these radials: the vessels being simply too large, too hard, and plainly inelastic. You may then observe the same state of things in the temporals, but in addition you will note these vessels to be extremely tortuous, and in bald persons sometimes coursing up the scalp like cork-screws. The extent of this twisting is pretty conclusive of the degree of obstruction which the blood within the artery has to overcome in the diseased arterioles and capillaries beyond. Such radial or temporal arteries of course, are never single in these morbid characters, for like changes are much more complete in the cerebral vessels, owing to the extreme delicacy and comparative weakness of the connective tissue which surrounds and supports them.

You are now ready both to recognize and understand the import of the peculiar pulse of a person who is in danger of a hæmorrhage into his brain. You should lay the tips of your four fingers on the radial, and note if by moderate pressure the pulse is arrested or not under the upper or first finger. A little practice will show you that in distinction from a healthy pulse, no matter how strong that be, the pulse of such a patient is not easily brought to a stop, but very probably is appreciable by all the four fingers. In a healthy pulse, on the other hand, though beating quite forcibly, as just after exercise, the elastic artery can be quickly compressed, so that the stroke beats strongly against the first finger, but does not pass under it to the remaining fingers, while with this morbid pulse you have to use twice the amount of pressure to arrest the wave. Now, an incompressible pulse like this, occurring in a thickened artery, is often mistaken for a strong and full pulse, whereas it may be quite the reverse of either. It is taken for a full pulse by those who are misled by the touch of a hypertrophied artery, whose real calibre is much less than natural, and an erroneous impression of strength is easily given also by the continued beat or seeming resistance under pressure. In the case of a patient fatally sick with Bright's disease, I once knew a distinguished physician pronounce a favourable opinion as to immediate risk, on account of his

"fine, full, healthy pulse." As the strength of any pulse is wholly derived from the heart, this gentleman would have discovered, if he had listened there, that the heart was beating so feebly that no impulse, and scarcely a first sound, could be made out. If there be some febrile excitement in a patient with an incompressible pulse, you may be quite puzzled sometimes to distinguish it from a strong pulse. But a purely febrile pulse ought to be a compressible pulse, no matter how strong it be, and the heart ought to give you a clearer impression of strength than the pulse; nor will fever ever harden an artery, so that you can feel it in its bed.

(To be Continued.)

PROGNOSIS AND TREATMENT OF PROGRESSIVE ATAXY AND SPASMODIC SPINAL PARALYSIS.

BY JULIUS ALTHAUS, M.D., M.R.C.P. LOND.

* * * * *

The *prognosis* in both lateral and posterior sclerosis is, in a general way, unfavourable, as soon as the symptoms have become fully developed, yet every physician who has seen much of these diseases knows of some cases in which complete, or almost complete recovery has taken place. Mostly, however, we must be satisfied if we succeed in arresting the progress and relieving the symptoms of the complaint. The prognosis depends greatly upon external circumstances and the mode of life adopted by the patient. Those who have to work for their living are worse off in this respect than those born with the silver spoon in their mouths; and the rake dies more quickly than the philosopher. Two of the most marked cases of ataxy which I ever saw, occurred, one in a member of the hereditary branch of the British Legislature, who, being of slight physique and calm and fastidious by temperament, surrounded himself with everything that may adorn life, and found consolation for his infirmity in the arts and literature. He lived to the age of sixty, after having been subject to the complaint for upwards of thirty years, and having hardly ever experienced really severe suffering. The other case was that of a hot-tempered Irishman, who,

after having made a fortune in Australia, returned to England to spend his life in the wildest excitement, intrigues, and debauchery of every description. He died within four years from the outbreak of the malady, after having undergone the most frightful tortures which man may be called upon to endure, and after having seen an originally herculean constitution undermined and wasted in a comparatively short time.

The treatment of both diseases must be persevered in systematically for a considerable time if any real success is to be achieved. Rest is of great importance, and we must endeavour to arrange all conditions of life as favourably as possible for the patients. Of specifics we have two, viz., nitrate of silver and ergot of rye. Some great cures have been effected by the use of either of these medicines, more particularly in the earlier stages of the complaint; but, in the majority of cases, and at a later period, their effect is disappointing. Nitrate of silver should be given in doses of from $\frac{1}{8}$ to $\frac{1}{2}$ grain, and must be stopped after 120 grains have been given. The urine should be tested frequently and the remedy omitted if albuminuria be induced by it. Ergot is given either as Bonjean's ergotine, in doses from 1 to 5 grains, or as the liquid extract, in doses from 20 to 120 minims. I have completely cured two cases of ataxy with drachm doses of the latter preparation, three times a day; and at no period during its administration, which in one instance extended to six, and in another to eight months, were there any symptoms of ergotism. Damiana likewise appears to have a special influence on the cord in these cases; I give it in doses of 20 to 60 minims of the liquid extract. Iodide of potassium, strychnia, and arsenic are generally ineffective. The constant galvanic current is useful for the relief of pain, paralysis of the ocular muscles, anæsthesia, and vesical debility. If used sufficiently early, it appears capable of arresting the disease. It is, however, essential for success that a gentle and perfectly steady current should be used, by large electrodes, for a short time, and that all shocks, Voltaic alternatives, or powerful and prolonged applications be avoided. A judiciously directed hydrotherapeutical treatment, and the thermal brines of

Rehme and Nauheim in Germany, and Droitwich in England, are also useful. For the relief of the pain of ataxy, I can strongly recommend the salicylate of soda, in twenty grain doses several times a day. It often acts better than the hypodermic injection of morphia or chloral, but is likewise, as all other remedies, occasionally disappointing. Special attention must be given to the state of the bladder and rectum. For catarrh of the bladder with ammoniacal decomposition of the urine, the salicylate of soda in the doses just mentioned is useful; while for constipation, the Hunyadi János water and allied remedies may be given. Where symptoms of general debility and impaired nutrition are prominent, phosphorus and cod-liver oil, alone or in combination, have proved to me most valuable.

For lateral sclerosis, ergot and nitrate of silver likewise deserve a trial. For the relief of the muscular rigidity and twitches, the bromides of sodium, potassium, and ammonium may be given. I have sometimes usefully combined them with extractum physostigmatis, in doses from $\frac{1}{8}$ to $\frac{1}{2}$ grain, and succus conii. The motor debility is often successfully combated by galvanization of the cord and suffering nerves; and the use of sulphur baths at a temperature of 98° or even 100° may prove serviceable.—*American Journal of the Medical Sciences.*

Good medical conduct needs a rare mixture of self-respect and humility, of unselfishness and reverence for others, of acuteness and simplicity, and of all the magnanimity that comes of the largest knowledge of human nature. This is a great demand. But there is something in the great school of medical education and medical practice which begets it alike in great physicians and in general practitioners.—*London Lancet.*

The *London Lancet* says that there is reason to believe that it is the intention of Mr. Calender, of St. Bartholomew's Hospital, to proceed to the United States early in December, with the intention of seeing the practice and teaching arrangements of the distinguished surgeons of America.

Surgery.

THE USE OF LINSEED AND LINSEED OIL AS THERAPEUTIC AGENTS IN DISEASES OF THE SKIN.

BY S. SHERWELL, M.D.

Every dermatologist must have had cases in which the exhibition of the fats and oleaginous foods has been indicated; and has had sometimes to lament that cod-liver oil disagreed with his patient. Such has been my experience, and I believe I find in linseed oil a more assimilable hydrocarbon. My usual methods of administration are three-fold.

First mode. The patient to carry about with him, in pocket or other receptacle, a few ounces of the seed in its natural state, from time to time taking a convenient quantity into his mouth and masticating it thoroughly and swallowing. In this way an average individual will probably take an ordinary teacupful in a day. Bombay or Calcutta seed, which I recommend, is nearly twice the size of that usually sold, and contains a much larger percentage of sweeter oil (nearly 30 per cent.). This is, in my experience, better assimilated than cod-liver and other oils, and does not cause the same gastro-intestinal disturbance.

Second mode. Grind the seed somewhat coarsely in a little mill; take one ounce or more of this meal and stir it up with warm or cold milk, to form as it were a porridge.

Third mode. Prepared in the form of bread. This linseed bread is made by mixing the meal with ordinary flour in any proportion, say from one to three-fourths, and is prepared in the same manner that ordinary bread is made.

I believe the first two modes of administration are the best. The second is to be preferred for women, children, and invalids.

In addition to the general nutritive qualities of this seed and oil, I claim for it specific virtues on the skin, especially in dry and harsh, or irritated conditions, as in pityriasis rubra, ichthyosis, eczema, etc. I believe it has a specific direction in favour of the sebaceous glands, and that their secretion is increased and improved thereby, as is shown, after a short time, in the gloss of the hair, and the lubricity

and flexibility of the epidermis itself. Used externally and alone, linseed oil is one of the most soothing applications I know of. It has not that tendency to decomposition or rancidity that oleum morrhue and oleum olivarium so markedly possess.

I will now give a brief resumé of some cases.

Case 1.—Pityriasis rubra. Annie S—, æt. 9. Father died of phthisis. No other history of diathesis in family.

Sept. 9, 1876. Found patient had been suffering some two or three months in bed, covered with the characteristic dry, scaly eruption from head to foot. I was told that she could be tracked from room to room by the scales falling off, from attrition of the clothing; they could be taken up by the handful from the bed. I used iron, strychnia, the mineral acids, and sometimes Fowler's solution, but above and beyond all, cod-liver oil, both internally and as inunction. For nearly six months the case slowly progressed towards cure; at length, as cod-liver oil was a somewhat expensive article, I substituted linseed and linseed oil, internally and externally. The change for the better thereupon was rapid, and a complete cure followed in six weeks from the date of first using. She gained more flesh in the short time in which she used linseed oil than in all the previous months. She had a slight relapse about four months ago, commencing on the lower limbs and back of neck and head. It yielded quickly to the same treatment, and she is now a well-nourished, healthy-looking girl.

Case 4.—Pemphigus vulgaris; inveterate and persistent. Mrs. Mc—, æt. 34; mother of three healthy children; husband healthy. She has been scarcely free from eruption for three years, and most of the time was in a condition most repulsive to herself and others. Had about two hundred patches of bullæ, and a number of fungating but superficial ulcerations. Was emaciated and generally broken down. She came under my care in February, continuing three months. During this time she used linseed and oil internally, externally, and almost eternally, together with appropriate tonic remedies. She gained thirty-two pounds, and became a healthy, plump, and cheerful woman.

I have now in my mind many cases of chronic eczema of hands, etc., which I have treated by external use of this oil, with cure in all cases save one, now under treatment. She is improving under application of raw linseed oil, with one or two wrappings or bags of old linen.—*Summarized from "Archives of Dermatology,"* October, 1878.

ON THE TREATMENT OF SEVERE BED SORES.

BY DYCE DUCKWORTH, M.D., EDIN.

In this short communication to the Association of American Dermatologists, I desire to call attention to some methods of dealing with severe bed sores. I have no intention to offer any suggestions respecting the preventative treatment of these troubles, because this subject is now very properly relegated to the attention of skilled nurses, who are happily being trained in this country and elsewhere in large numbers. I allude therefore to those grievous cases of large and deep sores, which no treatment has availed to avert, and which comes at once under the care of the practitioner. The worst instances are met with in heavy patients, in those of large build, with flabby and imperfectly nourished integuments. This class of cases is chiefly furnished by the subjects of acute disease of the spinal cord, myelitis more particularly, and in such instances there is not only the direct risk of irritation from involuntary passage of urine and fæces consequent upon paralysis of the sphincters of the bladder and rectum, but there is also a special vulnerability of the integuments dependent upon a rapid failure of their ordinary nutrition. Every educated physician and sick-nurse should know that all cases of this nature should be immediately placed upon a large water-bed in anticipation of such calamitous results as must inevitably ensue from neglect of such precaution. Two or three days of inattention to this point, together with imperfect nursing, will suffice to induce the worst forms of bed sore to be met with.

When such a grievous trouble is added on to the special difficulties of these cases, how is it to be met?

I wish to recommend that, in addition to the use of a water-bed the patient should lie with the buttocks and sacrum constantly upon poultices. These poultices should be made of linseed, (or, as termed in the United States, flax meal,) and if there be much discharge or fetor, the cataplasma carbonis of the Pharmacopœia should be used.

Since the introduction of so-called antiseptic

principles in surgical practice, some objection has been made to the use of poultices in any way, either to a broken or unbroken surface. They are supposed by some to be centres of mischief and unwholesomeness in themselves, and to produce unhealthiness of wounds. I wish to record my protest against this temporary wave of fashion in therapeutics, and to put in a plea for a little common sense and attention to plain clinical facts, *versus* theory and speculation evolved in the study, and *not at the bedside*. I take it for granted that these poultices are made of pure flax meal, and that they be frequently changed, the old ones being immediately burned, and not again warmed up, as is the custom in some French hospitals. They must be large, so as to cover all the affected parts, and if there be excavated sores over the trochanters, these must be also covered, and a binding sheet secured over the abdomen with safety-pins.

