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CANADA

MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

A Case of Idiopathic Peritonitis. By E. H. TRENHOLME, M.D., C.M.,
B.C.L., &c.

Michael Doughorey, labourer, aged 26, a native of Ireland, was taken ill at 1 p.m., on the 10th December. He complained of stoppage of the urine, and intense pain of the lower part of the abdomen, when I was called to see him at 3 p.m. of the same day. For some time past he had been working in a very exposed place, and often returned from his work with wet feet, and sometimes with wet clothes. On the day preceding his illness, he had partaken rather freely of strong drink, a thing very unusual with him, as he was of temperate habits, and had never been seriously ill before the present time. He says, the pain came on very suddenly at the time above mentioned, and continued unabated, although he had taken hot drinks, in hopes of obtaining relief. On examination, the abdomen was found slightly distended, the walls very tense and tender to the touch. There was marked tenderness over the region of the kidneys. Vomiting and the desire to defecate and urinate, but without the power to do so, were marked symptoms from the commencement. Ordered him hot turpentine epithems over the whole abdomen, till the surface was well reddened, and to be continued till relieved of pain; put him on grain doses of calomel and opium every three hours, and gradually lengthening the interval between the doses up to five hours, and to support him with cold fluid diet.

Monday, 10 a. m.--Much worse; passed a sleepless night, vomiting, pain and tension of the abdomen increased. The vomiting is not accompanied with much effort, and is more like regurgitation, and vomited matter consists chiefly of what has been swallowed. He has passed no urine for thirty-four hours. I passed a catheter and drew off about 3 ij. The medicine had been taken regularly, but the man would not

remain in bed, nor allow the turpentine epithems to be applied as ordered. Medicine and epithems to be continued. Pulse 100. Continued to grow worse up to 8 p.m., when I saw him, in consultation, with Dr. Howard. Meatus urinarius shows some signs of a clap. In addition to the present treatment, was ordered the application of a dozen leeches to right iliac region, and tepid water injection. After the injection, there came away a small amount of fæces.

Tuesday.—Much the same as yesterday: passed a restless night, slept in his chair but a few moments at a time. Had a pretty free and natural passage of the bowels this evening. Passed a very little urine. Pulse 110. Increased the calomel to 2 grains, opium 1 gr., every 4 hours. 9 p. m.—Suffering much pain; cannot lie down. Reduced the calomel to 1 gr., which, with the 1 gr. opium was continued every 4 hours. Ordered beef-tea every 20 minutes, and a tea-spoonful of brandy in water every hour, and a large bran poultice over whole abdomen, to be followed by turpentine epithems.

Wednesday.—Much easier this morning; slept a little during the night; walls of abdomen not so tense; passed about $\bar{5}$ iij urine. During the day not so well, and at night bad as ever with the pains, &c. Vomiting returned. Ordered another poultice, but it gave no relief.

Thursday.—Bowels tympanitic and very tender. Drew off about 2 oz. urine. Pulse 130. Breathing laboured. Gave him 8 grains calomel, in addition to the other treatment, but it had no effect on him. Passed a very restless and sleepless night in his chair.

Friday.—Abdomen more distended, and countenance gives signs of intense suffering. Abdominal tenderness greatest over upper part of right lumbar region. Great depression of vital powers; hands and feet growing cold, and is covered with cold clammy perspiration. Pulse 130.

Saturday.—Much worse. Has agonizing spasms of abdominal walls. Pulse 140. Omitted the calomel and opium, and gave $\frac{3}{4}$ grains morphia every 5 hours. Vomiting continues; retains nothing on his stomach.

Sunday.—This morning at 5, after a violent attack of vomiting, his bowels opened, and had two free liquid dark coloured passages, which gave him great relief. At 9 a.m., was very weak but drowsy. Ordered him small quantities of beef-tea and brandy, alternately, every few minutes; but in place of this, they gave him bread and butter and steak to eat. Pulse, none in left wrist, and very small in right. Surface cold. 12 o'clock.—Is dull of hearing, has no pain; eyes set. Ordered the beef-tea and brandy to be given as directed. Had another fluid passage and also passed a little urine. At 5 p.m., had two more fluid motions, when vomiting returned and continued more or less, up to 1 a.m. Monday morning, when he died.

Post mortem, 36 hours after death.—After section of abdominal walls, about 1 gallon serous fluid, with shreds of lymph in it, was removed from the cavity. Small intestines coloured dark; bound together slightly by recent effusions of lymph, and contained small amount fluid fæces and air; stomach empty. Pyloric end of duodenum and upper part of jejunum very dark coloured, and coats thickened. The lower part of duodenum very friable. Colon and vermiform process not specially involved. Kidneys congested; right one much so. Congestion most marked between tubular and corticle portions. Bladder empty, muscular coat and lining membrane of the fundus—where covered by peritonæum—very much congested, a dark colour, and very friable. Lining membrane not much congested elsewhere. Liver congested and firm, also somewhat enlarged. Spleen congested.

HOSPITAL REPORTS.

Case of Fracture of the Ribs, with Wound of Lung. Reported by JOHN BELL, A.M.

On the 15th November, 1865, Thomas Frazer, a sailor, aged 57, of weather-beaten appearance, was admitted into the Montreal General Hospital, under care of Dr. McCallum.

In the early part of the preceding night, while intoxicated, he fell over one of the stone quays to the wooden wharf below. He says he alighted on his side on a pile of stones. He was immediately carried to his ship where he remained, *insomnis*, until removed to the Hospital.

Fracture of the ribs was at once diagnosed by Dr. Drake, House Surgeon, who ordered him to be placed in bed, as he suffered acutely from the slightest movement, on account of contused state of right shoulder and hip as well as from the more severe injury.

At the time of Dr. McCallum's visit, the extreme sensibility of the injured parts precluded a thorough examination, but it was nevertheless satisfactorily made out that the sixth and seventh ribs were broken about in a line with the origin of the *serratus magnus* muscle. The sixth somewhat anteriorly to the seventh, and both evidently fractured obliquely, from the ease with which they could be displaced, the amount of motion allowed, and from sensible snap with which they returned into place.

The subcutaneous cellular tissue for a considerable extent around the seat of the fractures was quite emphysematous, crepitating freely under pressure. After this had ceased to crackle under the bell of the stethos.

cope, two other sounds were heard; first, that friction of the opposed pleural surfaces, now in the incipient stage of inflammation, and secondly, a moist crackling, one from local pneumonia, caused by laceration of the lung tissue by the jagged ends of the ribs.

He is ordered calomel : gr. j, antimonii tartarizati gr. $\frac{1}{4}$ every third hour; to be cupped under right nipple, and to be put on milk diet. Tongue dry and furrowed; pulse 108 per minute.

16th.—His feverish state, the pain which he constantly suffers, and the great embarrassment in the respiration, prevented him from sleeping more than a few minutes at a time during the night. From his inability to cough large quantities of mucus accumulate in his bronchial tubes, and produce a most painful sense of titillation. What he does expectorate is thick and tenacious, somewhat puriform and intermingled with a few specks of blood. The right side is dull on percussion. Sibilant râles abound behind on the right side, and with them a valvular click is heard at each respiration. A gurgling sound is occasionally heard over the position of the injury. All of these may be indicative of an inflamed state of some of the smaller and larger bronchi, with accumulation of mucus.

Friction sound more of a rubbing character than it was yesterday, but it changed somewhat during the day. Tongue moist and pretty clean, tip quite red. Urine sherry coloured.

The injured side of his chest was confined (after Hannay's method) with pieces of strong adhesive plaster, passing from the medium line behind to the same in front, and imbricated on each other until the whole was covered.

