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# THE CANADA LANCET,

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## Original Communications.

### REMARKS ON OVARIOTOMY.

WITH AN APPENDIX.

CONTAINING THE HISTORY OF SEVERAL TYPICAL CASES MET WITH IN PRACTICE.\*

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The operation entitled *ovariotomy*, first suggested by William Hunter, first taught by John Bell, and first performed by Ephraim McDowell, has speedily come to be recognized as a legitimate and established procedure for the radical cure of ovarian disease; and, indeed, offers a more favorable prognosis than most other capital surgical operations. Never has any medical procedure risen more rapidly into favor, nor gained a stronger hold upon the professional mind, nor been more frequently resorted to by eminent practitioners throughout the civilized world, than has *ovariotomy* during the past quarter of a century. Seeing, that the investigation of the etiology and pathology of ovarian disease have recently been brought to the best thought and experience of the age, and that *ovariotomy* has in so short a period accomplished so grand a career, rescuing many valuable lives from a premature death, this operation is justly entitled to be regarded as the monarch of gynecology.

Considering the growing frequency of the operation in the Dominion, it is desirable that the profession should discuss the different methods now practiced, with the view to arrive, if possible, at some definite conclusions as to the best means of completing the several steps thereof. In this, as

in every new development of science, the advance is not uncontested. There are to be found those who, with equal honesty and tenacity, hold opposing convictions. Ovariotomy has not won its final triumph, though destined so to do; its progress has been a succession of brilliant victories, and ere long, we may hope to see it coming out of the strife, its last opposition overcome, and having accorded to it a place chief among capital operations;

"Like some tall cliff, whose awful form  
Swell from the vale, and midway leaves the storm,  
Though round its base the threatening clouds be spread,  
Eternal sunshine settles on its head."

When about to perform this operation for the first time, being anxious to find some definite rules for guidance at certain points, great was the sense of disappointment upon finding that the acknowledged authorities did not supply the information required by a beginner. To remedy this defect, I was obliged to consult the record of cases published by different operators, in the several medical journals, and decide upon the plan to be adopted under certain circumstances. Recently, however, abundance of information on the several unsettled questions has been supplied. Though we have neither the literature, the tradition, nor the sobered reason of centuries to guide us in this, as in the better known capital operations, fortunately some of the greatest modern lights have sufficiently explored this hitherto unknown realm, with such brilliant results as startle the world, while supplying data, that to the reflecting mind will furnish rules for guidance in further operations—rules that may, as in all practice, from time to time, be amended, as new discoveries are made.

Though *ovariotomy* is of only recent date, there have been attracted to its investigation numbers of men eminent in the profession—the peers of the men of the past—who have pursued their researches from widely differing points of observation, and with so impressive results, that already from the mass of testimony thus supplied, we may glean such important facts as will enable us to reach conclusions, which, we venture to predict, experience will but confirm. True, some of the most experienced authorities have expressed the opinion that we are only on the threshold of knowledge respecting the etiology, pathology, and treatment of ovarian disease, and in their modesty refrain from making any deductions. The wisdom of such

\*Read by title at the meeting of the Canada Medical Association held in Montreal, 12th and 13th Sept., 1877.

a course is open to question. On the other hand, is it not their privilege, aye, and duty, to classify and utilize the knowledge already gained? Many things may be true which are comparatively valueless. To know the facts is important, but a further effort and patience in the pursuit of truth are required to ascertain which are the most valuable. The line must be drawn somewhere. Probably were we to attempt, at present, to distinguish between the different methods practiced in ovariectomy, no two investigators would be found agreeing in every particular. This supposition justifies the expectation now indulged, that the subject chosen for discussion this morning will prove interesting and profitable to all present.

The discussion of ovarian disease—its diagnosis and various methods of treatment, is not designed in this paper; but the diagnosis having been made, and ovariectomy decided upon, it is proposed to ascertain which are the most successful, and consequently the most useful methods of accomplishing the various steps of the operation. The plan proposed is to give a *resumé* of what the writer believes to be the best methods now practiced, and to assist in eliminating a mass of rubbish, which at present, encumbers the literature of this procedure. A desire for brevity, and the intention to avoid, *en passant*, a discussion of those points which may be more advantageously considered at the close of the paper, must excuse the peremptory manner in which the writer's views are occasionally expressed.

#### PREPARATIONS FOR THE OPERATION.

The operation should be undertaken only by that surgeon who realizes the full weight of the responsibility he assumes, and determines to be thoroughly prepared for every step of the procedure, as well as any emergency that is liable to occur; for, unquestionably, success greatly depends upon the preparations previously made, the care and skill exercised during each stage of the operation, and particularly the vigilant supervision given to the minutiae of the after-treatment. When possible, choice should be made of a pleasant and healthy locality, and of a large and cheerful room, capable of being heated and ventilated. The room should be thoroughly cleansed, the ceiling whitened, the walls calcimined or newly papered, and the wood-work and floor well washed, using plenty of soap and water. The carpet and furni-

ture should be new, and the bedding clean. It will be found convenient to have two beds, as nearly alike as possible, in the room, so that the patient may be easily lifted from the one to the other. The patient having, after a full and candid explanation to her of the possibilities of the operation, voluntarily decided to avail herself of this prospect of a radical cure, this question ought to be regarded as settled; and from that hour all discussion on that point entirely avoided, while every means should be employed to inspire her with hope and courage. In the absence of urgent symptoms, time should be taken to improve her physical condition, and elevate her vital powers. She should be kept free from excitement, her food nutritious and easily digestible, the bowels regular, and the kidneys secreting a proper quantity of normal urine. A few days preceding the operation, she should occupy her lying-in room, and be treated as an invalid. The evening before, or the morning of the operation, the bowels should be thoroughly evacuated by a sufficient dose of castor oil, after which, on account of the liability to sickness from the anæsthetic, no solid food should be allowed. A kind, intelligent, and experienced nurse should be secured—one who will faithfully and tenderly attend the patient, and maintain a firm yet gentle discipline over the room. It is obviously impracticable to decide, with absolute certainty, upon a fine day for the operation, as has been recommended, with the wind in a certain quarter. The choice has to be made some days previously, and no ordinary weather-prophet can calculate with much certainty the state of the weather two or three days hence. The patient prepared, the nurse and assistant on hand, and everything being in readiness, it would be exceedingly inconvenient to postpone the operation on account of a rainy day, or an east wind. The operator should have a written list of all the instruments and utensils usually needed, including those rarely required in any emergency, this list should be checked, and the instruments properly arranged on the table, convenient to his hand.

One hour previous to the operation, the patient should receive thirty drops of laudanum, and immediately before the anæsthetic, a little brandy and water. The anæsthetic administered, the assistants enter the room, the temperature of which should be maintained at about 80°, and all

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47, vol. 5.

liability to drafts from the opening of doors and windows prevented. The patient is then lifted from the bed and placed upon a narrow table, made comfortable with folded blankets and sheets, in front of a large window, transmitting an abundance of light. Her feet and legs should be kept warm by means of woollen stockings, flannel drawers, and a light blanket. The feet rest upon a stool or chair at the foot of the table. It is necessary to have five or six skillful, cool-headed assistants, free from all taint or suspicion of contamination, arising from dissections, *post mortem*, suppurations, or contagious diseases. The nurse must have in readiness, in the room, plenty of hot and cold water, carbolized water. (1 to 100) a tub, several pails, wash bowls, soap, towels, soft flannels and cotton cloths, napkins, &c. She should have three pairs of new sponges, readily distinguishable from each other: one pair for the external wound; the second, a large pair, for the contents of the tumor; and the third pair, extra soft and fine, for cleansing the peritoneum. Care must be taken to keep each pair in separate dishes, and the assistant who sponges the contents of the tumor must be careful not to touch the sponges reserved for the peritoneum.

The operator takes his place on the right of the patient, with his chief assistant directly opposite. The one in charge of the instruments should be familiar with his duties, and ready to anticipate the wants of the operator. The assistant in charge of the anæsthetic should be accustomed to its administration, and one who could be relied upon to faithfully discharge his duties regardless of the progress of the operation. The anæsthetic should be given in such quantity only as is necessary to maintain quietude. This is important, owing to the tendency to prolonged sickness and vomiting after ovariectomy. When chloroform, which I prefer, is used, it is astonishing how little is required to keep up complete anæsthesia, especially when sprinkled "guttatim" upon one thickness of a napkin covering the nose and mouth, held closely around the chin to prevent the loss of vapor, while the air is freely admitted from above on either side of the nose.\*

\*Perhaps the most systematic method of administering chloroform, is that adopted by Dr. A. M. Rosebrugh, of Toronto, in his Ophthalmic practice.—See CANADA LANCET, vol. 5, page 622.

All things being in readiness, the bladder should be evacuated with a catheter by an assistant, before commencing the operation.

#### THE ABDOMINAL INCISION.

The abdominal section is now always made in the median line, between the umbilicus and symphysis pubis, the length required depending somewhat upon the nature of the contents of the tumor. Even for explorative purposes the incision should be about five inches long, which will usually be found sufficient to allow of the extraction of the tumor after its size has been reduced, but if not, the incision can afterwards be lengthened. The section is made with a strong scalpel, commencing below the navel, at a point which will make a proper length of wound ending an inch above the pubic symphysis. Care must be taken to make the dissection along the median line, through the skin, areolar and adipose tissue, down to the *linea alba*. When this *tendinous line* has been reached, and uncovered throughout the extent of the external wound, it is picked up by a tenaculum, opened, a grooved director passed underneath, and carefully avoiding the sheath of the rectus muscle on either side, the aponeurosis is divided along the *linea alba*, from end to end. One more structure—the fascia transversalis with some adipose tissue, having been opened in a similar manner, the peritoneum is exposed. A little time should now be taken to sponge the wound and arrest the hemorrhage. The peritoneum is then raised by the tenaculum, snipped, and divided upon the director. A small quantity of straw-colored serum now usually escapes from the lower end of the wound, and occasionally, if not prevented by an assistant controlling the upper end, a loop of intestine will protrude. The peritoneal cavity having been thus opened, the tumor is brought into view, and in most cases presents the bluish-white, glistening aspect characteristic of an ovarian tumor, but in some instances, especially compound cysts, the appearance is darker, redder and more vascular. In other cases a loop of intestine may first present itself: the great omentum readily recognizable by its characteristic adipose appearance, may, like an apron, extend over the tumor; or a very vascular membrane may cover it, which on investigation proves to be hypertrophied projections of the pedicle, containing large blood vessels.

Some of these unexpected complications are very embarrassing to some operators, in the excitement of the hour, but a cool, quiet investigation will soon serve to clear up the perplexity, and the experienced surgeon will prove himself equal to the emergency.

#### ADHESIONS.

The tumor having been exposed to view, search is made for adhesions. The hand is washed, plunged into warm carbolized water, and two or three fingers are passed around between the tumor and the abdominal parietes. If slight adhesions are met with, they are gently broken down with the fingers. I have found the large curved steel sound, recommended by Professor Thomas, an excellent instrument for a more extended search for adhesions. It is warmed, dipped in the disinfectant, and passed gently around the tumor as far as the pedicle. With the aid of this harmless instrument the operator can satisfactorily assure himself of the presence or absence of adhesions around every part of the tumor excepting posteriorly. The most serious adhesions met with, are strong attachments to the bladder, uterus, omentum, and intestines. These bands must not be cut, unless first secured by a silk ligature; and this, I believe to be a good and safe method. But it is usual to enucleate them from the tumor by the fingers or the handle of the knife. Another excellent method of separating strong adhesions, is by making use of the temporary clamp and actual cautery. When, however, the cyst is firmly adherent to the bladder, intestine, or uterus, a small portion of the cyst wall should be cut out and left adherent to the viscus, the secreting membrane being dissected away. In such cases great care must be exercised to avoid perforating the intestine, or rupturing the fragile wall of the cyst.

#### TAPPING THE CYST.

The operator having confirmed his diagnosis, and ascertained that the removal of the tumor is possible, proceeds to diminish its size by removing the fluid contents. The cyst is seized at the upper end of the abdominal incision by strong, toothed, or deeply grooved forceps, and steadied, while the large trocar is plunged into it. An excellent instrument for this purpose is the trocar, known as Spencer Wells'. It is an ingenious contrivance, self-retaining, and has a flexible tube attached, through which the fluid is conveyed into

the receptacle below the table. When one of these trocars cannot be obtained in a country town, a large tube, sloped and pointed at one end, may be improvised for the occasion, an opening being made for it by a scalpel. In such an event, and indeed in all cases where there is danger of the contents escaping into the peritoneal cavity, it is best to turn the patient on her left side, while the fluid is flowing away, and every precaution must be taken with sponges and flannels to prevent the contents getting into the peritoneum. In the mean time, the assistant is keeping the cyst well into the wound, by steady traction with the forceps, while another compresses the abdominal walls against the tumor by one hand on each side of the incision. In compound tumors after the parent cyst has been evacuated, others come into view, and are, one after another tapped and emptied. The contents of some cysts are very gelatinous and tenacious, passing out through even a large tube very tardily. Under such circumstances, the patient being on her side, I have expedited their evacuation by laying them open freely with a scalpel. In other cases, the contents are semi-solid, or composed mostly of small cysts—honey-combed, which have to be incised, broken down with the hand inside, and scooped away before the cyst can be sufficiently reduced to be extracted through a fair sized opening.

#### REMOVAL OF THE TUMOR.

As the cyst is being emptied of its contents, the assistant, by continued traction with the forceps, gradually withdraws the lessened tumor through the incision, assisted, in most cases, by the hands of the operator. Care is now taken to have the tumor well supported by the assistants, to prevent its falling, or dragging injuriously upon the pedicle. When the length of the pedicle will permit, it is good practice to tie it tightly with whip-cord, near the tumor, make a loop with the cord, with which to manipulate the pedicle, and cut away the tumor. This may be now entrusted to a skillful and experienced assistant, who will attend to any unruptured adhesions, according to the methods previously described, while the operator gives his attention to the pedicle.

#### SECURING THE PEDICLE.

We come now to the most important step of the operation—the treatment of the pedicle. The

most effectual methods of securing the pedicle is certainly the most important, and the most anxious question the operator has to consider. He is impressed with the recollection that in his management of this step of the operation, he is required not only to effectually and permanently secure the stump against hemorrhage, but this must be done so delicately as not to drag or twist the uterus, nor inflict the slightest injury upon the parts which are to remain within the peritoneal cavity, so that there shall be no tissue likely to decompose or give rise to septic absorption; for it is obvious, the success of the operation in no small measure depends upon how these objects are accomplished—what risk is run of hemorrhage, shock, peritonitis, and septicæmia—the four great sources of mortality after ovariectomy. It is, therefore, not surprising that this question has been anxiously discussed among ovariectomists, and various methods of procedure warmly advocated.