In the case of there being any sloughing portions of muscular and fibrous tissue in the wounds, and also if the wounds be flabby or languid, the addition of balsam of Peru to the poultice becomes highly desirable. If there be deeply excavated sores, plugs of lint smeared with the balsam, should be placed in the cavities, and the edges of the wound be gently compressed by strips of diachylon plaster.

If the wounds become unduly vascular or granular, dossils of lint dipped in zinc, or copper-sulphate lotion, (two grains to the ounce) are very useful for a time, and should be placed in the cavities as described.

It will be found necessary to persevere with the poultices till the bed sores heal, and this is sometimes a matter of many months.

The practice here recommended is that which is followed with much success in St. Bartholomew's Hospital. I am not aware to whom is due the particular credit of the measures here urged.

Quinine in doses of two or three grains, thrice daily, is of service in the treatment of the general constitutional condition of such patients, but of course any other medicinal treatment can be carried out if required for the special lesions which have led to the complication.—*Archives of Dermatology.*

Midwifery.

ON CERTAIN FORMS OF NON-PUERPERAL UTERINE HÆMORRHAGE.

BY A. E. AUST LAWRENCE, M.D.

Physician-Accoucheur to the Bristol General Hospital.

(Concluded from our last.)

3. *Mucous and Fibrous Polypi growing from the Cervix Uteri.*—In the nine cases in which these existed, there was no difficulty in the diagnosis. They were easily felt by the finger, then a speculum was passed, and they were stripped off, and nitric acid applied to the place from which they grew, which in all cases was just inside the cervix. All the patients complained of leucorrhœa and the discharge of blood-stained mucus, and occasionally pure blood, independent of any menstrual period—conditions, in my mind, absolutely demanding a vaginal examination, which was all that was necessary for a diagnosis, and the treatment required was perfectly simple; and yet these women had been going on like this—some for months, others years—for the reason, as stated by them, that they did not like to see a doctor. The pain was not great, nor was there any great loss of blood at one time to cause them alarm: hence they put off the day until they became weaker and the hæmorrhage increased.

4. The next class includes ten cases of subinvolution of the uterus. The chief points complained of were excessive menstruation, with very profuse intermenstrual leucorrhœa. I have not included in this class cases where the uterus was displaced, or where there existed any other pathological condition, as a complication of the subinvolution. The cases to which I allude had a history of a confinement or miscarriage, dating back from a few weeks even to years. They all had the uterus enlarged, the cavity measuring from three to four, or even five, inches in length. The diagnosis was made partly by the history of the case and the physical examination, and partly by the exclusion of other states, the symptoms of which are somewhat similar. Although a certain proportion of cases of subinvolution are complicated with other states, yet these cases are mentioned simply as showing that the enlarged

uterus, left after the termination of the pregnant condition, is enough of itself to produce copious hæmorrhagic and other discharges, and this without any displacement or erosion of the cervix, etc., although these latter conditions often complicate subinvolution. The treatment I adopted in the ten cases I have brought forward was, to apply to the inside of the uterus the tincture of perchloride of iron, and to give ergot and bromide of potassium, and pay attention to the general health. I believe that, to obtain the proper involution of the uterus, it is most important to attend to the general health, as well as, of course, to rectify any local disturbance. They are tedious cases; but still a great deal can be done for them, if we are only allowed sufficient time.

5 and 6. *Retroflexion and Antelexion.*—The next class includes five cases of retroflexion and three of antelexion. They are mentioned, because the ordinary symptoms of these conditions were entirely absent. The patients came complaining of too much hæmorrhage at the menstrual periods, with a certain amount of leucorrhœa. They were all patients under forty years of age, and I could detect no cause for the excessive menstruation, except the displaced condition I have alluded to; and, as the periods lessened considerably when the uterus was maintained in its proper position by means of a suitable pessary, I think I am warranted in ascribing the menorrhagia to the displaced condition of the uterus. I simply mention these cases, so that it may enable any one to recognize a probable cause of hæmorrhage, when otherwise it might be overlooked, as the usual symptoms of the displacements mentioned were absent.

7. *Parametric Inflammation.*—I allude now to a very troublesome class of cases, viz., that of parametric inflammation, one of the forms of what is more commonly known as pelvic cellulitis. This condition, by fixing the uterus, has a great tendency to induce excessive hæmorrhage from that organ at the menstrual periods, more especially if the uterus be caught and held by the inflammatory effusion in a state of subinvolution. I mention this condition as being a cause of uterine hæmorrhage, chiefly on account of its being frequently overlooked, as

it is sure to be, by those who only examine with a speculum, instead of using the finger, by which the hardness in the vaginal roof is at once recognized. The treatment locally in these cases is negative. One must rely upon time, aided by iodide of potassium, ergot, and good food; this treatment, in a certain proportion of cases, does good, but others remain to a very great extent incurable.

8. *Pelvic Hæmatocele*.—I now allude to a condition which has been the cause of excessive and prolonged uterine hæmorrhage in four cases, very likely from its situation so close to the uterus. I allude to pelvic hæmatocele, due possibly to the rupture of some veins in the neighbourhood of the uterus, or, I think, in some cases really formed by escaped menstrual blood through the Fallopian tubes in cases where there is a narrow cervix uteri.

The history in my cases has been that a period was just coming on, that some exertion undertaken at this time was followed by great pain in the abdomen and faintness and discharge of blood *per vaginam*, and instead of the period passing over, it became constant, and had lasted some weeks when they came to the hospital. As the acute symptoms disappeared, so did the tendency to hæmorrhage. In these cases, we must not be in too much hurry to check the hæmorrhage, or lightly undertake to plug the cervix uteri, and so cause possibly more blood to escape into the pelvic cavity; and as long as the hæmatocele is recent, we must be very careful in making a vaginal examination. The best treatment in recent cases is to enjoin absolute rest in bed, with the pelvis raised. As for medicine, I prefer turpentine in recent cases to anything else; sometimes I combine with it small doses of ergot, but must often give it by itself. The cases that I have had all recovered in an average time of six weeks. It is surprising how great are the powers of nature, alone and unaided by art, to manage these cases—enormous effusions being got rid of in a comparatively short time; and with the subsidence of the hæmatocele, so has the tendency to menorrhagia become less and less, until eventually the periods have resumed their normal characters.

9. *Ulceration of Os and Cervix Uteri*.—The

next class of causes for uterine hæmorrhage is the one, I believe, best known, and is visible to any one through a speculum. I allude to the so-called ulceration of the os and cervix uteri. It is not so frequent a cause of hæmorrhage *per se* as one might suppose it to be; for I have had only twelve cases where I could say that it was the real cause, and uncomplicated with either of the conditions to which I have already alluded. A large number of cases of other pathological states of the uterus have the cervix abraded as a complication of those states, and one must not be led to treat a minor and induced state instead of the real diseased condition; for instance, let a woman have a retroflexed uterus, and very soon the posterior lip will become digested, and very likely what is termed ulcerated. Here there may be a double source of hæmorrhage, and the sequence of events must be borne in mind in treating the case. The cases I have brought forward were purely examples of what an abraded condition of the os and cervix uteri would do when uncomplicated with any other diseased condition. The menorrhagia and leucorrhœa induced by the above condition were both cured by local applications, the chief of which was nitric acid. The surface of the cervix healed in most cases, with about three or four applications of the strong acid, at intervals varying from a week or ten days, or a fortnight; and as soon as the surfaces were healed, the menstruation became normal.

10. *Stenosis, or Narrowing of the Cervix and Os Uteri*.—I have to allude now to a class of cases where, although pain is an important symptom, yet hæmorrhage is one that must be taken into account also; and it was mainly on account of the latter symptom that the six cases forming this class applied for relief. This condition, by not allowing a free exit for the menstrual fluid, allows a portion of it to coagulate *in utero*, and this acts as an irritant and causes a chronic congestion to be kept up, which of course, greatly increases the amount lost at the period. An examination with the sound reveals the cause. The treatment is simple: divide the os uteri externum to make it larger, and, if necessary, cut slightly the sides of the cervical canal; then pass a sound twice a week for a

month or two ; and, in most cases, the relief, both from hæmorrhage and from pain, will be permanent. It has been so in four of my cases ; the other two I have not been so fortunate as to entirely cure, although they are relieved to a great extent from menorrhagia.

11. *Anæmia*.—The last condition to which I intend alluding, as a cause of uterine hæmorrhage, is a general one, and that is anæmia. Although, of course, it is often the consequence of excessive hæmorrhages, yet it is occasionally the cause of excessive menstruation. I have had four cases, of which the following is a typical example. A thin pale girl, aged 17, began to menstruate at fifteen, and has done so about every two or three weeks profusely. No uterine disease could be detected ; in fact, the hæmorrhage was more like a constant oozing of blood, and not with much colour. The cases were cured by directing attention to the general state of anæmia, and insisting upon the recumbent position, with the hips raised during the continuance of the menstrual period.

In conclusion, I must ask you to excuse the very short account given of most of the conditions mentioned in my paper ; but all I wished to do was to place before you an analysis, as it were, of some of the causes of uterine hæmorrhage, so that it might be of the same assistance to you as it is to me.—*British Medical Journal*.

ACTION OF TINCTURE OF IODINE ON THE NECK OF THE UTERUS—(M. Laboulbène).—The tincture of iodine has a different action on the neck of the uterus, depending upon a sound or diseased condition. If the neck be sound the coloration is of a deep uniform brown ; if the slightest ulceration exist, there is produced at the affected point a more or less clear yellowish coloration, contrasting with the brown coloration of the neighbouring parts. Each granulation or vegetation remains yellowish and does not become brown. After the application of the red hot iron, which M. Laboulbène specially recommends for ulceration of the neck, the cauterized part is only coloured yellow in proportion as it is not entirely cured. After cure, on the contrary, the neck becomes browner and browner from the tincture. If the neck is large without being ulcerated, and if the tincture of iodine produces yellowish islets, we should suspect a neoplasia, and fear an approaching ulceration in the points where the tissue is but little coloured.—*La France Médicale*.

Original Communications.

MEDICAL EVIDENCE IN COURTS OF LAW.*

BY DANIEL CLARK, M.D.,

Superintendent of the Asylum for the Insane, Toronto, Ontario.

Anyone who has paid even a superficial attention to medical evidence given in courts of law, must have noticed, from time to time, how easily medical witnesses can be procured to give evidence on both sides of a case. It matters not how clear may be the merits of the question, nor how little grounds exist for difference of opinion, yet medical men are found who will give positive testimony on either side, at the shortest notice, and on very flimsy premises. Lawyers take advantage of such conflict of opinion, and set up one medical man against another, until both judge and jury value the evidence by the reputed credibility and professional standing of each, and virtually neutralize the evidence of all by a system of offsets. This only refers to medical opinions, for in respect to facts all witnesses—lay or professional—stand on common ground, and state what are matters of observation, “without note or comment.” It is true, medical science gives room for great differences of opinion, seeing it has not the exactness of mathematics. Herein lies the error of dogmatizing on much which is so obscure. Many of these varieties of opinion arise from a vain endeavour to explain everything connected with causes of litigation. In the presence of a court and the assembled multitude it may not be pleasant to pronounce our ignorance ; yet, in the endeavour to give answers hedged round with vain hypotheses of all kinds, the medical witness is apt to have unpleasantly forced upon him a display of how little he knows under a cross-examination, and thus what would have been received as competent testimony, if it had been confined to sure opinion, is marred and doubted by pretending to know too much. In this plethora of opinion lies one reason for so much contradictory evidence. It is well never to say more than the question covers, and to be guarded in even

* Read before the Canada Medical Association, at Hamilton, Ontario, September 12th, 1872.

doing that, if the interrogation happens not to be relevant to the case at issue.