17th.—Slept pretty well last night, but not long at a time. Does not feel so feverish; tongue not dry, but still covered with a dirty coat. Skin moist. Bowels open. Urine abundant, slightly reddish, with a diminution of chlorides, and containing a little uroanthin.

Pulse 80 per minute, full and forcible. Respirations 23 in the same time. Temperature in axilla, after allowing mercury full time to rise, 101.5 F. Observations taken each day at noon.

From the position and thickness of the plaster on his side, exact physical examination is prevented, but still the friction sound can be heard. It does not differ materially from that of yesterday. The patient now experiences no oppression or difficulty in breathing, the pain being altogether latent, so that he does not suffer except when he is compelled to cough or take a full inspiration. The irritation in his throat is less, and the expectoration is purulent in streaks, with a few specks of blood.

18th.—Patient slept somewhat soundly last night, and seems in every

way to be in a very favourable condition. All the secretions free. Face shews no febrile flush or fulness.

Pulse 72. Respirations 18. Temperature 100.4°.

A stripe of ecchymosis, of mottled purpled yellow and green, three inches broad, has now appeared, extending from the fractures and in the same line with them, to the crest of the ilium. The impaction of the humerus between the wharf and his side was probably the cause of both these lesions.

19th.—Patient was restless, and coughed a good deal last night, until the administration of a Dover's powder; after which he slept almost continuously until morning. He now looks very well and has neither coughed nor expectorated much. The Dover's powder is ordered to be continued each night, for a short time.

Above and around the seat of injury the respiratory murmurs are healthy. Below it, both behind and in front, the friction sound continues of a harsh rubbing character. A gurgling sound is also heard, which is quite distinct from that produced by the peristaltic action of the colon.

Pulse 85. Respiration 21. Temperature 99.4°. Skin cool; tongue moist and pretty clean.

20th.—Rested well during the night. The calomel and tartar emetic powders have been given as directed up to the present time. As the patient's bowels are now very loose and his gums "touched," they are ordered to be discontinued.

His appetite is poor. He is still on milk diet.

Friction sound well marked on occultation, and can be slightly felt on palpation. The gurgling already mentioned continues in the anterior and posterior part of chest.

He can now sit up and walk about. Pulse 80. Respiration 20. Temperature 100.6°.

21st.—Bowels still loose. Friction sound not so loud as yesterday. Respiratory murmur pretty clear and audible, contrasting forcibly with the superficial rubbing sound. The ecchymosis has now changed to an intense purplish black.

Pulse 76. Respiration 21. Temperature 100.7°.

His countenance to-day is relieved of the anxious expression it has hitherto constantly worn; and, generally, he seems to be in a decidedly convalescent condition.

22nd.—Pulse 76. Respiration 20. Temperature 101°. To-day he walks about with much ease. Percussion dull over fractures, where the friction sound is still harsh and grating. Occasional sibilant and submucous râles, with small gurgling, are heard at posterior part of

right side: in some extent due, probably, to the hypostatic congestion of the back of the lung, and to accumulation of mucus in the bronchial tube, from the recumbent position which the patient has been compelled constantly to retain. Sputum not very abundant, but glassy and frothy.

23rd.—Pulse 68. Respiration 32. Temperature 100.4°. Friction sound still heard below the fractures, also a sonorous blowing sound from mucus in the larger bronchi. Bowels regular. Appetite improving. Has an annoying tickling sensation in his throat, for which he is ordered a sedative cough mixture.

24th.—Pulse 65. Respiration 21. Temperature 100.8°. On inspection of the chest, the front part of the right side, which should have been supported by the fractured ribs, is seen to be flatter than the corresponding region of the left, and on percussion is duller.

25th.—Pulse 76. Respiration 22. Temperature 100.7°. Friction sound not so loud and harsh as yesterday, and heard chiefly at end of respiration. Cough greatly relieved. Patient can walk about freely, although some stiffness of the shoulder joint remains. He is ordered still to remain in bed.

As the temperature has maintained the same range for several days, its height being more probably due to incorrectness of the thermometer than to any abnormal state of the patient, its observation is ordered to be discontinued, as no longer necessary.

December 8th.—Patient to have his clothes, and to be allowed to get up.

12th.—To-day were removed the strips of plaster which have kept their hold in a most efficient manner. Whether from the good quality of the plaster, which was spread on thick twilled canvas, or from the very slight play of the ribs, the strips did not "become loosened after a few hours," contrary to the experience of Dr. F. Hamilton in such cases.

Friction sound still heard, over the side, and lower part of front and back of right chest, of a rubbing or creaking character: due most probably to the rubbing and stretching of adhesions which will remain permanently. That at end of inspiration coarser than that at end of expiration. It is only at these periods of respiration that the sound can be heard distinctly. The cough is almost entirely gone.

He can now throw his arm round in a circle, although it is slightly painful to do so. His side was ordered to be painted with tr. iod. co.

13th.—Friction sound continues much the same, but he says the iodine application gave him considerable relief.

20th.—The friction sound can now no longer be heard, and the right side of his chest has resumed its normal fulness. On examining the ribs

a swelling is felt on the fourth and fifth in the axilla, and also on the fifth at the nipple, evidently *calli* from complete or partial fractures, or other lesions less severe. All the patient now complains of is a slight stiffness about the right shoulder and chest.

26th.—Discharged.

Case of Injury of the Hand. Under DR. D. C. McCALLUM. Reported by MR. THOS. D. LANG.

John Bremner, aged 41, a native of Scotland, farmer has always enjoyed good health, up to the 13th December, 1865, when, while at work putting some straw into a thrashing machine, got his right hand involved in the cylinder, crushing and lacerating the first phalanx of the thumb, all the phalanges of the index and middle fingers, the first two phalanges of the ring finger, and the soft parts of the little finger.

He was admitted into the Montreal General Hospital, in this state on the same day that the accident occurred.

The man's occupation being that of a farmer, Dr. McCallum considered it prudent to save as much of each finger as possible; he accordingly removed the first phalanx of the thumb; all the phalanges of the index and middle finger, and the first and second phalanges of the ring finger. By careful dressing the little finger was saved.

The patient made a rapid recovery, and on the 6th Jan., 1866, was able to leave the hospital with a very useful hand.

The frequency of accidents, caused by thrashing machines, renders the above brief case of more than ordinary interest, showing, as it does, the results of Conservative Surgery. It was all important, from the nature of the man's occupation, to have as useful a hand as possible—which result was obtained by the attempt at saving his little finger—which proved successful, and confining the amputations simply to the injured phalanges.

Operation for Perineal Section. By DR. D. C. McCALLUM. Reported by MR. JAMES HAYS.

Joseph Racicault, a native of Canada, aged 26, was admitted into the Montreal General Hospital, November 18th, 1865, under Dr. McCallum. Seven years ago he contracted a gonorrhoea and one small chancre, but had no bubo.

Three months before admission was employed on board a steam-boat,

and, one day, while ascending a ladder fell upon one of the steps, and inflicted a severe wound in his perineum.

For two weeks after the accident he was unable to pass a full stream of urine, and what was passed contained blood. He gradually got better until a week before entering the hospital, when he caught a severe cold, and was unable to pass any urine whatever for two days. When he presented himself at the hospital, Dr. Drake, the house surgeon, succeeded, with great difficulty, in passing a No. 1 catheter into the bladder, which was retained there. The parts were much swollen, but subsided in a few days, and then the stricture could be distinctly felt with the finger, in the membraneous portion of the urethra.

It was considered a favourable case for an operation, and accordingly, on the 27th of Nov., "perineal section" was performed by Dr. McCallum.