The various methods practiced and recommended by their advocates, may be classified thus:

1. *The Extra Peritoneal,*
2. *The Intra Peritoneal.*

*Extra-peritoneal.*—(“without” the peritoneum). Under this division may be included the various modes of securing the pedicle outside of the peritoneum. This object is generally accomplished by either bringing the pedicle through the lower part of the incision, and fixing it outside with a clamp before dividing it, or first ligaturing the pedicle with silk, catgut, wire, or some other agent, and then either transfixing it outside, or with the abdominal parietes while closing the wound. The various plans resorted to for this purpose, have the same object in view—to keep the stump of the pedicle securely in, or outside of the abdominal wound so that it cannot drop into the peritoneal cavity, and there become the source of mischief. For the sake of brevity, I shall include all methods having the above objects in view, under the designation of *the clamp method*, as I believe the fixation of the pedicle externally can best be accomplished by a good, strong clamp—such as used by Mr. Spencer Wells. It should be borne in mind that some pedicles are very large and vascular, two or three inches in breadth, and containing the following structures: the broad ligament, the Fallopian tube, the ovarian ligament, sometimes the round

ligament, several very large arteries, and a number of greatly developed veins; and all this mass must be firmly and effectually secured, if possible, against the perils already mentioned.

*The clamp method* consists in embracing the whole pedicle, outside the abdominal wound, with a strong metallic constricting instrument, capable of being screwed together very tightly, and cutting away the tumor about half-an-inch outside of the clamp. The abdominal wound is then neatly closed around the pedicle, under the clamp, and the stump thus firmly held, is so treated as to prevent any septic matter from finding its way into the peritoneal cavity.

This, it is claimed, possesses advantages over the intra-peritoneal method, where the stump of that large vascular mass, whether severed by the actual cautery, “tied and dropped,” or treated by any other plan, remains within the peritoneal cavity, where it is liable to become the source of septic decomposition, and hazard the patient’s life.

The clamp method has been, and still is, the one most generally practiced; it was introduced by Mr. Jonathan Hutchinson, and is nearly always employed by Mr. Spencer Wells—that prince of ovariectomists, who himself has performed the operation nearly one thousand times, thus adding, according to the calculation of Lord Selborne, 20,000 years to the lives of European women.

*Intra-peritoneal.*—(“within” the peritoneum). Under this shall be included all modes which leave the stump of the pedicle within the peritoneal cavity: the actual cautery, the galvano-cautery, the *écrasoir* acupressure, deligation by various ligatures, torsion, and enucleation.

Several members of this association, in attendance at the International Medical Congress, in Philadelphia, had the pleasure of hearing Dr. Miner, of Buffalo, describe in plain, lucid language, his plan of performing “ovariotomy by enucleation,” and were deeply impressed with the conviction that his procedure is a capital method, in some cases at least, especially where the pedicle is so broad and short that it is impossible to apply a clamp, and hazardous to attempt to secure it by ligature, or divide it by the actual cautery. In a recent operation, where the pedicle was of this description, I availed myself of the method of enucleation, to separate the pedicle several inches from the tumor, in order to get sufficient length to

## OVARIOTOMY BY ENUCLEATION.



allow of securing it with a double ligature. This happy thought enabled me to complete the operation satisfactorily, and the result was successful. I therefore feel indebted to Dr. Miner, for giving his valuable discovery to the profession.

Dr. Miner's remarks were reported in the *Transactions of the International Medical Congress*, and may be abbreviated as follows :

"It is well known that the ovarian tumor is surrounded by a peritoneal covering; that the pedicle, proper, usually divides into three or four parts, passing up over the walls of the tumor in bands of variable width, which contain vessels, often of large size, and which gradually diminish in thickness and in the size of the contained vessels, until finally they are lost in simple, thickened portions of peritoneal covering. The peritoneal investment is not closely attached to the cyst, but separates readily, just as the peritoneum separates elsewhere in the pelvic cavity, being immediately lined by the subserous cellular tissue; thus no vessels of any considerable size enter the cyst. The tumor separates from its attachments with remarkable readiness, so much so that, in several instances, it is reported to have escaped the grasp of the operator, and fallen spontaneously from the pedicle by accident, thus plainly indicating the natural and proper method of removal. The accompanying cut,† from a drawing by Dr. Edward N. Brush, who has several times assisted me in operating, will give a very fair idea of the procedure."

\* See Appendix Case III.

† Kindly loaned by Dr. Miner.

The fingers of the operator are represented beneath a vascular portion of the pedicle, separating it from the walls of the tumor."

This separation is to be carefully made, until the vessels are traced to their termination. To make the illustration plainer, the tumor is represented as raised from the abdominal cavity, and supported by the hand of an assistant, but, of course, where extensive adhesions are present, this is impossible and the risks of removal are greatly augmented.

Formerly, the operation in such cases was abandoned. When adhesions exist, they are to be separated, and the process continued to the pedicle. The capillary vessels thus broken (during the process of enucleation) do not bleed, for the band contracts, and corrugates the larger trunks, while the broken off capillaries ooze a little for only a minute or two, and a dry napkin, applied for a short time, is all that is required."

As for securing the pedicle by the less valuable methods—acupressure, *écraseur*, the galvano-cautery, or by twisting and torsion, I shall not take up your time in discussing, as they possess no

advantages; but the remaining two methods—the actual cautery and the ligature—demand especial consideration.

*The Actual Cautery.*—This method introduced by Mr. John Clay, a celebrated ovariologist, of Birmingham, England, for the purpose of arresting hemorrhage from parietal and visceral adhesions, was seized by Mr. Baker Brown, for the treatment of the pedicle also; and with most excellent results. It consists in compressing the pedicle with a temporary clamp while being divided, or rather sawed off, by a wedge-shaped cautery iron, heated only to a white heat, so as to burn its way slowly through the structure. The clamp is then unscrewed, and after waiting a short time, to secure if necessary any bleeding vessel, by a ligature or another touch of the cautery, the stump is allowed to recede into the peritoneal cavity, and the abdominal wound is completely closed. Although this plan of dividing the pedicle yielded unparalleled results in the hands of the late Mr. Baker Brown, very few since his lamented death, have adopted his procedure, except in cases with very short pedicles, and then only as a *dernier ressort*. Recently, however, one of the most brilliant ovariologists of the day, Mr. Thomas Keith, of Edinburgh, has practiced this method in over fifty cases, "and out of 241 operations, (by various methods) has saved 206 lives—a success hitherto unequalled in the history of any capital operation." But most operators seem anxious to avoid this mode, except in cases where neither the clamp nor ligature is applicable; appearing to think that the danger of secondary hemorrhage decomposition, and septic absorption is increased thereby. For instance take the following quotations:

"In ovariotomy, the great thing is security against hemorrhage; and that, I think, is best gained by the use of the clamp or the ligature." Dr. Robert Barnes, "Transactions of the 'International Medical Congress,' of Philadelphia. Page 806.

Prof. Thomas, in his excellent work on the Diseases of Women, says:

"Mr. Baker Brown introduced the plan of amputating the tumor by means of the actual cautery, and claimed the astonishing results of twenty-nine cures in thirty-two operations. The insecurity against hemorrhage attendant upon the method will probably prevent its competing with those already mentioned, but in certain rare cases in which the part to be amputated is deep within the pelvis, it offers great advantages."

Schröder, in his recent work, page 422, remarks as follows:

"The actual cautery is especially recommended by Baker

Brown. The fear that the gangrenous eschar, replaced within the abdominal cavity may excite peritonitis, seems to have little foundation. The reproach is better grounded that cauterization does not surely prevent subsequent hemorrhage, especially from the large vessels; and the combination of ligature with cauterization of the pedicle seems to involve serious danger, because gangrene of the ligated portion more readily occurs under these circumstances."

And very recently, in a clinical lecture on the treatment of the pedicle in ovariotomy, Mr. Christopher Heath, made the following statement:

"I have employed it (the actual cautery) in several of my cases with good effect, but I do not think it so safe as the ligature: for however careful you may be to cut the pedicle slowly with an iron, not too hot, so as to sear the cut edges thoroughly, there is always the risk of some small vessels bleeding and requiring a ligature, and sometimes the burnt edges become separated and the bleeding is free. It is exactly the difference between applying torsion to a large artery and putting on a ligature; with the last, one feels perfectly safe, whilst with the former something *may* go wrong."

On the other hand, Mr. Thomas Keith after his large experience with the cautery, gives it as his opinion that:

"It is a good method and one which has had scant justice done since Mr. Baker Brown's death."

Apart, however, from Dr. Keith's large experience, nearly all ovariologists agree that the cautery method possesses great advantages in certain cases, especially when the pedicle is very short and deep within the pelvis. The only conclusion, it appears to me, deducible from this reasoning, is, that if the cautery method offers great advantages in certain difficult cases, it would answer even better in all favourable ones.

*The Ligature.*—The most approved manner of securing the pedicle by this procedure, consists in passing a strong double ligature, made of silk through the centre of the pedicle near its root, with a probe or large needle, dividing the loop and tying each half separately, and as an extra precaution passing one of the ligatures tightly around the whole pedicle; the ligatures are all cut off short, the pedicle divided half an inch outside of the ligatures, the stump dropped into the pelvis, and the abdominal wound a solutely closed. This method of "tying and dropping," according to Dr. Peaslee, one of the best authorities on these questions, was practised in New York over fifty years ago. But to the late Dr. Tyler Smith, belongs the honor, at all events, of reviving and popularizing the method, he having had a series of most successful

\* "The great strength of Dr. Keith lies in the thorough preparation of his cases, and in the care which he takes with them, personally I am ready to use any method that the case may demand." Dr. Alexander R. Simpson, of Edinburgh, at International Medical Congress, Philadelphia, page 807.



cases.\* Tyler Smith used Indian hemp; Marian Sims, silver wire; and others various other agents, such as horse-hair, catgut, whip-cord &c. It was claimed that catgut, being an animal substance and absorbable, would prove to be more effectual than any other agent; but experience proved that it was liable to slip and become untied, and consequently it failed to meet the expectation of its advocates. Gradually the good, old-fashioned, silk ligature, itself an animal product, has become the favorite for this purpose; strange to say, however, whatever ligatures are used, it is impossible to find them a few months afterwards, and the question is, what becomes of them? It has been suggested that they become partially if not entirely absorbed; but the experiments of Spiegelberg, Waldeyer, and Maslowsky, on the horns of the uteri of animals, prove that not only the ligatures, but also the stump beyond them, become encapsuled by effused lymph. It is claimed for this intra-peritoneal method, that it is simple, easy of adaption, applicable to all pedicles, and admits of the immediate closure of the abdominal wound in its whole length. That the "tying and dropping" method is a good and successful one, and gradually coming into popular favor, it is needless to dispute; indeed, it is easy to foresee that it is destined, ere long, to become the favorite procedure.

Having given as much space to the consideration of the best methods of securing the pedicle, as a paper of this kind will permit, it is now only necessary to make a few remarks by way of endeavoring to "draw the lines" a little closer than has heretofore been attempted. We have seen that there are two methods worthy of commendation: *The extra-peritoneal*, and *the intra-peritoneal*. We have seen that the extra-peritoneal method is best accomplished by means of a clamp, secured external to the abdominal wound, and the intra-peritoneal method, by either enucleation, the actual cautery, or the silk ligature; neither method appearing to possess advantages superior to the other.

The conclusion that forces itself upon the writer is, that either method, well-performed by a pains-

taking and skillful operator, who gives personal and great attention to the details of the preparation, and after treatment of his patients, will yield about equal results; and, consequently, it does not matter much to which method recourse is had, provided it is well executed and receives the same vigilant supervision.

It is highly important, therefore, that the operator should be unprejudiced—not wedded to any particular plan; but that he should proceed to each case prepared, and desirous to adopt that method which, under the circumstances, seems best adapted to that particular case.

(To be continued.)

## SECONDARY UTERINE HÆMORRHAGE.

BY A. D. MILLER, M.D., NEW DUNDEE, ONT.

Allow me space in your valuable journal for notes of an alarming case of secondary uterine hæmorrhage which I had the misfortune to encounter in my short experience in practice.

Mrs. M.—æet. 24. Canadian, strong constitution. Weight about 110 lbs. First confinement difficult; child expired on 2nd day. From her description subinvolution probably existed. Her health was poor until after her second confinement, which was quite easy. Tolerably healthy afterwards, but womb (to use her expression) "size of goose egg, up near the navel and pointing forward." During her third pregnancy she suffered from lameness of the left leg, and considerable pain in the breasts at night.

On the 24th of Oct., 1877. I was summoned to attend her in her third confinement. Labor difficult; as the legs were becoming paralyzed, uterine pains strong and child making no advance, I delivered her by instrumental aid (forceps.) Child still born, and seemed as if it had been dead for some time. Weight of child nearly 12 lbs; dimensions of head, bi-parietal, diameter 5 inches, occipito-frontal  $5\frac{3}{4}$  inches, occipito-mental  $6\frac{1}{4}$  in. Had I not seen the case, I would not have believed that so small a woman could have given birth to so large a child, without mutilation.

Oct. 28th. Well as could be expected; uterus apparently large but not tender on pressure; discharge natural.

\* I am myself inclined to the use of the ligature, and I now again refer to Dr. Tyler Smith's method of treating the pedicle as the best of all methods, and the one to which all others will, in my opinion, ere long give place.—Dr. E. R. Peaslee.

Oct. 31st. Still doing well.

Nov. 5th. Summoned to see her by her husband who said she was fainting; she sat up in the chair the previous evening for about five minutes while the bed was being made. About half-past one p. m. while turning in bed, flowing suddenly commenced, the uterus rising up on the left side as high as the umbilicus. Before my arrival she had fainted. I removed the clots, and by kneading and cold shower succeeded in arresting the hæmorrhage the uterus being apparently well contracted. I then gave instructions how to proceed if the hæmorrhage came on again, and left a mixture containing ergot, plumb. acetat., and cannabis indica.

Nov. 8th. Summoned again in haste; flowing had been gradual up to this time, but while turning over on the right side, it suddenly increased, the uterus rising up on the right side. Had succeeded in partially arresting the hæmorrhage by the time of my arrival. Found her unable to converse above a whisper, and complaining of strange sensations in her head. By pressure upon the abdominal aorta I completely controlled the hæmorrhage and relieved the sensation in the head, so that she was able to converse. Elevated the foot of the bed  $25^{\circ}$ , and left my enema so that they might use cold water injections in conjunction with cold showers if the hæmorrhage came on again. Ordered the medicine to be continued, and after renewing my instruction, giving particular directions about pressure upon the abdominal aorta, I reapplied the bandage and left her quite comfortable.

Nov. 10th. Summoned again; flowing commenced without any cause, collapse set in; had succeeded in stopping hæmorrhage before my arrival, principally by pressure upon the aorta. Raised the foot of the bed  $45^{\circ}$ ; this gave her a throbbing pain in head. Remained all night; proposed uterine injection of an astringent if hæmorrhage came on again. Slept about 2 hours.

