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TORONTO CLINICAL SOCIETY.

Stated Meeting, March 7th, 1900.

The President in the chair. *Fellows present:* Aikins, Peters, King, Primrose, Small, Trow, Lehman, Oldright, Thistle, Fotheringham, Rudolf, Silverthorn, Pepler, Fenton, McCollum, Dwyer, Boyd, Hamilton, and Elliott. *Visitors:* Dr. Clarence Starr and Dr. Spence of the T. G. H. *Nominations:* Dr. C. B. Shuttleworth and Dr. A. Y. Scott by Drs. Fenton and Pepler.

Nominations for officers for 1900-1901 will be held in April.

CASES ILLUSTRATING OPERATIVE PROCEDURE IN TUBERCULOUS DISEASE OF KNEE.

DR. A. PRIMROSE presented two patients, one a young man of nineteen years and the other a boy of eight, showing different forms, the first one complete excision and the second a case of erasion. The first patient came under his care in July, 1894. Three years prior thereto, great swelling occurred in the knee joint and patient was treated at that time by rest and the application of a Thomas' splint. Became apparently well under this treatment until February, 1894, when the trouble again appeared. Under somewhat similar treatment he became gradually worse, and at the time he came under Dr. Primrose's care, there was very advanced disease of the knee joint. At that time the knee was flexed at an angle of 100 degrees, with little or no pain unless on manipulation, when there was a slight amount of pain; there was also marked atrophy in the muscles of the thigh and leg—very pronounced symptoms of extensive tuberculosis of the

knee joint. He was treated by rest and the Thomas' splint; improved for a time, but during the next two months improvement did not continue and abscesses formed. He again came under the surgeon's care in February, 1899, and at that time he had sinuses in connection with the knee joint. One sinus existed in the popliteal space and one to the outer side of the joint, both discharging pus; and there was a great deal of thickening about the synovial sac of the joint. The operation was an extensive one. In the first place, the surgeon concluded that the best thing to do was, where one found the joint stiff, to attempt with a certain degree of force to break down the ankylosis, because ankylosis which occurs during the course of the disease of knee is usually not firm and readily yields. The surgeon exhibited specimen of bone removed, which consisted of the lower end of femur and upper end of tibia, each about an inch in length, and the posterior part of the patella. When broken down, it fractured obliquely, exhibiting a carious cavity showing tuberculous material. The operation was commenced with a U-shaped incision, the large flap being turned up, the joint exposed and the mass of diseased bone removed. Excavations were scooped out in both tibia and femur until healthy bone was reached. Then the operation was concluded by dissecting away all the tuberculous tissue about the joint. There was considerable bleeding after the operation, and the general condition of the patient was anything but satisfactory. The anterior wound healed up well. In order to secure union and osseous ankylosis, wiring was performed on one side alone, because of the lowness of the patient under the anesthetic. There is just the amount of flexion one would wish to have in these cases. There is firm ankylosis, so that he can put the foot firmly upon the ground. In December last, he had a sinus in the popliteal space and the surgeon determined to enlarge it. A small cavity in the bone was found which was curetted. The anatomical relations were fairly confused, of course, the external popliteal nerve being somewhere near. The sinus was stretched forcibly and the nerve was implicated, and an extreme neuritis was set up, with great pain on touching the sinus, and complete paralysis of parts supplied by this nerve. Subsequently this returned. He had reaction for faradic electricity. Whilst at first it took 25 milliamperes to cause any contraction, the muscles now react to less than 12; and from Dr. Dickson's experience that gradually decreases in the strength of the stimulus. This necessarily gives an extremely favorable prognosis, and in all probability he will recover

in time most of the functions of the external popliteal nerve. When he stands up, you can see how firmly he can come down upon the foot; he has firm, bony ankylosis; and the case illustrates how much can be accomplished in tuberculous trouble in the knee joint; he will have a good, useful limb. Sensation has returned, but he cannot extend the toes.

The second case exhibited was that of a boy about eight years of age, and was one of those cases where there is tuberculosis of the synovial membrane, and apparently confined to the membrane; no disease in the joint itself. This had become progressively worse, and he had been under treatment for considerable time—rest, extension, etc., but did not improve. In May, 1898, the surgeon performed the operation of erasion, as described by Mr. Cheyne, viz.: An H-incision, two vertical, an outer and an inner incision and a cross incision. The patella was sawn across and two flaps turned up and down, thus exposing the whole of the joint without any difficulty. The synovial membrane was pulpy and very much thickened, to the extent that it was impossible to make a clean dissection of the anterior part of it. The specimen was shown to the Fellows. The lateral ligaments were examined and tuberculous disease found there and the greater part of the crucial ligaments were also destroyed. The joint was thoroughly cleaned out, as regards the tuberculous disease. Then the wound was stitched up and plaster-of-Paris splints put on. The first dressing was done six weeks after, the splints removed and the stitches taken out; the wound had healed by first intention. It was kept in plaster for considerable time, and now the boy is going about having a good use of the joint. Dr. Primrose had expected ankylosis, but the boy has a good degree of movement. He can walk wonderfully well, which is an interesting feature in the case. The limb on the affected side is half an inch longer than that on the sound side. This the surgeon thought to be due to irritation at the line of the epiphysis, causing increased growth not going on to disease or destruction. This is an extremely interesting point in this case. Speaking again on the first case, Dr. Primrose stated there never were any reactions to galvanic electricity. It reacted to faradic electricity readily.

DISCUSSION.

DR. BINGHAM thought that Dr. Primrose ought to be congratulated on both results. In the first case he would have been tempted to perform an amputation at once. The fact of having secured such an excellent result by incision should be encourage-

ment in these cases. He had come across, more than once, lengthening in these cases, and thought the version given by Dr. Primrose the correct one.

Dr. Clarence Starr stated he had followed the case from the beginning, speaking of the latter one, and his angle of extension is now 165 degrees. It is a question whether that is not increasing until it goes on and gets in the neighborhood of a right angle. He should be watched carefully to see if that occurs, and if so he should be put on an apparatus to get the angle extended again. Excision in a child of that age is not to be desired if it can be avoided. He has seen all the way to eleven inches of shortening in these cases, and in a case like that it would have been better to have performed an amputation. He thought the final result in this case excellent.

Dr. Fotheringham spoke regarding the lengthening of the leg in the second case, and said it could be proved from other cases that the lengthening occurred in those in which the disease occurs in the synovial membrane. If it occurred in the bone in the neighborhood of the epiphysial line, you would inevitably have shortening..

Dr. W. H. B. Aikins asked whether the patient in the first case would not have been better off with the leg off. Is it better to have a stiff leg than a good artificial one?

Dr. Rudolf asked in regard to the electrical reactions in the first case—did the galvanic current cause no contractions?

Dr. Primrose : It will react to galvanic, but did not cease to react to faradic electricity. If the nerves are paralyzed, it reacts to galvanic, whilst if the nerves are present, it will react both to faradic and galvanic.

Dr. Primrose, in reply: With regard to Dr. Aikins' question, he would prefer to have a limb which was attached permanently, than one which would be constantly wearing out and giving, through misfit and such like things. A firm, stiff, stable limb—firm ankylosis, he considered better than an artificial one.

SERIOUS WOUND OF SKULL AND ACROMION.

Dr. William Oldright presented a boy of twelve years, who had been attacked in September last with a knife, the blade of which was about thirteen inches in length, having a handle of five inches in length. He had a triangular piece of bone cut in the vertex about 1 1-2 x 1 3-4 x 1 3-4 inches and a number of other cuts, nine in all, mostly in the occipital region. There was also a large wound through the acromion process. The strength of the shoulder joint is not impaired in any way.

APPENDICEAL ABSCESS.

DR. OLDRIGHT also exhibited this specimen removed after eleven successive attacks of pain and colic.

SYMPOSIUM ON HYSTERIA.

DR. J. T. FOTHERINGHAM read notes of a case of hysteria occurring in a young woman of eighteen years. The family history is insignificant. The eldest child of the family is living —an imbecile—aged 23 or 24 years. Two others died young of tuberculous meningitis. Two months before the attack of hysteria, the patient had suffered from rheumatism with swelling in front of the ankle, then in the other ankle, and then in other parts of the body and also in the shoulder joints. Her present condition appears to have developed gradually. As regards the respiratory system, the breathing was occasionally stertorous on inspiration. Dr. Fotheringham asked the Fellows in regard to the type of respiration in these cases. Circulatory system, normal; as was also the genito-urinary system. As regards the nervous system, ankle clonus was especially marked in the right leg, an unusual symptom, because it is not usually seen in hysterical cases. Peculiar postures were adopted while in bed, and all speech was conducted in whispers, jerky in character, as if sometimes at a loss for a word. As regards the special senses, she apparently suffered from severe photophobia. When the windows were darkened, she would be noticed watching from under the bed-covering. Hearing was abnormally acute. The treatment consisted in removal from home to a private hospital. Hyoscine, and valerinates of iron, quinine and zinc. Plenty of good food. She has been well for some months, and now works in a shop. Points noticed in this case: The absence of the hysterical fit; no serious moral perversion; and, thirdly, no delusions.

DR. W. H. PEPLER read notes of a case of what he considered to be hystero-catalepsy in a child five years old. There was nothing especially interesting in the family history, except that the father appeared to be decidedly neurotic. The child was a full-term child; walked at ten months; talked at nine months. An attack of measles noticed at two years of age; no complications; no sequelæ. Never suffered from indigestion or constipation to any extent. About a year ago the child was taken suddenly with an attack of stiffening of the limbs, both arms and legs, and blueness of the face. She is far advanced for her age, intellectually; more like a child of fifteen years. Present attack came on about 6.30 p.m. one day immediately

after being refused some article at the tea-table. She fell forwards with her head on the table. On the doctor's arrival, she gave the appearance of a healthy child apparently asleep, eyes closed, muscles all relaxed, eye-balls turned up in the natural position of sleep; pupils slightly dilated, but equal, responding slightly to light. The pulse was regular at 80; respirations at 17. The mouth was opened quite easily; tongue clean. There was no urine passed during this condition. On raising the arm, it would be kept in that position for for 20 to 30 seconds. Then it gradually fell. An enema was given, and the child ordered to be kept quiet. Two hours afterward it awoke.

DR. W. B. THISTLE said he had been impressed with the presence of ankle clonus in the case of Dr. Fotheringham, as many authorities seem to think that that is not consistent with the diagnosis. He recited the history of several cases and dwelt on the difficulty of diagnosis in these cases.

DR. RUDOLF confined his remarks to prognosis, and stated it was necessary to be careful in diagnosis to eliminate the presence of organic disease. He cited several cases illustrating this, which also had a bearing on the prognosis. As regards death intervening, the prognosis was nearly always favorable. Recovery was not so good.

DR. DWYER emphasized the importance of eliminating organic disease being present, and gave several apt illustrations proving the necessity of employing great care in excluding the organic factor. He was inclined to think also that the reports of a rise of temperature were not substantiated with solid and accurate facts.

DRS. PRIMROSE and OLDRIGHT contributed to the discussion by referring to cases seen by them.

DR. FOTHERINGHAM referred to the question of age: hysteria coming on after puberty is not recovered from to the same extent as that occurring before that age. The medicinal treatment was not of much use: the suggestive treatment was the best. Hypnotism, especially in children, was of no service. He closed the discussion with an allusion to the diagnosis.

GEORGE ELLIOTT, *Recording Secretary.*

Special Selections.

ON THE TREATMENT OF THE SLIDING HERNIAS OF THE CÆCUM AND SIGMOID FLEXURE*

BY ROBERT F. WEIR, M.D., NEW YORK.
Professor of Surgery in the College of Physicians and Surgeons; President of the American Surgical Association, etc.

The natural looseness of the peritoneum in the iliac regions of the abdomen allows not very infrequently the slipping or sliding of portions of the large bowel into a hernia, and thus makes a decided variation in the ordinary contents of a hernial sac. For instead of this sac being formed by the pushed-out parietal layer of the peritoneum, in which rests, ordinarily, free or adherent omentum, small or large intestine, in these slipped hernias, the "*hernies par glissement*" of the French authors, there is found an important variation in these usual conditions. It is, that the proper peritoneal sac is imperfect, usually on its postero-lateral aspect, where, instead of passing around the included bowel, the loose peritoneum rises up and passes over the herniated bowel to its other side. In other words, the protruded bowel is still outside the peritoneum. Figs. 1 and 2 show this more clearly than words can do. In these it will be seen that the bowel has been forced down, carrying with it a fold of loosened peritoneum into the scrotum, just as is done in the descent of the testicle. And, indeed, the congenital form of cæcal hernia is produced by the same agent that helps the descent of the testis, for the gubernaculum testis is included in the duplication of the peritoneum that contains the cæcum, and hence the bowel, from its action, is occasionally drawn down in the wake of the testis. A similar occurrence, although more rarely than with the cæcum, may happen on the left side where the gubernaculum ends under the sigmoid flexure.