After the operation a No. 8 catheter was secured in the bladder by means of pieces of tape and water dressing applied to the wound.

Nov. 29th.—Wound looking well, and patient easy.

Dec. 1st.—Catheter removed, and patient able to pass urine freely.

Dec. 4th.—Wound nearly healed, and No. 9 introduced quite easily. After this date a catheter was passed every third day till the 19th, when the patient was discharged from the hospital, with injunctions to return and have a catheter introduced once or twice a week.

Dec. 31st.—A No. 13 catheter passed without the least trouble.

Amputation of the Arm for Epithelioma. By DR. D. C. MCCALLUM.

Reported by MR. CHARLES E. HICKEY.

Thomas Laughlin, aged 41, farmer, was admitted to the Montreal General Hospital, on the 2nd of November, 1865, under the care of Dr. McCallum; was born in Canada, is of healthy parents, both having died of old age.

About sixteen years ago he had an attack of erysipelas on the left arm, on account of which he remained seventeen months in the Montreal General Hospital under the care of Dr. McDonald. It left a scar on the outer side of the arm, extending from below the elbow to the shoulder, resembling the scar of a burn, also left the arm rather stiff and atrophied.

On the second of last July, he fell from a horse, hurting this arm, and producing a small blister at the elbow on its outer side, which, bursting in a few days, formed a sore oval in shape having the appearance of an irritable ulcer. Kept increasing in size till its long diameter was five inches, and its short three inches. From it there was a very small dis-

charge thin and ichorous. Pain was acute and intense from the first, or from the time the blister was ruptured. The pain was not darting nor lancinating in character, but burning and confined to the sore.

It was diagnosed *epithelial cancer*, and on the 28th of Nov., 1865, the arm was amputated at its upper third. Cold water dressing was applied, and the wound healed mostly by first intention. The diagnosis was verified by the microscope.

The patient left the hospital on the 13th of January, 1866, the wound having nicely healed. He was well satisfied and apparently elated over his loss, for, in his own language, he would rather lose fifty arms than suffer so much pain again.

REVIEWS AND NOTICES OF BOOKS.

The use of the Laryngoscope in Diseases of the Throat, with an Appendix on Rhinoscopy. By MORELL MACKENZIE, M.D., M.R.C.P., Physician to the Dispensary for Diseases of the Throat. Philadelphia: Lindsay and Blakiston; Montreal: Dawson Brothers.

Among the many works which have been issued from the London press on the Laryngoscope, since its very general introduction, none perhaps is more complete, or contains a more comprehensive view of the entire subject, than this admirable work, of rather more than one hundred and fifty pages, by Dr. Mackenzie. The work is divided into eight chapters; the first, and by much the longest, is devoted to a history of the Laryngoscope, commencing with the attempt made in 1743 by Levret, the celebrated French accoucheur, to facilitate the application of ligatures to tumours of the throat, by means of a plate of polished metal, upon which the tumour was reflected. Beyond its use for this purpose, no further application of it was made; and from that date until 1807, when Dr. Bozzoni, of Frankfort-on-the-Maine, made a great sensation by the publication of a work entitled, "The Light Conductor, or description of a simple Apparatus for the Illumination of the Internal Cavities and spaces in the Living Animal Body," no progress was made. Notwithstanding the excitement its introduction caused, so great was the opposition it encountered, that it soon was forgotten. In 1849, Dr. Babington exhibited to the Hunterian Society of London an instrument which very closely resembled the Laryngoscope of the present day, one of the differences being that the illuminating mirror was a common hand look-

ing-glass, and the light used was natural and not artificial. This clearly proves the claim of Dr. Babington, as being truly the inventor of the Laryngoscope. The various improvements that were made from this time up to 1837, when the well-known experiments by Professor Czermack, of Pesth, were made, are briefly alluded to. To his untiring industry is beyond a doubt due the present wonderful results which the Laryngoscope, as remodelled by him, has produced. The second chapter contains a good description of the various parts of the instrument; and the third chapter gives the principles of the art, with clear and concise directions how to use the instrument. This chapter is exceedingly well written, and contains advice which should be carefully read by all before attempting the application of the Laryngoscope. He says, "Beginners, in their anxiety to get a good view, often give rise to faecal irritation, by keeping the mirror too long in the patient's mouth: the same condition is often caused by moving the mirror too much about at the back of the throat after its introduction. The practitioner should recollect that when an act of retching has once taken place, it is afterwards often impossible to get a good view of the larynx at the same sitting. Moreover, the act of retching always causes considerable temporary congestion of the laryngeal mucus membrane, and this is apt to lead the inexperienced to very erroneous conclusions." Dr. Mackenzie seems to think that, unless by the clumsiness of the practitioner, most persons could be examined at the first sitting without difficulty, and recommends that, for the purpose of gaining the patient's confidence, the mirror be introduced several times, leaving it at the back of the palate only for a few seconds, no attempt being made to see anything. He however admits having met with patients with such an irritable condition of the fauces as to render the application of the instrument almost an impossibility. Bromide of potassium and ammonium have been recommended in such cases, but in his experience without benefit, and recommends as the best treatment in such cases to get the patient to suck small pieces of ice for ten minutes previous to the use of the Laryngoscope.

Chapter four describes the appearances of the healthy larynx, and chapter five, the various accessories of Laryngoscopy, such as the examination of your own larynx, the demonstration of a patient's larynx, to others, &c., &c.

The next (6th) chapter contains practical remarks on the application of remedies by means of the Laryngoscope. Our author says, "For applying solutions to the larynx, squirrels or camel's hair pencil cut square at the ends and firmly attached to aluminum wire, bent at a proper angle, will be found the best. * * * * *

I shall merely remark that among the remedies I have found most efficacious, are solutions of nitrate of silver, perchloride of iron, sulphate of copper, sulphate of zinc, carbolic acid, and iodine. Glycerine will be found a useful solvent for most of these agents." Dr. Mackenzie states he does not approve of injecting fluids into the laryngeal cavity, one of the objections against injections being that they cause a great deal of spasm, and that it is more difficult to restrain the amount of the application or limit it to certain spots.

The remaining chapters are devoted to describing various pathological changes (illustrated by cases) which the Laryngoscope has revealed, such as warts on the vocal cords, &c., &c.

We shall merely again repeat our conviction, formed after a careful perusal of the work, that it contains information concerning the use of the Laryngoscope, which should be attentively studied by every practitioner of medicine, and we therefore recommend it to the notice of our readers.

A few pages are added as an appendix on Rhinoscopy, or the examining the posterior nares by placing a mirror at the back of the throat with its reflected surface directed obliquely upwards. It is however exceedingly difficult to perform, and has not yet been much put in use.

On Wakefulness; with an Introductory Chapter on the Physiology of Sleep. By WILLIAM A. HAMMOND, M.D., late Surgeon General of the United States Army. Philadelphia, J. B. Lippincott & Co., 1866. Montreal, Dawson Brothers.

Aside from the title of this work, the high position occupied by its author, in the United States Army, lead us to examine this little book with more than ordinary interest. Many of the facts contained in it were first published in the form of a paper "on Sleep and Insomnia," in the New York Medical Journal, and attracted considerable attention. At the suggestion of some of his friends, the paper was much enlarged, and re-written, and is now published in a most acceptable volume of about 100 pages.