Nov. 11th. Had the pleasure of meeting Dr. Bowly in consultation. He agreed with me about the seriousness of the case, and the treatment, and proposed in addition, ipecac as a uterine tonic, also agreeing that the cause was want of tonicity. Left about 11 a. m., leaving her comfortable, but was summoned again at half-past one, p. m. Hæmorrhage returned without any cause; had suc-

ceeded in partially stopping it before my arrival. Found her completely collapsed, unable to speak or see, and as she afterwards told me a ringing sensation in her ears, and unable to raise her finger from the bed, although putting forth all her strength. By firm pressure upon the abdominal aorta, and administering brandy and milk (as had previously been done), in about ten minutes she was able to converse, telling what change the pressure on the aorta made on the sensations in the head, although it paralyzed the lower half of the body. Previous to this the legs and arms were cold, also the face nose and lips. As the hæmorrhage had ceased, I waited until she could converse a little more. I then explained again about the probable result of the injection. She said it was a battle between life and death, death if flooding came on again, life probably by the use of the injection, and implored me to use it. Having given my position (pressure upon aorta) to a valuable assistant (her mother) I prepared the fluid for injection, containing one in ten of tr. fer. perchlor. About six ounces of the mixture was used. Filling the bulb with the fluid I passed the tube up to the fundus, making sure that the fluid could escape by passing my finger into the os by the side of the tube, and pressed gently upon the bulb, merely enough to force the fluid into the uterus. After about 2 oz. were injected, it began to return. The patient experienced a slight sensation of "smarting and drawing." The same medical treatment continued. A bladder filled with ice to be applied over the uterus for a few minutes every 2 hours while awake, and beef essence, milk and stimulants.

12th. Slept about 4 hours quite comfortably except a beating pain in the head; catheterized both morning and evening; bowels moved by means of injection. Pulse 125, not perceptible at the wrist.

13th. Slept quite well; pulse 120; had a slight flow which the nurse succeeded in stopping, and while she was kneading, a wedge-shaped clot came away the smaller end being florid.

At her request I used the injection again, 1 part in 12 of liquor ferri per-sulph.; used about 5 ozs. with same precaution as before.

14th. All symptoms improving, lowered foot of bed slightly. 15th. Still improving, applied ice every four hours. 16th. Continues to improve. Slept well. Ice applied four times a day. Dis-

continued ipecac. and acetate of lead, and added quinia and acid sulph. aromat.

18th. Still improving.

20th. Continues to improve, lowered foot of bed to level.

22nd. Feels quite comfortable. Discontinued application of ice, and ordered a mixture of iron, quinine and acid sulph. aromat. From this time she continued to gain rapidly, and to-day (Feb. 5.) is able to perform a considerable portion of her household duties, and her cheeks have regained their wonted rosy tint.

REMARKS.—The occurrence of hemorrhage in this case seemed to be due entirely to an atonic condition of the uterus. Query? Was atony caused by previous subinvolution, displacement, over-distension from carrying so large a child, or severe uterine contraction? In no instance does the practitioner require greater coolness and presence of mind than in such cases as these, for the life of the patient depends upon prompt and decisive action.

## TWO CASES OF MATERNAL IMPRESSIONS.\*

BY H. M. MACKAY, M.D., WOODSTOCK, ONT.

CASE 1.—Mrs. B——, the mother of a fine healthy boy was during her second pregnancy much affected by the sight of a hand with two thumbs on it. It so shocked her, that she became anxious and full of dread, lest her own unborn child should be similarly deformed. Having attended at her confinement, and not knowing anything about her alarm, she surprised me after the birth of the child by asking, "Are the hands all right?" On examining, I found on one of them a supernumerary thumb, of normal size, growing from the dorsum of the metacarpo-phalangeal articulation of the natural one. In every other respect the child was perfectly formed and well developed.

CASE 2.—Mrs. H——, mother of several healthy children, was severely shocked during the pregnancy referred to in this report by a sad accident to her husband, and which afterwards proved fatal.

To make the case more intelligible, I will first

relate the accident referred to. Mr. H——, a pump maker, was engaged in a well at the depth of thirty-five feet staying a pump, when the stone walls suddenly gave way. The stones, forming a partial arch over his head, prevented his being instantly crushed. After sixteen hours of anxious, weary labor, his voice, faint and indistinct, being audible all the time, he was found still living, with his arms and legs clasped around the pump-log, a position into which he sprang, as he afterwards stated, when he felt the stones moving. When taken out, cold and numb, his feet were turned inwards as in the act of climbing. Two stones had pressed upon him, one on the head left a contusion, the other, on the lumber region of the spine, produced a slough. He lived only five days after the accident. During this time he was very restless, but much relieved when some person leaned over him so that he could clasp his hands around them. Mrs. H——, six months advanced in pregnancy, was present at the rescue, and nursed her husband almost without intermission up to the time of his death. Three months afterwards she gave birth to a deformed infant, the abnormalities of which bore a striking resemblance to the condition and marks on the father, produced by the accident in the well. Its feet were turned inwards, with double talipes varus; on the side of the head was an ecchymosis, and in the lumbar region of the spine a wound differing from an ordinary spina bifida, in their being no abnormal fluid in the subarachnoid space, and besides the spinal processes and laminae of the part, all the structures external to the membranes of the cord were deficient. The cord of normal size was visible through the membranes. The wounds on the head and spine corresponded to those referred to on the father, more especially the latter, as a slough when removed leaves exposed the normal structures underneath. The child lived five days, the same length of time as the father lived after the accident. Another, and the most remarkable coincidence, was that the child resembled the father, in not resting, only when some one held its hands firmly grasped. The latter circumstance I could not believe until I saw unmistakable evidence of it. As I entered the room one day the child was sleeping quietly, the nurse holding its hands enclosed in her own. She mentioned to me the peculiarity, and as I expressed myself as being doubtful of the fact, she quietly and gently

\*Read before the County of Oxford Medical Association, January 31st, 1878.

relaxed her hold. No sooner done than the child screamed as if in great distress, and as soon as she seized them again it became calm and quiet, and remained so while the hands were held.

My first case admits of being explained as an accidental coincidence, for there does not of necessity exist any relation between the fact of the mother's having seen a hand with two thumbs on it, and that of her own child being born with a similar deformity. Although, when all the circumstances of the case are considered, it does seem to me as no more than probable that they stand to each other in the relation of cause and effect. But I do think that the laws of probability will not allow of a similar interpretation in my second case.

There were the five points of resemblance. Feet of child turned in like those of father when taken from the well; injuries on head and back corresponding with those on father; lived five days; and the disposition to have the hands supported, all constituting a chain of evidence not easily to be got over. I felt the greater confidence in bringing the latter case before you, knowing that a medical man here present, Dr. Millman, saw it, and I have no doubt but that he remembers the principal facts as I have here detailed them.

I am aware that the subject of maternal impressions is, at the present time, receiving a good deal of discussion, more especially in England, and also that able minds are ranged *pro* and *con*; so I thought the cases of sufficient interest to be brought before this Association.

#### CASE OF OVARIAN DISEASE WITH ABSCESS IN CORRESPONDING ILIAC REGION.

BY J. R. HAMILTON, M. D. C. M., STRATFORD, ONT.

Mrs. F.—, a married woman aged twenty-nine years, and the mother of two children, the youngest about three years of age, consulted me at my office on the 15th of October, '77, in reference to a uterine trouble, from which she had suffered for some two or three years, and for which she had consulted physicians innumerable.

The present condition of the patient is that of weakness, pallor, and slight emaciation. She complains of pain and tenderness in the hypogas-

tric region. In making a cursory examination I found the pulse only slightly accelerated, and the heart and lungs normal. When making a vaginal examination next day I found the os lower in the vagina than natural, the lips hard and contracted. On opening the os with a large catheter there was a quantity of pus escaped, and I was given to understand by the patient that this discharge was of frequent occurrence, and was always followed by temporary relief. Where this discharge came from I could not well make out, not being of a carcinomatous nature, and there being nothing to indicate an intra-mural abscess. For some time I doubted the patient (who was inclined to be hysterical) but on making examination subsequently, I found the same discharge when the os uteri was opened. I prescribed tonics and an opiate every night as she rested badly. She continued in this way for a time, expressing herself somewhat relieved of pain and able to walk to my office occasionally until the 26th December, when she was compelled to remain in bed, and on the 28th I found her with a very rapid pulse, tenderness of abdomen, vomiting, tympanites, pinched features, and all the symptoms of peritoneal inflammation. I prescribed opiates, fomentations, &c., but she remained in this state and gradually sank and died on the 5th inst.

Autopsy fifteen hours after death. Drs. Hyde, Roe, and Hanavan who had seen the case were present to assist me in making the *post mortem*. On opening the cavity of the abdomen we found the small vessels of the peritoneum injected and the greater portion of that organ highly vascular. We found the uterus very small and contracted, but without any trace of organic disease. The cavity of the abdomen on the left side as well as the pelvic cavity on the left side were filled with pus. We found the Fallopian tube and ovary of the right side in a healthy condition; the Fallopian tube on the left side was also normal, but the left ovary was almost completely gone, a collapsed cyst being all that remained, and that surrounded and imbedded in pus, the only outlet for which to the os that we could find must have been through the left Fallopian tube. The seat of abscess must have been in the ovary in the first instance, but the rectum as well as the sigmoid flexure of the colon were becoming involved; the liver and other organs of the abdomen as well as the contents of the thorax we found in a normal and healthy condition.

## ON SIMULATED ONE-SIDED BLINDNESS, AND HOW IT MAY BE DETECTED.

BY ADOLF ALT, M.D., TORONTO.

LECTURER ON OPHTHALMOLOGY AND OTOTOLOGY, TRINITY  
MEDICAL SCHOOL.

In countries where every healthy man is forced to do military service, it often occurs that young men try to evade their military duty by simulating one-sided blindness. A great many methods have been devised, therefore, to detect such simulation. This was the more necessary since there are cases of real blindness, of which we are not able to detect the cause by the ophthalmoscope. It is, however, not the military service only, which induces people to such simulation, and there are a number of reasons why one-sided blindness may be simulated in this country as well as in any other, for instance in actions at law with a view to obtain a large amount of damage for an injury etc. It thus would seem to be necessary for the general practitioner, to be acquainted with at least some of the speediest methods, of arriving at a correct opinion of the case before him.

The most common way to detect simulated one-sided blindness, and one which is well known, is by placing a strong prism before the pretendedly healthy eye, thus producing a double-image. This test, though perfectly reliable with an individual who does not know of its application, is nearly worthless now, since most of the simulators know it. The same applies to the test with a stereoscope which is based on the same principle.

A very simple test has been taught lately by Knapp. He makes use of the movements of the eye in monocular and binocular fixation. First leave both eyes uncovered, and move an object (your finger) towards and from the individual's face and direct him to follow its movements with his eyes. If both eyes keep their usual axis well fastened upon the object and follow it well, neither of them can be blind. Then you may alternately cover and uncover the alleged blind eye, while the other one is fixed upon the object of fixation. If the former, when quickly uncovered at once moves towards the object of fixation and fastens itself upon it, it cannot be blind, because a blind eye would not take part in the act of binocular fixation.

The same idea lies at the base of the method

applied by von Welz. He places a prism of about  $12^\circ$ , base outward, before the alleged blind eye. This will produce, of course, a double-image. In order to overcome the disagreeable feeling of seeing double the individual will turn the eye under the prism towards his nose, if it is not blind. If he is thus caught, we may catch him again by taking the prism quickly from his eye. If this eye now turns outward again to get rid of the now existing double-vision, the eye is doubtless doing its duty.

A very ingenious method is that of Cuignet. He traps the simulator by letting him read from a book and placing a rod, about an inch broad, before the healthy eye in such a way, that it intersects a line from this eye to the book and nearer the former. If the individual now reads quietly on without moving the head, he must read the letters which are covered by the rod for the healthy eye, with the pretendedly blind one.

Most recently Snellen published a new test, based on the perception of colours. He tests the defaulter with test-types of alternately red and green colour, after having placed a green glass before the sound eye. If the other one is actually blind, he will see the letters of one colour only; the red ones, if the letters are printed upon a white, the green ones only if they are upon a black background.

Some time ago I was ordered in my position as surgeon to the German Army to examine a young German with regard to his fitness for military service. After I had examined him and declared his pretended heart-disease a falsehood, he insisted upon his being blind of one eye. The simple test by watching the movements of the eyes in monocular and binocular fixation proved that a lie also. To make it more certain, I used a method which to my knowledge has not yet been described. He decidedly knew the test with one prism. I therefore placed two strong prisms with their bases together and these before his healthy eye in such a way, that the united bases crossed the centre of the pupil, and directed him to look at a candle about 12 feet off. He apparently did not know, how to get out of the affair now and after some hesitation he acknowledged to see three images. Two of these, of course belonged to the healthy eye and were due to the different refraction of the two prisms, while one (the middle one of the three) belonged to the alleged blind eye.

## Correspondence.

## THE CONTRACT SYSTEM.

To the Editor of the CANADA LANCET.

SIR:—I beg to call the attention of the profession to the dangerous position into which it is being drawn by the degrading and unprofessional practice of many of its members, in accepting the appointment of physician to certain "orders or societies" for a small yearly fee from each member, (generally \$1.00 per annum,) for medical attendance including medicine.

Doubtless, this duty is undertaken, relying mainly on making up the loss between \$1.00 and the usual charges by being employed to attend the families of the members of such societies; and upon the well-known fact, that the medical man of the "order," has a kind of lien upon the families of its members; and upon the further well-known fact, that in order to secure the success of this modern scheme for securing the services of medical men at labourer's wages, there is a continual canvass going on in the community by the members of these "orders," in behalf of the "society's doctor," to the great detriment of his brother practitioners. This whole proceeding, so unjust and injurious to the whole profession, except the few who descend to join in the scheme, is leading inevitably to a state of things equally detrimental to the profession and the general public.

No one can fail to be struck with the difference between the proceedings of these modern philanthropists, the Odd Fellows, the Foresters and many others, to which we shall doubtless soon have to add the Grangers, and the time-honoured order of Free-Masons. They all profess to be charitable associations. But the honest old mason contributes his charity from his own money. He is not content to give of "that which doth cost him nothing," whereas the vaunted charity of these modern organizations, is in great part a charity at other people's expense, and notably, at the expense of the medical practitioner. But what I desire particularly is, to ask my brethren to reflect, and endeavour to see before it is too late, what this modern movement is leading to. I do not refer to the evil effects to the community of a multiplicity of secret societies, whose sectarian zeal and private scheming for their own advancement, (like

that of all secret combinations,) places the rest of the public at an unfair disadvantage, and renders equal justice and fair play to all in the struggle for life impossible. These evils are not only patent to all who give the subject the smallest consideration, but they very far outweigh in my humble judgment, all the good that can fairly be claimed for them. Society does not exist exclusively for the benefit of secret societies, and what chance has the uninitiated and unsuspecting public against the secret cabaling and scheming of men, banded together for their own exclusive benefit. There can be no doubt that these evils have been the real cause of many of the modern organizations. Men came to feel, that the only way to counteract or defend themselves against the secret influences of existing organizations, was to get up other organizations. It has been a kind of mining and countermining. There is a secret society in this neighbourhood, formidable in numbers, and therefore formidable in influence. Of all the resident medical practitioners, only one would accept the appointment of "society doctor." The consequence of his appointment is, that there is a continual canvass going on, in favour of that gentleman, not only by the members of the society, but by many of their immediate friends and neighbours.