Another reason is in supposing ourselves as being witnesses for one side only, because we happen to be subpoenaed by one of the parties. The prosecutor or defendant, who calls a medical man, expects him to give *ex parte* evidence. He is paid a miserable pittance to cover railway and hotel expenses. Is his testimony not bought and paid for, to be used on the disburser's behalf? This feeling, often involuntary, gets hold of the witness, and immediately the examination begins, he is on the alert against the wiles of the opposite lawyer, and often unconsciously is put upon the defensive to the injury of the truth. We have all felt this tendency. This position is not intentional, but the badgering of an indiscreet lawyer may drive a medical witness to defend opinions which may give a colouring to a case not intended at the outset. This bias has to be guarded against. The witness is in court to tell *all and only* the truth as far as in him lies. It is not for him to think of the result, consequent thereon, to any party. In giving evidence it is not safe to weigh what will be the consequences flowing from its acceptance. "Let justice be done though the heavens fall." Unfortunately medical witnesses, giving opinions based on experience, are looked upon with suspicion by the courts. J. H. Balfour Browne, in the last edition of "The Medical Jurisprudence of Insanity," says: "That medical testimony, when received, should be received as of very *inferior worth*." Medical witnesses are said to be "rash," and "to have expressed crude generalizations with an imperturbable effrontery," and that alienist physicians ask to be believed, "with an implicit faith, which is only compatible with the grossest ignorance; lawyers should assert the utter uselessness of the evidence of scientific witnesses in relation to questions of insanity." Lord Campbell says that "hardly any weight should be given to the evidence of skilled witnesses." Judge Davis declares in cases of insanity, "men of good common sense would give opinions worth more than that of all the experts in the country." A book might be filled with such choice quotations. If those who have made this branch of

medical research a life-long study are such ignorant and unreliable witnesses, what shall be said of the intelligent thousands and tens of thousands in general practice?

It is also to be remembered that in cases of damage for malpractice, each surgeon may have a mode of treatment distinct from any other, but sufficiently practical to be approved of in general practice by any intelligent physician or surgeon. This treatment may be denounced by some one who is not able, from experience, to test its value, and an unlettered jury may decide the merits of the case in its professional aspects, by considering one method as only worthy of consideration, and give a verdict accordingly, to the astonishment of those best capable of judging. Next to the inscrutable ways of Providence stand the verdicts of juries, in their uncertainty and unforeseen results. This selection, by non-professional men, of one method of treatment, to the exclusion of all others, has been seen by me on several occasions. At one time the prosecution was because of a shortened femur, and the merits of the double inclined plane or a straight splint, were decided by a jury selected from one of the back townships. Another was decided in favour of a flap operation as against a circular, the jury being composed mostly of farmers, fresh from the harvest field. Not long since I attended a trial in this city and the jury were treated to clinics on the *dura mater*, *arachnoid*, *pia mater*, and their blood vessels. The jury understood the merits of the case, after several hours of medical dissertations, as much as if the Crown Counsel had given an address in Choctaw. I envied one jurymen who slept soundly through it all, except when elbowed by a neighbour.

Antagonisms unhappily existing among medical men lead to conflict of opinion. A case comes from a village, a town, or even a city. Observation teaches that the smaller the area from which such evidence is drawn, the stronger are the contentions in the locality, and the more likely does it become that sides are taken before the suit goes to court. It is a matter of every day experience that in a majority of cases, such a locality will furnish medical evidence for prosecutor and defendant. The reasons already given may have something to

do with this diversity of conception. I fear unfriendly feelings, of a professional nature, must sometimes be taken into account. To the honour of our profession, it is seldom that false testimony is given from motives of revenge. Animosity against a professional brother seldom reaches perjury; yet, a love of establishing proof on a different basis from that of a rival, often leads to false conclusions, not intended by the witness. If this itching for novelty leads to wrong impressions, they are still farther intensified by ambiguity, which may be caused by unnecessary economy of words, or by the other extreme of profuseness of illustration, not conducive to perspicuity. Such being the case, a court refuses to reconcile contradictions among those who are supposed to know the merits of the case.

The late Lord Campbell said to three intelligent physicians, "You may go home to your patients, and be more usefully employed there than you have been here!" An equally learned judge said of another doctor, who was well qualified to give good evidence, "You might as well have stayed at home and attended your patients." A Vice-Chancellor of the Empire stated "that his experience taught him there were very few cases of insanity in which any good came from the examination of medical witnesses. Their evidence sometimes adorned a case, and gave rise to very agreeable and interesting scientific discussions; but, after all, it had little or no weight with a jury." All judges do not sneer in the same manner, nor indulge in irony and sarcasm at the expense of the medical profession, but the weight given to a physician's or a surgeon's testimony is not commensurate with his capability to give intelligent and experienced medical opinions. I can see, however, indications of a better understanding between medicine and law. The study of the obsolete is giving place to the practical, and metaphysical distinctions to pathological conditions, in considering many of the exciting causes of human conduct coming under the head of jurisprudence. It will be seen how medicine and law are considered from different standpoints, and as a consequence, the conclusions are diametrically opposite to one another. Medicine holds that all insane per-

sons are afflicted with bodily disease. Law says this is not always the case. Medicine draws a necessary line between idiocy and insanity—the one being congenital and the other pathological. Law says they are one. Medicine declares that insanity, being a morbid state, no layman can properly pronounce judgment upon a patient's condition, nor in respect to facts that rise therefrom. Law asserts that a jury can, and should decide on the mental condition of the insane, based upon personal observation, just as an ignorant man would pronounce on the kind of disease a person had from appearances alone. Medicine can show from living examples that the sense of right and wrong, the possession of delusions, and many other tests propounded by the disciples of Coke and Blackstone, can have no value to discover insanity, when taken alone, for many insane have a keen sense of the former, and many not insane are troubled with the latter. Law says possession of the first is evidence of a sound mind, but the presence of the other shows insanity. Medicine extends the hand of charity to the mentally diseased, and asks that such be kept in durance for the purpose of cure or safety to themselves or others. Law applies its iron-clad tests, and punishes all who can not pass the crucial ordeal. Medicine seeks after causes of action. Law deals out justice on the groundwork of appearances. Experts are called into court to testify in cases requiring the special aid of knowledge in chemistry, mechanics, or any other branch of science and art, and such testimony is accepted in its entirety; but medical men who make a special study of mental diseases, must have their opinions measured by the mental capacity of twelve jurymen, or worse still, by the dicta of judges, who accept rules laid down a century ago, when medical research was still in its infancy. Germany, France, and many of the States of the Union have accepted the medical basis of proof. It is expected that the British and Canadian courts will not ignore a system that in everyday practice will be found to be none the less effective in punishing the guilty, while it will save many a poor wretch from the infliction of a punishment which he had not deserved; as an irresponsible being, any more than a child unborn.

Judge Doe, of New Hampshire, in addressing the jury, *State vs. Pike*, says:—

The legal profession, in profound ignorance of mental disease, have assailed the superintendents of asylums, who knew all that was known on the subject, and whom the world owes an incalculable debt, as visionary theorists or sentimental philosophers, attempting to overthrow settled principles of law; whereas, in fact, the legal profession were invading the province of medicine, and attempting to install old, exploded medical theories in the place of facts established in the progress of scientific knowledge. The invading party will escape from a false position when it withdraws into its own territory, and the administration of justice will avoid discredit when the controversy is thus brought to an end.

Judge Wharton, in his work on "*Criminal Law*," says:—

No jurymen, if properly tender of his conscience and of public opinion, will base his verdict upon other evidence than that of those best able, from long training and close attention, to understand the features of the case. In some cases the difference between a scientific, or technical opinion, and that of a layman, is not so much in the results attained as in the guarantee afforded by the superior attainments and more minute expertness of a man of science. The declaration of such a man is insured against the possibility of error to the full extent of the protection of science in its present state of development. *Pro foro*, this degree of certainty is sufficient, because it is the highest attainable; but, the same cannot be said of any other.

I make these few general observations to show that our position in court would be much improved did caution, consistency, discretion, and good judgment and candour prevail to a greater extent among ourselves. This would more readily be the case were all medical men, who might be subpoenaed upon a case, to meet together before being called as witnesses and in a calm, judicial way, discuss the different medical points bearing upon the approaching trial, and then go into the witness box, not as partisans "coached" for the occasion by counsel, but as unbiassed witnesses, who "nothing extenuate nor set down aught in malice." These qualities are needed very much in the witness who gives evidence in cases of insanity. In most of such found on the criminal docket the disease is obscure, and to "make haste slowly" is very necessary that judgment may be just. The defendant may be a malingerer or a monomaniac, who cunningly hides his peculiarities (as many of them do). Such may be afflicted

with melancholia, giving intelligent answers to questions, yet possessing homicidal or suicidal tendencies. The medical witness is often asked to give an opinion of the mental condition of such a person after a few minutes' observation and conversation, or at most after one or two interviews of short duration. There would be no difficulty in doing this were a patient maniacal and indulging in all sorts of "fantastic tricks," but anyone who has passed through the wards of an asylum knows that a very large proportion of the patients are not of this class. Visitors and grand juries often mistake patients for attendants, and *vice versa*. A few weeks ago an intelligent banker of Toronto wrote to me a letter beginning with these words, "The *housekeeper* mentioned to me yesterday." He had been a visitor to the ward every few days for weeks to see a sick friend; yet he mistook one of the most cunning patients in the ward for the housekeeper, and had been consulting him about matters connected with the patients. He was somewhat astonished when told that the *housekeeper* was at times one of the most intractable patients in the ward. A short time ago one of our city lawyers, who prides himself on his power to read almost intuitively the hieroglyphics of character, and who, in his own estimation, could tell an insane person at sight, mistook one of my clinical assistants for a lunatic, and commiserated him on his unfortunate condition. He afterwards came to me for information about the "poor fellow," as he had taken a deep interest in his forlorn and apparently hopeless condition. His pride had a fall when the truth came out. A prominent government official, not long since, mistook one of my most intelligent-looking attendants for a patient. I am prepared at any time to select, say twenty-four intelligent attendants or citizens, and twenty-four patients out of Toronto Lunatic Asylum, and present them to any court of law before our most eminent judges, lawyers, and jurymen. They will be allowed to make the same superficial examination which is often accorded to medical men in similar circumstances. The selection of patients shall be made from paretics in the early stage of the disease, from those afflicted with remittent insanity, from the melancholy and taciturn, and

from monomaniacs. The judgment given of the mental condition found in each case, by such an intelligent and acute board of examiners, would show in a comical light what a travesty of justice it is to ask even an expert to give an opinion of mental unsoundness, or sanity, after a cursory examination of a prisoner. About a year and a-half ago I was called to attend the assizes in a neighbouring county and asked to decide in a few hours the *mental status* of a prisoner, who had attempted to take the life of his neighbour by shooting him. The houses of the two parties were near together, being situated on opposite sides of a country road. The prisoner cut a hole in the gable end of his house, and being a bachelor living alone, there was no one saw him cut the hole or shoot. He shot twice at his neighbour, the last shot taking effect in his lung, but not fatally. Every one of the prisoner's acquaintance, lay and medical, thought him eccentric, but perfectly sane. The first two interviews I had with him, I was led to suppose the same. He could talk intelligently on every topic of conversation that was introduced, but would give no reason at first for the attempted homicide. At the last interview I had with him we began to discuss religious matters. Suddenly he asserted with great solemnity, and with a request to keep it a secret, that he was more than human. I suggested that possibly he might be God in human form. He asserted that I had found out the truth. He was omnipotent, and consequently could do what he wished. He had often lived sixty days at a time without food, to show that Christ's fasting of forty days was not a miracle. When he got out of gaol he intended to fast a year. He had been shot at with bullets by his enemies as he went along the road, or worked in the fields, but having an immortal body, they could not harm him. We were sitting on a bed, and I suggested that he might be smothered to death, but he said that he could live without breath. If his head were cut off, it would not affect him. He could make himself invisible whenever he pleased. Everyone's life was in his hands, and the wife of the man he shot was his by his divine right to her. Here it will be seen that a morbid idea led to the attempt at homicide. Had I

not happened to touch the key that opened the door to his chamber of fantasies, these aberrations would not have been developed. I was subpoenaed by the Crown, but the Queen's counsel knowing that my opinion would be that this man showed evidence of insanity, I was not put in the witness box. The defence had not sufficient acumen to see that this refusal to examine me by the prosecution was presumptive evidence of my opinion being inimical to the case of the Crown counsel. The prisoner was treated as a sane man and a criminal. He is now in the Penitentiary Asylum. This case is cited to show the danger of hasty conclusions in cases of insanity, and the difficulties medical men have to contend with when asked to decide the mental condition of a prisoner at a few hours' notice. What shall be said of the jury who must give a verdict based upon conflicting opinions, and not upon personal knowledge of the condition of the accused? Some time ago the Commissioners in Lunacy in Britain wisely recommended to the Government that, "If, upon the occasion of the trial of an indictment, the plea of insanity be set up, we are disposed to think that the question should be tried and determined by the court after taking medical and other evidence, and not by the common jury to try the facts."

An eminent English expert (Bucknill) says:

Generally the physician giving evidence can almost say that he paid *two or three* visits to the accused, and conversed with him in his *cell* in prison. In cases of concealed delusions, or of disease affecting the propensities, no medical man ought to give an opinion on such shallow grounds. I am not ashamed, he continues to say, to acknowledge that I have observed patients *daily for several weeks* without being able to detect existing delusions.