The physiology of sleep is a question so full of interest to the medical practitioner, and so many opposite views are entertained concerning it, that we have perused with great pleasure, and we believe with much profit, its very able introductory chapter. Of all our organs the brain is the only one, which has not its period of rest save during the time of sleep. Even the heart and lungs, those apparently ceaseless organs, have their periods of repose. Dr. Hammond says, "After the contraction and

dilatation of the auricles and ventricles of the heart, there is an interval during which the organ is at rest. This amounts to one-fourth the time requisite to make one pulsation and begin another. During six hours of the twenty-four, the heart is therefore in a state of complete repose. If we divide the respiratory act into three equal parts, one will be occupied in inspiration, one in expiration, and the other by a period of quiescence. During eight hours, therefore, of the day the lungs are inactive. And of the voluntary muscles, none, even during our most untiring waking moments, are kept in continued action." As might be expected from this ceaseless activity of the brain, every thought being formed at the expense of nervous tissue—that organ cannot long carry on its healthy function—without having repose. Hence after a certain period, this organ needs rests, and it is this want, that is the exciting cause of natural and periodic sleep; and to such an extent has the brain often been reduced, and so greatly felt the need of rest, that not unfrequently it is beyond the power of the will to evade it. Thus our author says, "I have frequently seen soldiers sleep on horseback during night marches, and have often thus slept myself. Sentinels on posts of danger often cannot resist this influence. To punish a man with death, therefore, for yielding to an inexorable law of his being, is not the least of the barbarous customs which are still in force in civilized armies." As might be anticipated, therefore, no punishment so cruel could be invented, as to sentence a man to death by depriving him of sleep,—yet, that such a punishment has been enforced, the following case clearly proves. Dr. Hammond quotes from Dr. Forbes Winslow, the author of an able treatise on diseases of the brain :—

"A Chinese merchant had been convicted of murdering his wife, and was sentenced to die by being deprived of sleep. This painful mode of death was carried into effect under the following circumstances: The condemned was placed in prison under the care of three of the police guard, who relieved each other every alternate hour, and who prevented the prisoner falling asleep night or day. He thus lived nineteen days without enjoying any sleep. At the commencement of the eighth day his sufferings were so intense that he implored the authorities to grant him the blessed opportunity of being strangled, guillotined, burned to death, drowned, garotted, shot, quartered, blown up with gunpowder, or put to death in any conceivable way their humanity or ferocity could invent. This will give a slight idea of the horrors of death from want of sleep."

The immediate cause of sleep is the question, however, which has given rise to a great amount of discussion, and it is therefore

interesting to notice the theory advanced and supported by our author. Perhaps the most generally received opinion is that the brain is in a state of approaching congestion. Drs. Carpenter, Dickson, and Sir Henry Holland, as well as others, assert that "a degree of pressure is essential to perfect and uniform sleep." Dr. Hammond, however, objects very strongly to this theory, and attempts to prove by experiments, that natural sleep proceeds from a cause, the exactly opposite of that held by the well known names mentioned above.

"That stupor may be produced by pressure upon the brain admits of no doubt. It is familiarly known to physicians, surgeons, and physiologists; the two former meet with instances due to pathological causes every day, and the latter bring it on at will in their laboratories. But this form of coma and sleep are by no means identical. On the contrary, the only point of resemblance between the two consists in the fact that both are accompanied by a loss of volition. It is true, we may often arrive at a correct idea of a physiological process from determining the causes and phenomena of its pathological variations, but such a course is always liable to lead to great errors, and should be conducted with every possible precaution. In the matter under consideration it is especially of doubtful propriety, for the reason stated, that coma is not to be regarded as a modification of sleep, but as a distinct morbid condition. Sir T. C. Morgan, in alluding to the fact that sleep has been ascribed to a congested state of the brain, for the reason that in apoplectic stupor the blood-vessels of that organ are abnormally distended, objects to the theory, on the ground that it assimilates a dangerous malady to a natural and beneficial process. He states (what was true at the time he wrote) that the condition of the circulation through the brain, during sleep, is wholly unknown.

"It is important to understand clearly the difference between stupor and sleep, and it is very certain that the distinction is not always made by physicians; yet the causes of the two conditions have almost nothing in common, and the phenomena of each are even more distinct.

"1. In the first place, stupor never occurs in the healthy individual, while sleep is a necessity of life.

"2. It is easy to awaken a person from sleep, while it is often impossible to arouse him from stupor.

"3. In sleep the mind is active, in stupor it is as if were dead."

"4. Pressure upon the brain, intense congestion of its vessels, the circulation of poisoned blood through its substance cause stupor, but do not induce sleep. For the production of the latter condition a diminished supply of blood to the brain, as will be fully shown hereafter, is necessary.

“ Perhaps no one agent so distinctly points out the difference between sleep and stupor as opium and its several preparations. A small dose of this medicine acting as a stimulant increases the activity of the cerebral circulation, and excites a corresponding increase in the rapidity and brilliancy of our thoughts. A larger dose lessens the amount of blood in the brain, and induces sleep. A very large dose sometimes diminishes the power of the whole nervous system, lessens the activity of the respiratory function, and hence allows blood which has not been properly subjected to the influence of the oxygen of the atmosphere to circulate through the vessels of the brain. There is nothing in the opium itself which produces excitement, sleep, or stupor, by any direct action upon the brain. All its effects are due to its influence on the heart and blood-vessels, through the medium, however, of the nervous system.”

Dr. Hammond performed experiments to prove the above. He took three dogs and placed them under the influence of chloroform, and from each removed a portion of the upper surface of the skull an inch square. The dura mater was also removed. Three hours after when the effect of the anesthetic had passed away, he gave one dog, one-fourth of a grain of opium, the next dog one grain, and the third dog, two grains, the brain of each being in a natural condition :—

“ At first the circulation of the blood in the brain was rendered more active, and the respiration became more hurried. The blood-vessels, as seen through the openings in the skulls, were fuller and redder than before the opium was given, and the brain of each animal rose through the hole in the cranium. Very soon, however, the uniformity which prevailed in these respects was destroyed. In number one the vessels remained moderately distended and florid for almost an hour, and then the brain slowly regained its ordinary appearance. In number two the active congestion passed off in less than half an hour, and was succeeded by a condition of very decided shrinking, the surface of the brain having fallen below the surface of the skull, and become pale. As these changes supervened, the animal gradually sank into a sound sleep, from which it could easily be awakened. In number three the surface of the brain became dark, almost black, from the circulation of blood containing a superabundance of carbon, and owing to diminished action of the heart and vessels it sank below the level of the opening, showing, therefore, a diminished amount of blood in its tissue. At the same time the number of respirations per minute fell from 26 to 14, and they were much weaker than before. A condition of complete stupor was also induced from which the animal could not be aroused. It persisted for two hours.”

During its continuance, sensation of all kind was abolished, and the power of motion was altogether lost.

"It might be supposed that the conditions present in numbers two and three differed only in degree. That this was not the case is shown by the following experiment :

"*Experiment.*—To the dogs two and three I administered on the following day, as before, one and two grains of opium respectively. As soon as the effects began to be manifested upon the condition of the brain, I opened the trachea of each, and, inserting the nozzle of a bellows, began the process of artificial respiration. In both dogs the congestion of the blood-vessels of the brain disappeared. The brain became collapsed, and the animals fell into a sound sleep, from which they were easily awakened. If the action of the bellows was stopped, and the animals were left to their own respiratory efforts, no change ensued in number two, but in number three the surface of the brain became dark, and stupor resulted. In order to be perfectly assured upon the subject, I proceeded as follows with another dog :—

"*Experiment.*—The animal was trephined as was the others, and five grains of opium given. At the same time the trachea was opened, and the process of artificial respiration instituted. The brain became slightly congested, then collapsed, and sleep ensued. The sleep was sound, but the animal was easily awakened by tickling its ear. After I had continued the process for an hour and a quarter, I removed the nozzle of the bellows, and allowed the animal to breathe for itself. Immediately the vessels of the brain were filled with black blood, and the surface of the brain assumed a very dark appearance. The dog could no longer be aroused, and died one hour and a quarter after the process was stopped."