Not every case, however, of cæcal or sigmoid hernia is of this kind; on the contrary, most of the cæcal variety and many of the sigmoid ruptures are found to have complete sacs owing to the fact that they are generally covered all around by peritoneum in their normal condition. This is particularly true concerning the cæcum and appendix, and it is a point of supreme surgical interest

*Read at a meeting of the Practitioners' Society, held January 5, 1900.

in connection with the surgical lesions of the latter, for which we are largely indebted to Treves for having made it widely known to us, although Scarpa, as long ago as in 1812, and later Bardeleben, in 1849, and other German observers early proclaimed the fact and its value in connection with perityphlitis. This mobility of the cæcum with its perfect peritoneal covering, which is only wanting in about eighteen per cent. of the observed cases, and a nearly similar condition in the sigmoid, where it is limited only by a mesocolon, narrow and of varying length, will explain why so many cases of cæcal and sigmoid hernias have been treated radically without surgical difficulty and with success. Such conditions are not considered here. Moreover, when the colon retains its long mesentery, which is its original development, the cæcum can present itself in a left-sided hernia or, *vice versa*, the sigmoid can show itself in a rupture on the right side of the body. *En passant*, this arrest of development from a long to a short mesocolon additionally permits the understanding of the left-side appendical difficulties which are occasionally encountered, and does away with the need of calling in the transposition of the viscera to help us in such questions. Macready says, concerning the variations of hernias of the cæcum, that in fifty-seven instances, thirty-six were right inguinal, five were right femoral, nine were left inguinal, and one was left femoral.

Most of the cæcal and sigmoid hernias are reducible, which means that they generally have a complete sac and that the intestine rests free as it does in other hernias. Merigot de Treigney, collected an interesting number of cases of hernias of the large intestine, and presented them as follows:

	Inguinal.	Crural.	Total.
Cæcum and appendix	8	5	13
Cæcum and end of ileum	11	..	11
Appendix alone	17	5	22
Transverse colon	4	..	4
Totals	40	10	50

With such hernial contents this class of ruptures can, as a rule, be readily reduced.

A brief digression may be here made to express clearly the distinction which should be, but is not generally, made between a cæcal hernia and one of the ascending colon, and, on the left side, between a sigmoid hernia and hernia of the descending colon. In reality it is anatomically well known, and it has been already alluded to, that the cæcum should be considered with a few exceptions as entirely surrounded by peritoneum; it is, how-

ever, not so well known that the sigmoid flexure, with a long or short mesocolon, as it may be, is in its most mobile part below the edge of the pelvis, only mounting above this line when distended into the upper pelvis, and that the descending colon, 6 to 12 cm. long, terminates in the iliac fossa, and is adherent to the iliac wall by the absence of peritoneum over one-fourth to one-eighth of its circumference. The colon on each side, while usually attached as described, may be more movable by reason of a mesocolon of variable length. Hernias, therefore, such as are spoken of in the present article as those of the slipped cæcum and sigmoid, really are hernias involving the ascending or descending colon.

This latter class of hernias—the subperitoneal, the sliding or slipped hernias of the ascending or descending colon—present difficulties of operative reduction which are not yet satisfactorily overcome, and in which my own endeavors, to be soon narrated, are but tentative, and yet need the corroboration of a larger personal experience and, more important, the confirmation of other surgeons.

Treigney, whom I have just quoted, presents sundry other cases of herniated large intestine which bear more closely on the point now in question. They are as follows:

	Inguinal.	Crural.	Total.
Hernias containing cæcum end of ileum, and ascending colon	8	1	9
Hernias containing sigmoid flexure	14	1	15
Hernias containing sigmoid flexure with small intestine	7	..	7
Hernias containing ascending or descending colon	5	..	5
Totals	34	2	36

Of twenty cases in which the ascending or descending colon, alone or accompanied by the cæcum or sigmoid flexure, was involved, a whole sac was found only in seven cases; in five it could not be determined, and in eight the hernia was *par glissement*. This will give some idea of the frequency of this complication. When it is present we have conditions that are prone to bring about such an amount of irreducibility that it demands a special surgical interference, or, if strangulation exists, which is possible, although rare, necessitates the surgeon to relieve only the constriction present and often to forego the intended radical cure of the hernia. The bowels in these instances, in which they have slidden into the hernial sac, are well seen in the diagrams, and are held in position by the connective tissue, which is generally

situated on the posterior or postero-lateral aspect, and which from its long subjection to the abnormal conditions is often dense and thickened. Pressure under such circumstances accomplishes but little in replacing the protruded bowel in the abdominal cavity, and hence sundry expedients have been resorted to in order to bring about the proper replacement of the intestine.

Before, however, proceeding to the surgical treatment of such slipped or slidden hernias, a word or two concerning their recognition may not be out of order. They are more common on the left side and in males in middle or advanced life. It is difficult to determine their nature before the required surgical intervention. Usually they present themselves with the history, in its early period, of reducibility which is not always amenable to a truss or to taxis, and which soon passes into a permanent irre-

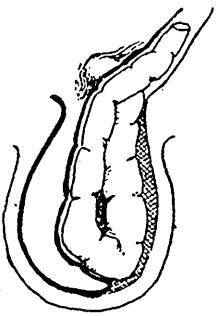

FIG. 1.—Showing the Large Intestine behind the Peritoneum.

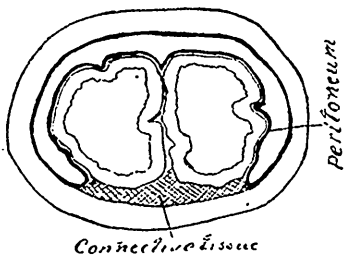

FIG 2.—Showing the Retroperitoneal Large Intestine in a cross section of the hernia with its incomplete sac.

ducible condition. They are usually scrotal when irreducible, and sometimes one can, in a left-sided hernia, suspect its being one of the sigmoid flexure or descending colon, from the inability to inject per rectum but a small quantity of fluid, or because by such an injection the bowel in the scrotum distends appreciably. So uncertain, however, is the diagnosis, and so often is the slipped large bowel associated with small intestine or omentum in the sac, that time is only misspent in endeavoring to solve the problem except with the scalpel. Only it is to be remembered that in a large irreducible hernia, whether on the left or right side, but particularly on the left side on account of its greater frequency, it is wiser to make the incision into the sac well to the inner side of the scrotal swelling, and not to carry it too low down, so as to avoid the accident of coming down to and incising an unrecognized bowel deprived of its tell-tale peritoneal protec-

tion. On opening the parietal portion of the sac wall, aside from the probably associated omentum and small intestine, which can be readily reduced and gotten out of the way if strangulation be not present, which is first to be relieved, there may be encountered as a hindrance to a possible reduction some enlarged epiploic even if reduction of these be impracticable or only temporary, as fringes. Their replacement can be attempted one by one, but they often reappear when the finger pressure is relieved, their displacement will frequently clear up the field of view so that the post-peritoneal condition of the bowel will be detected.

Now, as to the treatment. Very little information on this point is to be found either in text-books or special works on hernia. Ladroitte, in 1882, in a cadaver in which he found a slipped sigmoid hernia, stated that he could bring about its reduction only by completely separating the bowel along its cellular attachment up to the external ring. This published fact attracted but little attention, and but few attempts on this line have been resorted to by surgeons meeting such cases. The majority of these hernias have been unsatisfactorily treated either by being closed up after an exploratory incision, or after a vain attempt has been made to push up the attached bowel toward the external ring and to hold it there by sutures carried from below the intestine to the sides of the ring or through the abdominal wall. Such a plan I was compelled, like others, to use in my first cases, and, owing to my inexperience, the operation resulted in no benefit. Later I employed the separation of the bowel from its subperitoneal bed. This, while generally easy, has at times presented difficulties encountered by other surgeons from the denseness of the tissue, and sometimes, too, the nutrient vessels of the intestine may be so damaged as to bring about its gangrene.[3] Mayo[4] says it is not always wise to attempt this. In the two cases in which the method was resorted to by me, the fear remained that this raw surface of a possibly now greatly thinned and damaged bowel might materially enhance the risk of the operation, and therefore while the procedure permitted the proper suturing together of the internal ring as a part of the due performance of the well-known procedure of Bassini (which I prefer to any), yet I remained not satisfied with the technique of the procedure.

The difficulty of reducing these hernias and, in certain cases, the risk of separating them from their changed resting-place will be appreciated by referring to the collection of cases lately made by Froelich, of Nancy.[5] He has gathered some twenty-one instances, ten strangulated and eleven in which a radical cure was

attempted, "*a froid.*" There were six cæcal hernias, leaving four strangulated sigmoid hernias and nine non-strangulated. Of these Hydenreich had two cases, both followed by fecal fistula. Camplenon's case was followed by an artificial anus. Reverdin, Berger, Terrier, and Froelich all failed to cure their hernias. Terrier and Hartmann reduced the sac and the subperitoneal bowel and closed the ring in two instances. Finally, disturbed by the failure to secure a reduction in two cases, Juillard, of Geneva, boldly resorted to the severe measure of cutting away the protruding bowel and joined the divided intestinal rings by a Murphy button, and with success. He aided the closure of the internal ring and inguinal canal by the additional removal of the testis and spermatic cord. These names of celebrity in the surgical world exemplify the troubles that environ the satisfactory treatment of these hernias, and their results cannot be called brilliant. The successful outcome of Juillard's case will tempt only a rare repetition.

Anderson[7] gives three cases in which the bowel, although covered with peritoneum, could be pushed up sufficiently to allow of the suturing of the inguinal canal in two instances. In two of his cases the hernia promptly recurred. This looseness of the bowel I have likewise met with.

My records show that I have surgically treated six cases of sigmoid hernia and four cases of cæcal hernia, in one of which the cæcum was in a left-sided inguinal hernia, and in one instance it formed a part of a right-sided strangulated femoral hernia. In two of the sigmoid hernias I resorted to separation of the bowel by a dissection carried on mainly by the finger, and after liberating it and then pushing it up into the abdominal cavity I sewed up the ring and canal and thus completed the operation. I have not been able to trace many of these cases for any long period of time, but I am informed by Dr. Coley that in two or three patients on whom he operated similarly, and whom he had long under observation, they remained cured. In three others I succeeded in pushing back with some effort the herniated bowel and sutured the internal ring, but in a few months the hernia recurred.

In the four cæcal hernias two of them were of the cæcum proper and reducible, having a complete sac; one was found in a femoral hernia, another in a left inguinal rupture. The remaining cæcal and sigmoid hernias, one each, I ventured to attack in the following manner: Thinking that the reduction of the bowel after separation by dissection from the sac into the abdominal cavity was a surgically incorrect measure, as it left a raw

and perhaps thinned bowel in the peritoneal cavity, I made an essay, comparatively recently, in these two cases, after freeing the bowel from its bed, to cover the raw surface with peritoneum taken from the sac, as in the manner shown in Fig. 3. This was accomplished by dissecting it up on each side of the bowel, at the top, on a level with or a little above the internal ring, and at the bottom to a short distance below the bowel. The bowel is then loosened, by peeling off with the finger or, if tightly fastened, by cutting or snipping with scissors as widely as possible from it until it is released up to or above the internal ring, which is to be opened widely by retractors, or even enlarged by cutting if required to obtain a good view. Then the loosened peritoneum is turned backward and sutured behind the gut as far as practicable. The peritoneal flap should be an ample one, so as to permit to a satisfactory degree the unfolding of the bowel loop and thus avoid kinking, which, however, is rarely of importance in the large intestine. The ring is afterwards carefully sewed together after the newly covered bowel is reduced, and if the patient has consented to the justifiable proposition to sacrifice the testis on this side, a radical cure may be reasonably looked for. I cannot but hope that the peritoneal covering that is given by this procedure will, moreover, aid in preventing recurrence, as the direction of any further slipping or sliding is (if the upper incisions have been carried high enough) turned more away thereby from the hernial outlet. In a rebellious case a better exposure could be had by a hernio-laparotomy, as was practised by Terrier and Hartmann in three cases with success. This would allow of a more complete bowel separation and serous investment, and would permit a resort to an intestinal fixation of the intestine above if this extra means of cure was required to prevent any further descent of the bowel. Of the two cases in which the procedure just described was applied, one was of the sigmoid variety (descending colon) and the other of the cæcum (ascending colon), associated in the latter with the small intestine and the appendix in an incomplete sac. There was in neither case any material difficulty in carrying out the idea. In both more than eight months have elapsed since the operation was performed without any recurrence of the hernia, although in the cæcal case this good result was hardly hoped for, as the scrotal swelling was of huge size, and debarred the man from his vocation as a waiter. He was informed that the best that could be done for him was to render it possible for him to wear a truss. I may add in conclusion that Froelich advises, in cases in which strangulation exists with a slidden bowel, simply to relieve the constriction, to

return the caught small intestine and omentum, and to leave the large bowel alone. This should be borne in mind as safe and judicious.

The cases in detail are as follows:

CASE I.—Left inguinal hernia; slipped large intestine; operation; reduction; suture of internal ring; cure. W. S.——, male, aged sixty years, peddler; left inguinal scrotal hernia of twenty-five years' duration; reducible at first and controlled by a truss; later a hernia appeared in the right scrotum. Entered the New York Hospital January 30, 1885. The hernias were treated by Heaton's injections of tincture of oak bark, which served to keep them up for two months, when they recurred after a severe fall. A second injection was made at his request, but one month later

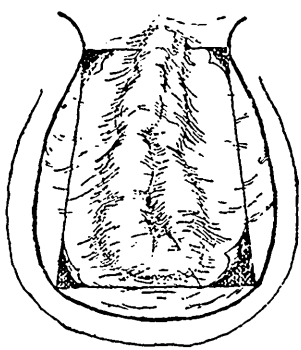

FIG. 3.—Outline of Peritoneal Lining of Sac utilized as a flap to cover posterior surface after it has been freed by dissection.

the left hernia recurred. It was then the size of a goose's egg, resonant at its top and partly reducible. On May 22nd the sac was opened up to the external ring; the sac was incomplete; its contents were the large intestine, the posterior layer of the sac passing over the intestine. The attachments of the bowel to the scrotal tissue were so lax as to permit the bowel with some force to be pushed back into the abdominal cavity. The sack was cut off as high up as possible towards the internal ring, which admitted the conjoined tips of three fingers. The edges of the ring were sewed together by three silver sutures and the outer wounds closed. He was discharged cured on June 9th. He was seen ten months later, and his rupture had not recurred.