The court has too high an estimate of the discerning power of the members of the medical profession. It must be remembered that there is no well-defined line between sanity and insanity. No man can tell where the one begins and the other ends. That belongs to omniscience, for we can only infer from manifestations what are the pathological conditions of the brain and mental disturbances consequent therefrom. A witness should never give a positive opinion in obscure cases, for it must

be remembered that while it is unjust to punish an irresponsible person who breaks the law, it is also not desirable that a cunning scoundrel should escape the just penalty of his crimes under a false plea sustained by medical evidence. We are not allowed to state as to a man's responsibility. The court decides that important point. Here lies a wide gulf between law and medicine, and, because of its existence, truth has suffered. No formula can ever cover all the phases of insanity, nor can a measure be found that is sufficiently accurate to map out the boundaries of responsibility, and to say to it, "Hither shalt thou come and no farther." All the conditions, physical and mental, of each individual must be known before the springs of action can be gauged with certainty in the shadowy borderland of insanity. "Is there insanity?" asks the court of the medical witness. "Is he responsible?" is an enigma for the judge and jury to solve.

Bucknill, in his monograph on Lunacy, quotes a vigorous writer in the *London Times* on this point:—

Nothing can be more slightly defined than the line of demarcation between sanity and insanity. Physicians and lawyers have vexed themselves with attempts at definition in a case where definition is impossible. There has never yet been given to the world anything in the shape of a formula upon this subject which may not be torn to shreds in five minutes by any ordinary logician.

Make the definition too narrow, it becomes meaningless; make it too wide, the whole human race are involved in the drag net. In strictness, we are all mad when we give way to passion, to prejudice, to vice, to vanity; but if all the passionate, prejudicial, vicious, and vain people in this world are to be locked up as lunatics, who is to keep the key of the asylum? As was fairly observed, however, by a learned baron of the Exchequer, when he was pressed by this argument, if we are all mad, being all madmen, we must do the best we can under such untoward circumstances. There must be a kind of rough understanding as to the forms of lunacy which can't be tolerated. We will not interfere with the spendthrift, who is flinging his patrimony away upon swindlers, harlots, and blacklegs, until he has denuded himself of his possessions and incurred debt. We have nothing to say to his brother madman, the miser, who pinches his belly to swell the balance at his bankers—being seventy-three years of age and without family—but if he refuses to pay taxes, society will not accept his monomania as pleadable at the bar.

(To be continued.)

[To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.]

TWINS: HEAD-LOCKING.

DEAR SIR,—In reply to Dr. James Langstaff, who reports a case of "Cephalic Lock of Twins" in your journal of this month, I send the following extract, taken from "Barnes' Obstetric Operations," American edition, 1876, pages 180-3.

Yours truly,

ADAM H. WRIGHT.

Toronto, Nov. 1st, 1878.

The most common form of locking occurs through the hitching of one head under the chin of the other: and this may happen whether both children present head first, or one by the breech, the other by the head. The latter case appears to be the more frequent. A child presents by the feet or breech; and when born as far as the trunk or arms, it is found that the labour does not proceed, and on making traction to accelerate the delivery, unexpected resistance is encountered. You pull, but the child sticks fast in the pelvis. The first surmise is, probably, that the head is too large, from hydrocephalus, or that the arms have run up by the sides of the head, wedging it in the brim. You liberate the arms, and pull again, and still the head refuses to move. And now you must explore fully. You may get information in two ways. First, produce anaesthesia, and pass your left hand into the cavity of the pelvis, so as to reach above the child's breast, feeling for its chin or mouth. Instead of feeling this first, you may be surprised at meeting a hard, rounded mass, jammed in the neck and chest of the presenting child, which can hardly be anything else than the head of another child, which has got in the way of the first. Secondly, by external palpation, you may succeed in making out through the abdominal walls the head of a child above the symphysis pubis, inclined to one or other side, in a position which its relation to the trunk partly born, and to the head you have felt whilst exploring the interior of the pelvis, will satisfy you is the head of the first child.

If the children are small, they may, with more or less difficulty, come through the pelvis together in this fashion.

Sometimes it has been possible to seize the second head by the forceps, and to extract it and the embryo to which it belongs without disturbing the first child. But if the children be at all large, this proceeding is not likely to save them. The pressure to which both must be subjected is too hazardous. Even with children of the average size, the head of the second child, resting on the neck and chest of the first, form a wedge too large to clear the brim.

The apex of the wedge formed by the trunk of one child has traversed the pelvis; the base, formed by the head of one child pressing against the neck of the other, is too large to enter the pelvis; and if traction is exerted on the apex, the only effect is to jam the head tighter against the neck, hooking the two heads more firmly together. The problem is, how to extricate one head from the other, so as to allow one child to pass at a time. There are several methods of accomplishing this. But, before deciding on one, it is well to study how the children are affected by the complication. Is one child in greater jeopardy than the other? If so, which? If we find that the situation involves extreme peril or death to one child, we shall, of course, not hesitate to mutilate this one, if, by so doing, we can promote the safety of the other. The first thing you will try to accomplish is, to disentangle the heads without mutilating either child. It is still possible that both may be born alive. The patient being rendered insensible, you press back the trunk into the pelvis as much as possible, so as to lift the heads off the brim, and so to weaken the lock. Then, by external manipulation, aided by a hand in the pelvis, you try to push the heads apart in opposite directions. If you succeed in unlocking them, support the head of the second child out of the way, whilst you or an assistant draw down the body of the first child and engage its head in the pelvis. If you can manage this, the difficulty is over.

Now, experience and reflection concur in shewing that the first child whose trunk is partly born encounters by far the greatest danger. Its umbilical cord is likely to be compressed; its neck and chest are forcibly squeezed. On the other hand, the umbilical cord of the second child is comparatively safe, and the

pressure upon its neck is less severe. You may, moreover, find, by feeling the cord of the first child, that it is pulseless and flaccid, and that tickling its feet excites no reflex action. Having thus determined that there is no hope for the first child, you turn to the best means of rescuing the second. You may decompose the wedge formed by the two heads by detaching the head of the first child. This is done by drawing the body of the child well backward, so as to bring its neck within reach. Being held in this position by an assistant, you pass the fingers of the left hand into the pelvis, so as to hook them over the neck, and serve as a guide to Ramsbotham's or Braun's decapitator, or the wire *écraseur*. If these are not at hand, the task can be accomplished by strong scissors, or even by a penknife.

As soon as the neck is severed, the trunk will be extracted easily enough. The head of the first child will slip up or on one side, or you make it do so by passing your hand inside the uterus. If the head of the second child do not descend by the spontaneous action of the uterus, you may either seize it by the long double-curved forceps, or seize a leg and turn. The first head will follow last of all. If it offer any difficulty, it may be dealt with as described in Lecture XVI. (by the crotchet, the forceps, the craniotomy-forceps, or the cephalotribe).

If there be reason to conclude that the second child is dead, it would be justifiable to perforate its head, and lessen its bulk by help of the crotchet. This is another mode of breaking up the base of the wedge. The head will then flatten in, and permit the trunk and head of the second child to be delivered.

In the other case, when the head of the first child presents, and gets locked by the head of the second, a similar rule of action will apply. You may disentangle the heads by external and internal manipulation. Failing this, you may seize the foremost head by the forceps; and whilst an assistant pushes away the second head, you can extract the first child. A good case, in which this plan succeeded, is related by Dr. Graham Weir (*Edin. Jour. of Med.*, 1860). Hohl recommends to apply forceps to second head.

[Playfair (page 356, second American edition), in the chapter on *Dystocia from Fœtus—Two heads interlocking*, says:—"The first endeavour should be to disentangle the heads; this is sometimes feasible if the second be not deeply engaged in the pelvis, and the hand be passed up so as to push it out of the way. This will but rarely succeed; then it may be possible to apply the forceps to the second head and drag it past the body of the first child, and this is the method recommended by Remiau (*American Journal of Obstetrics*, Jan., 1877)." These methods failing, the treatment as quoted from Barnes is recommended.—EDIT.]

LITHOTRITY BY A SINGLE OPERATION.

N. A. POWELL, M.D., EDGAR, ONT.

Sarah Towns F——, æt. now five years, first presented symptoms of trouble referable to the urinary organs in October, 1876. Pain, partial incontinence and the passage of blood and mucus continued from this time, and in January, 1878 a bit of "gravel" the size of a split pea came away. During the following spring the desire for urination became almost constant, and vesical tenesmus was marked. On June 12th, my friend, Dr. Blackstock, of Hillsdale, was called to see her, and on the 13th, under an anæsthetic, he examined, and found a calculus at the neck of the bladder.

An operation for its removal was advised, and pending this, anodynes were freely given. On July 9th, the writer, in consultation, saw the case for the first and only time. The child was said to be failing very fast: she was much emaciated; was suffering severely; and seemed to gain a respite from her pain only when violently rocked while in the knee-chest position in a cradle. P. was 140, T. 102½°F. Chloroform, replaced later by ether, was given, and a stone found jammed into the upper part of the urethra. This was displaced upwards, caught in the blades of a smaller Weiss & Thompson Lithotrite, and crushed. The scale showed ⅝ of an inch separation of the blades. Further comminution of the fragments was effected by means of long polypus forceps. Evacuation was accomplished by the same,

aided by the frequent injection and aspiration of warm water through a large size Eustachian catheter, to which a strong rubber bulb had been attached. This last was the best substitute at hand for Bigelow's or Clover's apparatus. The vagina was too small to admit a finger without undue stretching, but water could be retained in the bladder by pressure upon the urethra.

The first calculus being removed, suprapubic pressure brought two other and smaller ones within reach, and these were treated as the first had been. The distance between the outer surfaces of the blades of the forceps used when grasping the largest fragment removed, was $\frac{3}{10}$ of an inch; this, then, was the limit of urethral dilatation. The lithotrite was used for crushing five times, the forceps twenty or thirty times. The time occupied was 1½ hours. The bladder being washed and aspirated till, as nearly as possible, freed of its solid contents, the child was put to bed with hot applications over the pubes and to the extremities, and a full anodyne was given. The detritus collected at the time of operation weighed 241 grains; subsequently, 7 grains more were obtained from the strained urine.

For the history of the case after this, I am indebted to notes kindly sent me by Dr. Blackstock or his assistant Mr. Gould, who, with my students, Messrs. Shepherd and Bremner, gave assistance during the operation. "Partial control of the urine returned on the day following the lithotritry, and complete control, except during the night, after three days. The desire to void urine occurred about every hour for several days, and at the end of a week, about every third hour. Slight hæmaturia was noticed for two days." Under date August 27th, I hear that "the child's general health is good. She is gaining in flesh, and has no symptoms of her former trouble."

The above case would a year ago, hardly have merited transcription from the case-book of a country physician to the pages of a medical journal. But since the appearance of Dr. Bigelow's paper on Litholapaxy* the whole subject of the tolerance of the urinary bladder for prolonged instrumentation has come up for

* *American Journal of Medical Sciences*, January, 1878.

reconsideration, and this is offered in evidence.

From Civiale down, all lithotritists, so far as the writer's knowledge extends, have held that the visits of a lithotrite to the interior of a bladder must be strictly limited in point of time. Though experts may, at times, have given themselves more latitude, they have always taught others not to exceed five minutes for any one crushing. Of late years, also, the tendency has been to confine the operation within narrow and yet more narrow limits, treating by it only such moderate sized stones as could be got rid of in from two to four sittings. It remained for the Harvard professor to demonstrate that the calculus, containing bladder of an etherized man might be manipulated for one, two, or more hours, and yet not resent it by cystitis or subsequent atony; *provided* that no sharp fragments were left in it to do outrage to its lining membrane. Although the case just given occurred in a female child instead of in an adult male, it seems to support Dr. Bigelow's conclusions as to vesical tolerance. Surely the delicate tissue of a child's bladder is ill adapted for prolonged contact with instruments, while the proportion of the organ covered by peritoneum in the child being greater than in the adult, there would seem to be a greater danger of serous inflammation. Yet, here all irritation promptly subsided when the irritant was removed, although its removal took 1½ hours. May we not expect like results when even large stones are crushed in the male bladder and evacuated by the new method? Statistics so far,—seventeen cases, sixteen successful,—seem to point that way.

It may be asked why the urethra was not more widely dilated in this case! My answer is that too large a proportion of those thus treated have been made dribblers for life by it. The ease with which stretching may be accomplished, and the free access which it gives to the bladder, will strongly tempt a surgeon who does not look, beyond the operation he has to do, at the future life of his patient. Prof. Simon, of Heidelberg,* made many accurate measurements to determine the extent to which the adult female urethra may be dilated without the risk of incontinence. His limit is in width

2 centimetres, (= .8 inch); in circumference, 6.3 cen., (= 2.4 inches.) This would allow a finger to pass, but not a finger plus a pair of forceps. Mr. J. R. Lane thinks no stone larger than an acorn should be removed entire through the urethra of an adult female, and none larger than a bean through that of a child. Dr. Hunter McGuire, of Richmond, Va., states that many cases of so-called successful operations by dilatation and extraction have, to his personal knowledge, been followed by incontinence. Rapid dilatation, however, seems to be less dangerous than slow. In proof of this, I may, in conclusion, mention that I have knowledge of the case of a girl, æt. twelve years, into whose bladder a pair of sequestrum forceps were pushed, a calculus seized and extracted *vi et armis*, dilating and lacerating the urethra as it came. The stone was as large as a pigeon's egg. Absolute incontinence existed for twelve days, but was followed by recovery.