Respectable mechanics complain that they cannot get employment from members of a certain secret society, if any mechanic of that society can be got. They go past the neighbouring shop to buy their goods of a member of the society. A man sees that his neighbour is provided with medical attendance including medicine for \$1.00 a year. The inevitable result of all this must be the continual increase of secret organizations, as a matter of self-defence against existing ones—until the country is filled with rival cliques and combinations, more or less hostile, from one end to the other.

Supposing medical men can be found to take the appointments on the terms demanded by these societies, how, it may be asked, will that affect the medical profession and the general public? I do not pretend to be able to answer these questions fully; but I think it is easy to foresee the following results: (1) At least nineteen-twentieths of the professional men must betake themselves to some other occupation—for the large portion of the entire community that would be absorbed in these

numerous societies, would require a comparatively small number of medical men: (2) the public would lose the services of the ablest men, for as a rule it would be only second or third class men who would submit to the humiliating terms imposed by the societies: (3) the rapid decay of medical science, and the lowering of the social status of the profession. This scarcely requires proof; it is self evident—What professional man that entertains even the most modest estimate of his just claim to the respect and esteem of his fellow men, would consent to place himself in a great degree at the mercy of every noisy demagogue belonging to the "society." Once he accepts the appointment, every member will have a voice in his dismissal, and therefore he is forced to pander to the ignorance and prejudices of all. His bread and butter depends on his subserviency. The medical men will come to occupy very much the status of the Russian clergy, who are more the slaves than the religious instructors of the gentry, and even of the middle classes. All this will necessarily lower to a lamentable degree, the literary and scientific standard of the whole profession as a body. Much more may be said, and ought to be said on this subject, but I feel that I have already trespassed far too much on the space allowed to correspondents.

Yours truly,

Feb. 12th, 1878. ONE OF THE PROFESSION.

#### AFFILIATED MEDICAL SCHOOLS

To the Editor of the CANADA LANCET

SIR,—In the issue of the LANCET for February, I noticed a paragraph to the effect that the Toronto School of Medicine has been advertised for the past three years as the Medical Department of Victoria College, Cobourg. I was much surprised at this statement, and have been at some pains to look into the matter, and have been much struck with the following facts of which sooner or later some notice must be taken by the Senate of the University of Toronto. On page 25 of the Victoria College calendar for 1877, will be found the following:—

"MEDICAL DEPARTMENT—PROVINCE OF ONTARIO.

Students intending to graduate in Victoria University, are recommended to attend lectures in the Toronto School of Medicine, from which school certificates of attendance will be accepted by the medical examiners of this University."

Then follow the names of the different members of the Faculty of the Toronto School of Medicine: Drs. Aikins, Wright, Richardson, Ogden, Thorburn, Barrett, Oldright, MacFarlane, &c., &c. At the close of the announcements in the medical faculty, the calendar says:—"Additional information may be obtained from Dr. Aikins, President of the Toronto School of Medicine."

How a pious Methodist, like Dr. Aikins, could say in the face of this, in his letter to the Lieutenant-Governor in Council, asking for the disaffiliation of all medical schools connected with the Toronto University with a view to a re-arrangement, "that the students of the Toronto School of Medicine can avail themselves of the degree of the Toronto University *only*" is a mystery. (See Return No. 32, 40 Vic. 1877, page 10).

Some may not be aware of the fact that this school being thus advertized is in direct contravention of, at least one of the conditions of affiliation lately laid down by the Toronto University and which are the same for every affiliated school, and of course equally obligatory upon all. The condition thus contravened is the first resolution, passed June 12th, 1877, by the Senate of the University of Toronto, and is as follows:—Resolved firstly: "That no medical school or college should be admitted to, or continued in affiliation, which is, or becomes, connected with another University, either as its medical faculty, or by its professors or lecturers being examiners for the degrees, honors, scholarships, or standing, of another University, or its holding out in any way that its examinations will be accepted by another University, as entitling to degrees, honors, scholarships, or standing—Provided that this shall not preclude any one, or more individual professors or lecturers *bona fide* becoming examiners in another University—the intent being, that the faculty of any affiliated college, or any part thereof, shall not be permitted to substantially conduct the examinations of their own students for degrees, honors, scholarships, or standing in another University."

Any school applying to be affiliated shall be informed of this regulation, and shall be required to enter into an undertaking to observe it, subject to the express condition that upon breach of such undertaking, the statute shall be repealed and affiliation cancelled."

Yours respectfully,

M.B., TORONTO UNIVERSITY.

March 13th, 1878.

GREAT WESTERN RAILWAY MEDICAL  
TARIFF.

To the Editor of the CANADA LANCET.

SIR, -If too much space has not already been taken up in discussing the subject of the Great Western Railway Provident Society and its relation to the medical profession, allow me to call attention to a few points which seriously affect the profession at large. Mr. Broughton's letter regarded the matter from a commercial point of view. I propose to look at it from a medical standpoint. What shall the conduct of the profession be towards the officer of a company who, by adopting a *cutting-under* tariff, sets himself in antagonism to the tariff of fees adopted by the Division Medical Association?

All division associations which have adopted a tariff of fees, have decided on a dollar as the minimum charge for a single visit to a patient. This action by the profession has been conceded by the laity, as fair between man and man, but if the officers of the Provident Society will take the trouble to compare the old with the new *regime* they will find that the latter will not average fifty cents per visit, out of which they have to pay for medicine. In a malarial district such as the railway passes through near Windsor where quinine is so much required, it would be simply impossible to live at the company's prices. The physician would be compelled to use cheap drugs, his patient's recovery would be delayed, and instead of being a provident it would be an *improvident* society.

Railway employees are, as a rule, well informed men, and general readers; they will very soon discover that they are the victims of *cheap treatment*. One of the prospective advantages of the society's medical employee is, that if he treats the head of the household he will also be called in when other members of the family are ill. This is the point where the code of medical ethics adopted by the profession will clash with the rule adopted by the company. Here is a medical man, by virtue of a rule laid down by a railroad company, secured the *entre* of a family where, only for the fact of his being the company's officer, he would never have been employed. The society's rule has introduced him and supplanted me. Am I to accept the situation in a spirit of resignation, or am I going to

take such a stand as will protect my own interests, and by so doing place myself in antagonism to my brother practitioner? In other words, am I going to extend the etiquette of the profession to a man who is taking away my practice, by a system of *cheap charges*? I trow not.

You state the case correctly, when you say that the medical profession has itself to blame for this state of things, by its members encouraging clubs and societies to benefit themselves, principally at the expense of the doctor. It lies with medical men themselves to say whether they shall stand by one another and secure an honest fee, or lend themselves to clubs, societies, and life assurance companies, to perform the work upon which the very existence of these organizations depend, for the insignificant fee usually offered. The very spirit of the medical act, and the code of ethics instituted under it, are violated; the whole tendency of medical associations which seek to foster and secure fraternal conduct, is defeated by the introduction of such elements of discord.

Mr. Broughton has no very decided opinion of the motives which induced 26 out of 28 physicians to accept the pittance offered by the society. I can tell him that he will find the true explanation of it in the spontaneous desire on the part of medical men to aid any good work—not stopping to enquire into its merits—together with their general apathy about making money, attributes which serve to make the profession in Canada, and perhaps the world at large, poor, where they might be rich; these motives, I say, will furnish the true reasons for the hearty, though ill-considered response he met with in calling for medical assistance on such beggarly terms.

Yours very truly,

C.

Windsor, March, 1873.

To the Editor of the CANADA LANCET.

SIR,—In the March number of your journal, a case of poisoning by arsenic is reported as having been treated by dialysed iron.

After relating the history, he says:—"I administered the emetic and promoted vomiting by large draughts of warm water. After the stomach had been thoroughly emptied, I gave a tablespoonful of dialysed iron, diluted with water, which was



rejected in a few minutes." He then goes on to describe the symptoms of collapse, with the treatment adopted to combat them, and concludes by attributing the woman's recovery "entirely to the dialysed iron."

Now, Sir, inasmuch as he admits that no iron (the antidote) was administered until the stomach had been entirely emptied of its contents, I would like to know in what way he supposed the iron acted.

Yours very truly,  
"MEDICUS."

Ottawa, March 11th, 1878.

### PILIFEROUS SEBACEOUS CYST.

To the Editor of the CANADA LANCET.

SIR:—I enclose you a short account of a case which to me at least seems worthy of inserting in your valuable journal. In November 1876, a young man, J. R.—, came to my office wishing me to remove a tumour about the size of a hen's egg, situated over the mastoid portion of the temporal bone, behind the left ear. He says it has been there for the last 14 years, and as well as he can remember grew to its present size in a few weeks without any previous cause being assigned. It has given him no inconvenience since, only its appearance; it is conical in shape with a broad base and gives a soft ganglionic sensation to the feel. On cutting down upon the tumour which I endeavoured to remove intact, I found it to be cystic in character, filled with a white sebaceous looking matter of a soapy consistence, mixed up in which were numerous black hairs from 9 to 12 inches in length loosely coiled round in the cyst, and of the same colour as the hair of the patient's head. As the cyst walls were very friable, and blood was flowing pretty freely, I broke it up well, evacuated it thoroughly, and filled the cavity with lint soaked in carbolic oil and allowed it to discharge freely for 4 or 5 days. At the end of a couple of weeks it had healed completely with no trace whatever, save the scar.

In the first week of Jan. 1873, two years since first removal, he returned again, it having reappeared he says about a year after the first operation, and attained its former size in a couple of months. It looked similar in every respect to the one before mentioned, but was somewhat larger. Owing to the peculiar nature of the contents of the former tumour

I resolved to remove it completely this time, but as before I found it utterly impossible to preserve the cyst unbroken, the matter oozing out; it also contained the same peculiar black hairs. Having evacuated the contents I got hold of one side of the cyst and carefully dissected it off the bone to which it was firmly attached. On examining the cyst I found that the inside presented a well formed cutaneous surface with a soft velvety feel and was very thickly studded with black hairs proving to my surprise that they had actually grown from the inside. None of those attached were longer than from an inch to an inch and a half, as all the long hairs were lying loosely in the matter unattached. The case seems to me unique: there was no history of previous injury or anything to account for the abnormal growth of hairs within the cyst walls.

Yours respectfully,

D. O'BRIEN, M.D.

Renfrew Feby. 24th, 1878.

### Selected Articles.

#### CASE OF TRAUMATIC TETANUS: RECOVERY.

BY A. LAWSON, M.R.C.S. LOND., PROFESSOR OF SURGERY, HALIFAX MEDICAL SCHOOL, N.S.

The following case is probably sufficiently interesting to be placed on record.

G. S.—, a fisherman's son, ten years of age, living at Sambro, a village about twenty miles from here, on August 1st, whilst running barefooted, accidentally ran against a scythe, receiving a wound about two inches long on the instep of the left foot, which implicated the extensor tendons; also another on the little toe of the same foot, nearly severing the toe. He was brought to Halifax. Sutures were inserted and the wounds dressed. He then went home to Sambro. On August 9th I saw him for the first time, and found him in the following condition:—The jaws were firmly locked; the risus sardonicus well marked; whole body stiffened with decided opisthotonos; great difficulty in swallowing and breathing; sweating profusely; pulse 144; temperature 103°. The wound of instep was granulating healthily, the stitches having evidently sloughed out, and a small piece of bone was protruding from the little toe, which I removed. The poor boy was literally covered with poultices, all the windows religiously closed, and a fire in the stove, although it was a very hot day in August. If left in this condition much longer the boy must

have soon died. Severe spasms were induced by the slightest movement. I gave him immediately fourteen grains of hydrate of chloral, and ordered eight grains to be given every hour, with a mustard poultice the whole length of spine, and milk to be given every time he took the chloral, which however, he could only suck through the teeth, and the difficulty in swallowing made it no easy matter. I remained all night administering the chloral and milk myself.

August 10th.—Pulse 120; temperature 100°. No relief of trismus. Body still stiff, but spasms not so frequent or violent. Ordered a continuance of the chloral, eight grains every hour, with milk, and dressed the wound with carbolic acid and oil (1 to 20).

11th.—Worse again, boy refusing both milk and chloral. Temperature 101°; pulse 136, very weak Profuse sweating; trismus continuing with opisthotonos. I remained four hours, giving eight grains of chloral every hour; he also took about half a pint of milk during this time.

14th.—Doing fairly well. Pulse 116; temperature 99°. But few spasms; trismus slightly relieved; spine still rigid, but the legs could with ease be bent upon the abdomen. Continues chloral, but takes very little nourishment. Bowels relieved by enema; passed quantities of flatus. Wounds healing well.

17th.—Had been doing well since last visit, but boy refused chloral, and the spasm had increased again. Gave sixteen grains of chloral with marked relief, and to continue eight grains every two hours; still taking the milk. Is very weak.

20th.—Decidedly better. Pulse 98; temperature 99°. Trismus and opisthotonos both relaxing. Boy still fights against both nourishment and medicine. To take ten grains of chloral every three hours.

23rd.—Scarcely any spasms except when moved, even then slight. Pulse 88; temperature 99°. Could pass my fore-finger into the mouth.

From this time he recovered rapidly; the chloral was continued in small doses for a week, and then only given at night. On Sept. 7th he was able to get about.

This case is interesting, I think, in that it was a very acute case, in which recovery is rare; that no other drug except chloral was administered; no stimulants; no nourishment except milk, and very little of that, from Aug. 9th until 23rd.—*The Lancet*.

[Several cases of tetanus are reported in the *Lancet* for Feb. 16th in which chloral hydrate either alone or in combination with atropine, cannabis indica or bromide of potassium has proved of great value in the treatment of this affection] Ed. CANADA LANCET.

## PROTRACTED SYNCOPE UNDER THE ADMINISTRATION OF CHLOROFORM.

(Under the care of Mr. Bryant), Guy's Hospital.

T. C., aged fifty-seven, suffering from disorganisation of the metatarso-phalangeal joint of the great toe on the left foot. History of three distinct attacks of gout.

The House-Surgeon commenced to administer chloroform on a "Skinner" of ordinary size, saturated with the anæsthetic. The "Skinner" had just been used in a prior operation of some length for epithelioma of the tongue. The patient soon began to struggle, not strongly, but in a spasmodic, tremulous way. More chloroform was then poured on the "Skinner," and the patient became quiet, when Mr. Bryant, who was about to operate, required him to be moved along the operating table. This was done in the ordinary quiet way, as used with people under an anæsthetic. Almost immediately the House-Surgeon noticed that the respiration had ceased. The patient was pulled back along the table, his head depressed, and artificial respiration resorted to. The femorals of both sides, as felt simultaneously by Mr. Bryant and Mr. F. Durham, had ceased to beat. The tongue was drawn forward, artificial respiration maintained about twenty-eight to the minute. Mr. Bryant assisting the Sylvester method by intermittent pressure on the thorax with the palms of both hands. The colour of the patient during this period was that generally noticed prior to sickness or heart-failure under chloroform. At this time (four minutes from the commencement of artificial respiration), no pulse at the femorals being apparent, four drops of nitrite of amyl, from a capsule freshly broken on lint, was applied to the patient's nose. Almost simultaneously the colour of the face improved and the pulsation in the femorals returned; the patient came round very quickly, so as to be "lively enough now," as Mr. Bryant expressed it, and the operation was continued under ether, the pulse beating well at 120, the respiration good, and quicker than normal.