CASE II.—Incarcerated sigmoid hernia; operation; incomplete sac; reduction; suture of internal ring. F. B.——, male, aged fifty-eight years, priest; left inguinal hernia for twenty-

eight years, reducible and controlled by truss until within the last four months. Since this time it has become more difficult to reduce, and he has had more pain and distress in this region. He has lost flesh from the discomfort. The hernia is the size of a cocoanut, and on entrance to the New York Hospital on February 12, 1889, it was in an irreducible condition and the size of a cocoanut and very tender. The incarceration was overcome mainly by gentle taxis after a morphine injection. The internal ring was large, admitting two or three finger tips. Under ether the next day an incision was made from the external ring to the bottom of the sac, exposing the hernia. There was an incomplete sac, the peritoneum passing over and being adherent to a knuckle of the sigmoid flexure, which was at the posterolateral part of the mass. Six or seven ounces of fluid was found in the sac. With much difficulty the herniated bowel was pushed up into the abdominal cavity, and with a Macewen needle a strong silk ligature was passed through the conjoined tendon and the outer edge of the internal ring and Poupart's ligament, and duly secured. Other sutures were similarly applied to the large ring. The canal was closed by two other stitches, a drain introduced, and the wound closed. Healing was much interfered with by a sharp bronchitis, and the major part of the wound healed by granulation. The patient was lost sight of after leaving the hospital.

CASE III.—Strangulated right femoral hernia, containing cæcum and appendix; sac complete; reduction; Bassini's operation. E. H.——, aged fifty-five years, seamstress, has had a small irreducible femoral hernia for ten years. After a fit of coughing, it became larger and developed the usual signs of strangulation. A long tumor about six inches long and three inches wide was seen in the right groin. Under ether, Dec. 18, 1894, an incision was made parallel to Poupart's ligament, opening a sac containing a little adherent omentum, two loops of the small intestine, the cæcum, and the appendix, which were free, and which, after nicking the roof of Gimbernat's ligament, were easily reduced into the abdominal cavity. The omentum was tied off, the sac ligatured at its neck, and the canal and opening were closed with chromicized catgut after Bassini's method. On January 19, 1895, she was discharged cured. She was seen a year later, and the hernia had not recurred.

CASE IV.—Hernia of sigmoid flexure; complete sac; Bassini's operation; gangrene of testis; sepsis; death. F. I.——, male, aged forty-seven years, engineer; admitted to the New York Hospital on December 24, 1894. He had a left inguinal

hernia for ten years and had worn a truss for about a year. The hernia was reducible but frequently painful. Bassini's method was used, and on opening the sac, omentum and a loop of the sigmoid flexure were seen free in a complete hernial sac. The internal ring was dilated to the size of three finger tips. The omentum was tied off with catgut, and the ring and canal were closed with kangaroo tendon. The patient did badly, with scrotal swelling, which was opened, revealing a gangrenous testis due either to a possible twist, for the epididymis was forward; or, more probably, to a too tight closure of internal ring. This was among my earliest Bassini operations, when acknowledged inexperience might have led to such a mishap. The testis and cord were removed and the wound was left open and dressed with iodoform. Sepsis prevailed, and the patient succumbed on January 6, 1895.

CASE V.—Sigmoid hernia; incomplete sac; reduced by freeing bowel and completing rest of sac by peritoneal flaps; cure. C. W.——, male, aged forty-four years, baker; admitted to the New York Hospital on January 23, 1895. He had noticed hernia of the left side for about eighteen months. Lately it has become irreducible and painful, and he could not return the hernia even when it was reducible. Operation was done on January 26th, by the Bassini method; the sac was incomplete; and the large intestine (descending colon) was present behind the peritoneum on the posterior aspect of the sac. The internal ring was enlarged upward for better inspection and manipulation. The herniated bowel was then dissected up from its bed of connective tissue and pushed into the abdominal cavity. The incomplete sac was cut off, and then the reflection of the peritoneum at the internal ring was incised laterally outward and inward so as to obtain a closure of the peritoneal ring behind the intestine pushed into the abdominal cavity. The ring itself and canal were closed *seriatim*. The result was a good one. When last seen, three months afterward, no recurrence was present.

CASE VI.—Right inguinal interstitial hernia containing cæcum and appendix; complete sac; Bassini's operation. R. W.——, male, aged fifteen years; ruptured himself on the right side while running two years ago. The hernia was irreducible and did not descend into the scrotum. He wore a truss, but had a good deal of pain. On January 14, 1895, operation revealed an interstitial congenital inguinal hernia, containing the cæcum and appendix free in the main one of two sacs present. Ligature of the sac at its neck and closure of the ring and canal after Bassini's method were resorted to. He was discharged cured. He was seen one year later; no recurrence.

CASE VII.—Congenital left inguinal hernia containing cæcum; sac complete; Bassini's operation; cure. G. H ——, aged twenty-seven years, engineer, had a hernia of thirteen years' duration, from heavy lifting. Left inguinal hernia was irreducible up to four years ago, the size of two fists. Operation was performed on October 12, 1895, by Bassini's method. The hernia was found to be congenital and to have as its contents the omentum and the cæcum free from adhesions. The omentum was tied off and the cæcum returned. Primary union occurred. He was discharged from the hospital on November 4, 1895; he has not since been traced.

CASE VIII.—Left inguinal hernia containing small and large intestines; sac incomplete; reduced by pressure; Bassini's operation; cured. W. I. N ——, male, aged sixty-four years; rupture in left groin from a fall received eighteen years ago. Six months later a hernia also appeared on the right side. He was able to wear a truss on the left side for eight years. Since then, now ten years, he could not retain the hernia by any appliance, though both ruptures could always be readily reduced. Both scrotal rings were much enlarged. Under ether both hernias were operated on January 14, 1895, at the same sitting. On the right side the small intestine and omentum were found; four inches of the latter were tied off in sections and removed. Bassini's operation was completed. On the left side a portion of the large intestine was found on the posterior part of the sac, covered loosely by peritoneum. As a consequence an incomplete sac was formed. Some small intestine was also present. The sigmoid flexure could with some effort be pushed up into the abdominal cavity so that the sac could be tied off at the internal ring, which was thereupon narrowed by sutures, and the other steps of Bassini's operation were carried into effect. There was no recurrence up to four months later, when the patient was last observed.

CASE IX.—Large right inguinal irreducible hernia containing cæcum, appendix, ascending colon, small intestine, and omentum; sac incomplete; plastic covering of separated colon by peritoneal flap; reduction; Bassini's operation. C. H. D——, aged forty-one years, waiter, has had rupture in right groin about eight years without knowing origin. At first it was reducible, and for its retention he used a truss up to three years ago, when the hernia could not be retained by such means, and he was forced to employ a bandage for support. On entrance into the New York Hospital a hernia as large as a child's head was seen in the right inguinal region, irreducible and largely containing intestine. He was urgent for operative help, as the deformity was apparent

through his clothing and deprived him of work. It was candidly told him that such large hernias had greater risk to life, and that only a partial cure could at best be promised. With this understanding, under ether, and using rubber gloves, which is yet the latest fad, and not altogether a satisfactory one, the sac was opened March 8, 1899, revealing as its contents small intestine and omentum, with the cæcum and appendix and part of the ascending colon. The small intestine was reducible. The omentum was adherent in many places. These were tied off, and when duly freed, a large portion was tied off and its stump reduced. This showed very clearly that the sac was an incomplete one, and that while the cæcum and appendix were free and reducible, still the reduction of the ascending colon, which rested at the back and outer part of the protrusion, was impossible by reason of its immobility, it being firmly fixed behind the peritoneum by dense connective tissue. This was carefully divided with scissor snips or else separated by the fingers until the bowel could be easily replaced in the abdominal cavity. Before it was left there, however, the peritoneum from the sac was loosened up and turned backward so as to cover over the raised surface of the bowel, and there held by interrupted fine silk sutures. Then the sac just completed was sutured at its neck, and the other steps of a Bassini operation were proceeded with. The patient made a prompt recovery, and when seen eleven months afterward, no tendency to recurrence was found. He is presented this evening to you for inspection.

CASE X.—Sigmoid irreducible hernia; sac incomplete; release of intestine with plastic covering from sac and its reduction; completion of rest of sac; Bassini's operation. M. C——, aged forty-seven years, merchant, referred to me by Dr. De Plasse, January 24, 1899. By lifting a heavy pail of water, thirteen years ago, the patient brought on a left inguinal hernia. This was kept under control by a truss for six years, but since then this has proved comparatively useless. The hernia was partly reducible, found to be scrotal, and in size about three by five inches. Operation was done January 26, 1899. On opening the sac it was seen to be incomplete, and the subperitoneal intestine, which was the lower end of the descending colon, was held *in situ* by somewhat loose connective tissue. The serous coat of the sac was cut on each side a moderate distance from the bowel, which was lifted out with the peritoneal flaps easily from its bed up to the internal ring. These flaps were then passed behind the bowel and sutured together, and the covered intestine was reduced into the general abdominal cavity. It was then seen that

the just-covered loop of bowel fell within the abdomen below or beyond the region of the internal ring. The ring then completed by this little plastic effort was duly closed by sutures, and the remaining steps of the ordinary Bassini operation completed the case. It progressed uneventfully. He was lately seen, and has had no recurrence now nearly a year after the operation.

Of these ten cases, six were sigmoid hernias of which there was a complete sac containing an ordinary loop of the sigmoid with a long mesentery which allowed of its ready reduction. Five, however, had slidden out behind the peritoneum and required in three cases only firm pressure to force the bowel back into its place in the abdomen. In the two remaining cases the bowel was freed from its bed, then covered with the peritoneum of its incomplete sac, and finally reduced. Four other cases were of the cæcal variety. Three of these had a complete sac, and the hernial mass was readily reduced. In the remaining case the intestine (ascending colon) was freed by dissection and covered by peritoneum from the incomplete sac and successfully reduced. —*Medical Record.*

1. *Thèse de Paris*, 1887.
2. *Bulletin Soc. Anatom.*, 1882, p. 169.
3. Desbordes: "Des Hernies Adhérentes de S Iliaque," p. 37, *Thèse de Paris*, 1896.
4. Mayo: "Des Hernies par Glissement du Gros Intestin." *Thèse de Paris*, 1897.
5. De la Cure Radical des Hernies par Glissement du Gros Intestin." *Gaz. Heb. de Méd. et Chir.*, No. 43, 1899.
6. Congrès de Chirurgie, 1895, p. 433
7. *Brit. Med. Jour.*, October 29, 1895.

THE DIAGNOSIS OF APHASIA.

J. A. Caldwell, Jr., writing in the *Cincinnati Lancet-Clinic* of October 28, 1899, on speech and its disorders, gives the following classification of aphasia:

Sensory Aphasias—Word-blindness, non-recognition of word meanings. Word deafness, non-recognition of word sounds. Visual apraxia, non-recognition of object meanings. Auditory apraxia, non-recognition of object sounds. Amusia, non-recognition of musical sounds.

Conduction Aphasias—Paraphrasia verbalis, non-recollection of word sounds. Paragraphia, non-recollection of word meanings. Paranoia, non-recollection of names of objects.

Motor Aphasias—Psychic motor aphasia, spoken word-construction loss. Executive motor aphasia, spoken word-utterance loss.

It will be seen that in the above classification of the two expressions, non-recognition and non-recollection, are extensively used.

Ordinarily, by non-recollection we mean loss of memory, but when used in this sense the word is undoubtedly etymologically distorted. When we are unable to recollect a word it is gone from us only temporarily; and sense perception of the word will immediately recall it to our mind. By non-recognition is meant loss of memory; when we no longer remember a word it cannot be recalled, nor will we recognize it as correct when we hear it spoken or see it written. Many other classifications of aphasia have been proposed, but the one given seems to cover practically all our knowledge of the subject. An anatomico-pathological classification of cortical, transcortical, and subcortical is also used. Wyllie and Elder use, instead of these expressions, pictorial, suprapictorial, and infrapictorial.

For the differential diagnosis of aphasia, Elder proposes the following list of questions:

1. Can the patient hear sounds of any kind?
2. Can the patient hear words spoken?
3. Can the patient understand words spoken?
4. Can the patient see objects of any kind?
5. Can the patient see words written or printed?
6. Can the patient understand words written or printed?
7. Can the patient speak voluntarily?
8. Can the patient repeat words?
9. Can the patient speak words? (Can he read aloud?)
10. Can the patient write voluntarily?
11. Can the patient write to dictation?
12. Can the patient copy?

—*Medicine.*

ANTIVIVISECTION ONCE MORE.

Prominent antivivisectionists gave due warning years ago that they hoped to succeed by keeping unremittingly at it in securing the utter abolition of animal experimentation. True to their promise, the bill for the regulation of experiments upon animals in the District of Columbia comes up at every session of Congress. This law, it is confessed by the antivivisectionists themselves, is meant to be only the entering wedge for legislation along similar lines throughout the country. The prestige of a legislative victory at the national capitol would carry great moral weight with the State legislatures. Moreover, the Government laboratories, most of them, are situated in the District of Columbia, and the blow is specially aimed at them, since, so long as animal experimentation is carried on directly under authority

from the Government, the opponents of experiments upon animals cannot hope to prevent this method of investigation at other places.

The gauntlet has been definitely thrown down. The battle for the right of experimentation on animals is on. Each succeeding session of Congress sees the struggle renewed. If the medical profession of the country would not see invaluable opportunities for the investigation of disease in this country ruthlessly snatched away because of irrational fanaticism, it must not tire of this ever-recurring contest.