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SUBCUTANEOUS RUPTURE OF TENDON OF TRICEPS BRACHII.—By Güterbock (*Langerbeck's Archiv*). A strong woman, forty-seven years old, while carrying a basket on the right arm, had fallen down stairs a few steps, and attempted to support herself with the right hand. Examination showed that the right forearm was in active flexion, but could not be extended except passively; in spite of the swelling of the elbow region, an horizontal rupture of the triceps tendon could be felt above the olecranon. The upper margin of the tendon was distinctly marked about one inch from the olecranon. The olecranon was well defined, and the finger could reach the posterior supra-trochlear fossa. The elbow-joint was fixed in extension in plaster of Paris for one week, the second week maintained in moderate flexion. After this time the triceps began to exert action on the forearm, and its functions gradually became almost normal—that is to say, all movements could be made with force, only active extension was impossible beyond 180°. The horizontal cicatrix was marked as a linear furrow.—W. T. B.

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Dr. Bullen, of Hamilton, died suddenly on November 2nd.

* Translation in N. Y. Medical Journal October, 1875.

TRAUMATIC ANEURISM OF TEMPO-
RAL ARTERY—LIGATION OF COM-
MON CAROTID—DEATH FROM SEC-
ONDARY HÆMORRHAGE.

BY A. McPHEDRAN, M.B., TORONTO.

(Read before the Toronto Medical Society.)

W. C. A.—, aged fifty-eight, fell from a second floor window to the ground below, a distance of about twelve feet, on the night of June 28th last. I saw him at four a.m. : he was in a semi-unconscious state, much bruised about left side of head and neck ; blood was oozing freely from the ear and mouth, and the soft palate and neighbouring parts were much swollen from extravasated blood, causing great difficulty in respiration. Notwithstanding the severity of the injury, he soon began to improve, and the swelling to disappear, except in the region of the temporo-maxillary articulation—here it became more firm and slight ; pulsation was noticeable about the tenth day after the accident, and a day or two later the existence of a traumatic aneurism became evident. The tumour extended from the meatus auditorius extremus, which was almost closed by pressure on its anterior wall, forwards about $1\frac{1}{2}$ in., covering about half the masseter muscle ; and from the zygomatic arch above to a line on a level with the lobe of the ear below. Dr. Graham saw the case with me on Thursday, July 11th ; and it was decided to give potas. iodide and tincture of ergot, and direct that perfect quietude be observed. During Friday night, July 12th, the patient suffered much pain on left side of the head, and next morning the tumour was found to have increased in size ; it now extended forwards to the anterior border of the masseter, and the pulsation was much more marked. Dr. Richardson saw the case in consultation that forenoon, and ligation of the common carotid was determined upon as the only course giving much hope of success : in this opinion, Dr. Graham, who was absent from home in the morning, on his return, acquiesced. We met next day, July 14th, and, with the assistance of Dr. Richardson, I cut down upon and ligated the artery above the omo-hyoid muscle, opposite the upper part of the thyroid cartilage. The patient showed no bad symptoms after effect of

the ether passed off, and subsequent treatment consisted simply in keeping him quiet, morph. sulph. being given for a day or two as needed, and giving plenty of nutritious fluid food. Slight pulsation returned in the tumour on the evening of day of operation, but it disappeared in a few days, and the tumour steadily diminished till scarcely a trace was left after a few weeks. The proximal portion of the common carotid continued to pulsate after the operation. The ligature separated on Monday, August 12th, four weeks after ligation. The wound in the neck was nearly closed, and only a slight discharge taking place ; it continued to improve during the next few days. I did not see the case again till September 11th, at which time the opening was larger than when last seen, and discharge more abundant. Gave a tonic, and brought sides of opening together with adhesive blaster. But no improvement followed. Severe neuralgic pains in the side of the head and neck set in about September 20th. During the night of September 26th slight hæmorrhage took place, about three ounces of blood being lost. Pressure was directed to be made in case hæmorrhage returned. Dr. Richardson saw the patient with me next day : it was thought that the blood might come from granulations, as he exhibited a tendency to scorbutus. Citric acid, grs. v., every three hours, was ordered ; to continue the tonic he was taking. Sept. 28th, one p.m., bled very profusely ; had ceased, and blood had coagulated, before I could see the patient. Bleeding did not again recur till the night of the 29th, during which it returned repeatedly. It returned again at five p.m. on 30th, and he died shortly afterwards.

At the *post-mortem* all the structures of the neck were found in a healthy state except the common carotid from its origin to point of ligation. The walls were much thickened and adherent to the surrounding structures ; the lining membrane much disorganized by inflammation and the cavity of the vessel filled with pus. The end, at seat of ligation, was open, although much contracted. From this it is evident that a second ligature could not have been passed, and that if hæmorrhage had been controlled death must have resulted from pyæmia, of which it is surprising there were no symptoms even under existing circumstances.

(To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.)

HOSPITAL CONSULTATIONS.

DEAR SIR,—Amongst the by-laws of the Toronto General Hospital is to be found a regulation requiring a consultation of the whole staff—physicians and surgeons—before any major operation can be undertaken, and enacting that the opinion of a majority present at such consultation shall govern the procedure in the case in question.

It is my intention, in the first place, to direct your attention to the rather anomalous fact, *in view of the premises*, that no consultation is required to determine the treatment to be pursued in a medical case, no matter how grave its nature, or how uncertain its result, and that, too, in face of the knowledge that medical practice presents incomparably more numerous obscure and difficult cases than surgical experience. Is the loss of a lung then of less consequence than the loss of a leg; or a lesion within the cranium of less moment than a stone in the bladder? I am at a loss, sir, to understand the principle upon which the rule is founded, unless it have been, *ab initio*, conceded that surgeons are less trustworthy than their medical *confrères*; and that the habitual handling of a knife unqualifies a man in respect to sound judgment, and necessitates a surveillance upon his actions and decisions, in the public interest. Then again, that a man, who has made surgical work the study of his lifetime, should be liable, at a hospital consultation, to have his maturer judgment questioned, and his proposed line of action interdicted by a majority, composed of men either his juniors in experience or those whose tastes and circumstances of practice have determined their sphere of labour in other fields, is a monstrous absurdity which should be no longer tolerated.

The undesirability of this condition of affairs has been many a time discussed, but the late issue of a circular from the Board of Trustees to the medical officers of the institution, again directing attention to the by-law, and requesting compliance with its provisions, seems to demand a new ventilation of the question. Let us hope that it may be followed by the abatement of a nuisance which must *stink in the nostrils* of all men of right perceptions.

In Old Country hospitals the practice is unquestioned that a surgeon or physician should be governed in the conduct of a case by his own judgment, and he assumes the responsibility of his own actions. If he feel that his own judgment would be bettered, and the interests of his patient promoted by a consultation, or if he feel inclined to share the responsibility of a case with a brother colleague, he asks whomsoever he pleases, on the staff, to see his patient with him, and then, having had the advantage of other opinion or opinions, he proceeds to follow that line of conduct which under the circumstances seems to him fit.

At St. Bartholomew's Hospital in London a certain day in each week is reserved for consultations, on which such members of the staff as find it possible, or convenient to attend, meet together in the theatre before the students. Cases on which consultations are desired are then brought in; the medical attendant narrates the history and circumstances of the case, and states his opinion as to the treatment it is desirable to pursue. The others, turn by turn, in order of seniority, beginning with the youngest, examine the case, express their opinion—if they form one—and make any suggestion they may deem desirable. The gentleman in charge of the case then decides upon what he will do, and the matter is settled.

This course is so inestimably superior to any other, both in the interest of the patient and that of the students, whose instruction all hospitals claiming clinical advantages are bound to consider, that it is a matter of wonder it is not universally adopted. It is unquestionably of greater benefit to a student to know why a certain conclusion has been arrived at in a given case, than it is to see an operation or other procedure, resulting from that conclusion, a hundred times repeated.

Were some such regulation as this to replace the old by-law of our hospital, its efficiency as an educator would be greatly enhanced, and its utility as a reliever of suffering not diminished, whilst, at the same time, one stigma of absurdity would be wiped from its statutes.

It is in the hope of not proving a vain suggestion that this communication seeks admission to your columns.

Your obedient servant,

COMMON SENSE.

P.S.—The Royal Infirmary, Manchester, has just adopted the Bart's practice.

Translations.

Hôpital des Enfants Malades.—(M. Bouchut.)

ON CHLORALIC ANÆSTHESIA FOR EXTRACTION
OF TEETH AND SURGICAL OPERATIONS IN
CHILDREN.

When, in 1869, I published in the *Gazette des Hôpitaux* the anæsthetic properties of chloral in children, this fact, announced by Liebreich, was unknown in France. At that time I pointed out this substance as the best remedy for violent and grave choreas. Since then, by daily experiments and daily observations of this anæsthesia, I have confirmed my first affirmations. More than 10,000 instances bear witness to them, for in my wards, every day for the last nine years, from four to eight patients have taken this remedy in anæsthetic dose. This, then, is an established fact in the medicine of childhood, and I say the medicine of childhood because a similar result is not observed in the adult. Perhaps we might obtain anæsthesia in the adult if we could make him swallow a sufficient dose, but the adult has such a repugnance for the acrid taste of chloral that he rejects or vomits it, so that above four or five grammes (sixty to seventy-five grains) its employment is difficult. * * * *
In children, on the contrary, the administration of chloral is easy. Here, at the hospital, my nurse has never encountered a single failure. All the children take this remedy well, and do not vomit it. I give 1, 2, 3, and 4 grammes (15, 30, 45, and 60 grains) according to age; below seven years it is not necessary to exceed 3 grammes (45 grains), and between three and five years 2 grammes (30 grains) may be given without danger. The dose is administered all at once, dissolved in 100 grammes (3iij) of some very sweet vehicle. Half an hour afterwards the child is asleep, and an hour afterwards insensible. This sleep lasts from three to six hours, then awakening occurs, and the child experiences nothing disagreeable. He eats and plays as usual. This may be reiterated the next and following days if necessary. In chorea there are children who thus take these doses for a month continuously without inconvenience, and I have seen chil-

dren who have swallowed in a month 100 and 120 grammes (1,500—1,800 grains) of chloral.

Exceptionally, as in chloroformisation, there is a period of ebriety, drunkenness, or excitation preceding the anæsthetic sleep, but this is very rare. I have only observed it ten times in 10,000 cases.

Once the anæsthetic sleep of chloral arrives, it may be utilised for a great number of surgical operations. It presents no other inconvenience than that of keeping the child asleep for three or four hours after the operation. There is never any danger, and I have never had an accident to contend against or anything untoward to regret. Once only, in Belgium, has a case of death been reported, but then 5 grammes (75 grains) were given and the child was only three years old. At this age I only administer 2 grammes (30 grs.). This was therefore a fault of dosage, and should not incriminate the remedy.

* * * * *

When the object is only to obtain anæsthesia, instead of giving the chloral by the mouth and stomach, the rectum may be used and the medicine given by injection, or in suppository, in the same dose. Thus we may prescribe an injection of decoction of marsh mallows: 100 grammes (3iij) with 1, 2, or 3 grammes (15, 30, 45 grains) of chloral hydrate, but as this injection may be rejected, it is better to have recourse to suppositories. The suppository should be made of cacao butter, melted with one-fourth of *blanc de baleine* or spermaceti; without this, incorporation of the chloral is impossible. The desired dose of chloral is then mixed in the suppository, which is introduced within the anus, to be lost in the rectum. Once melted the suppository sets free the chloral which is absorbed, and which, as when given in injection, determines anæsthesia. Chloral then produces the same effects by the rectum as by the mouth; but, if it be necessary to continue the use of the remedy for a long time, this mode of introduction is bad. And this is why: the rectal mucous membrane bears chloral well two or three times, but at the fourth it becomes inflamed, and more or less painful tenesmus results. This is not the case with the stomach in children. I have been able to give every day for a month 3 grammes of chloral without in-

convenience, and without producing gastralgia, vomiting, or diarrhœa. * * * *

To sum up :

Chloral hydrate is better borne by children than by adults. In children chloral may be administered for a long time, continuously, without danger.

According to the age, one, two, or three grammes and more administered by the stomach will produce complete anæsthesia, lasting from three to six hours.