Our author then enunciates his theory which, in a modified form, has been brought forward before by Blumenbach—but not received with much favour. He says: "I believe that sleep is directly caused by the circulation of a less quantity of blood through the cerebral tissues than traverses them while awake." He then states an experiment made by Dr. Fleeming of Queen's College, Cork, who tried the effect of compressing the carotids on the functions of the brain—the result being a gradual insensibility which continued so long as the compression was kept up. The interesting volume by Durham on the Physiology of Sleep is alluded to. Dr. Hammond stating that previous to its publication he was engaged experimenting in the same direction—but yields to Mr. Durham the priority, and states that his experiments were not carried as far as those of Mr. Durham's.

"In 1854 a man came under my observation who had, through a

frightful railroad accident, lost about eighteen square inches of his skull. There was thus a fissure of his cranium three inches wide and six inches long. The lost portion consisted of a great part of the left parietal, and part of the frontal, occipital, and right parietal bones. The man, who was employed as a wood chopper, was subject to severe and frequent epileptic fits, during which I often attended him. In the course of my observations, I soon became acquainted with the fact that, at the beginning of the comatose condition which succeeded the fits, there was invariably an elevation of that portion of the scalp covering the deficiency in the cranium. As the stupor passed away, and sleep from which he could easily be aroused ensued, the scalp gradually became depressed. When the man was awake, the region of scalp in question was always nearly on a level with the upper surface of the cranial bones. I also noticed on several occasions that during natural sleep the fissure was deeper, and that in the instant of awaking, the scalp covering it rose to a much higher level.

"After my attention was thus drawn to this subject, I observed that in young infants the portion of scalp covering the anterior fontanelle was always depressed during sleep, and elevated during wakefulness."

Various other experiments were performed on dogs—portions of the skull being removed, and ether and chloroform being administered. With the ether the brain sank below the inner surface of the skull, and the vessels which could be perceived contained dark blood—as the anesthetic passed off the circulation of the brain became more active, and its volume increased. With chloroform the effect was different—there was no sinking of the brain substance—on the contrary, it protruded. "Not only was unoxygenated blood circulating to a great extent through the brain, but there was very decided congestion." As another illustration, Dr. Hammond alludes to the soporific effect heat has, and ascribes it to the amount of blood which flows during high temperature to the surface of the body, consequently diminishing the amount going to the brain. Excessive loss of blood also produces sleep, says Dr. H., which is easily accounted for by the theory he advances as the immediate cause of sleep—but which is difficult he says to explain upon any other hypothesis.

In many ways the theory advanced by Dr. Hammond is a very plausible one—and while we must admit that he has brought forward much to support his theory, we still feel that his experiments are not all quite satisfactory to our own mind. However much credit is due him for the able manner in which he has handled his subject—and eventually much good will result from its publication.

We have devoted so much space to the first portion of the volume, that but little is left us in which to notice the latter part. Wakefulness is a complaint which every physician is constantly brought face to face, and often the treatment adopted—in the majority of cases, opium or its kindred preparations, gives but little benefit. We generally find this complaint in persons, whose brains have been overtaxed by mental exertion. Mental effort long continued, demands an active brain circulation—hence the cerebral vessels have been overdistended, and Dr. Hammond, asserts this over-distention causes the vessels to lose in a great measure their contractile power, hence a larger amount of blood is circulating in an overtaxed brain than was normal. To such patients he recommends a total cessation from active mental exertion—sleep to be sought for, not in the recumbent posture, but in an easy chair in an upright position, stimulants in the shape of whiskey, coffee, &c., and above all the bromide of potassium in doses of ten to thirty grains. From experiments our author states that this salt invariably lessens the quantity of blood circulating within the cranium. We wish that it were possible for this little work to find its way into the hands of every one of our subscribers. Besides helping to pass a couple of hours pleasantly and profitably, (for it is a very interesting volume,) it contains so much of practical value concerning cases constantly coming under observation, which have often been treated unsatisfactorily, that we believe the practitioner would certainly profit much by its perusal.

PERISCOPIC DEPARTMENT.

Surgery.

ON AMPUTATION AT THE HIP-JOINT.

By JOHN H. PACKARD, M. D., one of the Surgeons to the Episcopal Hospital, Philadelphia.

The remarks which I have to offer to the readers of the Journal are based upon a case which occurred at the U. S. A. Hospital at Beverly, N. J., last winter. By the courtesy of Dr. Clinton Wagner, U. S. A., the surgeon in charge, under whose orders I was acting as Consulting Surgeon to the Hospital, the manual procedure was entrusted to me; but, as Dr. W. justly remarks in his (unpublished) Report of Surgical Operations, the successful result was mainly due to the surgical skill and the kind and unremitting attention of Dr. J. C. Morton, Executive Officer of the Hospital.

The patient was a private in the 11th Reg't Maine Volunteers, aged 19, and was brought to Beverly, August 22d, 1864, by steamer, having been wounded at Deep Bottom, Va., on the 16th. The ball had passed through the head of the tibia from before backward.

Sept. 12th, secondary hemorrhage having occurred, chloroform was given, and after a careful examination it was thought proper to amputate, which operation was performed through the lower third of the thigh, by the circular method. No untoward symptom was observed until October 17th, when bleeding was again set up, and the femoral artery was cut down upon and tied in Scarpa's space. The ligature came away in ten days.

November 5th, the end of the femur protruding through the retracted soft parts, about four inches of the bone were removed by means of the chain-saw. Shortly after this, the stump became enormously swollen and painful, and abscesses formed here and there in it.

January 19th, 1865, the bone was exposed, and found to be greatly enlarged, and in a state of necrosis, as high up as the trochanters. The patient being already under chloroform, the femoral artery was at once exposed and tied in the groin, and the disarticulation of the hip performed by antero-posterior flaps. Some slight difficulty was experienced in controlling the artery accompanying the sciatic nerve, but the quantity of blood lost in the operation was not large. Extreme depression was exhibited, the patient being of necessity kept on the amputating table for two or three days, lest the effort at removal should prove fatal. Large quantities of stimulants and concentrated food were administered, and the surface temperature artificially maintained.

January 27th, bleeding again occurred, and the external iliac artery was tied. The ligature came away in twenty-one days.

February 19th, two days afterwards, the lower end of the divided artery poured forth blood furiously, and was only controlled with great difficulty by direct pressure, which was kept up for about two weeks.

After this, recovery progressed steadily, and by the end of March the man was well. In May, on the breaking up of the Beverly Hospital, he was transferred to that at Whitehall, and in June he was sent to his home in Maine.

Probably most of the readers of the Journal are acquainted with the case lately published by Dr. Van Buren, of New York, in his valuable "Contributions to Practical Surgery." Here the patient's condition was much more favourable. The first operation was done for disease of the femur, of twenty years' standing; the second for return of the disease.

about two years after. No untoward accident in the shape of hemorrhage occurred. Death took place five years later, from renewal of the disease in the pelvic bones.

Dr. Van Buren refers to three other cases in which amputation at the hip was successfully done after previous removal of the same limb above the knee: one by Sir A. Cooper in 1824, one by Mr. Mayo in 1841, and one by Mr. Sands Cox in 1844.