*Notes.*—The case is a very instructive one throughout, as there was no doubt in the minds of all present that but for the means of resuscitation used the man would have died. The patient had urate of soda deposits in his fingers and toes, knee trouble of the same character, but otherwise seemed healthy. Subsequently his arteries were examined and found slightly affected. The chloroform was very pure (I have since tested it), administered fearlessly, and the efforts for resuscitation attended with complete success. Skinner's "inhaler" is convenient for hospital work, but the material used in it should be changed often. Struggling very often accompanies the administration of chloroform, especially if given boldly to strong, robust

people. The struggling in this case was of that character noticed in persons addicted to stimulants. In either robust or alcoholic individuals is it right to continue the administration boldly? Most emphatically, No. The Edinburgh school may boast of immunity from death by their method, but I think their healthier patients and the purer air may explain much; but whatever it be, no one who administers chloroform to a purely London *clientèle* but will be driven by experience to give it most carefully. The patient should be moved as little and as gently as possible while under an anæsthetic, and also during recovery. In this case there was no excessive movement, the operation was on the foot; the patient had plenty of air. In operations about the jaw, in addition to the dangers consequent on the part, I have seen a difficulty arise from the pressure on the chest, of instruments, or a casual elbow or hand. Sylvester's method of artificial respiration is the best, with this modification: grasp the arm just above the elbow, instead of at the wrist. The reasons are obvious; and the respiration should not exceed twenty-five per minute. When sufficient assistants are present the artificial respiration can be much more efficiently performed by two—one standing on each side of the patient, and working one arm apiece. This is better than only one behind the head; the assistant that pulls forward the tongue and keeps the lower jaw forward can then stand at the head. The tongue should be well pulled forward until the entrance and exit of air to the chest can be heard. The legs should be raised at right angles to the body; this assists the circulation, is an improvement (without interfering with the Sylvester) on the "hanging up head down" plan (which, however, is good in the case of children), and in addition relaxes the abdominal walls. There is no doubt of the efficacy of nitrite of amyl on the circulation; it is now prepared in hermetically sealed capsules, which can be obtained sufficiently strong to carry loose in the waistcoat pocket. I have broken only one so carried during the last twelve months. Those containing five drops are the most useful. I think the strength and frequency of the pulse after resuscitation on this occasion were entirely due to the amyl. Should the patient not come round in six or seven minutes, I should recommend immediate tracheotomy or laryngotomy, as I think the air passing direct through the tube is a stronger stimulant than when passing through the normal passages warm and already impregnated with chloroform vapour. If ice be handy, a piece put in the rectum can do no harm, and has been already noticed as of avail; it interferes in no way with the rest of the process. If the heart still continues beatless after the inhalation of the nitrite of amyl, I should feel inclined to puncture the pericardium, so as to reach the apex of the heart with the electric needle. This

being unsuccessful, the substance may be pierced. In no case ought artificial respiration to be relaxed until the above measures have been tried, when, if the patient has undergone a very serious operation and a long anæsthesia, I trust the operating surgeon will always share the result with the administrator of chloroform.—*Medical Times and Gazette, Feb'y. 16, 1878.*

#### ON PARACENTESIS OF THE PERICARDIUM WITH A SUCCESSFUL CASE.

BY WILLIAM PEPPER, A.M., M.D.,

Prof. Clin. Medicine, University of Pennsylvania.

GENTLEMEN: You will remember that in connection with two cases of pericarditis of moderate severity, which formed the subject of a lecture several months ago, I referred to a desperate case of pericarditis, with effusion, in which it had been necessary to perform paracentesis. My chief object to-day, in returning to the same subject, is to report at length the latter case, and to make a few practical remarks in connection with that operation.

Sarah C., æt. 17, a well-developed girl, enjoying general good health, had noticed since May, 1877, some shortness of breath on exertion, especially after mounting the long flight of stairs leading to the fringe factory where she worked. She had also been obliged to pass urine more frequently than usual. She had never mentioned either of these symptoms to her parents, fearing that they would make her stop working. In early childhood she had passed through a mild attack of measles; but had never had any other exanthem or rheumatism. On Sunday, September 2, she suffered with præcordial pain. No cause could be assigned for the attack, unless it were that she had been chilled by a draft which blew upon her as she worked. On Monday the pain continued with some sense of oppression. She did not leave the house, but it was not until Wednesday, September 5, that she became quite suddenly so ill as to confine her to bed, when she was seen by Dr. George Rex, with whom I saw the case in consultation, and to whose courtesy I am indebted for many of the facts in connection with it. He found her with a very moderate degree of fever, but with some anxiety and distress, and with rapid pulse, frequent breathing, and severe præcordial pain. By Friday, September, 7, she was much worse. There was still severe præcordial pain with great restlessness and distress. The respiration was very frequent and much laboured. The pulse was extremely rapid, feeble, and irregular. The apex beat of the heart was felt with difficulty, and the

sounds were feeble and distant, though apparently without valvular murmur. The area of cardiac dulness was increased. The tongue was moist and somewhat furred. The stomach was retentive, though there was no appetite. The urine was rather scanty. From time to time there were paroxysms of terrible dyspnoea and cardiac distress, in some of which she seemed almost asphyxiated. Her condition became, in all respects, somewhat worse during Saturday and Sunday, and, in addition, there were on the latter day two convulsive attacks, with loss of consciousness for a few minutes, and slight muscular spasms of the face, arms, and legs.

I saw her in consultation with Dr. Rex, first on Sunday night, September 9. The patient was lying in bed, with but a single pillow under the head. The face was very pale, and the lips livid; the extremities tended to be cold. There was extreme restlessness and jactitation, with a sense of suffocation if any one even approaches her. It was necessary to fan her constantly. The respirations were over 60; the pulse at least 145; very small, feeble and intermittent. The pupils were dilated; the expression very anxious; the intelligence clear. There were constant complaints of severe præcordial pain. The paroxysms of alarming dyspnoea were now very frequent. On physical examination no lesion of the lung was found. The præcordia was somewhat prominent. The impulse of the heart could neither be seen nor felt, and its sounds were hardly audible, being distant and feeble, and apparently without murmur. The point of their greatest intensity was at mid-sternum, opposite the third interspace. At the normal position of the apex-beat no sounds were audible. No friction sounds were heard. The area of cardiac dulness was much enlarged, and of rudely triangular shape. Its base was on the level of the seventh rib, and extended from one inch to the right of the sternum to two inches to the left of the line of the left nipple: the upper limit of the dulness was the second interspace. Its greatest transverse diameter corresponded to the level of the fifth interspace. Changes in the position of the patient's body produced no effect on the horizontal lines of dulness.

The urine contained a slight trace of albumen, and microscopic examination showed a few fragmentary hyaline or granulo-hyaline tube-casts, and a few cells of renal epithelium. There was no œdema of any part, save a slight puffiness about the ankles. The question of tapping the pericardium was discussed, but the parents would not consent. She had been using digitalis and a diuretic mixture. These were continued, ten drops of digitalis being given every three hours. A blister four inches square was applied over the præcordia. She objected violently to stimulants, even in very small doses, asserting that they immediately caused agitation of the heart, with great distress in the head.

On the other hand, Hoffman's anodyne gave some relief to the paroxysms. During Monday and Tuesday (September 10 and 11) she grew worse, if possible, and had several slight convulsive attacks. I saw her again with Dr. Rex, late on Tuesday night. She was then dull and listless, with livid lips and cold extremities. The respirations were mere shallow gasps 75 to 80 in the minute. The pulse was over 100, extremely thready and intermittent. At times, also the respirations were distinctly of tidal character, ascending and descending with marked intermissions. Each paroxysm of dyspnoea seemed as if it would prove fatal, and it seemed clear that death would occur before morning. The consent of the parents being obtained, I immediately performed paracentesis of the pericardium with the assistance of Dr. Rex and of C. B. Nancrede. The smallest needle-pointed canula of Dieulafoy's aspirator was employed, with a vacuum jar. The puncture was made in the fifth intercostal space, about one inch inside of the line of the left nipple, *i. e.*, nearly in the normal position of the apex-beat. The needle was introduced in a direction upwards and inwards. As soon as its extremities were fully covered by the soft tissues, the communication with the vacuum jar was opened, and the needle was cautiously pushed onwards. When the liquid began to flow into the jar, and the point of the needle was felt to be free in the pericardial sac, the needle was directed somewhat downwards and outwards. Rather more than eight fluid ounces of reddish serum were removed, after which the flow ceased. The serum contained a large proportion of albumen, many red blood globules, and a large proportion of pseudo-fibrin. No difficulty whatever was encountered in the operation. Once or twice the point came in contact with a firm and apparently roughened surface, which was probably the apex of the heart, coated with lymph. The effect of the operation was magical. The pulse fell to 114, became regular, and much more full. The respirations soon fell to 40, and became much more deep and regular. The apex-beat of the heart could be felt, though still feeble and too high up. The cardiac sounds became immediately much more distinct. The lips grew more red, and the expression improved vastly. She expressed herself as feeling much better, and able to lie quietly. She was ordered iodide of potassium gr. v. and tincture of digitalis gr. x, each every four hours. The diet of skimmed milk was continued. There was no evidence of any return of pericardial effusion, and for two days she continued very comfortable, although the urine was still faintly albuminous. On Friday, September 15, two severe convulsions occurred; the mind grew dull; the respiration again became rapid, and tidal in character; and the pulse intermittent. On September 16 she continued in a partially uræmic state, with several convulsions.

Still no sign of increased pericardial effusion occurred; but, on the other hand, the area of dulness progressively diminished, and the impulse and the sounds became more distinct. On the evening of this day an enema of infusion of jaborandi (5j of powdered leaves in ʒiv water) was given. The effects were rapid and marked—violent headache, repeated vomiting, copious salivation, and drenching sweat, lasting six or seven hours. She passed a more quiet night, and was better the following day. The pulse was now regular, and more full—108 in the minute; and the breathing easier. The cardiac impulse and sounds more distinct, and slight friction sound audible. The use of digitalis, iodide of potassium, and diet of skimmed milk continued.

She had two convulsive attacks on September 17, and on September 18, three severe attacks, in all of which she was unconscious, with frothing at the mouth, and general convulsive movements. The cardiac symptoms continued to improve. There was a trace of albumen in the urine, but no tube casts could be discovered. On September 19, a second enema of infusion of jaborandi was given with the same prompt and severe effect. No further convulsions occurred. The cardiac symptoms continued to improve slowly but steadily. There was no severe dyspnoea after September 28. She was able to leave bed on October 7, twenty-six days after the operation, and from that onward her progress towards recovery was quite satisfactory.

*Remarks.*—It will be seen that in this case the preservation of life was solely due to the operation of paracentesis. It seemed abundantly evident that, on the evening of September 11, without immediate operative relief, life could not be supported through the night. The renal complication which existed was probably due to the pericarditis and, after the heart's action was liberated, it became possible to deal successfully with the uræmic symptoms. In this connection, it is interesting to note the great value of jaborandi. We have in this remarkable drug a new agent of vast power for the relief of such symptoms. After the operation, there was not the least sign of any return of pericardial effusion, and, although it is probable that adhesions have formed, there are no evidences at present that the heart's action is embarrassed by them. So far as the original disease is concerned, it may be said that a complete cure was effected. The subsequent attacks of subacute peritonitis, and of plastic pleurisy indicate a constitutional character for all of the successive affections of the serous membranes, and I fear that it may prove that they have been tuberculous. \* \* \* \* \*

You will, of course, perceive that at the basis of these practical rules lies the question of an accurate diagnosis. Fortunately, in the vast majority of cases, this can be made without serious difficulty. It is indeed true that errors in diagnosis have been

made even by skillful and experienced observers; but in such cases it will be found that very unusual complications or anomalous conditions existed. Certainly, if the case is an acute one, and has been under observation while the effusion formed, an accurate diagnosis can readily be made. Nearly always there will have been a friction sound of cardiac rhythm, and this may persist, especially about the base, even after considerable increase in præcordial dulness from effusion has been developed. Then, carefully repeated percussion will show at first extension of dulness about the base of the heart, but soon this will be followed by a change in the shape of the area of dulness, which assumes a rudely triangular form with its base downwards, together with a decided extension of the area. If percussion be practised both when the patient is in the sitting and in the recumbent position, scarcely any difference will be observed in the horizontal level of the dulness, but if the patient be turned first to one side and then to the other, it will often be found that the area of dulness, without changing its shape, has some mobility from side to side. The position of the apex-beat of the heart will also be observed to change as the effusion occurs; it becomes raised more and more, and then becomes lost, though sometimes an obscure sense of shock can be felt over the præcordia after a distinct cardiac impulse can no longer be detected. The sounds of the heart become markedly feeble, distant, and obscure; and the centre of their greatest intensity may be observed to vary from its normal position. In addition, there may be found, in cases of very large effusion, prominence of the præcordia, slight bulging of the intercostal spaces over the heart, and even fluctuation on palpation. If the case has been under observation from the beginning, and careful attention has been paid to the above signs, a large pericardial effusion can scarcely escape detection—unless, indeed, there should coexist pleurisy with effusion on both sides, or on the left side alone. In this event it would probably be impossible to decide as to the presence or absence of pericardial effusion until the liquid has been withdrawn from the left pleural sac by aspiration. If the combined effusions were not sufficiently extensive to cause symptoms demanding operative interference, the ordinary treatment for pleurisy would suffice; while if such symptoms did appear, as in all probability they would, it would be proper to tap the pleural sac first, after which the pericardial effusion could be easily recognized, and treated as seemed appropriate. The case where the greatest difficulty occurs in the diagnosis of pericardial effusions are those which come under observation only after the disease has lasted some time. Here we could scarcely expect to find friction-sounds, and we would be without the valuable aid furnished by observing the progressive changes in the extent and shape of the area of dul-

ness, and in the position of the apex-beat. We must then rely upon the prominence of the præcordia; the enlarged triangle of dulness, with its base below; the absence or altered position of the apex-beat; the distant and feeble character of the heart-sounds; the displacement of the anterior border of the lungs; and the extreme disturbance of circulation and respiration. It is true that an enlarged and dilated heart has been mistaken, and has even been tapped, in mistake, for a distended pericardial sac. But a searching investigation into the history of the case—the fact that the apex-beat, however feeble, is on the lowest level of præcordial dulness—the shape of the area of dulness, which here also is triangular, but with its base upward and to the right; and the character of the heart-sounds, which, though, feeble, are much less distant and obscure than in large pericardial effusions—all of these will combine to enable a correct diagnosis to be made. Again, a solid, mediastinal tumor has been mistaken for a distended pericardium; but I am confident that close attention to the diagnostic points I have given would prevent the commission of this error. —*Med. News and Library.*

#### BLOODLESS TRACHEOTOMY.

Everyone who has been called upon to perform tracheotomy upon a young child suffering from threatening asphyxia, where the venous plexuses of the neck are engorged, and each touch of the knife may flood the wound with blood, will appreciate any method of operating by which this danger can be avoided, and tracheotomy added to the list of the bloodless operations. The attempt to accomplish this has been several times made. In 1872 M. Verneuil employed the galvanic cautery instead of the bistoury in several cases with success; but this method is evidently ill-adapted for general use, as the necessary apparatus is cumbersome, and only to be found at hospitals. More recently Mons. G. Poinset, of Bordeaux, has used Paquelin's thermo-cautery with excellent results, and his example has been followed by other French surgeons. The skin and soft parts quite down to the trachea should be divided by successive light touches of the point of the cautery, heated to a dull red color, and when the trachea has been exposed it should be opened with the knife, and the tube inserted in the usual way. The cautery must be used lightly, or its action will be too extensive, and a thick eschar be formed; and if it be used too hot, as is well known, it loses its hæmostatic power. The cautery is not suited for opening the trachea, because the radiation from its hot point introduced into the air passage would be harmful, and there is some risk of burning its posterior wall; while in adults it is difficult to sever the firm rings with it, and particularly if they are at all ossified, and the loss

of substance that an eschar necessarily involves might cause trouble from narrowing of the air-tube. On the other hand, as the use of the knife for this purpose does not cause hæmorrhage, it is free from objection. In fat subjects the wound may become filled with molten fat; this is readily removed with a sponge. In addition to the bloodlessness of this mode of operating, Mons. Poinset claims for it two other advantages—the spontaneous retraction of the edges of the wound, rendering unnecessary the aid of assistants for this purpose, and giving a funnel-shaped opening down to the trachea; and the protection of the wounded surfaces from the contagion of diphtheria. Slight secondary hæmorrhage has followed this operation in several cases, but in no case has it been severe, yielding readily to simple treatment. Although the wound gapes widely at first, the resulting cicatrix contracts to a small size, and has not given rise to any unpleasant symptoms in any recorded case. This appears to be one of the most useful applications of this recent addition to the surgeon's armamentarium. It promises to change tracheotomy from an operation which is always anxious and often very trying into a safe and simple proceeding; and we may hope that it will, in this way, add to the value of the operation by leading to its more frequent and earlier adoption in obstructive diseases of the larynx.—*The Lancet.*

#### RAPID CURE OF ANEURISM OF THE ANTERIOR TIBIAL BY ESMARCH'S BANDAGE.

For the notes of this interesting case we are indebted to Mr. G. W. Rigden, house-surgeon, Tamton and Somerset Hospital.