Given by injection or suppository, chloral produces the same effects as by the stomach.

In children the anæsthesia, so readily obtained by chloral, may be utilized for the extraction of teeth, the opening of abscesses, aspiration, breaking up anchyloses, the use of caustics, thoracentesis, and a number of surgical operations.—*Gazette des Hôpitaux*.

TREATMENT OF EPILEPTIFORM FACIAL NEURALGIA BY THE AMMONIACAL SULPHATE OF COPPER.—(FÉROËL).

The patient, thirty-two years of age, had been for two months the victim of neuralgic spasms of the fifth pair, of excessive intensity, succeeding each other at intervals of a few minutes. The pain, located on the level with the left temporal region, occurred suddenly, and radiated into the upper jaw of the same side. At the same time, the face was deeply congested. At the end of a variable period, but generally not exceeding five or six minutes, the attack ended with the flow of a few tears. M. Féroël had had recourse at first to granules of aconitine, then to sulphate of quinine, to the recently recommended gelsemium *semper virens*, to hypodermic injections of atropine, of morphia, to blisters, to bromide of potassium, to chloral and to *granules de dioscoride*, but all without success. In view of this obstinacy, and understanding that his colleague, M. Bourdon, physician to *La Charité*, had successfully employed the ammoniacal sulphate of copper in a similar case, M. Féroël determined to administer this remedy. He began by prescribing it in doses of five centigrammes (three-fourths grain), to be taken before meals as a powder, with sugar. The next day a notable

amelioration was observed; the attacks were less numerous. There was a little pain in the stomach, with slight nausea. The next day he prescribed a draught containing ammoniacal sulphate of copper ten centigrammes ($1\frac{1}{2}$ grain) cherry-laurel water, ten grammes (3*ij*ss) syrup of morphia, thirty grammes (3*vij*ss). The following day great amelioration: no attacks during the night or morning. After eight days' use of this potion, the attacks had ceased.

The very day on which this patient left the hospital, M. Féroël admitted another with intermittent neuralgia of the supra-orbital nerve, of an extreme severity, accompanied by redness of the conjunctiva and lachrymation, recurring each morning between seven and eight o'clock, to cease at midday. M. Féroël began with an application of leeches, a blister the next day, and the sulphate of quinine in the dose of a gramme (fifteen grains) at first, afterwards a gramme and a half. There was a perceptible amelioration, which was not, however, maintained. At the end of a few days the neuralgia had assumed its former intensity. He then prescribed the ammoniacal sulphate of copper in the dose of ten grammes ($1\frac{1}{2}$ grains) per day, then at the end of three days he increased the dose to fifteen grammes ($2\frac{1}{4}$ grains). The pain disappeared completely and the patient left the hospital cured.

TWO VARIETIES OF SCIATICA—TWO KINDS OF PAIN—TREATMENT.

There are two varieties of sciatica, one in which the nutrition of the limb is unchanged, the other accompanied by atrophy of the limb. In the first class the neurilemma alone is affected, in the second, the nerve fibres are attacked by the inflammation and cause atrophy of the limb. There are two kinds of pain, one only present on motion of the limb, the other when the limb is at rest. In all cases the first element of cure is rest. To this in cases of the first class must be added blisters and hypodermic injections. The pain being allayed, dry fumigations should be used. Dry heat is better than douches of sulphurous or terebinthinate vapours. In default of the former, vapour douches give the best results.—*L'Union Médicale du Canada*.

ON A NEW MANNER OF OPENING CERTAIN ABSCESSSES NEAR THE MARGIN OF THE ANUS.

BY PROF. VERNEUIL.

There exist, you know, two very distinct varieties of abscess of the anal region. In the one the abscess occupies the ischio-rectal region, but the purulent collection occupies the buttock and bulges here. the rectal wall is unaffected and is not laid bare at any point. In the other variety, on the contrary, the pus does not point toward the buttock, there exists only a slight tumefaction, a little redness and heat in this region; the purulent collection has destroyed the perirectal cellular tissue and burrows and points in this direction.

In the first variety of abscess the pus has a tendency to find exit in the region of the nates; in the second, it tends to ulcerate through the wall of the rectum and to open into its cavity. From this difference of seat important therapeutic consequences result, and these it is my object to lay before you.

In the first case a simple incision of four or five centimetres ($1\frac{1}{2}$ to 2 inches), practised in the direction of the anus, generally suffices for the evacuation of the pus, cicatrization then rapidly follows without leaving any traces or a fistula behind.

In the second case, if the rectal wall be bulged or bared, even a very large incision is insufficient, and fistula inevitably occurs. (Cases in point are here cited, after which he continues :) As soon as I find the pus pointing towards the rectum I incise not only the abscess in the region of the buttock, but I also, and at the same time, do the operation for anal fistula. In these cases I puncture the purulent collection, and introduce a grooved director, which I make to strike the rectal wall so as to bulge and perforate it at a point as far as possible above the part laid bare; I then bring the director out through the anus and divide by means of the thermo-cautery all the bridge of tissue between the two openings. * * * * The only objection which can be taken to our procedure is that the operation is a little longer and a little more serious than simple incision, but to that we may reply that the duration of the treatment is ultimately infinitely shorter than with a simple incision.—*La France Médicale*.

AMYLOID DEGENERATION.

In pronounced amyloid degeneration, says M. Cazalis, if there be at the same time albuminuria and diarrhoea, the surgeon ought to undertake no operation; but his intervention may properly be invoked if the most serious symptoms be only a progressive emaciation and an easily recognised hypertrophy of the liver or spleen. At such a time a bold operation may alone, in many cases, save the life of the patient. It has been objected, says Giraaldès in his *Clinique des Maladies des Enfants*, against the utility of resection of the hip, that the general state of coxalgia is one of prostration from suppuration. We have always to do with scrofulous patients in whom alterations of different kinds, tubercular or amyloid, of the lungs, the kidneys, the liver, and the bowels, dominantly impress their characters upon the case. Coxalgic children operated upon in these bad conditions are nevertheless ameliorated, and their general condition undergoes changes of such a nature as to presage a cure. Hence the conclusion: By putting an end to the suppuration you place the patient under better general circumstances, as a consequence of which recovery may result. In steatosis, two sorts of degeneration may be observed; the one developing slowly like the amyloid; the other, consecutive to septicæmia, developing rapidly like the steatosis which follow certain intoxications, the phosphoric intoxication for example. This acute degeneration has still to be studied; but there already exists a sufficient number of cases (the majority will be found set forth in this thesis of M. Cazalis) to place beyond all doubt the relation between visceral steatosis and septicæmias. It is therefore of the highest importance that in surgical diseases of long duration and in septicæmias, the clinician should have his attention fixed upon the viscera, and especially upon those so accessible to his observation as the liver, the spleen, and kidneys.—*L'Union Médicale*.

ANALYSIS OF ICTERIC URINE.

When jaundice is not well marked, it is of great assistance in establishing the basis of sound treatment, to analyse the urine by

means of certain reagents. The three following give characteristic results :

1. *Chloroform*, when poured into normal urine, falls to the bottom of the test tube, and indicates its presence by a transparency quite crystalline. When poured into icteric urine, and after shaking well, left for a short time to settle, it falls, by reason of its density, to the bottom, and by its dull colour stands in contrast to the yellow colour forming the superficial layers.

2. *Tincture of Iodine*, poured into icteric urine, need not be shaken up. At the upper part we find three well-marked tints. The upper layer formed by the tincture is of a violet colour : below this first layer is a sort of diaphragm of a sea-green colour. A third layer formed by the urine has a yellow tint.

3. *Nitric Acid*, poured into icteric urine and shaken, produces a bottle-green colour, passing into olive. This appearance is very characteristic—*Rev. de Ther. Medico-Chir.*

URTICARIA—A LITTLE-KNOWN DIAGNOSTIC SIGN —SEDATIVE REMEDIES FOR THE CUTANEOUS HYPERÆSTHESIA.

M. Hardy points out a simple means of diagnosis in obscure cases of urticaria. In some cases under observation one sees no eruption ; the patient complains of severe itching of the palms of the hands and soles of the feet. If one scratches the skin with the nails, well-marked red lines appear. To allay the annoying itching, Hardy frequently employs frictions with flour ; if this fails to relieve, he uses a lotion of one part alcohol and nine parts of water : this gives immediate relief.

SOLUTION FOR GINGIVITIS—(PINARD).

Hydrate of chloral ziv ; spirits of horseradish ziv—mix. This solution is recommended for the gingivitis of pregnant women. This inflammation of the gums gives rise to painful mastication, slight hæmorrhages, loosening of the teeth, and sometimes even their expulsion. Every day or every other day the free border of the gums should be touched with a dossil of cotton wool dipped in this solution, after the tartar has been carefully removed from the teeth.—*L'Union Médicale.*

THE CANADIAN

Journal of Medical Science,

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

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 sending reports of the proceedings of their Associations to the corresponding editor.*

TORONTO, DECEMBER, 1878.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS, KINGSTON—STU- DENTS' ANNUAL DINNER.

The annual dinner in connection with the above institution was held on Friday evening, November 8th, in the British American Hotel, Kingston. The occasion was a most enjoyable one, and demonstrated to the guests the existence of the most cordial relations and fullest confidence between professors and students. The attendance was large, there being present, besides the members of the Faculty and students, a number of limited guests. Letters regretting their inability to attend were received from Sir John A. Macdonald, Lieut.-Col. Hewitt, His Worship the Mayor, Very Rev. Principal Grant, Dr. Campbell, President of Ontario Medical Council, Dr. Pyne, Secretary Ontario Medical Council, Prof. Dickson, Prof. Fowler and Prof. Yates. The dinner was of a *recherché* character, and, in short, the whole banquet proved an unqualified success. The chair and vice-chair were ably occupied by Messrs. W. H. Henderson and R. A. Leonard, House Surgeons of Kingston General Hospital. Following the usual loyal toasts from the chair and their enthusiastic reception, Mr. Donovan, of the Final Class, proposed "The Medical Council of Ontario," which so nobly protected the province from quacks preying upon the public credulity.

Dr. M. Lavell, Professor of Obstetrics, responded in an eloquent speech. He entered *in extenso* into a history of the difficulties connected with the establishment of the Council, and clearly showed how all its efforts had been to elevate the profession. He assured them that

they had the sympathy and support of the members of the Council. After complimenting the students on their success at their examination in the past, he said that for next year there was an excellent Examining Board, who would exact no information from them they should not possess. He concluded a fluent and facetious address by assuring the students that the members of the Council would always be ready to reciprocate any kindly sentiment they might evince towards them.

Mr. Smith proposed "The Faculty of the Royal College of Physicians and Surgeons," paying several compliments to its members for the earnest and painstaking manner in which they performed the duties of their respective positions.

Dr. Sullivan, Professor of Surgery, responded in a speech replete with eloquence. He congratulated the students on the success of their banquet, which, he said, was indicative of their culture and taste. He referred to the success which had attended the college since its establishment, a fact which was shown in the increased attendance and efficiency exhibited. In closing, he assured the students that the Faculty reciprocated their kindly sentiments.

Dr. A. Oliver, Professor of Institutes of Medicine, and Dr. T. R. Dupuis, Professor of Anatomy, also responded in suitable addresses.

Dr. Lavell proposed "Queen University" in felicitous terms, and Dr. K. A. Fenwick, M.A., M.R.C.S., Professor of Medical Jurisprudence, replied. He was glad that such a good feeling prevailed towards Queen's University, which at no time in its great history was so efficient as now. He alluded to the success of Principal Grant's Endowment Scheme, and concluded by proposing "Our Sister Universities," to which Messrs. H. H. Chown, B.A., and R. N. Horton made suitable responses on behalf of Victoria and Albert Universities respectively.

Mr. Leonard, from the vice-chair, proposed "Our Graduates," and Dr. Phalen responded, referring to the success of their graduates in the practice of the profession and to the high positions they had taken before the Examining Boards in Europe.

Dr. Sullivan, in complimentary terms, pro-

posed "The Graduating Class," and Messrs. Hossie, W. F. Cleaver, R. K. Kilborn responded.

The toast to "Primary Class" brought forth acknowledgments from Messrs. Odlum, Dickson and Galbraith.

"The Sophomore Class" elicited suitable responses from Messrs. Reeve, McPhayden and Herrington.

"Our Freshmen," was drunk with great enthusiasm, and replied to by Messrs. Denike, Wallace and Chisholm.

"The Press" was the subject of a glowing eulogy by Dr. Stark, of Stormont, and was responded to by the representatives of the city press.

"Our Host," with all honours, cheers for "The Chairman" and "Our noble selves," and the singing "God Save the Queen," concluded a most enjoyable evening. The gathering was a success in every respect, and "the feast of reason and flow of soul" was in no measure marred by the total abstinence principles which strictly prevailed on the occasion.