Another, making six, has been published by Fayrer, of Calcutta. I met with the account in a recent number of the *British Medical Journal*; the exact reference has escaped me. It is so interesting that an apology is hardly necessary for reproducing it here. "The operation was performed when the patient was very low, suffering from clear indications of blood contamination, the result of a diseased condition of the medulla, which is unfortunately frequent in India, after section of the long bones, and the cause of many unsuccessful amputations. The operation was performed and the recovery occurred at a very hot season of the year, the thermometer ranging from 86° to 104° . Cholera and other diseases were very prevalent at the time.

"On April 10th, 1864, a native boy, 16 years old, was thrown from a horse; at the inner side of his knee the soft parts were severely injured, but the joint was, apparently, unhurt; on the 12th it was found that the joint was opened. The limb was then removed at the lower part of the thigh. After the amputation, fever and extensive necrosis of the bone followed, so that, as a chance of saving life, the limb was removed at the hip-joint. The knife was entered a little above and in front of the great trochanter, and emerged at the root of the scrotum. The flap being raised, the femoral artery was tied before the posterior flap was cut. On dividing the bone at the great trochanter drops of pus oozed out of its cancellated tissue; Dr. Fayrer thereupon seized it with the lion-forceps and dissected it out without loss of time. The acetabulum was healthy. All bleeding points, venous and arterial, were tied. The loss of blood was very small—less than eight ounces. His pulse, which was over 150 when the operation was commenced, was very little weaker after it was over. Stimulants were given and hot bottles applied. After the operation the patient immediately improved, and eventually recovered. The last report of him is as follows: 'He goes to work regularly as a tailor, and is in robust health. He uses crutches, and gets over the ground rapidly; is getting fat, and is much grown in height as well as circumference since his accident. He was admitted on April 10th, 1864; thigh amputated on April 12th; hip amputated on April 24th; perfectly cured on July 13th, 1864—just one hundred days from the operation.' "

Dr. Gross, in speaking of this subject, says: "Of seven cases of this kind, in the hands of Astley Cooper, Textor, Mayo, Cox, Syme, Bradbury and Van Buren, all were successful. In an instance, in the practice of Mr. Guthrie, where the operation was performed on account of gangrene and hemorrhage, after amputation of the thigh for a gun-shot wound, the result was fatal."*

Four of these cases, those, namely, of Textor, Syme, Bradbury, and Guthrie, I know of through this quotation only; but they bring the whole number of cases up to *ten*, with only one fatal issue. From them it seems to me that some valuable hints may be gained. In two of them, my own and Fayrer's, the circumstances were most unpromising; in the former, the great natural courage of the patient, and the untiring assiduity with which he was watched over by Dr. Morton, carried him through the fearful experience which has been detailed. I know of no parallel case on record. † Disarticulation of the hips is, both to the patient and to the operator, one of the most formidable procedures in surgery, whether we look upon it in its immediate surroundings or in the light of its statistics. The reason does not, however, clearly appear why so many of these cases should turn out badly. Sédillot says: "Its dangers are due to the proximity to the trunk, the extent of the wound, the mass of flesh divided, the difficulty of obtaining union, and the nervous shock arising from the loss of a member.

* System of Surgery, vol. ii., p. 1046. (3d edition.)

† I am tempted to quote here a curious passage, which I met with a few days since in a lecture delivered by Mr. (afterwards Sir) Charles Bell, at the school in Great Windmill street, London, in 1824. He says:

"The mania for amputation at the hip-joint, which has of late years prevailed, I have seen finely exhibited in an individual, who, when the subject was mentioned, actually tore his hair, and exhibited the appearance of the deepest distress; one might have supposed that some of his dearest friends had fallen sacrifices to this operation; but no, the feeling was excited by his recollections being awakened, by the sight of a caries thigh bone, of an opportunity of operating which he had lost."

In a foot-note Mr. Bell adds:

"A friend, on reading this, reminded me that he had been present at this singular exhibition of professional zeal, and states, what I had forgotten, that the enthusiast, in alluding to the particular instance in which he might have performed the operation, told us 'that as the child had previously lost the greater part of the limb by amputation for disease of the lower part of thigh-bone, there would have been little danger from the shock of separating such a mass as the quarter of the body; I should have only,' said he, 'had to pick out part of the bone from the socket; and thus I should probably not only have been the first of the few whose patients have survived this operation, but have been even the first to have performed it.'"

representing nearly one-fourth of the entire mass of the body ; which shock is so great that the patients often fall into a complete collapse, and die without any assignable cause." *

On the other hand, Erichsen says: "In amputation at the hip-joint the great danger to be apprehended is excessive hemorrhage, the incisions being made so high up that no tourniquet can be applied, nor pressure of the groin trusted to." †

Dr. Gross says that the great risk which attends this operation "is due to the loss of blood, suppuration, erysipelas, and pyæmia." ‡

It would take up too much space to adduce other opinions ; those quoted embrace the views of leading writers of the present day in this country, England and France. Some of the sources of danger mentioned may be set aside, as not especially belonging to amputation at the hip.

Pyæmia, erysipelas and excessive suppuration may ensue upon much slighter operations. Hemorrhage may be altogether prevented by compressing the abdominal aorta, either by means of a large clamp tourniquet or by the fingers of assistants.

Ovariectomy, herniotomy, the Cæsarean section, all these show a larger proportion of successful results, and yet they would at first sight seem to involve even graver risk than the disarticulation of the hip. Against the exposure of the large wound-surface in the latter, we have to set off the opening of the peritoneal cavity, so often necessary even to a wide extent in the other operations mentioned,

Probably the true cause of the mortality in coxo-femoral amputation is to be found in the great mass of living tissue removed, and the shock thereby involved ; an idea which is supported not only by the fact that the statistics of amputation of the thigh in its upper third are nearly as unfavourable, but also by the far better results attending the operation when the previous removal of the thigh has done away with the circumstance alluded to.

If now we look into the subject of the ordinary operation of amputation at the hip-joint, we shall find in the first place that the greater proportion of successful cases have been those of disease ; and that the patient's chances of benefit are increased in traumatic cases by delaying the operative interference as long as possible. §

* *Traité de Médecine Opératoire, etc.*, tome i., p. 157. (Paris, 1853.)

† *Science and Art of Surgery*, p. 48. (London, 1861.)

‡ *Op. cit.*, p. 1043.

§ *Gross, op. cit.*, p. 1046. Legouest, quoted in "Longmore on Gun-sho

To quote the experience of American surgeons only: I have been able to collect eight cases of successful amputation at the hip-joint, but one of which was for injury. This was one done by Dr. Edward Shippen, of this city, while in the army; it was performed for a gun shot wound of the femur, received six hours previously. The patient was subjected, a month afterwards, to the horrors of a Richmond prison; and yet his recovery was perfect.

Mott operated for disease following a badly united fracture; Duffee for coxalgia; Gross for deformity after a burn; Pancoast once for osteo-sarcoma, and once for some other disease to me unknown; Warren for osteo-sarcoma; May for caries of the upper part of the femur.*

Contrasting this list with those so much more familiar, (for instance, Legouest's, of thirty primary operations, all ending fatally,) we can not but regard the prognosis in cases of disease as far more favourable than in cases of injury. The opposite opinion prevailed until set aside, by experience. Dr. Pancoast, in his "Operative Surgery," published in 1844, says: "It may be important, however, to observe that nearly all the successful cases have been those in which the operation was practiced for traumatic injuries, and almost immediately after their infliction; while the greater number of fatal results have been consequent to the operation on subjects previously exhausted to more or less extent by disease." I have no doubt that this eminent surgeon would alter this statement were he to write at present on the subject, and mention his view, as expressed, in order to show by how high authority it was indorsed.

If, then, we consider the cases in which the surgeon may be called upon to undertake the coxo-femoral disarticulation, we find them divisible into four classes, according to the degree of probability of success.