A young agricultural labourer, aged twenty, was admitted into the hospital with the following history:—During the last week of August he wounded his right leg with a scythe. He lost a large quantity of blood at the time, but the wound healed after he had been in bed about a month. When he began to get about he noticed that his foot dropped on that side, and for this he came to the hospital for advice.

On admission, it was found that he could not raise his foot on the affected side, but there was no stiffness of the joint, the whole foot being perfectly flaccid. The cicatrix of the wound was noticed, about the middle of the outer side of the leg, and beneath this was found an ill defined tumour, deep in the muscles of the leg, which exhibited a distinct pulsation synchronous with each beat of the heart, and on listening with a stethoscope a distinct bruit could be heard.

After he had been kept at rest in bed a few days, the tumour became much more defined; it was less in size, but the margin of it much more distinct; it was very deep and appeared about the

size of a small hen's egg. There could be no doubt it was a traumatic aneurism of the anterior tibial. It was resolved to attempt to cure it by means of Esmarch's bandage in the manner recommended by Mr. Thomas Smith in *THE LANCET* of May 26th, 1877.

On December 2nd, at 11.20 A.M., a flannel bandage was applied from the toes to the tumour, and a second bandage from the tumour to the middle of the thigh, leaving the tumour itself exposed. Esmarch's bandage was then applied with modern tightness from the toes to the tumour, and the patient made to stand out of bed, in order to fill the tumour well with blood. Esmarch's bandage was then applied from the tumour to the middle of the thigh, and the thick india rubber tubing firmly fixed above it. The tumour itself being still exposed, it was noticed that the pulsation in it was quite arrested, and no bruit could be heard with the stethoscope. The patient was then directed to keep quiet in bed with his leg well raised on pillows. He did not complain of any pain till twelve o'clock (forty minutes), when he began to have the sensation of pins and needles in his foot; this pain had become so intolerable at 12.20 (one hour after the application of the bandage) that a horseshoe tourniquet was fixed firmly at the groin, and the india-rubber tubing and Esmarch's bandage removed, the flannel bandages being allowed to remain. It was noticed that though the colour returned to the limb, no pulsation could be felt either in the tumour or in the femoral artery. A dose of chloral hydrate was given, and the patient directed to keep quiet. At 3.30 P.M. a pad of lint was fixed by strapping on the line of the femoral, and the tourniquet slightly relaxed. It was further relaxed at 4.30 P.M., and removed altogether at 7 P.M. The patient was put on a milk and beef-tea diet, and directed not to move if he could possibly help it.

There has never been the slightest return either of impulse or bruit; the tumour has gradually become smaller till now it cannot be felt at all; the power of lifting the foot returned as the tumour diminished in size, and now, in less than three weeks, is almost natural. The patient will be discharged in a few days.—*The Lancet*.

**PROSTATIC TUMOR REMOVED DURING LITHOTOMY.**—Mr. Bryant exhibited specimens of prostatic tumours which he had removed successfully during lithotomy. The first specimen was from a man of sixty-seven, who was operated on in Guy's Hospital in January, 1875, after having suffered from symptoms of vesical calculus for eighteen months. The blunt gorget was used; the stone was caught, and found to be large; a resistance was felt, and discovered by the finger to be a pros-

tatic tumour situated between the stone and the hinge of the forceps. The whole was removed, when the calculus proved to be one inch and a half, in diameter, and the tumour to consist of prostatic tissue and muscular fibre. There was no hæmorrhage, and recovery was perfect. The second specimen was removed from a gentleman of seventy years, who had suffered from vesical symptoms for four years, and was extremely ill. Lithotomy was performed; the gorget had to be used; and the stone, when seized, could not be extracted. A portion of the prostate was then ascertained to be in the way, when, by rotation of the forceps and pressure backwards on the tumour, the hinge of the instrument caught the growth, and both it and the calculus could be extracted. The patient was perfectly well in six weeks. The growth consisted of prostatic tissue. Mr. Bryant said that in both these cases the patients had been relieved of stone and of another cause of distressing symptoms by a single operation. Convalescence was not affected by the operation. In other words, benefit seemed to have followed the removal of prostatic tissue. It appeared to him that in a similar case the surgeon might follow his practice, or even search for the condition; but he would hardly suggest operation for the relief of symptoms due to enlarged third lobe of the prostate. The operation had first been mentioned by Sir William Ferguson thirty years ago.—*Med. Times and Gazette*.

**THE COMING DUTIES OF THE ACCOUCHEUR.**—Prof. Gaillard Thomas, lecturing on a case of neglected preclapsus uteri, makes (*New York Medical Record*, December 22) the following observation:—

"The time is not distant when confinement cases will be treated very differently from what they are at the present day. This is a subject of the utmost importance. There is the most urgent need of a radical change in the practice of the majority of the profession, and the time is ripe for the appearance of a stirring and able paper on 'The Proper Management of Natural Labour,' which will awaken medical men to a sense of their duty in obstetrical cases. The physician should be expected and required to visit his patient from time to time all through her pregnancy, in order to see that everything is progressing favourably for a successful delivery, and to remove, if possible, any condition (as albuminuria, for instance) which is likely to interfere with this; and I am fully convinced that it will not be long before the accoucheur who does not pursue this plan will be held culpable. Again, he will be held equally culpable if he discharge his patient at the ninth day, or at the end of a fortnight, without making a physical examination, to ascertain that the parts have sustained no injury from the strain and pressure of parturition, and that the process of restoration to the normal

condition is going on satisfactorily. A little attention paid at that time will often prevent the most serious consequences in the future. If the physician had made such an examination in this case, and had found the cervix lacerated, he might have waited a month, and then, ascertaining that trouble was resulting from it, he should have sewn it up, and also restored the perineal body which had given way. . . . All this could have been readily done in the second month after delivery, and it would certainly have been a great deal better to do it than to wait thirteen years before undertaking the operation. It is true that this woman has suffered comparatively little pain and inconvenience in consequence of the neglect of her physician, but this is a very rare exception to the general rule; and, as I said before, the time is not far distant when the medical man will be held responsible for allowing such a condition to continue without interfering to prevent the evil results so sure to follow from it."—*Med. Times and Gazette.*

**THE EXCISION OF HARD CHANCRES.**—Professor Auspitz, of Vienna (*Vierteljahrsschrift für Derm. und Syph.*, 1877), has excised the primary syphilitic induration, or hard chancre, in thirty-three cases, as first recommended by Hueter in 1867, with the following general results:—1. In a large number of the cases no further syphilitic symptoms appeared, although at the time of the operation there was almost invariably indolent enlargement of the inguinal glands. This fact Auspitz regards as a proof that the initial sclerosis is not a pathological result of a pre-existing general systemic infection, but a starting-point or an original depôt for the infective material by which syphilis is transmitted. 2. In those cases where no secondary induration appeared after excision in the seat of the former chancre, there were, as a rule, no further symptoms of syphilis. 3. In some cases excision was followed by secondary induration and a general outbreak of cutaneous and other syphilitic phenomena, but here the probability is that either the whole of the original chancre was not removed, or that the disease had spread too far along the neighbouring bloodvessels before excision was performed. 4. In four cases the hard chancre was preceded by a soft sore, and in none of these did general symptoms follow excision. 5. The operation can be recommended as a preservative measure against general infection where the induration has been of short duration, where no lymphatic glands are indurated but the inguinal glands, and no other syphilitic symptoms are to be detected; and where the chancre is favourably situated, and can be properly dressed and attended to after the operation. 6. Further evidence is required to shew whether excision exercises any influence on the duration or severity of the general syphilitic symptoms in those cases in which it fails

to prevent their outbreak, but there are grounds for believing that it possibly may. On the whole, Professor Auspitz's results are extremely encouraging, and deserving of serious attention. "Prevention is better than cure" is an adage which is certainly applicable to the treatment of syphilis.—*Med. Times and Gazette.*

**CÆSARIAN SECTION.**—Dr. J. Braxton Hicks performed this operation at Guy's Hospital, upon a patient whose vagina was occupied by a scirrhus mass, which involved the rectum and recto-vaginal septum. The placenta was found beneath the line of incision, and the fetal head at the fundus uteri. However the membranes were reached from the lower end of the uterine wound, the head seized, and brought out first. There was very little hæmorrhage. The uterus contracted firmly after the removal of the placenta. The uterine wound was brought together by interrupted silk sutures closely placed, and a large catheter retained in the uterus, passing through the vagina, to prevent accumulations and to facilitate injections in case of need. The child, slightly premature was living up to last account.—*Ibid.*

**IMPACTED FRACTURE OF SHAFT OF FEMUR.**—Mr. Bryant also showed this specimen. A man of eighty-three fell down area steps, and believed that he alighted on his right knee. It was found that the right limb was shortened four inches; the position of the foot was normal; and there was crepitus to be felt above the knee. The diagnosis made was fracture in the lower third of the femur, and a splint was applied. The man died three weeks after of uræmia; and, post-mortem, there was found suppuration of the kidneys. At the junction of the lower and middle thirds of the right femur there was extensive fracture, and the proximal portion was driven one inch into the distal portion of the bone, causing a second fracture of the lower fragment above the condyles. Mr. Bryant said that this was probably the only specimen on record of the kind; and that the peculiar impaction was perhaps due to the patient's having fallen on the distal end of the bone. The condition explained why extension failed to reduce the shortening; and it suggested the advisability of letting parts alone under such circumstances, rather than run further risk, including the danger of vertical fissure of the bone.—*Med. Times and Gazette*, Feby. 16th 1878.

**ADAM'S OPERATION IN ANCHYLOSIS OF THE HIP.**—This is the third of a series of cases in which Mr. Bryant performed Adam's operation for relief of ankylosis of the hip. The ankylosis resulted from disuse while suffering from necrosis of the tibia. The necrosed bone was removed Nov. 5. 1875, ten months after the accident that led to the



disease. The femur was divided on the 23rd of the same month. The following is from notes on the case taken by Mr. Poland :

"November 23.—Chloroform having been administered, a small incision, half an inch long, was made with a long tenotomy-knife above the great trochanter of the left side, through the soft parts down to the neck of the bone, and then with a saw the neck of the femur cut through, and the thigh straightened. The Sartorius muscle was divided at the anterior superior spine subcutaneously, and the small wounds covered with a pad of lint. A large outside splint, with foot and cross-piece, was applied, and a morphia injection given, which eased the pain, but he was a little sick after the operation." Both wounds did well. He complained of great pain in his back for a few days, but this soon wore off.

"February 10, 1876—He was sent down to Bognor. There was still a little discharge from the right leg.

"When at Bognor the wound over the tibia completely closed. He could walk well, the parts about the hip having firmly consolidated."—*The Lancet*, Nov. 17, 77. *Med. Record*.

EXCISION OF THE SPLEEN.—Another case of splenotomy has been put upon record by Mr. H. L. Browne. After all the dangers had been thoroughly explained to the patient, the operation was performed on Feb. 23, 1877, in the West Bromwich Hospital. There were no adhesions, nor was there any distinct pedicle. Four large arteries were met with, which were secured by double ligatures before division, and also their veins. There was no hemorrhage. The lad rallied very well from the chloroform, but five hours afterwards died suddenly. There was no hemorrhage after the operation. The tumor, which was found to be a simple hypertrophy of the spleen, was eighteen and a half pounds in weight.

No theory of the cause of the disease is offered. The lad had leucocythemia. There was no other glandular affections. The youth of the patient (20 years), the almost certainty of a splenic tumor being non-malignant, the absence of other disease, and the fact that the patient was dying, and would have died in a few days from the pressure alone on the viscera and blood-vessels by the weight of the tumor—these are some of the strongest reasons why the operation was and should be performed.—*The Lancet*, Sept. 1, 77. *Med. Record*.

TWO CASES OF STENOSIS OF THE TRICUSPID ORIFICE, WITH OBSERVATIONS.—By R. P. Howard, M.D. Montreal 1877.—This paper is reprinted from the Transactions of the Canada Medical Association for 1877. The first case of especial interest, having been under the author's observation for fifteen years. The patient had chorea when

eight years of age, but never rheumatism; and during life the physical signs pointed to mitral and aortic disease, and, finally, tricuspid regurgitation, but the tricuspid stenosis was not diagnosed. Death occurred from cardiac dropsy, and the right auricle was found "capable of holding a good sized orange," its muscular walls, which were fatty degenerated, being greatly thickened. The tricuspid orifice admitted the little finger to the first joint, the valve-cusps being united, and forming a fibrous septum. This contraction was greater than that of the mitral orifice, which was also funnel-shaped, and the aortic orifice was similarly stenosed from cohesion of the valve cusps. The second instance is that of a heart in the McGill College Museum, and a figure is given in the paper showing the oval tricuspid orifice formed between united cusps. There was marked mitral stenosis in this case also, and the aortic valves were thickened. Dr. Howard notes the almost invariable association of tricuspid disease with affections of the other valves, and he contends against the idea that the lesion is of congenital origin.—*Lancet*.