CONVOCATION OF TRINITY COLLEGE.—At the annual Convocation of the University of Trinity College, there being a large attendance of friends, the following degrees of Medicine were conferred by the Chancellor:—M.D.—A. J. Sinclair, W. McKay. *Matriculation (Medicine)*.—H. A. Allen, W. L. Allen, L. Bentley, W. M. Brett, M. L. Cameron, J. F. Cattermole, F. D. Canfield, W. Fairbairn, A. Farncomb, C. M. Freeman, A. C. Gairdner, J. W. Hunter, J. M. Johnstone, J. P. King, F. Lundy, J. F. Martin, H. B. McCausland, H. R. McGill, W. F. McLean, N. McPhatten, D. A. McTavish, J. McWilliams, R. McWilliams, R. Patterson, A. Pringle, R. Raikes, T. M. Robinson, E. A. Spilsbury, A. N. Sloan, H. W. Smith, E. A. Smith, A. E. Stutt, G. H. Stark, E. D. Vandervoost, J. Walker, H. C. Wilson, F. A. Woolvester.

CANADIANS IN ENGLAND.—Drs. Luke Teskey and Charles Sheard have passed the primary examinations of the Royal College of Surgeons, England. Dr. Teskey has returned to Toronto for the winter.

TORONTO SCHOOL OF MEDICINE.

FIFTH ANNUAL DINNER.

The fifth annual dinner of the Toronto School of Medicine took place in the large dining hall of the Rossin House, on November 7th.

The hall was very neatly decorated with flags, amongst which were hung the mottoes of the School. The tables were very handsomely laid, and the *menu* did much credit to the cookery department of Mr. Irish's establishment. The attendance was large as the list of the guests shows. The chair was occupied by the Rev. Mr. McCarroll; the first vice-chairman was Mr. James A. Anderson; the second vice-chair was occupied by Mr. L. M. Sweetnam. Mr. H. C. VanNorman was Secretary to the Dinner Committee. Of the invited guests, there were present Hon. Chief Justice Moss, Prof. Goldwin Smith, Mr. John Gillespie, Mr. McCrosson, Dr. Strange, M.P.; the Rev. Dr. Nelles, President of Victoria University; Lieut.-Col. Otter; Dr. O'Reilly, of the Toronto General Hospital; Prof. Ramsay Wright, of the School of Practical Science; Dr. Kennedy; Dr. Daniel Clark, Medical Superintendent of the Toronto Asylum; Prof. Croft, Dr. I. H. Cameron, Dr. Langstaff, Dr. McConnell; Dr. T. White, of Hamilton; Dr. Pollard and the following members of the Faculty of the Toronto School of Medicine, Dr. Aikins, Dr. H. H. Wright, Dr. Barrett, Dr. U. Ogden, Dr. Richardson, Dr. Thorburn, Dr. W. W. Ogden, Dr. F. H. Wright, Dr. Zimmerman, Dr. Reeve, Dr. Graham, Dr. George Wright. There were also present a number of graduates. No wine was used during the evening, and the toasts were drunk in water. The band of the Queen's Own Rifles enlivened the evening before and during the dinner.

Dinner having been served and the cloth removed, the Chairman said he supposed if the public were present he might congratulate it upon having in its midst such an institution as the Toronto School of Medicine. In the absence of the public, however, he might congratulate the friends of the institution on the improvements which had been made in it, and the general advancement which had been effected

in its ways and means of teaching. While doing so, he might assure the members of the faculty of the appreciation in which they were held by those who attended the School, on account of their efforts in behalf of the students and in behalf of the public, to whom they (the students) would in after years be called upon to minister. He concluded by proposing the health of the Queen.

Band—"God Save the Queen."

The Chairman then proposed the toast, "The Governor-General and the Lieutenant-Governor of Ontario," which was heartily received.

Band—"The Campbells are Coming."

Mr. VanNorman, Secretary of the Dinner Committee, read letters of regret at inability to attend from the Lieut.-Governor, the Mayor, Hon. O. Mowat, Mr. W. H. Howland, Dr. Workman, Dr. Baxter, M.P.P., Dr. Widdifield, M.P.P., Hon. Dr. Tupper, Prof. Loudon, Dr. McCaul, Dr. Sinclair, Dr. Covernton, and others.

The toast, "The Active Militia of Canada," was then proposed.

Lieut.-Col. Otter briefly thanked the assembly for the kind manner in which the toast had been received.

Dr. Thorburn also replied.

Song—"Florence Nightingale"—Mr. Manning and chorus of students.

The Chairman proposed the toast, "the Dominion and Local Governments."

Dr. Strange, M.P., who was called upon to reply, was cordially received, and replied to the toast in a very appropriate manner.

Mr. Jas. Anderson, of the School of Medicine, recited "Noodle's first speech in Parliament."

Toast—"The Mayor of Toronto and the City Council."

Duet by Messrs. Leslie and Marsh—"Larboard Watch."

Toast—"Prosperity to the University of Toronto," coupled with the names "Chief Justice Moss, Dr. Richardson, and Prof. Croft, D.C.L."

Chief Justice Moss, who was received with cheers, offered his thanks for the opportunity afforded him of being present. He was sure

his hearers would acquit him of any affectation when he said it was exceedingly pleasant to himself to meet those connected with the Toronto School of Medicine, for many associations clustered around him when he rose to address a body composed mainly of professors, with whom he had enjoyed intimate acquaintance, and of pupils whom he had had the privilege of investing with the degree of the University of Toronto. Regarding the latter class of persons, he hoped it would be his privilege to aid some of them to escape from the chrysalis state of the undergraduate and to assume the full plumage of the graduate—(applause)—and he hoped that the connection with any other matter in which feathers might be mentioned would end there. (Laughter.) He would not express his surprise at the hearty manner in which the toast of the University was received, because the connection between the University and the School had been so long and so intimate as to render it impossible that the students from the School should fail to wish the larger institution the fullest measure of prosperity. (Applause.) Many of our most distinguished medical men had received their training in the School and their degrees in the University, and therefore he might safely ask those present to sympathize with the University in its efforts in the direction of higher education, and to share in its triumphs. He would not speak of the triumphs of the University in the past because he felt he could look forward to still greater achievements in the future. The subject of the faculty of medicine had, as his hearers were aware, at no very distant period engaged the attention of the governing body of the University, and regarding it some changes had been made. All changes had some opponents, and he did not suppose that the curriculum recently adopted by the Senate had been accepted with universal favour by the students in the school. But, possibly, that curriculum resembled the prescriptions which it would be the aim of his hearers in the future to administer to their patients; it was likely to be salutary in its effects, though somewhat bitter to the taste at the moment. (Laughter and applause.) Among the advantages of the curriculum was the

annual examinations. In law by such examinations, it had been found that the interest of the students had been greatly advanced, and he was sure that medical students, like the students in the sister profession, would be benefited by the adoption of that system. In framing the curriculum, the Senate had regard to the advantages which the pursuit of the physical sciences was calculated to confer on the practice and study of medicine, and consequently established such advantages as they could in favour of those who, while pursuing the undergraduate course in the Faculty of Arts, and having their ultimate view fixed on the study of medicine, took an honour course in the physical sciences. He hoped for some good from even that trifling boon. He hoped for still more good from the establishment in the general course of a comparatively high standard in the physical sciences. Science and medicine had always, he contended, been co-workers, and medicine had profited largely by every step made in any branch of physical science. That connection instead of becoming more slender, must in the progress of time become stronger, and as medicine strove more and more to assume a place among the sciences, she would find her a most powerful ally among the physical sciences, and especially, as he thought, in the science of experimental physiology. He believed that the best physicians were fully satisfied with the belief that it was from the progress of experimental physiology in its larger sense that medicine might fairly hope to take its place among the exact sciences. He strongly recommended the establishment of laboratories, in which good practical work in the experimental sciences could be done, believing that a course in these sciences would greatly increase the usefulness of the students when they had become physicians. In conclusion, he said he had heard with pleasure of the connection of the Medical School with the arts of war; he had heard with pleasure of the position the profession occupied in the councils of the country, and he wished both the profession and the School still greater success. (Applause.)

Dr. Richardson and Prof. Croft also replied.

Toast—"The College of Physicians and Surgeons."

Dr. Daniel Clark was called upon to reply, and spoke of the advantages to the profession and public of the standard of education adopted by the College.

Mr. James Anderson sang "The Learned Man," and Mr. Milne and Mr. Duncan sang the duet "All's Well."

Toast—The Toronto School of Medicine, coupled with the names of Dr. Aikins and Dr. Barrett.

Dr. Aikins responded. He said that the Faculty of the School of Medicine heartily desired the success of its pupils.

Dr. Barrett also replied. He pointed out that the number of pupils in the School was increasing every year, and that the facilities for teaching were improving. During the past year an additional building had been erected in connection with the School, and in that building would be found ample room for a laboratory for the study of experimental physiology.

Song and chorus—"Bright Star of Hope."

Mr. Anderson, one of the Vice-Chairmen, in a very humorous speech, proposed the toast, "The Toronto General Hospital."

Dr. O'Rielly and Mr. Gillespie replied.

Song by Mr. J. Lesslie—"Tom Bowling."

Mr. Sweetnam proposed the toast, "Sister Institutions," connected with which were the names of Prof. Goldwin Smith, Dr. Nelles, Prof. R. Wright, and Dr. Kennedy.

Prof. Goldwin Smith, in replying, said that as the hour was late he would not make a speech, but he supposed the University of Oxford, of which he was once an officer, might be called a sister institution, although she was rather an older sister and a larger one. The University of Toronto was the sister of that of Oxford, only in virtue of its aims and objects, but there was no reason why it should not in time attain to the greatness of Oxford, which could be effected if those who at some future day would be at the head of affairs—for such a change could hardly be expected in this generation—should tread the same path as the founders of universities in Europe, and instead of scattering their resources, concentrate them in one great university. When he was last at Oxford the subject of the possibility of restoring the connection between medical and university

education was being debated. In former days the professions of medicine, law, and theology dwelt under the same academical roof, but in recent times law had migrated to the Inns of Court and other places where law was practised, and medicine had migrated to the great London hospitals. The question now was whether the connection could be restored. He trusted it would be, for it was to the interest of all professions that there should be no divorce between professional work and a liberal education. It was not to be expected, that the man who was to make his bread by his profession could devote himself to recondite subjects, but it was desirable that physicians should possess a good classical and liberal education. It was desirable for their own sakes, because it would add dignity to their lives; it was desirable for the patient under their treatment. It was also desirable for science, because only with such an education could the physician pick up matters for scientific investigation. He hoped that the union between the profession and the University might continue, and it would tend to make the lamp of science burn more brightly. (Applause.)

Rev. Dr. Nelles responded on behalf of Victoria University, agreeing with the last speaker as to the importance of a close alliance between the professions and general culture. Young men in this country were so pressed to enter into the practice of their respective professions that their preparatory literary education was too often of a scanty and superficial character. Every inducement should be offered by all our educational institutions to secure for our young men, a broad, liberal culture as the basis of a sound professional training. This was all the more important because in this young country so few could afford to devote themselves entirely to literary pursuits like the distinguished gentleman who had last spoken. In alluding to the expected arrival of the Marquis of Lorne, he expressed the hope that that event and its concomitant circumstances would lead to a better understanding of Canadian affairs, and especially of Canadian geography on the part of English journalists.

Prof. Ramsay Wright responded on behalf of the School of Practical Science, remarking that

the establishment of that institution was a most important event in the educational history of the Province, and one for which the Ontario Government deserved the thanks of the community.

Dr. Kennedy responded on behalf of Trinity Medical School, expressing his pleasure at the kindly feeling that subsisted between it and the Toronto School. Both were working for the same object, and a little friendly emulation would do neither of them any harm. He bore testimony to the high character of the teaching in the Toronto School, and to the standing which Canadian medical men were acquiring in Great Britain.

The toasts, "The Graduates," "The Freshmen," "The Ladies," and "The Press" were then given and duly responded to, after which the gathering separated.

INFANTS' FOOD.—We have received a communication from a correspondent anent Infants' Food, in which the writer corroborates from his own experience the statement contained in Dr. Wright's paper on Infant Feeding, with reference to the laxative properties of Nestle's food. As, however, our correspondent is anonymous, it would be contrary to journalistic practice to insert his communication, notwithstanding the fact that his suggestion with regard to the use of Wyeth's Papoma may be a valuable one.

LUBIN'S PORTABLE TURKISH BATH.—We beg to draw the attention of our readers to the advertisement of the Lubin's Portable Turkish Bath, which appears in our advertising columns. They offer an article cheap, convenient, and efficient. Physicians will find it useful after attending cases of infectious diseases, such as puerperal fever, &c.