(1.) Those in which the same thigh has been previously amputated for injury or disease.

(2.) Those of chronic disease. It would scarcely be fair to place cases of hip-joint disease in this class, although the first successful case in this city (Philadelphia) was of this character. It so often happens that the

Wounds," p. 115. (The principle as laid down by Legouest was confirmed by a Committee of the *Société de Chirurgie* of Paris, in 1860.)

Baudens puts this very forcibly: "Let us remember that, while the disarticulation of the knee should be done at once, that of the hip seems not to succeed (*paraît ne pouvoir réussir*) unless delayed some time after the receipt of the wound." *La Guerre de Crimée*, p. 132.

* I have been told, but am inclined to doubt the story, that amputation at the hip-joint was twice performed with success by rebel surgeons, during the late war, for gun-shot injuries.

acetabulum is seriously involved, that in many cases no operation could be of benefit.

(3.) Those in which an attempt has been made to save the limb after injury, and this operation becomes the only hope of the patient.

(4.) Those in which the desperate character of an injury recently inflicted renders death inevitable, unless this slender chance is afforded.

Even in the most favourable cases of the first of the above mentioned classes, amputation at the hip-joint is not to be lightly undertaken. I do not even consider it, as asserted by some writers, one of the easier amputations to perform. The necessity should be stringent, the weighing of the chances careful, the decision conscientiously arrived at. But it does seem to me that the degree of success attained in the recorded cases is such as to make it the imperative duty of the surgeon to perform the operation under the circumstances indicated. In other words, it is not a matter of choice for him whether he will seek to exhibit his prowess with the knife or avoid the risk of failure. He is not only justifiable in operating, but he would be unjustifiable in not doing so.

Should the result be unfavourable, he may, it is true, have painful doubts as to the propriety of the course he was led according to his best judgment to adopt. Probably all honest and conscientious surgeons have known what it is to be so troubled—some, from their mental peculiarities, more than others. And such doubts would be more likely to arise when operative interference had been resorted to than when it had been decided against. Still, this is one of the elements of the responsibility assumed by the surgeon, and can not be evaded.

Before concluding these remarks, it may be proper to observe that, in regard to all operations, a larger proportion of the successes are apt to be placed on record than of the failures. And such may be the case with amputations of the hip after previous removal of the same thigh at a lower point. But when we consider the very extensive discussion of the general subject of coxo-femoral disarticulation, and the fact that an operation of such magnitude is not apt to be confined to the knowledge of a few persons only, we may fairly suppose that the known cases of the kind just spoken of afford at least as correct a basis for the estimate of a patient's chances as we have for our guidance in regard to any other surgical procedure.—*New York Medical Journal*.

CANCER OF THE PYLORUS.

A few weeks ago I was called to see a man, 49 years of age, who was suffering from what was supposed to be dyspepsia for the last twenty-

five years, but more severely during the past year. Last fall he fractured his leg, and the confinement aggravated his dyspepsia. He had been under the care of different physicians, but they failed to give him any relief. I thought, from the history of the case, that it was an aggravated case of dyspepsia, and might be relieved by simple treatment and attention to diet. He vomited nearly everything—it would stay down about half an hour, but would then be ejected, and as a consequence he was much emaciated. He said he also had a feeling that nothing passed through him; he used injections, but they only relieved the lower bowels. I gave him bismuth, and milk and lime water, and also a pill composed of blue mass, ext. colocynth, co. and ext. belladon, to relieve the pain. The next day the stools were blackened, which seemed to prove that the bismuth had passed through. He grew worse, and I examined his abdomen, and found a tumor near the umbilicus, which made the case more grave than I first thought it. Prof. Wiltenberger was then called in consultation, and we agreed that nothing could be done but give relief, as the tumour was probably carcinomatous. He had had vomiting of blood, which is often connected with cancer of the stomach. He died a day or two ago, and here is his stomach. You see here a scirrhus tumour occupying the pyloric orifice and allowing little if any matter to pass. The small intestines were congested, which nearly always occurs in persons who die of starvation, as this man did. The liver, spleen, and pancreas appeared to be healthy. His case has been one of gradual starvation. A person will live longer with pyloric cancer than cardiac, for the former will allow some small portion to be absorbed before it is ejected, while the latter will allow nothing to enter the stomach.—*Med. Clinic of Prof. McSherry, in Phil. Med. Reporter.*

DESTRUCTION OF THE NOSE AND LIPS: NARROWING OF THE OPENING
OF THE MOUTH BY CONTRACTED CICATRICES: SUCCESSFUL
OPERATION.

The following remarkable case occurred in the practice of Professor von Balassa of Pesth. A lad, aged 16, named Karl Szatmary, of pale cachectic appearance, came into the hospital there with a terrible disfigurement of his face. This had been produced a year previously, as far as could be ascertained, by some febrile disease (perhaps pernicious intermittent or typhus); after which the nose, lips, external ear, and a part of the toes, had become gangrenous. The process of cicatrisation which followed this extensive destruction, had left in the place of the nose and lips an uneven cicatrix, firmly adherent to the surface of the jawbone, and

narrowing the nostrils to a small longitudinal cleft, and the mouth to a roundish hole of the size of a bean, of which two-thirds were occupied by the middle incisor teeth, so that there remained only an opening of the size of a crowquill, with rigid walls. Respiration and nutrition were necessarily greatly impeded; fluids only could be administered in scanty quantity. Speech was difficult; and saliva flowed almost constantly from the mouth.

It was evident, that the impaired constitution of the patient would not allow the immediate performance of a plastic operation; the indication was therefore to improve his health, and to remedy the defects by operations; performed at intervals of time.

The patient having been well nourished for some months, and his health having improved, the formation of an upper lip was undertaken on May 5, 1862. The cicatricial tissue occupying the place of the upper lip was first removed by two vertical semilunar incisions, joined by a horizontal one parallel to the lower edge of the orifice of the nose. This being done, semi-elliptical incisions, about an inch apart, were made from the ends of the semilunar cuts, nearly as far as the ears. The upper incisions were somewhat longer than the lower, and had their convexity directed upwards; the lower were convex downwards. The transplantation of the flaps was favoured by their curved edges allowing them to be drawn in the proper direction; but it was also necessary to make incisions into them, dividing also the mucous membrane. Hæmorrhage having been arrested, the flaps were united in the middle line below the nasal orifice with figure-of-8 sutures, as in the operation for hare-lip; and their upper edges, and the outer third of the lower, were also united in the same way with the corresponding edges of the incision in the face. Ordinary silk sutures, both deep and superficial, were applied in the intervals between the pins. Sutures were also applied to the free edges of the flaps, so as to form the upper lip, the angles of the mouth, and a part of the lower lip. Union rapidly took place; and, when cicatrisation was complete, the patient had not only an upper lip with its red mucous membrane, but also a mouth-opening of sufficient size, and capable of being enlarged by the now free movements of the lower jaw.