We venture to say that in recent years the cause of antivivisection has gained more adherents than has the principle of animal experimentation. This is mainly due to the fact that a most persistent and untiring propaganda of the doctrines of the antivivisectionists has been made. Fanaticism has a special attraction for our generation. It is only necessary to recall in this connection how many supposedly intelligent persons are carried away by the shallow absurdities of Christian Science. There are any number of people constantly on the lookout for some new fad. When their latest hobby happens to be antivivisection, they become most earnest advocates and zealous propagandists. As an offset to all this, every doctor should make it his business to spread the light of a right understanding of the position of the profession in this matter. Only in this way can we be assured that offensive legislation will not eventually be enacted. Apathy because of confidence in past defeats of the bill may at any time lead to enactments that would not only seriously cripple the great work of the Government laboratories, but start a wave of legislative enactments that would be felt disastrously in every experimental laboratory of the country.—*Medical News.*

Iodide of Potassium in Hemorrhagic Endometritis.—Silvestri (*Gaz. degli. Osped. e delle Clin.*) draws attention to the value of iodide of potassium in the treatment of fungous endometritis and the metrorrhagia of uterine fibroids. He records five cases, in each of which, with one doubtful exception, syphilis could be excluded, where the administration of moderate doses of KI brought about a cure. The author further recommends the use of this drug in habitual abortion when threatening, or as prophylactic agent. The mode of action is somewhat uncertain; it may be in virtue of its absorbing powers, or through improving the state of the blood, depressing the heart, and as an aphrodisiac moderating the function of the genital organs, and thence the reflex congestion.—*Brit. Med. Jour.*

Progress of Medical Science.

Medical News, February 17th, 1900.

BACTERIOLOGICAL INVESTIGATIONS UPON YELLOW FEVER.—Aristides Agramonte gives the results of experiments in which he injected serum taken from convalescents from uncomplicated yellow fever. The serum is perfectly innocuous; it is more readily absorbed than the equine serum. It has never produced any cutaneous manifestation, and within twenty-four hours every sign of the injection has disappeared except at the point of puncture, where a minute red spot may be visible. No case is injected which is seen after the fourth day of the invasion. The disease has been distinctly modified in every instance. In these experimental injections two facts have been emphasized: (1) the absence of hemorrhagic tendency; (2) the rapidity with which patients who received the serum went through the period of convalescence; the fever having once left them, their reparative functions were quickly started, and they were ready to return to business in an unusually short period of time.

IMPROVED OPERATION FOR ACUTE APPENDICITIS, OR FOR QUIESCENT CASES WITH COMPLICATIONS.—Robert F. Weir in this method increases the intermuscular space of McBurney. He tears off with the finger-tips, or with the end of blunt scissors, the already denuded fascia of the external oblique muscle from the sheath of the rectus quite up to the median line, where it is held retracted by an assistant. The anterior sheath of the rectus is now divided transversely in a line continuous with the opening made in the peritoneum by the original muscle-separation operation. The outer edge of the external rectus is then lifted up and carried by a retractor to the median line. The epigastric vessels should be divided and ligatured. The posterior sheath of the rectus and the peritoneum should be cut in a manner similar to the outer sheath. When blunt retractors are now passed into the peritoneal cavity and the abdominal wall is put on the stretch, there is a very superior exposure of the whole pelvis and of the right iliac fossa.

CONSIDERATION OF ACUTE INFLAMMATORY RHEUMATISM.—W. H. Neilson believes that inflammatory rheumatism is an infectious disease; that its natural history points to this, its complications point to it, and the treatment found so effective proclaims it. He approves of the use of salicylic acid and its compounds.

RUPTURE OF THE RIGHT LOBE OF THE LIVER: LAPAROTOMY, RECOVERY.—H. Beekman Delatour says that the question of when to operate in these cases is the all-important one, and must be decided for each case individually. In the first of these two cases, had operation been at once resorted to, probably a fatal issue would have resulted, while in the second case unavoidable delay nearly cost the patient's life.

BUBONIC PLAGUE.—Edwin Klebbs declares that the bacillus pestis bubonicæ is undoubtedly the cause of bubonic plague. The first step in combating the spread of the plague must be by general hygienic measures. The demonstrated cases should be at once isolated in a plague hospital.

POST-EPILEPTIC AMNESIA.—David Trumbull Marshall reports this case, in which the amnesic period was ten days. There was great difficulty in obtaining a history of epilepsy, since the family did not wish the matrimonial prospects of the patient blighted.

Journal of the American Medical Association, February 17th, 1900.

HOCKEY-STICK INCISION.—Willy Meyer describes this incision, useful in certain complicated cases of appendicitis. He says that its chief advantage is that it enables the operator to respect the fibres of the external oblique muscle, and that, if properly lengthened at its lower angle, it gives sufficient access to the small pelvis and its contents for whatever work may be necessary, at least as far as the adnexa of the right side are concerned. The author calls it the "hockey-stick" incision on account of its shape. In most cases the incision commences at a spot about one-half inch above and midway between McBurney's point and the anterior superior spine, and ends about one-half to three-quarters of an inch from Poupart's ligament. Meyer has used this incision in ten cases of appendicitis, gangrenous, perforative, or complicated with tubal or ovarian affections, and recommends it as a typical mode of entering the abdominal cavity in such cases, as by it extensive work can be done within the small pelvis without necessitating an additional median incision.

CORNEAL CORPUSCULAR ACTIVITY.—In his discussion of this subject Joseph E. Willetts says that the phenomenon consists of bright moving bodies filling the field of vision. He adds that all the evidence is in favor of these bright bodies being the ameboid leucocytes circulating through the lymph canals of the cornea.

HAVE WE IN NATURE A BASIS FOR A SCIENCE AND ART IN MEDICINE?—H. J. Herrick says it is the purpose of this paper to show that the conditions with which the physician deals have such uniformity of phenomena and facts that the subject may be properly termed a science, and that such conclusions may be reached and practical results attained, as to be unquestioned by any intelligent inquirer, and that when those principles are applied to practical use for the curing of disease, it may appropriately be styled an art.

WHY THE NEGRO DOES NOT SUFFER FROM TRACHOMA.—Warwick W. Cowgill says that this disease is common only among the poorer classes of whites in the country districts. Between this class and the negro there is a wide gulf fixed. Assuming, therefore, as the author does, that the disease is contagious, the conclusion is reached that the negro owes his immunity to his lack of contact with the source of contagion.

BILHARZIA HEMATOBIA.—Edwin Walker says that the authors who have described this parasite all supposed that Africa was it only habitat. But one other case has been reported in this country, the patient being a resident of Sparta, Ill. In the case reported by Walker great care was taken to avoid error; the parasite was found in the specimen of urine passed in sterile vessels, as well as that drawn by catheter.

MADDOX ROD OR PHOROMETER.—Alvin A. Hubbell gives results of his own experience with these two forms of test, and says that in view of the fact that by the rod test there is introduced no extraneous impulse to muscular contraction, and as its findings are in the great majority of cases equal to or in excess of the phorometer, he believes the rod to be the more precise and trustworthy guide in daily practice.

MUCOCELE IN THE NEW-BORN.—Clark W. Hawley reports six cases of this disease in his practice, from observation of which he has reached the following conclusions: 1. The disease is a rare one. 2. The indications are to establish drainage into the eye if it is not possible to cause flow into the nose. 3. The tumor should be opened by a very small incision. 4. An anesthetic should be given and probing done.

RAILWAY HYGIENE AND EMERGENCY EQUIPMENT.—W. W. Grant says that the present methods of ventilating cars and of cleaning their furniture are entirely inadequate. He suggests many radical improvements, including the equipment of every train with a hand litter for the removal of the sick.

THE OPERATIVE TREATMENT OF CHRONIC GLAUCOMA.—Alexander W. Stirling discusses the usual operations for this disease, viz.: iridectomy, sclerotomy, and sclero-iritomy. As to the relative advantages of myotics or operation he thinks it impossible to speak dogmatically.

EVISCERO-NEUROTOMY.—J. G. Huizing describes a new method for evisceration of the eyeball, and claims for it all the advantages of the Mules operation, as well as those of enucleation, without their disadvantages.

CONVERGENT STRABISMUS.—William B. Meany reports this case of total apparent strabismus—convergent—of 62 degrees, in order to demonstrate the method used for this individual case by Professor Landolt in his clinic.

EOSINOPHILIA IN DERMATITIS HERPETIFORMIS—Duhring.—Mark A. Brown and George P. Dale report a case of this disease in which a clinical examination of the blood changes showed a large percentage of eosinophilia (at one time 43.3 per cent.).

BUBONIC PLAGUE.—Edmund Souchon gives some points of special interest to sanitarians regarding this disease, which he has gathered from the writings of Kitasato, Nakagawa, Yersin, Wyman, and Manson.

New York Medical Journal, February 17th, 1900.

FOUR CASES OF DIABETES MELLITUS OF APPARENT BACTERIAL ORIGIN, AND THEIR SUCCESSFUL TREATMENT.—J. P. Sheridan states his belief in the bacterial origin of this disease, though he gives no proofs to sustain his position. He finds the ideal remedy for the malady in a combination of bromides of gold and arsenic.

OVERSTUDY.—L. M. Yale is sceptical as to the fact of overstudy being the cause of physical ailments, but believes that physical ailments underlie difficulty in school work. The physician should never accept "overstudy" as a cause for deranged health until he has carefully sought for and failed to find a physical reason.

DIGITALIS AND ACONITE; THEIR PHYSIOLOGICAL AND THERAPEUTIC VALUE.—F. O. Hawley makes a study of the peculiarities of these drugs, and condemns the loose methods of assay so frequently practised. To the resulting unreliable preparations we owe much of the uncertain effects so often seen in administration.

IMPORTANCE, BOTH MEDICO-LEGAL AND CLINICAL, OF THE EARLY RECOGNITION OF CERTAIN ORGANIC AFFECTIONS OF THE NERVOUS SYSTEM, INCLUDING PARESIS.—J. Leonard Corning discusses the early symptoms of locomotor ataxia, multiple sclerosis, paralysis agitans, and general paresis. All these maladies play a considerable part in the litigation of to-day to determine the presence or absence of insanity. He calls attention to the care necessary in studying the symptoms of prisoners in order to arrive at a proper diagnosis, and shows how juries are often influenced by the lay idea that organic disease of the nervous system necessarily entails insanity.

PLEA FOR THE MORE EXTENDED USE OF ANTITOXIN.—From statistical tables compiled from New York City Health Reports, J. S. Billings claims that the increased number of cases of diphtheria in the city for 1899 was due in part (in the author's view) to a neglect of immunization by antitoxin. He believes that 300 units should be used in children and 500 units in adults.

THERAPEUTIC VALUE OF ALCOHOLIC STIMULANTS.—F. A. Castle maintains that it is the volatile ethers which give to wines and spirits their chief therapeutic value.

THE GENERAL TREATMENT OF PHTHISIS PULMONALIS.—G. A. Evans discusses the general therapeutics of the disease, and gives tables referring to diet and mode of living.

SKIN MANIFESTATIONS OF INFLUENZA OBSERVED IN THE PRESENT EPIDEMIC.—J. E. Herman has seen eruptions resembling, respectively, measles, scarlatina, and herpes.

Philadelphia Medical Journal, February 17th, 1900.

PLEURAL FRICTION SOUND.—Albert Abrams describes several manœuvres of value in eliciting this sound. (1) Respiration is suspended, and then the arm on the affected side is raised while in extension, the suspected area being auscultated in the meanwhile. (2) The patient lies on the affected side for a minute or two and then rises suddenly, suspending respiration. The affected area is now auscultated while the patient takes a deep breath. (3) Pressure in an intercostal space with the buttoned rod of the phoneidoscope screwed to a piece of tin, which is fitted over the hard-rubber bell of the stethoscope. The phoneidoscope itself cannot well be used, for when pressure is exerted with the buttoned rod in the intercostal space the patient's breathing gives rise to adventitious sounds which are confusing.

GANGRENOUS STOMATITIS TREATED WITH ANTISTREPTOCOCCUS SERUM.—W. C. Cahall reports a case of noma in a child seven years old suffering from typhoid fever. The disease was treated first by cauterization, then by the curette, and finally by an extensive cutting operation, but each time the gangrene reappeared. Then an injection of 10 c.c. of antistreptococcic serum was made, and within twelve hours a line of demarcation formed, and within twenty-four hours the gangrenous part had disappeared, leaving a healthy-looking wound.

EARLIEST RECORDED AUTOPSIES IN AMERICA.—Francis R. Packard says the earliest mention of an autopsy in America is to be found in "An Account of Two Voyages to New England," published in London by John Josselyn in 1674. Four other post-mortem examinations were made in New England during the remainder of the seventeenth century.

UNUSUAL CASE OF MOLLUSCUM FIBROSUM.—Daniel H. Williams reports the removal of a tumor of this character weighing twelve and one-half pounds and measuring fifteen by eighteen and one-half inches.

STATE CARE OF CONSUMPTIVES.—Charles E. Nammack enters a plea for the fresh-air treatment of tuberculosis and for the establishment of State sanatoria for the poor.

Medical Press and Circular, January 31st and February 7th, 1900.