APPOINTMENT.—T. H. Smyth, B. Sc., Edinburgh, M.A., Toronto University, has been appointed Lecturer on Botany and Zoology at the Toronto School of Medicine.

ELASTIC ADHESIVE PLASTER.—Can be made by coating india-rubber with a plaster made of one pound of lead plaster and six drachms of resin.

MALTINE.—Read the advertisement.

Book Notices.

Wood's Physicians' Vade Mecum and Visiting List. Arranged and prepared by H. C. Wood, M.D. Philadelphia: J. B. Lipincott & Co.

Annual Address delivered before the American Academy of Medicine, at Easton, Pa. By FRANK H. HAMILTON, A.M., M.D., LL.D., New York.

The Medical Journal Advertising Bureau Gazette. Published quarterly. Price 10 cents per copy; per annum, 25 cents in advance. C. W. BERNACKI, M.D., Editor and Publisher, New York.

Physicians' Visiting List for 1879. 28th year of its publication. Philadelphia: Lindsay & Blakiston. This Visiting List is too well known to need any commendatory notice. No better one is published.

The American Quarterly Microscopical Journal. This is a new quarterly, edited by Romyn Hitchcock, and published by Hitchcock & Wall, 150 Nassau Street, New York. The first number has reached us, and impressed us very favourably. We wish the editor all success. The journal is well prepared and well printed, the articles excellent, and the illustrations good. Each volume will consist of 350 pages of matter. Terms—one year, \$3.00; single copies, 75 cents. It deserves the encouragement of all interested in microscopy.

The Nature and Treatment of Inebriety; also, The Opium Habit and its Treatment. By EDWARD C. MANN, M.D., Medical Superintendent of Sunnyside Medical Retreat, Washington Heights, New York. This pamphlet consists of a series of interesting addresses delivered at various times before the American Association for the Cure of Inebriates.

I. "Intemperance and Dipsomania as related to Insanity."

II. "State medicine in relation to the Intemperate and the Inebriate."

III. "The Relation and Hereditary Tendency between Inebriety and Epilepsy."

IV. "The Causes of Premature Mental Decay and Nervous Exhaustion, induced by Inebriety, and their Treatment."

V. "The Pathological and Psychological Action of Opium, and its effects upon the Human Race."

In chap. V., "On Treatment," the author speaks of constant and induced currents of electricity as *the* remedy in nerve exhaustion and mental decay. Phosphorus, cod-liver oil, strychnine, quinine, Zinc phosphide, Indian hemp, monobromide of camphor, prolonged warm baths, &c., are the remedies recommended to meet the various symptoms.

Reviews of the following publications will appear next month:—

The Science and Practice of Surgery, including special chapters by different authors, with 969 illustrations on wood, mostly new and original. By Frederick James Gant, F.R.C.S. Second edition, in two volumes, pp. 1787. Revised and re-written, and much enlarged throughout. London: Ballière, Tindal & Cox; Philadelphia: Lindsay & Blakiston; Toronto: Willing & Williamson.

Brain. A quarterly journal of neurology. Edited by J. C. Bucknill, M.D., F.R.C.P., F.R.S., J. Critchton-Browne, M.D., F.R.S.E., D. Ferrier, M.D., F.R.C.P., F.R.S., and J. Hughlings Jackson, M.D., F.R.C.P. London and New York: Macmillan & Co. July, 1878. Part II., price \$1.25; yearly subscription, \$4.00. Willing & Williamson.

Habitual Drunkenness and Insane Drunkards. Dr. Bucknill, F.R.S. London: Macmillan & Co., 1878. Toronto: Willing & Williamson. Price \$1.00.

Practical Surgery, including Surgical Dressings, Bandaging, Ligations, and Amputations. By J. EWING MEARS, M.D. Philadelphia: Lindsay & Blakiston.

The Cell Doctrine; its History and Present State. By JAMES TYSON, M.D. Philadelphia: Lindsay & Blakiston.

Diseases of the Bladder and Urethra in Women.

By A. J. C. SKENE, M.D. New York: Wood & Co.; Toronto: Willing & Williamson.

A book of this kind has been very much needed by the profession, and the author's well-known position as a gynecologist eminently fits him for the task of its production.

Diseases of this class occur to the practitioner every day, and we have long felt the want of some safe guide to their diagnosis and treatment. Such we have found in Dr. Skene's book, which is plain, practical, and short.

We have been much pleased with the lecture on functional diseases of the bladder, wherein he speaks of that very troublesome affection, nocturnal incontinence of urine in children and adults, simply because he has the courage to say that some cases will not be cured by any treatment whatever. He divides these cases into two classes or types. First, the anæsthetic; second, the hyperæsthetic, or irritable bladder. Each may exist alone or both at the same time. In the first the retaining power of the sphincter is defective, and the fault is probably in the vesical nerves. In the second there is an irritable condition of the bladder which renders its expelling power greater than that of retention.

In some cases he says the cure is easily effected; in others it cures itself at or just after puberty; but in a few no medical or other means afford any relief. The treatment is not always satisfactory. In anæsthesia, local or general, stimulate. In hyperæsthesia, allay irritability. In some cases syr. ferri iodid has effected a cure in a few days by its action on the blood and general system. In some cases belladonna will act satisfactorily, but in others it will fail. Sometimes a combination of belladonna and chloral hydrat. or narcotics and tinct. ferri chlorid, will succeed. Oil of sandalwood has done well in some cases. While narcotics are hurtful in the anæsthetic cases, such remedies as strychnia, quinine, and iron may prove useful. He advises the heartiest meal to be taken in the middle of the day, and but little towards evening, plain, unseasoned food, without tea or coffee, and early hours of retiring. He insists that children who are subject

to it should not be sent to school too early. He gives two excellent lectures on the different forms of cystitis, their etiology, pathology, symptomatology, and treatment; the different methods of examining the bladder and urethra, and of applying remedies. He utters a well-timed caution in regard to extreme dilatation of the urethra, an operation in which there is great danger of lacerating the canal, and which will sometimes occur to the most skilful operator even when every effort is made to prevent it. It has been found that the tissues sometimes give way suddenly where the operator was proceeding carefully, and that permanent incontinence is the result, for even restoration of the urethra *does not* restore the retaining power of the bladder. Under these circumstances, it is well that caution should be observed, for since Mr. Heath proposed rapid dilatation of the urethra for irritability of the bladder, that practice has been rather too common. It is only a few months since we saw a fine young woman who was invalided for life by an attempt at rapid dilatation, which resulted in complete destruction of the whole length of the urethra, with incontinence of urine, and violent vesical tenesmus, under the influence of which the general health was completely broken down. But the whole book is worthy of its distinguished author. It treats of a class of diseases met with every day, and about which little is to be found in the ordinary text-books on gynecology or general surgery. We heartily commend it to the profession.

Physics of the Infectious Diseases. By C. A. LOGAN, A.M., M.D. Chicago: Jansen, McClurg & Co.

This is a very pretty little book of 212 pages, being beautifully printed on nice paper, made up of the author's observations and reflections during a residence of four years in the capacity of American minister to Chili, treats of a great variety of subjects, considering the size of the book, and while some of his views are decidedly novel and open to criticism, a good deal can be said in support of others. Under the head of "Physical Aspects of

the Pacific Coast," he discusses the subject of earthquakes and their relation to thunderstorms, the influence of mountains on climate, the subject and source of wind and rain, the source and property of ozone, the forces of nature, &c., &c.

Then he speaks of its medical aspects, and gives some very interesting information in regard to the sanitary condition of the cities of that region, whereby it appears, that, notwithstanding the utter neglect of all sanitary rules, there is an immunity from zymotic diseases that is truly wonderful. "Ravaging epidemics, afflicting other parts of the world with such great mortality, are entirely unknown by like results in any portion of that region, with the exception of small-pox," which is almost always present, and seems to have lost its identity in some respects, as vaccination affords no protection against it, many persons taking the disease three or even four times, although it remains true to its type in mortality, which sometimes reaches fifty per cent., but the prevalence of the general class of acute infectious diseases is inversely to the electric energy of the locality. The author says that venomous reptiles and insects have no natural existence throughout the whole Pacific coast, and Quito, a city of 40,000 inhabitants, with the country for many miles around, nearly under the equator, at an elevation of 10,000 feet above the sea, is one of the healthiest places on the globe, consumption, dysentery, and fevers being almost unknown. It should therefore be a choice place to live in, were it not for the "*terremoto*," which have a rather familiar way of shaking people up, for he tells us he has a record of the phenomena of three hundred earthquakes that occurred during three successive years; but, after all, it is simply a matter of taste or choice between scorpions, lizards, and snakes, on the one hand, and earthquakes, with their attendant phenomena, on the other. The author's theory that the earthquake is the result of electrical or magnetic disturbance, and can be absolutely prevented by levelling down all the mountains of the world to a height permitting of an unobstructed and regular annual rainfall in its various parts, will probably be somewhat criticised by scientists, and yet he gives some

strong evidence in favour of his propositions. He believes that ozone is a strong factor in the sanitary condition of earthquake and volcanic regions, and we think there is ground for the belief. Speaking of the influence of bacteria, in the production of disease, he says, that, "in view of all the evidence, it is not a fair inference that the infectious diseases are caused by bacterial germs."

Chapters on the "forces of nature," and the "ideal functions of the nervous system," are too metaphysical for our comprehension, and we must refer the reader to the book itself for the true exposition of the author's views on these points, premising that while there is a good deal of fine writing, the point of which is hard to discover, there is also much that is calculated to stimulate thought and afford satisfaction to the enquiring student.

Miscellaneous.

TREATMENT OF WHOOPING COUGH BY TINCTURE OF MYRRH.—(By Campardon.)—Whooping Cough yields easily and rapidly to the alcoholic tincture (15 drops to the tablespoonful) in quinine wine or Vichy water. A tablespoonful every hour or two. This treatment in no way interferes with the appropriate remedies for the tracheo-bronchitis or the pulmonary congestion.—*Bull. Thér. Lyon Méd.*

GLYCERIN OF THE OXIDE OF ZINC, (F. POLLET).—Glycerine ʒiv, starch ʒij, oxide of zinc ʒi, mix. For the dressing of rhagades and chronic inflammation of the anus. Rhagades, which are little fissured ulcerations, situated in the natural folds of the anus, or frequently at the base of, or in the angle formed by mucous patches, vegetations or condylomata, often yield to simple cleanliness, to dressings with aromatic wine, or light cauterizations with nitrate of silver. It is when they are rebellious to these means that recourse is had to the glycerine of zinc. In point of fact, in order to obtain a definitive cure, it is first of all necessary to dissipate the lesions which give rise to the rhagades, and of which they are only a complication.—*L'Union Médicale.*

COLIC CURED BY STANDING ON THE HEAD.—Dr. D. L. Phares, in *Trans. Mississippi State Med. Association*, 1878, recommends as a prompt and effectual cure in many cases of colic, to place the patient in an inverted posture. Some cases which have resisted the ordinary treatment for hours and even days, have by this simple means been relieved and permanently cured in from one to five minutes. Sometimes relief appears to be afforded from the escape of air from the rectum. In other instances, the air in the bowels changes its place, to the relief of the patient. Some movement of gas in the intestines appears to be essential to relief by this method. Of course it is only flatulent colic which can be permanently relieved by this treatment. The confidence with which Dr. Phares asserts the success of the plan entitles it to a trial. The treatment could be easily applied in popular practice. The patient might at least be held up by the heels till the arrival of the doctor, (provided he comes within a few hours).

Births, Marriages, and Deaths.

BIRTHS.

In Cayuga, on November 1st, the wife of Dr. Baxter, M.P.P., of a son.

MARRIAGES.

On October 22nd, at Berlin, Ont., E. P. Clement, Barrister, to Janie, eldest daughter of D. S. Bowlby, M.D.

On November 14th, at Paisley, Stuart McArton, M.D., M.C.P.S., Ont., to Annie, only daughter of the Rev. James Chance.

On October 29th, J. E. Eakins, M.D., L.R.C.S., and L.R.C.P., Edin., to Nettie, eldest daughter of Sydney Warner, Esq., Wilton.

At Toronto, on October 29th, Arthur H. Hughes, Esq., M.D., L.R.C.P.E., M.R.C.S., England, Professor in Grant Medical College, Bombay, to Louisa Rosalind, youngest daughter of H. G. Bannard, Esq., of Toronto.

On November 20th, at St. Paul's Church, Yorkville, George McNairn Shaw, M.B., of Hamilton, to Isabel Thorburn, eldest daughter of John Symons, Esq., Avenue Road, Yorkville.

DEATHS.

At Toronto, on October 31st, Irwin Bridgman, M.D., aged 33 years and 7 months.

At Fenwick, on November 17th, Dr. H. R. Haney, M.P.P. for Monck, aged 43.