SCARLATINA BY LETTER.—Under this heading the newspapers narrate a case in which scarlatina was undoubtedly communicated by letter, from an infected house to a previously healthy family. The children "had the envelope to play with," and took the disease. We have, in *The Lancet*, repeatedly called attention to this risk. It is satisfactory to know that a not uncommon, but too long overlooked, method of infection is at length beginning to be recognised. The danger which attends the practice of writing letters, and sending papers, books, and parcels, from sick rooms to disseminate the "germs of disease" is of no small magnitude. Probably paper, in its familiar forms, is as effective a carrier of morbid material as linen or wool. The notion of "disinfecting" books and letters is practically untenable. Such means of infection should be themselves destroyed. Circulating libraries are too often the circulating media of communicable disease.—*The Lancet*.

DIFFERENCES BETWEEN ANÆMIA AND CHLOROSIS.—Zimmermann, in *Ziemssen's Cyclopædia*, XVI., page 501, gives the following: 1. In chlorosis proper the change in the blood appears to be strictly limited to the red corpuscles, whereas in anæmia, other constituents of the blood, especially the albuminates of the plasma, are also modified. (2). In many respects the etiology of chlorosis is peculiar and obscure and its pathogeny does not admit of being traced, like that of ordinary anæmia, to causal factors with which we are familiar. (3). The striking effects of suitable treatment would oblige us, even in default of other reasons, to separate chlorosis clinically from other forms of anæmia.—*Clinic*.

# THE CANADA LANCET.

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TORONTO, APRIL 1, 1878.

## RECIPROCITY IN MEDICAL REGISTRATION.

The next meeting of the British Medical Council takes place in May, and as the question of the registration of Colonial graduates, will probably come up, it is very desirable that some decision may be arrived at, by which all those who are registered and entitled to practice in Great Britain or any of her Colonies may "*ipso facto*" be considered equally qualified to practice in either, on payment of the proper registration fees, and without further examination. The inconvenience of the present state of things, and its unsatisfactory results scarcely require to be urged. They were sufficiently illustrated by the action of the Board of Trade a year ago, and are experienced by all who have visited England for the purpose of obtaining diplomas, or of remaining to practice, in proof of which may be noticed the numerous letters on the subject from Foreign and Colonial graduates in the English medical journals, and the recent formation of a society at Birmingham, with the object of obtaining recognition of such degrees. The appointment of Dr. Gowan to the superintendency of the Toronto Lunatic Asylum a little over two years ago, is an instance of the inconvenience, working the opposite way, where a highly qualified and experienced English physician was legally incapable of practising here, because he declined to submit to examination by men whose equal he was in experience and professional acquirements.

The British Medical Council has already expressed its willingness to register Colonial degrees, but in a manner that only partially meets our wants, as the distinction that is made by inserting the Colonial degrees in a separate section of the Register, implies, that there is a difference in the

nature of the training given here, or a doubt as to the sufficiency of the examinations to render us worthy to be associated with men holding British qualifications. It is not stated, moreover, whether such registration would entitle a man to hold office under the Local Government Board. If not, it would be of but little value, as it is a well known fact that the holding of a poor law appointment in country practices is almost essential to success in many cases. If, however, we ask for our graduates the privileges enjoyed in England by home graduates, we must at least be prepared to concede something in return. It seems that there is amongst our Ontario Medical Council a feeling of jealousy that makes them resent a man's going over to Great Britain and obtaining his qualifications there, rather than here. It is looked on as a slight to the College, and as an attempt to set it at defiance, and is punished by a refusal to register his British qualifications without further examination here, on the ostensible ground that these qualifications are conferred by irresponsible close corporations, instead of, as here, by a body chosen by the profession and responsible to it, for the proper performance of its duties.

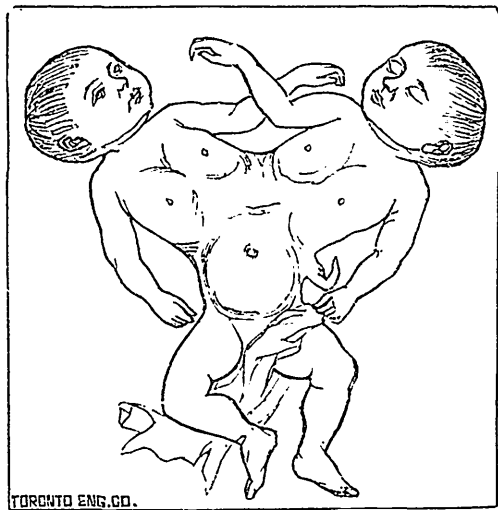
Surely this is a mistake. Desirable as it doubtless is, that there should be in Great Britain but one portal into the profession, yet there is no ground for assuming that the examinations there are imperfect, or slurred over in any way, while the practical advantages derived from the abundant clinical material and instruction in the old country hospitals, are so great that every encouragement should be offered to the student who desires to avail himself of them. The majority of Canadian students have but slender pecuniary resources, and these are frequently taxed to the uttermost in their efforts to benefit by the educational advantages of Great Britain, and to exhibit the proof of having done so, by acquiring the right to append to their names the various home professional titles. The objection entertained by the student who has spent time and money thus, to increase his already great expense by paying a further sum for examination in subjects he has already proved himself proficient in, should be attributed to this, its true cause, and not to any disrespect for the qualification conferred by the Ontario Medical Council. It would be more generous, and conduce to the advancement of the profession in Canada if he were met half-way, and the

same professional value accorded to his degree that it would obtain on the other side, i. e., entitling him to practice medicine, surgery, midwifery, any or all of them as the case might be; while if his qualification only extended to one of these, he should be allowed to submit himself to examination in the others at a reduced proportional fee. The same privilege should be granted to those who have pursued their studies entirely within the limits of the United Kingdom. The question of the diminution of the revenue of the Council ought not to be considered in this matter at all, and in point of fact it is not probable that the plan proposed would materially diminish it, for the number of those who go over yearly is very small, and would not be likely to be much increased by this concession. On the other hand against the small loss of revenue which might ensue, ought to be placed the advantage it is to the country to have its medical men possessed of the most extended experience and attainments possible; the spread of that "esprit de corps" that might be expected to result from the union of the profession throughout her Majesty's dominions into one body existing under the same conditions, and enjoying the same privileges, and which ought to distinguish medical men everywhere, instead of those of each Province being jealous of each other, and striving by local rules and regulations to prevent outsiders from competing with them. Lastly, the admission by Ontario of British graduates to registration on the terms here suggested, would open the way to according similar advantages in Great Britain to those who had obtained the imprimatur of the Ontario College.

It must be borne in mind that one great obstacle to the recognition of our diplomas by the British Medical Council is the existence of varied regulations in different Provinces. Melbourne, for example, seeks the same advantages for her graduates that we do for ours, and throws the same obstacles in the way of registering British diplomas. The end desired can only be obtained by the assimilation of regulations for qualification everywhere, and should the proposed conjoint scheme of examination for Great Britain be adopted at the next meeting of the British Medical Council it may be found advisable for us to modify our own regulations slightly, so as to bring them into conformity with those contained in it, if it be practicable to do so.

### WONDERFUL LUSUS NATURÆ.

There is at present in Montreal, one of the most remarkable and interesting specimens of abnormal genesis of which we have any record on this continent. It is in reality a case of monopelvic, twin female children. They were born on the 28th of January 1878, at the village of St. Benoit, Que. a midwife only officiating. The mother is a young woman about 20 years of age, of medium stature, mild expression, light complexion, and a good nurser. It is her second birth. The father is a tall man, of dark complexion, aged about 23; both parents are well formed, and no such freak of nature was ever before known in the family. We append the following wood-cut which gives but a faint idea of them as they really appear to the professional eye.



Looked upon as they lie in the cradle, they appear to be two distinct infants, with their heads lying in opposite directions, healthy and rather good looking. On exposing the lower parts, the two bodies are seen to blend in one, at the point of ordinary situation of the liver of one, and the spleen of the other. The heads, arms, thoracic organs, and apparently stomachs are distinct; but there is only one umbilicus, and apparently but one abdominal cavity, one pelvis, one sexual apparatus (well formed female), and two legs as in ordinary formation. The spines blend in one about the 12th dorsal vertebra and growing out of the left loin, near the pelvis is a rudimentary arm

(which has been taken to be a leg) having a humerus at the elbow, lower arm, and a partial hand terminating in one finger. This possesses power of motion, and opens and closes with the child's will. Passing the finger over the spine, it is found highly sensitive and easily disturbed. When nursing, the children lie in the mother's lap so as to be able to take each a breast and nurse at the same time, with the legs extended out in front of the mother, and the rudimentary arm lying closely pressed to the back and finding accommodation in the space between the mother's knees.

Looking at them, at first glance they appear as if a perfect child were on the left side, lying in a bent position with another child engrafted on its right side, and becoming blended into one below. They are now being exhibited in Montreal as a natural curiosity, and the fatigue entailed may prove disastrous to their health, and thus the father may find he has killed the "goose that lays the golden egg" by exhibiting them prematurely.

#### PREVENTION OF OBESITY.

The part which water plays in producing increase of adipose tissue in the human system can scarcely be over-estimated, for without a liberal supply of this important fluid it is impossible to become fat. A liberal supply of the carbonaceous elements of diet are supposed to induce obesity, but this would only produce derangement of the digestive organs without having its due effect in producing fat, unless accompanied by the needful supply of water, and it will be invariably found to be a fact that great water drinkers are prone to become fleshy. This is the fact with respect to both man and beast. In fattening animals the more water they can be induced to drink, as every farmer knows, the easier and more rapidly are they fattened, while observation proves that fat men and animals are always great drinkers of water or some of its solutions, and small eaters of solid food; on the contrary lean people and animals are small drinkers and great eaters.

Now applying these observations to the human system it will be readily understood that using the excessive quantity of carbonaceous food as is the custom of most persons, the additional chemical elements furnished by the water, at once facilitate

the metamorphosis into fat in the system. And when unused for the purposes of combination or when its change is retarded by the presence of the small quantities of alcohol present, as in lager beer, ale, &c., fat is deposited and the person becomes obese. It follows then that abstinence from water or rather from fluids, generally is the first requisite in the prevention of obesity, or the reduction of weight, when this is desirable. Mental and bodily activity are also unfavorable to the deposit of fat in the system. But, although lager beer drinkers and gourmands are liable to form fat, as do the servants on sugar plantations during the sugar season; yet it is well to remember that it is not necessary that people should be beer drinkers to become fat, and that the free imbibition of water is sufficient for the purpose.

#### HOSPITAL FOR INSANE, HALIFAX.

We have just received the Report of the Medical Superintendent of this asylum, for 1877, from which we take the following:—In hospital 1st of January 337; admitted during the year 94; discharged cured 48; relieved 7; died 25; remaining in hospital at end of year 351. This gives a mortality rate of 5.8 per cent, and a recovery rate of 51.06 on the admissions. The recovery rate is most satisfactory in connection with this institution and has been equally high for many years past. Dr. DeWolf has been connected with this asylum for the past 20 years, and we regret to learn that he has resigned the superintendency in consequence of some charge of "neglect as to measures to ensure cleanliness, and dishonesty in the administration of rations," brought against the management, as stated in the report of the committee of enquiry. Dr. DeWolf positively denies the former charge, and if the latter be true, the commissioners are to blame. But what Dr. DeWolf complains of most—and he certainly has good ground of complaint—is, that he has not had an opportunity "of appearing before the tribunal which condemned him." It can hardly be possible that the Government would perpetrate so glaring an act of injustice as to condemn a man unheard. If so it must lose all claims to respect, and take the consequences of the reaction which will certainly be produced, by any injustice done to an old and faithful servant.

## THE TORONTO GENERAL HOSPITAL.

The visitor at the Toronto General Hospital of a few years ago, will scarcely recognize in it the same institution either in external appearance or internal appointments of former years. The Board of Trustees and Medical Superintendent are to be congratulated upon the high state of efficiency to which the Hospital has been brought, for never before in the history of the institution has it been in such perfect working order. The scheme of amalgamation which is now being so energetically carried out will in a short time place this hospital in the front rank of institutions of the kind on this continent. The fever Hospital which is being erected, at a cost of about \$20,000, to the west of the main building is now rapidly approaching completion and will be ready for occupation in a few weeks.

The new Burnside Lying-in-Hospital which, under the amalgamation project is being erected in the extreme north-western portion of the grounds at a cost of \$11,000, is also near completion, and will be ready for occupation in the summer. It is a handsome white brick building, with Ohio stone dressings, and is in a style in keeping with the rest of the buildings. The Eye and Ear Infirmary to the east of the main building, is now about to be commenced. It will cost about \$15,000. This building will be connected with the main building by a corridor—the Fever Hospital is of course entirely disconnected. All these buildings are of the most modern and improved style, and every attention has been paid to heating and ventilation that skill and forethought could suggest. The number of intern patients in the main building under treatment averages from 175 to 185, and the number of externs average from 20 to 30 per day. Owing to the increased facilities for clinical instruction which the Toronto General Hospital now affords, medical students are no longer attracted to other cities, because of superior hospital advantages. Regular daily clinics are given the year round by the medical officers of the staff, the majority of whom are connected with one or other of the medical schools.

This prosperous state of affairs is no doubt due to the able and judicious management of the board of trustees. They have boldly grappled with every difficulty, broken down all monopolies, and dealt out evenhanded justice to all; and so long as they

hold the balance equally, there will be no jarring or want of harmony among the members of the medical staff. Another element of success is that the board of management has the entire confidence of the public, and subscriptions and substantial aid from private sources, and also from the Government are being received from time to time. Great credit is also due to the Medical Superintendent, Dr. O'Reilly, and his able assistants, for the neatness and cleanliness of the interior, and the good order and discipline everywhere manifested.

## TORONTO ASYLUM REPORT.

This is a carefully prepared report and not a mere mass of dry figures as is too frequently the case. We have only time and space to notice a few prominent points. At the commencement of the year there were 631 patients in the asylum, and 232 were admitted during the year, making a total of 863 as against 956 in the previous year. This difference was owing to the transference of a large number of chronic and incurable cases to the Hamilton asylum. The number of patients at the close of the year was 671. The discharges during the year were 112; of these 75 were cured, 22 improved, and 15 unimproved. The number cured and improved is about 42 per cent. of the admissions during the year. There were 58 deaths during the year, making the rate of mortality equal to 6.66 per cent. on the total number of inmates.

There is still the cry of want of room, and it is sincerely to be hoped that the Government will secure increased accommodation. It is a crying shame that poor unfortunates of this class have to be sent to jail for want of proper accommodation in the asylum, and this at a time when medical treatment is of the utmost consequence, viz., at the outset of an attack. Dr. Clark alludes at considerable length to the alarming prevalence of an "enshrouded moral pestilence," in other words, self-abuse, as one of the most prolific causes of insanity. He suggests as a means of arresting this evil, in view of the improbability of any other means being adopted, that pamphlets should be issued on the subject and sent broadcast throughout the community. In discussing the question of restraint *vs.* non-restraint, in the management of the unruly, the Dr. very properly says:—Let it (restraint) be a final resort when moral suasion, or

it may be, gentle manual effort fails; but the practice that would allow a patient to injure himself or herself, or others rather than have exceptions to a praiseworthy sentiment, is a method neither distinguished by discretion nor judgment."