CORRELATION OF SEXUAL FUNCTION WITH INSANITY AND CRIME.—H. Macnaughton-Jones concludes his paper, taking up climacteric insanity, which occurs chiefly in women but also in men. The correlation of insanity and disordered sexual functions arising out of affections of the generative organs is a factor to be taken seriously into consideration. A careful examination should be made when there is suspected a condition of the generative organs which might produce or aggravate the mental affection. Due weight should be given irregularities in investigating criminal acts in women, especially during the menopause, etc. The special dangers of the climacteric period (climacteric mania) must be remembered. Pelvic examination should be made when moroseness, depression, hysteria, hallucinations, unfounded suspicions, and apprehension are leading symptoms. There is greater predisposition to mental disturbances after operations on the generative than other organs. Those previously insane are predisposed to relapse under such operations. Suicidal impulse and crime at the climacteric should be anticipated by operation if gross lesions are detected.

RARE FORM OF ULCERATION OF THE FEMALE URETHRA.—Richard Dancer Purefoy says the external female genitals furnish some of the best illustrations of chronic syphilitic disease being confounded with malignancy. In a case observed there was upon the inner surface of the left nympha a circular excavation with sharp cut overhanging edges, the base being white cicatricial tissue. The entrance to the vagina was closed by a morbid growth with red nodular surface hanging from an enormously dilated urethra. Dr. West had seen six similar instances —mostly in women giving a history of syphilis or venereal disease. The writer has seen it as an independent affection and also associated with condylomata. The lower wall of the urethra is often like cartilage and the aperture is permanently patulous. Sometimes the urethra will admit one or two fingers through its whole extent. Strong nitric acid may produce enough contraction to control the urine. This rare affection is similar to, if not identical with, Huguier's lupus hypertrophicus.

POSTERIOR (CONGENITAL) LUXATION OF SHOULDER JOINT.—G. Burbridge White says posterior luxation is the most unusual form which congenital dislocation of the shoulder assumes. He relates an instance in which, when examined, there was total inability to move the arm or forearm, to pronate or supinate or to flex or extend the hand. The forearm was turned in so that the dorsum of the hand rested on the loin. Treatment consisted in careful massage until motion in the arm independent of that of the scapula took place. When slight active motion was possible, dumb-bells and an American elastic exerciser rendered improvement more rapid. After twelve months there was considerable use of the arm possible. The *x*-ray confirmed the diagnosis of luxation of the acromial end of the clavicle and atrophy of the head of the humerus.

ACUTE CHOREA TREATED WITH LARGE DOSES OF ARSENIC.—Murrell carried out the treatment recommended by William Murray, but somewhat modified. Instead of giving fifteen drops of liquor arsenicalis three times a day for a week, he gave smaller doses over a longer period, but vomiting was a distressing symptom, and the drug was discontinued. He finds that the duration of the attack is immensely shortened by giving arsenic.

REMARKS ON THE OILS OF CAJEPUT AND CUBEBS AND THEIR USE IN INHALATION.—Robert J. Lee finds that these oils may be vaporized without difficulty, and as their properties are well understood, it is unnecessary to point out the class of cases in which they may be inhaled with benefit.

FIVE CASES OF ANGINA PECTORIS.—Dr. Salomon reports five similar cases. There were no asthmatical symptoms. In a few weeks the pain began to radiate to the left arm. The pain was often started by slight movements, as in undressing. The duration of the attack was from ten minutes to several hours. Three patients died, and two recovered. Two had had syphilis, one influenza. The writer does not believe that iodides are of benefit in genuine ordinary angina. Patients with coronary angina die; those with neurasthenic angina get better. Iodides along with hygieno-dietetic treatment must always occupy the first place.

DILATATIONS AND DIVERTICULA OF THE ESOPHAGUS.—John Knott divides these rare abnormalities into congenital and acquired, each being arranged, according to Rokitansky, under three heads: (1) The cylindrical or fusiform, in which a great part of the length of the tube is enlarged; (2) the sacciform, in which one or more pouches are found, which involve all the coats of the esophagus; (3) the hernial, in which the mucous membrane alone expands, and this coat, protruding through the muscular layers, forms diverticula or hernia. Illustrations are given, and the subject is to be continued.

REMARKS ON OPERATIVE TREATMENT OF UTERINE FIBROIDS.—W. Gow supports the view that, of all radical operations for fibroids, abdominal hysterectomy with subperitoneal treatment of the stump is the best and safest procedure, and that this operation may confidently in the future be looked upon as giving a mortality of not more than one or two per cent. He relates four cases in which single or double pyosalpinx existed, and gives a table of forty-seven patients treated in this way with a mortality of just over two per cent. There were thirty-nine consecutive cases of recovery.

British Medical Journal, February 10th, 1900.

AN UNDESCRIBED FORM OF PLAGUE PNEUMONIA.—W. C. Hossack reports five cases of an indefinite and obscure form of plague, differing in character and general symptoms from the classical form of plague pneumonia in that its onset is not fulminant but insidious, and the symptoms are slight. The most striking characteristic of the disease is the pulse, which presents grave characters quite out of harmony with the brief duration of the illness and the limited amount of lung mischief. Every case the writer has heard of, including the five coming under his immediate notice, has ended quite unexpectedly in death on the

fifth to the tenth day. In answer to the probable objection that these cases were not plague at all, but simple broncho-pneumonia, the writer evidences their clear connection with the plague, their occurrence in series with indisputable plague cases, and their apparently inexplicable fatality.

PREVENTIVE INOCULATION AGAINST BUBONIC PLAGUE.—A. Lustig and G. Galeotti assert that preventive inoculation is the only means by which this disease may be rationally combated when it has manifested itself in epidemic form. They give the results of experiments on animals by means of a nucleo-proteid which they have succeeded in extracting from the plague bacilli. The authors claim that this product is free from the drawbacks of Haffkine's vaccine, and that its advantages may be summed up as follows: (1) Its efficacy has been proved from the experiments made on various animals; (2) the substance is innocuous in the case of man; (3) if the cultural liquids possess an immunizing power they owe it to the nucleo-proteid which the writers have isolated; (4) the advantages of using an active substance isolated and pure instead of cultures which contain it mixed with heterogeneous elements are evident.

MALIGNANT MALARIAL FEVER WITH CEREBRAL SYMPTOMS TERMINATING FATALLY, IN ENGLAND.—D. C. Rees reports this case, and says that he has never seen such an enormous number of parasites in peripheral circulation in any other case of malignant malaria. It is noteworthy that the patient was only five days in a malarial country. The writer points out the importance of blood examinations in such a case as this. The patient was unconscious; no reliable history could be obtained; he had practically no pyrexia, no rigors, no sweating; without the blood examination the diagnosis of malaria would hardly have been justifiable.

NOTE ON SPECIES OF ANOPHELES FOUND AMONG MOSQUITOS SENT FROM SHANGHAI AND JAVA.—George Thin pictures two specimens of mosquitos sent to him for examination from Batavia and Shanghai. They were both probably A. pictus, as appeared from a comparison with specimens of A. pictus and A. claviger caught in Spain.

EPIDEMIOLOGY AND PROPHYLAXIS OF MALARIA IN THE LIGHT OF RECENT RESEARCHES.—In this article, A. Celli traces the life cycle of the malarial organism in man and the mosquito, discusses the habits of Anopheles, and deduces therefrom certain prophylactic measures which experience has also shown to be of service.

SERUM DIAGNOSIS OF MEDITERRANEAN FEVER.—T. Zammit says in every case of fever the method of serum reaction should be used in diagnosis. He submits the following facts gathered during the past year: (1) The micrococcus of Bruce can be grown successfully from a culture seven months old; (2) cultures of the micrococcus two years old give a clear serum reaction; (3) the micrococcus does not grow on sea water solidified with agar, not even when the water was taken from a sewage outfall; (4) the micrococcus grows on an agared solution of normal human feces.

"BEEF WORM" (DERMATOBIA NOXIALIS) IN THE ORBIT.—This case is reported by Frederick T. Keyt. He says the "beef worm" is commonly found in British Honduras and Central America in dogs and cattle, and often in human beings. The natives treat it by applying tobacco leaf over the swelling and occluding the orifice; the worm is narcotized or killed, and its expulsion is easily effected by squeezing. Occasionally it gives rise to serious inflammation of the subcutaneous tissues, demanding liberal incision and free drainage.

CINNAMON IN TREATMENT OF TROPICAL DIARRHEA.—A. Norris Wilkinson reports good results from the use of cinnamon in teaspoonful doses, mixed with milk to mould it into the shape of a bolus, and chewed night and morning. In all cases ranging from ordinary diarrhea to severe cases of dysentery the author relies upon this mixture given in conjunction with a mixture of quinine sulphate, potassium bromide, and antifebrin.

POISONING BY CASTOR-OIL SEEDS.—In this case, reported by W. P. Meldrum, the patient, a dock-laborer in good health, ate a couple of castor-oil seeds. No medical aid was sought for three days. There were then incessant purging and vomiting with cold extremities and weak pulse. Under treatment the purging stopped, but the vomiting persisted, and the patient died from exhaustion.

VESICAL CALCULUS IN SIERRA LEONE.—In this case, reported by W. Renner, recovery followed lithotomy. The author says the case is of interest from the fact of the rare occurrence in this colony of a case of stone in the bladder, so rare in fact that there was not in the colony a single instrument for the operation of lithotomy, and one had to be sent from London.

SALINE TREATMENT OF DYSENTERY.—W. J. Buchanan gives notes of five hundred and fifty-five consecutive cases of dysentery treated by a saturated solution of sulphate of magnesium, with only six deaths.

RESEARCHES INTO THE NATURE AND ACTION OF SNAKE VENOM.—In his account of these researches, Robert Henry Elliot describes his method of collecting and storing venom, bile, etc.; he gives the standardization of solution and mode of administration, describes the preparation of the animal, with the calculation of dose based on idiosyncrasy, and notes the variations in lethal dose for different animals

Boston Medical and Surgical Journal, February 15th, 1900.

CLINICAL VALUE OF OLIVER'S HEMOCYTOMETER.—David D. Scannell describes this instrument in detail, and extols it as being time-saving and accurate as compared with the Thoma-Zeiss procedure.

A MAN WHO SWALLOWED HIS SUSPENDERS.—Maurice H. Richardson, by external esophagotomy, extracted the ingested wearing apparel, and the patient, a previous inmate of an insane asylum, made a good recovery.

SYSTEM OF CLINICAL INSTRUCTION.—A. H. Wentworth describes the method which he employs for the simultaneous instruction in small sections of a large number of students.

DIFFUSE PERITONITIS FROM ACUTE APPENDICITIS.—J. Coplin Stinson reports a case in a young girl in which operation was followed by recovery.

The Lancet, February 10th, 1900.

FURTHER OBSERVATIONS ON PERNICIOUS ANEMIA; A CHRONIC INFECTIVE DISEASE.—In this final article of the series, W. Hunter calls attention to the relation between this infection and infection from the mouth and stomach. The nature of the infection is a mixed one, as it occurs in all classes irrespective of surroundings, and as there is an abundant presence of organisms of coccal and short streptococcal nature forming zoogloea-like masses amid the catarrhal and inflammatory exudation contained in the vomit. Treatment must include hygiene of the mouth and teeth, local treatment of the stomach and intestine, arsenic, and serum injections. The nature of the serum to be used is still to be determined.

FETICHISM IN SURGERY.—E. Stanmore Bishop thinks that the modern surgeon is especially liable to fetichism in two directions: undue importance attached to certain details in technique, and a desire to operate with a rapidity which is injurious to the patient.

PROGNOSIS IN APPENDICITIS.—From a series of two hundred cases H. A. Caley discusses prognosis as to recovery and as to recurrence. Under the former, he studies the pathological basis of prognosis from the nature and extent of peritoneal infection and the nature and course of the appendix lesion; the clinical basis requires the consideration of local symptoms, general symptoms, local signs and progress of the case.

CONSANGUINEOUS MARRIAGE AND DEAF-MUTISM.—A. H. Huth gives elaborate statistical tables, from which he concludes that when there is a family taint of deaf-mutism, more deaf mutes are liable to be born in families in which there is a double inheritance through the relationship of the parents than when this is not the case.

NEW AND MORE PERMANENT METHOD OF MOUNTING AMYLOID SECTIONS STAINED WITH IODINE.—A. B. Green recommends the employment of Weigert's iodine, liquid paraffin, and xylol, with iodine crystals. Each is to be used on the section in the order named. A cover-slip smeared with vaseline is then placed over the section.

PRESENT POSITION OF AURAL SURGERY.—W. B. Dalby thinks that the advance in aural surgery has greatly dispelled quackery and calls attention to the vast amount of study which is now being given to the subject of chronic suppurative discharge.

EIGHTY SUCCESSIVE CASES OF STACKE'S OPERATION.—Full tables are given with an analysis of symptoms. Only three deaths resulted, and all these cases did not come under observation until a very advanced stage of pyemic poisoning had been established.

COMPLETE INVERSIO AND PROLAPSUS UTERI.—F. L. Pochin records this case occurring in a primipara aged twenty years. Reposition was successful, and the puerperium was without special incident.

SUCCESSFUL CASE OF ENTERECTOMY FOR GANGRENOUS HERNIA.—A. H. Burgess removed four inches of gut from a boy aged fifteen years. Healing occurred without suppuration, and the patient was up in three weeks.

MENTAL DISSOLUTION.—A clinical lecture by G. H. Savage, in which he calls attention to the physical and mental peculiarities seen in persons passing into a condition of mental weakness.

Deutsche med. Wochenschrift, January 25th and February 1st, 1900.

SALIVA AND ITS INFLUENCE ON GASTRIC DIGESTION.—Martin Cohn says the alkalinity of the saliva varies in different individuals and in the same individuals at different periods of the day. The average corresponds to a 0.0154 per cent. solution of caustic soda. He never found an acid reaction, such as was noted by Sticker in the interval between breakfast and dinner. It has been suggested that retained products of metabolism may be got rid of by increasing the salivary secretion, but the author was unable to discover any evidences of such vicarious elimination in cases of renal disease. The digestive activity of the saliva does not cease with deglutition, but is continued for a time in the stomach. As has been shown by Van der Velden, there are two stages of stomach digestion. In the first the acidity is not sufficient to inhibit the saccharifacient action of the saliva (amylolytic stage), but in the second this action is arrested by the increased secretion of hydrochloric acid (proteolytic stage). It has been asserted by Sticker that the saliva has an influence also in the digestion of albumen, but Conn does not think the experiments offered in proof of this assertion are conclusive. His investigations led him to the conclusion that the presence of saliva in the stomach is beneficial, but he was unable to determine that its presence was of extreme importance in digestion, or that its absence impaired the process very materially.

EMPLOYMENT OF A HEART-SUPPORTING APPARATUS IN CARDIAC AFFECTIONS, ESPECIALLY IN CARDIAC DYSPNEA.—Abee, observing that patients with heart disease often instinctively make pressure with the hand over the cardiac region, was led to devise a mechanical support in which a pad should take the place of the patient's hand. He reports two cases of various cardiac affections in which the subjective symptoms, especially pain and dyspnea, were markedly relieved, and the patients were able to take moderate exercise when previously they had been unable to walk without the greatest distress. The writer has studied the physical effects of the pad and finds that it elevates the heart as much at times as 2 to 3 cm. and causes an axial turning of the organ, as shown by the altered apex beat; the pulse is slowed by as much as ten beats in the minute; and finally the limits of lung expansion anteriorly on the right side are increased 1.5 to 2 cm. All these changes are constant, and occur within two or three minutes after the adjustment of the pad.

CASE OF PNEUMATHEMIA.—Paul Bernhardt reports the case of an idiot, fifty-four years of age, who died after a brief illness

marked chiefly by diarrhea, anuria, and extreme restlessness. At autopsy the blood was found to be fluid and of a peculiar crimson tint. The heart, especially the left auricle and coronary veins, was swollen, and when opened under water its contained blood was found to be mixed with air. Incision of the inferior vena cava gave exit to a bloody foam. The liver was enlarged, its surface was covered with little vesicles, and on section a thin, bright-red foam exuded; the hepatic veins, when cut, gave exit to more air than blood. Examination of cover-glass preparations of the liver fluid showed the presence, in almost pure culture, of thick rods with rounded extremities 1 μ thick and from 3 to 5 μ in length; there seemed to be an indistinct capsule; they did not form chains; they were stained by gentian violet, carbol fuchsin, and after Gram's method. The writer thinks it was probably the bacillus aerogenes capsulatus, which has been so carefully studied and described at the Johns Hopkins laboratory.

CLINICAL AND EXPERIMENTAL STUDIES OF DURAL INFUSION.—Paul Jacob gives an account of his experience with the injection of various fluids into the subarachnoid space after the removal of an equal quantity of cerebrospinal fluid through a lumbar puncture. The fluid must be injected very slowly (fifteen to twenty minutes being required for the passage of 25 c.c.); otherwise the most alarming pressure symptoms might be produced. Animal experiments with methylene-blue solutions showed that the fluid injected into the lower part of the subarachnoid space very quickly reached the brain, that it was eliminated very slowly, and that within a very short time it permeated the cerebrospinal substance. The writer reports a case of tetanus cured after dural infusions of antitoxin, and three cases of cerebrospinal syphilis treated most successfully by dural infusions of sodium-iodide solution. He believes there are great therapeutic possibilities in the treatment of many diseases of the central nervous system by this method of bringing the curative agent into direct contact with the diseased foci.

CIRCUMSCRIBED ABSCESS OF THE ABDOMINAL CAVITY.—Sonnenburg cautions against rashly opening into the peritoneal cavity in suppurative appendicitis. A free and rapid opening of the abscess cavity is permissible only when the general symptoms are threatening and septic symptoms are present. In all other cases when it is a question of operating upon a circumscribed purulent collection, one should not immediately open the peritoneum, but should first seek for the abscess and evacuate it, and often the appendix will be found in the cavity. Great care should be taken not to break up the protecting adhesions.

SPECIFIC IMMUNIZING SERUM AGAINST SPERMATOZA.—Moxter injected guinea-pigs with the spermatoza of rams, and found that the injected organisms gradually acquired a more potent spermatozoicide property. This power resided in the body of the guinea-pig, for the blood serum removed from the vessels did not possess it. The anti-body resulting from these spermatoza injections is also hematolytic in relation to the red corpuscles of sheep.

ILEOCOLIC INVAGINATION.—Lewerenz reports a case of intussusception of the ileum into the colon through the ileocecal valve occurring in a boy twelve years of age. The abdomen was opened, and the invagination was reduced with some difficulty. The patient made a good recovery.

Wiener klinische Rundschau, January 28th, 1900.

TUBERCULOSIS OF THE SEROUS MEMBRANES IN MAN, WITH THE MACROSCOPICAL AS WELL AS THE MICROSCOPICAL APPEARANCE OF BOVINE TUBERCULOSIS.—Josef Pelnar draws these conclusions from his observations on this subject. There exists in man a tuberculous affection of the pericardeum and peritoneum which is characterized by small connective-tissue tumors with pedicles. Sometimes these are the only signs, then again there are besides these tumors other small tuberculous growths. These little swellings are both macroscopically and microscopically like the nodules in bovine tuberculosis. In these nodules tubercle bacilli are sparingly found, and show the morphological peculiarity that they almost always appear in little masses which are like those seen in actinomycosis. Cholangitis and pericholangitis tuberculosa hepatis can be seen as solitary thick-walled cysts of the size of a walnut, without other demonstrable tuberculous changes in the liver.

SIMPLE METHOD FOR APPLICATION OF CARBON DIOXIDE.—Rudolf Hatschek states that a good method of applying carbon dioxide is to take gr. lx. of sodium bicarbonate mixed with a little warm water, and with this mixture rub the patient. Carbon dioxide is evolved.

Berliner klinische Wochenschrift, January 29th, 1900.

THERAPEUTIC EMPLOYMENT OF MOIST HEAT.—H. Davidson describes and figures an apparatus devised by him for this purpose. It consists essentially of a coil arrangement shaped to human frame and supplied with a cover-lid. The coil is supplied with hot water from a reservoir to which is applied a spirit lamp.

SIMULTANEOUS GUNSHOT WOUNDS OF THE THORACIC AND ABDOMINAL CAVITIES.—F. Koenig concludes a lengthy article by a brief summary of the various pathological processes which follow injuries of this nature in the regions indicated. He calls attention to the fact that in addition to the injuries sustained along the course of the wound there may be severe lesions at a distance caused by the explosive force of the missile. Bacterial infection may arise not alone from the outside, but from the migration of germs from their natural habitat in the intestinal and biliary tracts. Products of inflammation may be removed by puncture. This failing, opening of the cavities is indicated.

SURGERY OF CANCER OF THE STOMACH.—H. Lindner discusses the question of possibly more radical intervention in the future. The removal of infected glands suggests itself and is to be attempted. On the other hand, recurrence in the glands is comparatively rare. In cases in which a radical operation is impossible, gastro-enterostomy is to be commended. In the latter class of cases it has been suggested that jejunostomy is the preferable procedure, but the author is not disposed to grant this point.

Wiener klinische Wochenschrift, February 1st, 1900.

AIR EMBOLI IN PLACENTA PREVIA.—Hugo Hubl says that diagnosis of this affection should be made: (1) By the exclusion of other possible diagnoses such as ruptures of the cervix and uterus, death from anemia or from chloroform, and thrombus emboli. (2) If there is present over the heart a clucking murmur, and if in that region there is a tympanitic or dulled tympanitic percussion sound, then the clinical diagnosis of air emboli is certain. Hubl gives two conditions which make possible the entrance of air into the veins: (*a*) Pressure in the abdominal-uterine vessels is suddenly diminished, and so air is sucked into the open vessels. (*b*) Pressure in the interior of the uterus is increased, and in this way air within the uterus is pressed into the gaping vessels.

LIMITATION OF LAPAROTOMY IN FAVOR OF VAGINAL CELIOTOMY.—F. Schauta believes that the improved technique of vaginal celiotomy is one of the most valuable advances in modern operative gynecology. Its mortality is about half that of the abdominal method. The course of healing is painless and uncomplicated, while there is an absence of suppuration and hernia, resulting from the operation, so common in the other method. As to the objections raised about "operating in the dark," he

lays special stress on the fact that the technique should be so skilfully managed that the operation is under careful observation from beginning to end.

OVARIOTOMY PER ANUM.—Hubert Peters cites the history of a Russian woman, thirty-seven years old, who had from early youth suffered from constipation. For years she had noticed a rectal prolapse on defecation. On examination, a cystic tumor was also discovered, corresponding in position to the left ovary. In order to shorten the operation as much as possible on account of the precarious condition of the patient, ovariotomy was performed at the same time with the rectal operation by means of the anal method, instead of the usual abdominal or vaginal celiotomy or the perineal or sacral method. The ovarian tumor proved to be a serous cystadenoma.

BACILLI OF THE STOOLS OF NURSLINGS COLORED BY GRAM.—Ernst Moro has isolated a bacillus from the stools of infants which he calls bacillus acidophilus because it flourishes in acid media. Tissier has also isolated a bacillus from the same source by means of anaerobic culture methods. Both are stained by Gram's method.

Münchener medicinische Wochenschrift, January 30th, 1900.

CONTRIBUTION TO THE QUESTION OF THE CAUSES OF DEATH IN BURNS BY FIRE AND BY SCALDING.—E. Scholz gives the results of two series of experiments made for the purpose of ascertaining the influence of the skin in the formation of toxins in the living body. First, he compares equally extensive burns, by fire, of the skin and peritoneum. Next, he compares burns of the skin—in the first place, skin with the circulating blood, then in a bloodless condition. He concludes that in scalding the skin changes do not play a chemical role, but that the chemical changes result from the influence of heat on the blood. In peritoneal burns a great number of blood corpuscles are changed. The burn of the skin, because of the protecting covering it affords, is not so destructive as the same injury of the peritoneum. Scalding of the bloodless skin, which would, if the blood were present, cause death, is followed by no such effect in the anemic part. This shows that the formation of toxic substances is not concerned with the skin. Neither do the blood changes occur through the absorption of toxic materials, but death by fire or scalding is due to the combined influence of the physical and chemical waste products of the blood resulting from the effect of heat.

PSYCHIATRY IN RELATION TO THE QUESTION OF SCHOOL PHYSICIANS.—W. Weygandt declares that the use of the school physician for the psychical observation of the students is still in the experimental stage. Psychology and pyschiatry are chiefly useful in the building up of this theory. The physician, with psychological and psychiatrical education, has the best foundation for the position of school physician in the higher schools of learning. In the public schools the students should be sifted and the weak-minded separated from the others and put in classes by themselves.

ACUTE PERICHONDRITIS AND PERIOSTITIS OF THE NASAL SEPTUM OF DENTAL ORIGIN.—Gustav Killian reports the case of a man thirty years old. Pain was severe, and foul-smelling pus escaped from the left nostril. The left second incisor ached. The mucous membrane of the nasal septum was opened and dressed. Six months later the patient again appeared, the tooth was extracted and a cyst was disclosed. This was excised, and recovery followed.

PERITYPHLITIS IN A HERNIAL SAC: RESECTION OF THE CECUM AND VERMIFORM APPENDIX.—C. Goschel, after giving a history of this case, speaks of the literature on this subject. Diagnosis between incarceration and perityphlitis in a hernial sac cannot be made before operation. Happily this has little influence on the treatment of the affection. Operation is always indicated.

SEVERE OPIUM POISONING OF AN ATROPHIC CHILD OF TEN WEEKS; TEN HOURS' FARADIZATION OF THE PHRENIC; RECOVERY.—August Model reports the case of a young child to whom its nurse gave an overdose of the tincture of opium. He applied faradization to both phrenic nerves with the happiest results. After this treatment the infant, who had been very feeble, improved greatly in general health.

EXPERIMENTS CONCERNING THE INFLUENCE OF NEW ANTISEPTICS ON INFECTED CORNEAL WOUNDS.—Wilhelm Hauenschild has experimented with protargol, silver nitrate, and oxycyanide of mercury of different strengths on infected corneal wounds, and finds the vitality of the micro-organisms in no way affected by the antiseptics. So far, mercury oxycyanide applied under high pressure has had the best results.

[The extracts for the Progress of Medicine for this month are from the *Medical Record*.—ED.]

MONTHLY REPORT.

Issued Feb. 20, 1900,
P. H. BRYCE, M.A., M.D., Secretary.

Issued by the Provincial Board of Health of Ontario for January, 1900. Showing the deaths from all causes and from Contagious Diseases in the Province, as reported to the Registrar-General by the Division Registrars throughout the Province.