In the treatment of epilepsy, nitrite of amyl has been used in upwards of 25 cases with very good success. It was given in most of the cases in half-drop doses, three times a day, and it was observed that when it was omitted for a day or two the fits returned with their usual violence and frequency. On the whole, the experiments with this new remedy show that it is of considerable service, and worthy of a more extended trial.

MORIALITY OF TORONTO FOR 1877.—During the past year the city was notably free from disease; there were no epidemics, except a few temporary occurrences of scarlet fever and a few cases of diphtheria. The total number of deaths was 1,850, which represents an annual death rate of 26.42 per thousand, estimating the population at 70,000. The annual death rate for 1876 was 28 per thousand, showing a decrease of 1.58 per thousand for 1877. This is attributable no doubt, in some measure, to the increased drainage of the city. The diseases which caused the greatest number of deaths were—debility, 187; consumption, 173; diarrhoea, 168; inflammations, 154; scarlet fever, 85; brain diseases, 81; heart disease, 57; bronchitis, 53; convulsions, 46; typhoid fever, 41; croup, 26; whooping cough, 7, &c. It is to be regretted that the large number of 488 were unclassified, and it is to be hoped that in future more care will be taken in this matter by medical men and others, when certifying to the cause of death.

HYDROBROMIC ACID AND SEDATIVE DOSES OF QUININE.—Dr. Boyd of Ogdensburg, N. Y., has been using hydrobromic acid and sedative doses of quinine for the past six months in the treatment of typhoid fever, and has come to the conclusion that it is superior to any other treatment. He generally commences by giving from v. to viij. grs. of hydrarg. chlor. mit. After the bowels have moved two or three times, he commences with the acid and quinine, i. e. if the temperature is high—say 102 or 103—by giving a tablespoonful of the following

medicine: Acid. Hydrobromic,  $\bar{z}$  iss., Quinia Sulph.  $\bar{z}$  i., Aquæ  $\bar{z}$  iss. Of this mixture he gives one tablespoonful every two hours until four doses are taken; if the temperature is not lowered from 12 to 14 hours after administering the first dose, he generally repeats the doses as above, until the temperature falls. He has given on an average from 20 to 30 grains a day, without the patient complaining of that abominable ringing noise in the ears, and very seldom administers opiates. Headache generally ceases after the patient is fully under the influence of the medicine, and does not return with proper diet and hygiene.

Hydrobromic acid may be prepared extemporaneously as follows:

R Pot. Bromidi  $\bar{z}$  x.  
Acid Tartaric  $\bar{z}$  xij.  
Aquæ  $\bar{z}$  xl.

Mix, and allow it to stand until precipitation ceases. The results of the reaction are the formation of bitartrate of potassium (cream of tartar), which is nearly insoluble, and sufficiently pure hydrobromic acid diluted with water, each fluid drachm of which contains ten grains of bromine.

GOITRE TREATED BY IODINE INJECTIONS.—In the *Journal de Medicine* for November an article will be found in which the above named method of treating goitre is highly recommended. It is known as the method of Luton. By this method Dr. Luton has frequently produced cures which were rebellious to medical treatment. It consists in injecting into the centre of the tumor from 15 to 40 drops of tincture of iodine, officinal strength. In some instances morphine is added to relieve pain and irritation. The injections may be repeated every ten days. Luton met with but one case in which it failed—a vascular goitre. Morell McKenzie who has tested the remedy on a large scale, cured 59 out of 73 cases, diminished the size in 9, got no results in 3, and 2 patients gave up treatment.

THE ANATOMIST.—This is an etching of a picture of the same name exhibited at the centennial in Philadelphia, which attracted considerable attention. It is printed on white paper 12½ x 15 inches, and would make a very suitable picture for a physician's office. It may be had by addressing the LANCET office. Price \$1.

**MILK OF MAGNESIA.**—This preparation only requires to be better known to be more fully appreciated by the profession. It is a perfect hydrate of magnesia, and not as many suppose, calcined magnesia triturated and suspended in mucilage. When examined by the microscope it presents a uniform cloudiness but no particles of magnesia are to be seen. It readily mixes with water, and may be given alone or in combination with any other remedy which is not incompatible with magnesia. It has a perfectly smooth, palatable and milk-like taste and is one of the best antacids whether for adults or children. In the constipation of infants it is a most useful remedy. For acidity of the stomach, either in adults or children, there is nothing better; it is easily administered and very efficacious. Those who choose to test it will not be disappointed in the results.

**THE NEW ANTISEPTIC THYMOL.**—The new antiseptic thymol bids fair to entirely supersede carbolic acid—possessing as it does superior antiseptic properties, and being perfectly innocuous. It is the essential ingredient of oil of thyme, prepared by treating it with a strong alkaline solution, or by distilling the seeds of *Phytotis ajowan*, an East Indian plant. Solutions containing 1 part thymol to 1000 will completely arrest saccharine fermentation, and only small quantities are necessary to check decomposition. It is now being used in Germany instead of carbolic acid in the application of Lister's antiseptic dressings, with marked success. It is only as an external antiseptic that thymol is recommended; its internal use has not answered the expectations which were formed of it.

**BELMONT RETREAT.**—This most excellent private Hospital for the Insane, has provided a separate department for the treatment of inebriates. It is situated in one of the most beautiful and picturesque spots in the neighborhood of the city of Quebec. The extensive grounds surrounding it are most beautifully laid out, the building is well appointed, and every care and attention is bestowed on patients of all grades and classes, by the medical superintendent Dr. Wakeham, who has had great experience in the treatment of such cases. Among the class of inebriates the cures have averaged about 75 per cent. It is the only institution of the kind in Canada, and is deserving of the consideration of the profession.

**THE LATE DR. HODDER.**—At a meeting of the Medical and Surgical society of Montreal, held recently, resolutions were passed expressing regret at the death of the late Dr. Hodder, in whom the medical profession has lost one of its most distinguished practitioners, one of the ablest teachers, and one of the most honorable members.

The following resolution has also been sent to the students of Trinity Medical school by the McGill students medical society :

*Resolved.*—That having heard with deep regret of the death of Dr. Hodder, late Dean of the Trinity Medical School, whose eminent services in the cause of medical science and medical education are so well known in this country, we do express our sincerest sympathy in your loss, and with the family of the deceased in their bereavement.

Prof. Osler,

*Chairman.*

L. D. Mignault,

*Secretary.*

**LACTOPEPTINE.**—This preparation, which is a composition of pepsine, pancreatine, diastase or vegetable ptyaline, lactic and hydrochloric acid, and sugar of milk, is acquiring a great reputation both in England and America, in the treatment of many forms of dyspepsia, and wasting diseases of children. We have used it in several cases with remarkably beneficial results, and we feel certain the profession will not be disappointed in its effects. It is also an excellent remedy in gastritis, vomiting of pregnancy, dysentery, and diarrhoea of children. Pepsine is undoubtedly a valuable remedy in many forms of dyspepsia, but it does not seem to meet all the indications fulfilled by lactopeptine.

**HEALTH REPORT CITY OF NEW YORK.**—We have been favoured through the kindness of Dr. Nagle with a copy of the City Record containing the vital statistics of the City of New York, for 1877 from which we glean the following. There were 26,203 deaths (13,624 males and 12,579 females) during the year just past, which represents an annual death-rate of 24.50 per 1,000, the estimated population being 1,069,362. Among the diseases which caused the greatest number of deaths, may be mentioned, zymotic diseases 8,042; phthisis pulmonalis, 4,046; diarrhoeal diseases, 3,557; nervous diseases, 2,378; pneumonia, 2,148; Bright's disease, 1,139; bronchitis, 1,033; scarlatina, 983; diphtheria, 951; croup, 472; whooping-cough, 440.

Of the total number of deaths 7,419 died before they reached the age of 1 year; 2,495 before the end of 2nd year; 1,133 before the 3rd year; 736 before the 4th, and 524 before the end of the 5th year, or a total of 12,307 before the end of the 5th year. Of those who reached 100 years and upwards there were 21; 15 females and 6 males—a circumstance which has been frequently observed, viz. that more females than males reach this great age.

The number of suicides during the year was 148; 123 males, and 25 females. The report says the most "popular agents resorted to for self-destruction were pistols" of which there were 49; hanging 20; poisons 47, of the latter Paris green caused 15.

The total number of births for the year was 25,569—13,074 males and 12,495 females; or 634 less than the number of deaths.

**APPOINTMENT.**—Dr. N. H. Beemer has been appointed assistant physician to the Asylum for the Insane, London. Prior to his leaving Wyoming he was made the recipient of an address and presentation of several articles of silver plate, by a number of his friends as a token of their regard and esteem. The Dr. carries with him the good-wishes of a large number of friends and acquaintances.

**REMOVALS.**—Dr. C. W. Covernton, formerly of Simcoe, Ont., has removed to this city. His office is on the corner of Church and Queen sts., in the house formerly occupied by Dr. Rosebrugh. Dr. McDonald, of Guelph, is also about to remove to Toronto, having rented the premises occupied by the late Dr. Hodder.

Dr. Stevenson, formerly of L'Orignal, Ont., has removed to Montreal. He was entertained at a public dinner by his friends in and around L'Orignal, prior to his leaving. His Honor Judge Daniell presided, and a pleasant evening was spent by all present, and one long to be remembered.

The death of Dr. Blundell, of London, at the age of 87 years, is announced in the British medical press of a late date. Also that of Dr. Fleetwood Churchill, of Dublin, in the 70th year of his age.

The death of Dr. L. P. Vandell, of Louisville, Ky., in the 73rd year of his age, is announced.

## Reports of Societies.

### MICHIGAN STATE BOARD OF HEALTH.

The regular quarterly meeting of this Board was held at Lansing, January 8, 1878. Dr. Kedzie, President, gave a brief statement of some interesting experiments which he had recently made in relation to the permeability of walls and clothing, and the relation of these to the healthful condition of houses and clothing.

Leroy Parker read a report on a proposed amendment to a law requiring the transmission by the county clerks to the secretary of state, of the names and postoffice addresses of coroners as well as those of other county officers now reported. The proposed amendment will enable the state department and the secretary of the state board of health to communicate with these officers, and to learn from them the number of sudden and violent deaths, and the causes of same, with a view to remove the causes when possible. Mr. Parker stated that he had been in correspondence with the authorities of Massachusetts in regard to the recently amended laws of that state relative to coroners and coroners juries, which seem to be much better than the law in this State. He also read a report pointing out the fact that section 6852 of the compiled laws of 1871 makes it the duty of supervisors to prosecute householders and physicians for not giving notice of cases of diseases which endanger the public health. The Secretary reported that circulars had been sent to correspondents, giving details of plan for making weekly reports of diseases; also blanks for the annual reports of 1,224 clerks of local boards of health and 1,102 health officers throughout the State; blanks were also issued to meteorological observers for their monthly reports; the names and addresses of 800 health officers of townships, 28 health officers of cities, and 67 health officers of villages have been received; and six or eight documents were sent to each health officer so reported. Most of these health officers have been appointed because of the past action of this Board. Many of them are physicians.

Dr. Baker presented a bill drawn by Dr. Folsom of the Massachusetts state board of health, to prevent the pollution of streams by sewers, slaughter-houses, manufactories, etc. The Secretary stated



that diphtheria had been more prevalent than usual in this and other states, and suggested that the board issue a circular on the subject. Dr. Hitchcock was requested to prepare such circular. The causes of diphtheria were thoroughly discussed, and the opinion seemed to prevail that sewer gas, dampness, and mould had much to do in causing it, although it is a contagious disease.

Dr. Kedzie made a brief report, giving an account of experiments and tests for the detection of lead in tin utensils in common use, having examined quite a number of specimens. He found about three-fourths of all the specimens examined contained lead in considerable amount. These examinations were brought about by a communication from Dr. Edward Dorsch, of Monroe, Mich., which had been referred to Dr. Kedzie as committee on Prisons, etc. Dr. Dorsch detailed some cases of lead poisoning from the use of tin utensils. The test which Dr. Kedzie gave for this adulteration is quite simple. Place a drop of nitric acid on the tin to be tested, and evaporate to dryness; then add a drop of iodide of potassium. If lead is present, there will be a yellow coloration. If it is not present the spot will remain white.

A communication was received from the local board of health in the township of Minden, Sanilac county, stating their action for preventing the spread of glanders by killing and burying a horse affected with that disease, and that an action for damages had been commenced by the owner of the horse against the individual members of the board.

UNION MEDICAL ASSOCIATION.—At a meeting of the "Union Medical Association" held at Mount Forest on the 15th of February, it was unanimously resolved:—"That it is the opinion of this association that the principles of contract prices with families, secret societies, clubs, or railway companies, is unjust to the profession at large, and has a tendency to lessen the respect due us from the community, and also to lessen the estimation in which our services should be held by the public."

Also:—"That the charges for office practice, advice, &c., should range from \$1.00 to \$4.00, this being only an equivalent to the charges made by other professional men for less important services."

Moved that a copy of these resolutions be sent to the CANADA LANCET for publication.

THOS. KIERNAN, M.D.,  
Secretary.

MEDICAL ASSOCIATION, COUNTY OF OXFORD.—On Thursday, the 31st Jan., a large number of the medical men of the County of Oxford met in the Mechanics' Institute, Woodstock, for the purpose of forming a medical society for the county. The meeting having been called to order, Dr. Bowers in the chair, the minutes of two preliminary meetings were read and confirmed. The following officers were then elected for the ensuing year:—President, Dr. John Turquand, Woodstock; 1st Vice-President, Dr. Bowers, Ingersoll; 2nd Vice-President, Dr. Massecar, Tilsonburg; Secretary, Dr. A. H. S. Hill, Woodstock; Treasurer, Dr. T. Millman, Woodstock.

Dr. H. McKay, of Woodstock, read an interesting paper on "Maternal Impressions" which, after having been discussed, was requested to be published in the CANADA LANCET. The meeting adjourned to meet in Ingersoll, on the second Thursday in April.

COUNCIL EXAMINATIONS.—The professional examination of the College Physicians and Surgeons of Ontario will commence on the 29th inst. The matriculation examination will take place on the 23rd and 24th inst.

CORONERS.—A. McKay, M. D., of Ingersoll, to be an Associate Coroner for the Co. of Oxford.

J. G. Davidson, M. D., of West Flamboro', to be an Associate Coroner for the Co. of Wentworth.  
John J. Farley, M. D., of Belleville, to be an Associate Coroner for the Co. of Hastings.

The death of Prof. Wm. Stokes of Dublin, is announced.

### Births and Deaths.

At Glanford, on the 10th Feb., the wife of Dr. Farewell, of a son.

In Toronto, on 1st March, the wife of A. De La Haye, M.D., of a son.

At Tavistock, on the 16th of January, John Adams, M.D., in the 36th year of his age.

In Montreal, on the 27th Feb., Dr. Duhamel in the 68th year of his age.

In Belleville, on the 23rd ult., James Lister, M.D., in the 67th year of his age.

\* The charge for notice of Births, Marriages and Deaths is fifty cents, which should be forwarded in postage stamps with the communication.