YEAR.	MONTH.	Total population of province 2,283,182	Total municipalities of province, 777.	Total deaths reported from all causes.	Rate per 1,000 per annum from all causes.	Scarlatina.	Rate per 1,000 per annum.	Diphtheria.	Rate per 1,000 per annum.	Measles.	Rate per 1,000 per annum.	Whooping cough.	Rate per 1,000 per annum.	Typhoid.	Rate per 1,000 per annum.	Tuberculosis (Consumption).	Rate per 1,000 per annum.
1900....	January	Total population reporting 2,057,465 90%	Total municipalities reporting 638 82%	1,771	10.0	13	0.07	51	0.3	2	0.01	4	0.02	16	0.9	183	1.6
1899....	December	2,276,532 99 7%	756 97%	1,843	10.0	20	0.09	42	0.2	3	0.01	6	0.02	38	0.1	157	0.8
1899....	November	2,125,864 93%	640 82%	1,501	9.0	12	0.07	40	0.2	6	0.02	8	0.04	40	0.2	146	0.8

YEAR.	MONTH.	Total population reporting.	Total municipalities reporting.	Total deaths reported.	Rate per 1,000 per annum from all causes.	Scarlatina.	Rate per 1,000 per annum.	Diphtheria.	Rate per 1,000 per annum.	Measles.	Rate per 1,000 per annum.	Whooping cough.	Rate per 1,000 per annum.	Typhoid.	Rate per 1,000 per annum.	Tuberculosis.	Rate per 1,000 per annum.
1899 ...	January	2,232,053 98%	717 92%	2,154	11.2	23	0.1	48	0.3	5	0.03	9	0.05	21	0.1	184	1.0
1898....	December	2,173,906 96%	687 92%	*237	....	10	0.06	51	0.3	2	0.01	12	0.07	21	0.1	141	0.8
1898....	November	2 253,416 95%	677 91%	*284	....	17	0.09	59	0.4	6	0.03	6	0.03	50	0.3	140	0.8

* November and December, 1898, include deaths from contagious diseases only.

DOMINION MEDICAL MONTHLY

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COLLECTIONS.

This is a burning question, a live issue, one which demands speedy adjustment. Proverbially, the doctor is a bad business man; that is the cause of it all. Ancient, trite, and pregnant with wisdom as this may be, covering perhaps a multitude of sins, it is neither all nor everything that can be said in the matter of collections. The rapid multiplication of hospitals, dispensaries and fraternal organizations, with the brilliant spectacle constantly before the public of members of our profession chasing after these appointments at break-neck speed, insanely anxious to proffer their services for no tangible financial return, all tend to create in the mind of the general public the idea that the doctor has no conception of business. Pointedly speaking, the doctor is afraid to admit or assert that he is in the profession for the business, *i.e.*, the money that there is in it. In this respect he rivals the clergyman, whom no one would be mean enough to charge with being in the ministry for a living and a competency. Just why doctors should give of their talents and their time so much to medical charity in the way of visiting, consulting and attending physicians on the institutions cited, is a difficult matter to answer, though the general public will answer it with a rush: "Because of the practice there is in it." There are many callings in life which do no "charge" or credit business whatsoever. Take for instance the laundrymen. Their system of cash on delivery of parcels is one that works well to

their advantage, a system which has been brought about and rendered possible by mutual co-operation. But the unwritten laws of professional etiquette are not strong enough to bind the members of the profession into a close corporation. If you do not attend a poor or charity patient, when he is sick, for nothing at all in the way of financial return, you will be held up to public scorn by the lay press as a man devoid of pity and compassion, inhuman, brutal; but you will wait a very long time indeed before you see the lay press delivering their goods to the poor, gratis. Why not have law hospitals, dispensaries, and fraternals for the poor? Would not the poor man be immensely benefited in his litigation by a law hospital, with its leading legal luminaries as consultants, and its mediocres as visiting staff? Religion is free and all charity, if you care to overlook the fact of the mortgages. On a physician's prescription, the druggist will trust any one for the first time; after that, if you don't pay you have got to go somewhere else. Then there are the scamps and the scalawags who can pay for their treatment, but who won't pay for a year or two years, or probably—and just as likely—never. The necessaries of life, such as beer, the theatre, good clothes, cigars, summer resorts, all they must have first: the doctor is a luxury in the time of sickness. It would be an interesting fact to know who and what people, and how many, who walk the streets of any of our cities, have been born into the world attended by a physician, both the birth and the attendance still remaining unpaid. Yet men and women bring, and still continue to bring, children into the world without money and without price so far as the accoucheur is concerned. But it would be unjust to teach these very people a lesson. Fraternal societies may have done a great deal of good in the world, but it is a true assertion that they have debauched the doctors' electorate. Cession of lodge practice, visiting physicians and operating surgeons to all hospitals and dispensaries, except for proper financial recompense; then the formation of a close corporation, a physicians' fraternal organization pure and simple for mutual protection and defence, thus doing away with the profession of medicine, and making it the business of medicine, will make towards the desired end. If a man drops out of a fraternal society—*i.e.*, in some societies—owing something in the way of dues and assessments, he will not be permitted to enrol himself on the books of another branch of that organization until he settles his liabilities with his former associates. The adoption of some such principle in the practice of the "business" of medicine—not to prescribe for or treat "suspicious" characters, until assurance is had that the

former sickness has been settled for, would be treating many to a dose of their own medicine. Any of our younger men who have just passed the confines of the "starvation" period, or who are still within the clutches of the octopus, can attest with keen-edged sarcasm to the philanthropy of the medical profession. They desire a tumor in their hip pocket, but not of sarcomatous growth. The *Medical Council* for February devoted several pages to a consideration of the "Business Side," one article of which, "The Payment of the Doctor's Bill," from an editorial in the *Cleveland Medical Gazette,* contributes a ray of hope. In this we are told, "better times are in store for the doctors," and that this abuse has reached its worst, and that even now we are on the up grade. Probably a unanimity of effort in the monthly attempt to collect by a properly systematized execution of accounts would reap rewards, but so long as older practitioners continue the slip-slop, hap-hazard method of making collections, those imbued with business principles will accomplish very little. Judging from our own personal opinions in the matter, combined with a little experience, we do dislike receiving accounts dunning us every month for coal, meat and groceries, to say nothing of the instrument dealer, who ought to know better than to harrass us in this way, and we finally get mad and pay the bill, vowing we shall never go into debt again. One month of poor collections, and our good intentions vanish as the wind. Let us, however, make an honest effort all round to do better.

PLACENTAL INSPECTION.

From a perusal of the report of the proceedings of the Toronto Clinical Society in our February issue, we gather that Dr. J. W. F. Ross of this city was the advocate of a departure in obstetrical practice which at first blush will scarcely, we think, commend itself to the obstetrician—viz., the adoption of digital examination of the interior of the uterine body immediately subsequent to the delivery of the placenta. The object of this practice, of course, is to satisfy oneself that there have been left in the cavity of the uterus no portions of the after-birth; then, when septicemia intervenes, and a rise of temperature calls for a thorough digital examination of the interior of the uterus, no blush of shame will arise on the cheek of the accoucheur at an apparently faulty technique in the practice of the art of obstetrics. It is not so very long ago—many practitioners now living who practised thuswise—that visual inspection of the perineum even had no

place in the practice of obstetrics, the lacerations being left unsutured, and the patient allowed to get along as best she could under the circumstances. Probably the vast majority of obstetricians at the present time satisfy themselves with an inspection of the perineum, and give no thought, or very little, to the condition of the walls of the vagina and the cervix of the uterus. In nearly all cases, after spending mayhap several hours at the bedside of these patients, the physician is in a hurry to take his departure, and this same desire to get away often conduces to a hurried and perfunctory toilet of the lying-in woman. There is no doubt that many women have lost their lives from retained portions of placenta either acting primarily or secondarily as the cause. In these days of modern methods and new departures, we scarcely think, with all that, that the practitioner of obstetrics is prepared to go to the extent indicated by Dr. Ross, having in mind also the fact that abdominal palpation alone is considered by many writers to be sufficient to arrive at a diagnosis of the presenting part, and that the obstetrician should keep his index finger out of the vagina as much as possible, to say nothing of the cavity of the uterus. Whilst the infection in these cases may arise through the introduction of micro-organisms from the external parts through the medium of the examining finger, absolutely aseptic as that finger may have been, the question constantly keeps cropping up: Have we ultimately and finally got down to hard pan, in demonstrating the absolutely exact cause of puerperal fever in all cases? We think not. There is more in the incidence of this unfortunate malady than that so far elucidated. If portions of placenta retained in the cavity of the uterus subsequently prove themselves to be exceptionally good breeding-grounds for the infective germs of the disease which attacks the puerperal woman, they should certainly be removed at once, and not when a rise of temperature advises us to do it. The question seems natural, then: Can we always be perfectly satisfied from an inspection of the placenta and membranes that all parts have come away and that there is nothing whatever left in the uterine body? Certainly the practical training that students of midwifery obtain at our hospitals is not of the best possible character; and for a good many years after active practice, physicians are constantly and continually picking up some points of practical value. If, however, there should be any doubt in the mind of the accoucheur that everything has not been extruded from the uterus, manifestly he should go after it; there should be no negligence in the matter. The analogous reasoning of Dr. Ross in regard to routine treatment of miscarriages appears

good and substantial; and whilst all from the report apparently condemned the innovation flat-footed, without any thought or consideration, but on the spur of the moment, we would consider the procedure important enough for ample and, if need be, extended consideration, especially so when it is universally admitted that in ordinary obstetric technique that now and again there is some hurry to get through with our labors in these cases.

TRINITY MEDICAL ALUMNI ASSOCIATION.

The eighth annual re-union of the members of the Trinity Medical Alumni Association will be held in this city on the evening of May 18th. The Executive Committee having decided that the gathering shall partake of a social function alone, there will in consequence be no reading of scientific papers and discussions thereon this year. The attention of all interested herein is directed to the following excerpts from the Constitution of the Association:

The Alumni Association includes Active, Associate and Honorary Members.

Graduates in medicine of Trinity University, Fellows by Examination of Trinity Medical College, Teachers past or present of Trinity Medical College and the Undergraduates' representative on the Executive Committee are eligible for Active membership. Undergraduates of Trinity Medical College are eligible to become Associate members. Honorary members are those elected as such at any general meeting.

The objects of the Association are: The furtherance of Medical science, and to foster an *esprit de corps* and fraternal feeling among the Graduates and Undergraduates.

The General Meetings are held annually in Toronto on the day appointed for the conferring of Medical Degrees. Yearly dues, fifty cents.

REGULATIONS, ETC.

All Alumni are requested to send their present address, or other items of interest, to the General Secretary.

ALUMNI GOLD MEDAL.

The Association offers annually a gold medal, under the following conditions: Only Graduates and members of the Graduating Class in Medicine of Trinity University or of Trinity Medical College, or Fellows of Trinity Medical College who are Members of the Association in good standing, can compete for this

medal. The medal may be awarded annually for the best thesis on any subject pertaining to modern medical science. All these must be sent to the General Secretary of the Association on or before May 1st, 1900, signed only by pseudonym, name of writer to accompany his thesis in separate cover. The awarding of the medal shall be determined by a committee of three, to be appointed annually by the Executive Committee of the Association. The thesis standing first and second, respectively, in merit shall be read by the writers, and the medal presented at the annual re-union. If in the opinion of the judges no thesis of distinguished merit has been submitted, the medal shall not be awarded.

It is certainly interesting and gratifying to know that the competition for the Trinity Medical Alumni Gold Medal is each year becoming more keen, the participants last year doubling those of the previous year. It is also worthy of note that the competition is not confined to the younger men and the more recent graduates. Amongst others who sent in theses last year were men who had been in practice all the way from ten to thirty-five years, evidencing the fact that the efforts of the Association in this respect are thoroughly appreciated. It is to be hoped this year that more of the men who have recently been doing post-graduate work will enter the competition. Announcements in regard to the Annual Banquet will be mailed to the members at an early date.

J. ALGERNON TEMPLE, M.D., *President.*

GEORGE ELLIOTT, M.D., *General Secretary,* 129 John St., Toronto.

ONTARIO MEDICAL ASSOCIATION.

The annual meeting of the Ontario Medical Association will be held in the Normal School Building, Toronto, on the 6th and 7th of June, 1900, under the acting-presidency of the First Vice-President, Dr. Adam H. Wright, Toronto.

The annual dinner will take place on the evening of the 6th of June. Part of one day will be given to a discussion of Inter-Provincial Registration. There will be a large instrument, etc., exhibit. Members are requested to send titles of papers to the General Secretary as early as possible. The following is the list of officers:

First Vice-President, Acting President, Adam H. Wright, Toronto; Second Vice-President, M. I. Beeman, Newburgh, Ont.; Third Vice-President, R. J. Trimble, Queenston, Ont.; Fourth Vice-President, A. F. McKenzie, Monkton, Ont.;

General Secretary, Harold C. Parsons, 97 Bloor Street West, Toronto; Assistant Secretary, George Elliott, Toronto; Treasurer, George H. Carveth, Toronto; Chairmen of Committees: Credentials, A. T. Hobbs, London; Public Health, D. Gilbert Gordon, Toronto; Legislation, J. C. Mitchell, Enniskillen; Publication, W. H. B. Aikins. Toronto; By-Laws, G. H. Burnham, Toronto; Ethics, A. McKinnon, Guelph; Advisory, J. D. Macdonald, Hamilton; Papers and Business, Albert A. Macdonald, Toronto; Arrangements, Allen Baines, Toronto; Audit, A. B. Welford, Woodstock; Necrology, J. L. Bray, Chatham; *re* Interprovincial Registration, J. A. Williams, Ingersoll; *re* Hospital Abuse, W. J. Wilson, Toronto.

News Items.

DR. J. F. MACAULEY, Medical Superintendent of the General Hospital St. John, N.B., has issued his annual report for the past year. There were 1,004 patients treated during the year. Of these, 460 were medical cases, and 467 surgical cases, and 77 eye and ear cases. There were 650 discharged cured, and 102 improved. Sixty-three died, and the number of patients in the institution at the close of the year was seventy-one. The cost of maintenance was $21,755.80, equal to 0.72 4-5 per cent. cost per patient per day.

A SANITARIUM for the treatment of cases of pulmonary tuberculosis has just been opened in the province of Quebec. It is situated about sixty-four miles from Montreal in the Laurentians, with an elevation of 1,550 feet above sea-level. Dr. Eust. Meli is the resident superintendent, and many of the leading members of the profession in Montreal are on the consulting staff.

DURING the quarter ending January 1st, 638 patients were treated to conclusion in the wards of the Montreal General Hospital. Of these 47 died, a death-rate of 7.37 per cent. The average number treated daily throughout the quarter was 160; the average time of retention 23.5 days. 9,381 consultations in all departments were given in the out-door service.

THE report of the death of a child after vaccination comes from New Brunswick. There seems to be considerable excitement in St. John over the general vaccination of school children; and an inquest was ordered on the death of the infant alluded to.

THE annual meeting of the Montreal branch of the Victorian Order was held on the 19th of February. This branch is now two years old. During the past year, there have been 319 calls; the total number of visits made was 5,565, making an average of something over 17 visits per case. Most of these visits were free, the remainder paying from five to fifty cents per visit. The Hon. Senator Drummond was elected President, Dr. Craik, Vice-President, and Dr. J. George Adami, Secretary.

A DEPUTATION, headed by Dr. Barrick, who has taken an active interest in the establishing of sanitariums for the consumptive poor, and consisting of Drs. Oldright, A. A. Macdonald, John S. King and others, waited on the local Government on the morning of the 7th inst., urging them to bring in legislation encouraging municipalities in establishing these institutions for the consumptive poor.

THE Victorian Order of Nurses held its annual meeting on March 1st at the Capital. It was decided the nurses in the Klondike should be withdrawn. Two local branches were inaugurated during the past year, viz., those of Hamilton, Ont., and St. John, N.B. Eight district Councils were formed throughout Ontario. The local Government subsidized these to the extent of $2,500.

DR. CHARLES A. PETERS (McGill, '98) has received an appointment on the medical staff of the British forces in South Africa. He served in 1899 on the resident staff of the Montreal General Hospital. In autumn, 1899, he received his degree of M.R.C.S. of England, and L.R.C.P. of London.

THE *Maritime Medical News* has been calling the attention of its readers to the advertisements of abortifacients in the daily press. It is a timely topic for discussion in medical journals, as also the advertisements in regard to gonorrhea, syphilis, etc. The great power and liberty of the press needs severe scrubbing with plain, ordinary, every-day soap-suds.

BY the terms of the will of the late Mr. Walter Drake, a prominent citizen of Montreal, the Chair of Physiology of McGill University receives $25,000; Montreal Western Hospital, $10,000; and the Montreal General Hospital, $4,000.

AN anti-vaccination league has been formed in this city. It is understood that they will shortly wait on the Provincial Government asking that compulsory vaccination be abolished.

DR. N. E. MACKAY, the Chairman of the Board of Health of the City of Halifax, N.S., has issued a circular upon the infectiousness of tuberculosis, and the means necessary to prevent its spread, to the citizens generally. This is a move in the right direction of education of the public in regard to this disease.

IN the Divisional Court at Osgoode Hall this week (Mon., Mar. 5th), "osteopathy" as represented in the person of "Dr." Cluett, of Ottawa, received a stunning blow. The conviction of the Ottawa Police Magistrate was confirmed.

THE first death from the outbreak of smallpox in Kamouraska Co., Quebec, has just been reported, Dr. Cote, of the village of St. Pascal being the victim. There are now only fifteen cases of the disease in the province.

THE local Board of Health of this city will likely in the near future take up the question of educating the public in the matter of promiscuous expectoration on the streets, in public conveyances and in public places.

THE Sisters of Mercy, Winnipeg, have just completed the erection of a fine maternity hospital. A special feature of the building is the large sun-galleries on each flat.

DR. COTTON, a member of the Quebec Legislature, has received an appointment on the Protestant Committee of the Council of Public Instruction in that province.

DR. H. L. DICKEY, of Charlottetown, P.E.I., has been appointed to the Eye, Ear, Nose and Throat Department of the General Hospital of that city.

THE students of McGill in British Columbia will donate a $100 scholarship each year to their *alma mater*.

DR. ARTHUR SIMARD, Quebec, has been appointed to the Provincial Board of Health of that province.

Physicians' Library.

Operative Surgery. By JOSEPH D. BRYANT, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital, Medical College, etc., etc. Vol. I., comprising chapters on General Principles, Anesthetics, Antiseptics, Control of Hemorrhage, Treatment of Operation-Wounds, Ligature of Arteries, Operations on Veins, Capillaries, Nervous System, Tendons, Ligaments, Fasciæ, Muscles, Bursæ, and Bones. Amputations, Deformities. Plastic Surgery. This volume contains seven hundred and forty-nine illustrations, fifty of which are colored. New York: D. Appleton & Co.

Through three editions has this most excellent work now gone, and the repeated calls for this third edition bear high testimony to the perfection of the work. Expressly written at the request of innumerable pupils, the first editions soon found their way outside that limitation, and many strangers to the author live to appreciate and attest his unusually splendid effort in operative technique. All sections are most profusely and admirably illustrated; especially interesting are those on the ligature of arteries, amputations, and plastic surgery. The graduates in medicine whom it has been the author's pleasure to instruct in anatomy and surgery during the last twenty years, can point with pride to their preceptor's handiwork in the world of medical literature. Brought up to date as regards the most modern and latest scientific procedures in the operations dealt with, the present volume, bearing marks of careful and painstaking revision, will whet the operative appetite in anticipation of a complete work covering the entire field of operative surgery.

A Text-Book of Obstetrics. By BARTON COOKE HIRST, M.D., Professor of Obstetrics in University of Pennsylvania. Second edition. Octavo, 848 pages, 618 illustrations, and seven colored plates. Cloth, $5.00 net; Sheep or Half Morocco, $6.00 net. Philadelphia: W. B. Saunders, Publisher. Canadian Agents: J. A. Carveth & Co.

With the practical knowledge obtained from fourteen years of exclusive work devoted to obstetrics and gynecology in private practice, and many of the principal hospitals in Philadelphia, and a life-long experience in teaching medical students in the clinics, laboratories, lecture-rooms and hospitals of that city, the author

has certainly had exceptional training in fitting himself for the preparation of this work. Commencing with the classical "Anatomy of the Pelvis," and "The Female Sexual Organs," all through to the closing chapter on "The New-born Infant," there is displayed an admirable handling of each subject, the work being embellished by many fine colored plates, photogravures, wood-cuts, diagrams, etc., which the student of this branch of medicine will not fail to thoroughly appreciate. Most helpful to the beginner will be the chapter on the use of the forceps, wherein appropriate illustrations adorn the text, exhibiting in very striking manner the technique of this operation, and the various phases assumed whilst manipulating the instruments in this procedure. The abnormalities are dealt with in an intelligent and comprehensive way, many of the illustrations being new in works of this character. Comprehensive is the chapter on puerperal sepsis; and of especial importance in an obstetrical work is the section on the new-born infant, fittingly included in a production of this character. We look to see "The Text-Book of Obstetrics" adopted as such in many of the medical colleges on this continent.

Refraction and How to Refract. Including Sections on Optics, Retinoscopy, the Fitting of Spectacles and Eye-Glasses, etc. By JAMES THORINGTON, A.M., M.D., Adjunct Professor of Ophthalmology in the Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Surgeon at Wills' Eye Hospital; Associate Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia; Member of the American Medical Association; Ophthalmologist to the Elwyn and the Vineland Training Schools for Feeble-minded Children; Resident Physician and Surgeon Panama Railroad Co. at Colon (Aspinwall), Isthmus of Panama, 1882-1889, etc. Two hundred illustrations, thirteen of which are colored. Octavo. 301 pages. $1.50 net, cloth. Philadelphia, Pa.: P. Blackiston's Sons & Co., 1012 Walnut St.

The physician is very often alluded to as a man who has no business instincts; and it may be due to this that the practice of fitting glasses has drifted into the hands of so-called "doctors of refraction." Had the general practitioner, or the great majority of general practitioners, been competent to perform this work, it is very probable that this practice, which is said to be a very lucrative one for the druggist and the jeweller in some cities and

towns, would have been kept where it certainly ought to belong, in the confines of the profession of medicine. A work, then, which deals with this question so clearly, and at the same time so concisely, must certainly appeal to the profession, and those who would still have some of this practice ought certainly to possess themselves of so meritorious a work. Written in a style easily comprehended by all, devoid of all abstruseness in detail, it might in some places have been rendered more clear, a defect which will probably be remedied in a future edition, as we feel satisfied that the demand for the work will soon call for another edition. It certainly ought to commend itself to the general practitioner as a means of qualifying himself in a righteous effort to counteract the tendency of others in usurping a branch of medical and surgical science, important enough, not to be incorporated in the commercialism of laymen.

Text-Book of Diseases of Women. By CHARLES B. PENROSE, M.D., PH.D., Professor of Gynecology in the University of Pennsylvania; Surgeon to the Gynecian Hospital, Philadelphia. Illustrated. Third Edition, Revised. Philadelphia: W. B. Saunders. Toronto, Ont.: J. A. Carveth & Co., Canadian Agents. Price, $3.75.

Increased knowledge in the branch of Gynecology during the last three years called for a revision of this work, which has been carefully performed, and a few necessary additions added thereto. Primarily and solely written to occupy the position as a text-book in our medical colleges, the work can be recommended to students as a clear, concise exposition of the teaching of modern gynecology, minus the antiquated theories and unused methods. In fact, it has been the author's aim to keep out of the text all unnecessary material which would only tend to burden the mind of the student with unnecessary detail, fitting him alone for the practical side of gynecology. One especial department of the work will commend it to the embryo practitioner, viz., the precise methods of treatment which the experience of the distinguished author tells him is the best. With the acquired knowledge that these plans of treatment have been followed with the best and happiest results, beginners in the branch of gynecology may at once adopt this system so advised, without being put to the necessity of making a choice of several and diversified methods of treatment advised in many works of this character. For this reason also, then, the Text-Book of Gynecology, by Dr. Penrose, will be sure to meet with popular favor at the hands of

the profession. In the hurry of the general practitioner's life, it will also fill a place, in this respect, and will no doubt be met with a warm appreciation.

Notes on the Modern Treatment of Fractures. By JOHN B. ROBERTS, A.M., M.D., Professor of Surgery in the Philadelphia Polyclinic, Mutter Lecturer on Surgical Pathology of the College of Physicians of Philadelphia. With thirty-nine illustrations. New York: D. Appleton & Co. Price, $1.50.

This work is certainly iconoclastic. The time-honored and classic methods of treating many fractures are attacked, and new and simpler methods which have proven successful at the hands of the author, and also by others in the wards of the Philadelphia hospitals, are submitted for trial by the profession generally. While we cannot fail but be struck with the really simple methods of treating some fractures, such as that of the lower end of the radius, conservatism holds such sway in this particular branch of surgery, and the many malpractice suits over this identical fracture haunting the profession, that unless we had the opportunity of studying the effects of the simplified treatment clinically we are afraid we would lack the temerity of treating this fracture with a round or two of adhesive plaster. Certainly, the treatment of many fractures seems too elaborate, and if simpler methods can accomplish as good results, with at the same time more comfort and convenience to the patient and no risk to the surgeon, those methods ought to receive careful trial and consideration at our hands. The work is certainly most interesting and refreshing, and we are forced to admit that the respective plans seem feasible; we also acknowledge a feeling of desire to put some of the methods to a practical test on the very first opportunity.

Crockett's Gynecology (Lea's Series of Pocket Text-Books).—A Pocket Text-Book of Diseases of Women, by MONTGOMERY A. CROCKETT, A.B., M.D., Adjunct Professor of Obstetrics and Clinical Gynecology, Medical Department of the University of Buffalo, N.Y. In one handsome 12mo. volume of 368 pages, with 107 illustrations. Cloth, $1.50 net. Flexible red leather, $2.00 net. Philadelphia and New York: Lea Brothers & Co. February, 1900.

This volume of Lea's already popular Series of Pocket Text-Books gives in convenient form and concise language a compen-

dious and well-illustrated presentation of the present status of Gynecology. The name of its author is a sufficient guarantee of the trustworthiness of the work. Entire originality is of course neither possible nor desirable in a work intended to summarize the best knowledge in a modern progressive branch of medicine. The reader has the benefit of the author's experience at every point which needed rounding out and illuminating, and the result is a remarkably judicious and even presentation of the entire subject. For the student, Crockett's Gynecology will prove of great convenience and utmost value, while the practitioner may well refer to it for the latest points on every phase of its subject. It is amply illustrated and exceedingly low in price.

A Manual of the Practice of Medicine. Prepared especially for students. By A. A. STEVENS, A.M., M.D., Professor of Pathology in the Woman's Medical College of Pennsylvania, and Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania. Fifth edition, revised and enlarged. Illustrated. Philadelphia: W. B. Saunders. Toronto: J. A Carveth & Co. Price, $2.00.

Admirably bound, neat and concise in arrangement of text, this work will appeal to all students, who wish to get the salient points well mastered on the eve of an examination. The reviewer remembers perfectly laying the heavy works on the practice of medicine aside about a month before examination, and reading this manual alone. The result was first place in medicine.

REPRINTS RECEIVED.

"Sterility and Pelvic Deformity." By JOSEPH BROWN COOKE, M.D., New York City.

"A Review of the History and Literature of Appendicitis." By GEORGE M. EDEBOHLS, A.M., M.D., New York.

"Acute Inflammation of the Middle Ear, Complicating Scarlet Fever and Measles." By CHARLES H. MAY, M.D., New York.

"Some Considerations in Sugar-Testing, with Description of a Method for the Detection and Estimation of Sugar in the Urine." By ARTHUR R. ELLIOTT, M.D.