From this time the patient improved in health and appearance, and was able to take food in the ordinary way. The furrows also, which were produced by the contraction of the cicatrices along the edges of the flaps, gradually disappeared; so that, at the end of February, 1863, scarcely any difference in the level of the skin could be distinguished. On March 8th, rhinoplasty was performed; the flap being taken from the forehead, a portion of the scalp also being used to form the septum. The

flaps of cicatrised tissue on each side of the nose were not extirpated, but were brought together towards the middle line and held there by threads so as to form a bridge for the new nose. Knotted sutures were not employed, as they would have interfered with the application of the flap from the forehead. In performing the last mentioned part of the operation, a portion of the frontal periosteum was removed with the flap. Union took place readily by the first intention, not only between the nasal flap and the sound skin, but also between the septum and the upper lip. The portion that had been used to form the bridge of the nose also became united from within outwards to the flap taken from the forehead. A considerable time was occupied in the after treatment, in preventing the septum from becoming united with the *alæ nasi*; and the patient was therefore kept in hospital until the end of July. This delay, however, gave an opportunity of observing that there was no sinking in of the new nose, but that it had retained the form given it in the operation. The consistence of the bridge of the nose had not undergone the least change; and, as there was no trace of bone having been formed by the transplanted periosteum, this retention of shape must, says Dr. von Balassa, be attributed to the retention of the cicatricial tissue of the nose, so as to form a support for the flap. To prevent the nostrils from becoming closed, a special proceeding was required. This consisted in passing a leaden wire through the part of the septum which lay beneath the point of the nose, and was united at the upper part with the *alæ*. The wire having been introduced by a lancet shaped needle, its end was again brought through the septum at a distance of about two lines; and the two ends were then drawn out through the right nostril and twisted together. It was necessary to leave these leaden loops until the newly formed nostrils were fully cicatrised. The small bridges of skin between the leaden wire and the *alæ nasi* were not at first cut away; and it was not until the end of some weeks, when the nasal openings had fully cicatrised, that a horizontal incision was made on each side from the nostril into the *alæ*; and, after these were healed, the vertical bridges of skin which extended outwards from the leaden loops were divided. The patient remained in hospital a month after the completion of the operation, during which period the cicatrisation of the septum and *alæ* pursued a favourable course, and the nostrils appeared to be certain of retaining a proper size. He went home in October, and returned in 1864, when the leaden ring was removed, and a slight plastic operation was performed for the improvement of the lower lip. There was not the least trace of the formation of bone by the transplanted periosteum; but the nose retained its proper shape, and the nostrils remained quite pervious. (*Berliner Klin. Wochenschr.*, August 14, 1865.)

TUMOUR, INVOLVING THE PNEUMOGASTRIC; PERIPHERAL AND REFLEX PAINS.

CLINIC AT THE DISPENSARY OF MEDICAL COLLEGE OF OHIO.

Reported by H. M. HITTNER, Chief Clinical Assistant.

History.—Mrs. Spellman, aged fifty years, a native of Alabama, presented herself to the Dispensary of the Medical College of Ohio for treatment. She stated that a tumour appeared about two years ago on the left side of the neck, about an inch below the angle of the inferior maxilla, which gave her much annoyance, and did not yield to the remedies suggested by various physicians. The tumour was first noticed in October, 1863; although at that time rather small, it gradually increased. In six months it had acquired a size about two and a half inches in diameter. Without any local application it broke and discharged a sero-sanguineous fluid, less in quantity than any one would have anticipated from the size of the tumour. From that time until the patient came to the Dispensary, the tumour closed and broke, at intervals; when open, always discharging a small quantity of sero-sanguineous fluid. But this swelling was not the only annoyance to the patient. She complained of shooting pains along the left side, extending almost over the entire thoracic region, and to the stomach. For two years she was troubled with nausea and vomiting, and the different medicines directed to the stomach by physicians, did not relieve her in the slightest.

Other symptoms also presented themselves. Dimness of sight and partial loss of hearing; this was more marked on the left than on the right side. The special sense of smell was also impaired; but the most marked of all the symptoms was a neuralgic pain in the head.

Symptoms.—A tumour presents itself near the angle of the jaw on the inner margin of the sterno-cloido-mastoideus. This tumour appears to be produced by an inflammation of the alveolar tissue, and a deposit of fibrin, which involves the sheath of the vessels. There are pains in the side, extending over the chest with slight difficulty of breathing: pain in the epigastric region with nausea, and pain radiating over the organs of the abdominal cavity. Her senses of sight, smell and hearing are more or less impaired, especially on the left side, and she has violent neuralgic pains in the distribution of the fifth pair. ●

Diagnosis.—The symptoms in this case are undoubtedly due to the presence of this tumour. The mode in which it acts to produce the phenomena observed may be explained by either of the following theories:

1. The tumour impinges upon the pneumogastric nerve, which, passing down from the jugular foramen, is contained in the same sheath with

the carotid artery and internal jugular. This irritation of the trunk of a nerve, in accordance with the usual law, is felt at its peripheral distribution; hence the thoracic and abdominal pains and nausea. How shall we explain the occurrence of neuralgia in the distribution of the fifth pair and the disturbance in function of the nerves of special sensation; impressions may be transmitted back to the nerve centre and from thence reflected to other nerves. In this case the impression upon the pneumogastric is also transmitted to the nerve centre, reflected and distributed throughout the fifth nerve. But the trifacial is not the only nerve involved. The impairment of the functions of the auditory, olfactory and optic nerves, must be undoubtedly accounted for by the same general law of reflex action.

2. The tumour may involve the branches of the *descendens noni*, which anastomose freely over the sheath of the vessels. If this be the correct view, the nervous phenomena are all of a reflex character.

The first is probably the true explanation.

Treatment.—Under either of these theories the true method of treatment consists in the removal of the tumour, the cause of the irritation. With this view a succession of blisters will be applied over the tumour and the blistered surface dressed with the compound ointment of iodine. To relieve constipation an active cathartic is administered.

Subsequent Progress of the case.—The size of the tumour diminished, the sensation of vomiting and nausea ceased gradually. As the tumor disappeared the functions of the enumerated nerves of special sensation were again fully established without any special medication, nor were any medicines given for the relief of neuralgia. All the symptoms the patient presented and from which she suffered for two years, disappeared, as soon as the neck was reduced to its normal bulk. This case illustrates beautifully the ordinary law of transmission and reflex action.

AMPUTATION, DISARTICULATION AND RESECTION STATISTICS OF THE CONFEDERATE STATES ARMY.

Amputations of the thigh, whole number, 507; primary, 345; recovered, 213; died, 132; 38 per cent. Secondary, 162; recovered, 43; died, 119; 73 per cent.

Amputations of the leg, whole number, 464; primary, 314; recovered, 219; died, 95; 30 per cent. Secondary, 150; recovered, 76; died, 74; 49 per cent.

Amputations of the arm, whole number, 434; primary, 294; recovered, 252; died, 42; 14 per cent. Secondary, 140; recovered, 87; died, 53; 37 per cent.

Amputations of the fore-arm, whole number, 114; primary, 69; recovered, 61; died, 8; 12 per cent. Secondary, 45; recovered, 35; died, 10; 22 per cent.

Disarticulations, whole number, 135; primary, shoulder-joint, 79; recovered, 54; died, 25; 31 per cent. Primary, elbow-joint, 4; recovered, 3; died, 1. Primary, wrist-joint, 7; recovered, 5; died 2; Primary, hip-joint, 3; recovered, 1; died, 2. Primary, knee-joint, 5; recovered, 2; died, 3. Secondary, shoulder-joint, 28; recovered, 8; died, 20; 71 per cent. Secondary, elbow-joint, 3; recovered, 3; died, 1. Secondary, knee-joint, 6; died, 6.

Resections, whole number, 130; primary, shoulder-joint, 41; recovered, 28; died, 13; 27 per cent. Primary, elbow-joint, 25; recovered, 22; died, 3. Primary, wrist-joint, 2; recovered, 2. Primary, knee-joint, 2; died, 2. Secondary, shoulder-joint, 26; recovered, 19; died, 7; 21 per cent. Secondary, elbow-joint, 29; recovered, 23; died, 6; Secondary, wrist-joint, 1; recovered, 1. Secondary, hip-joint, 2; recovered, 1; died, 1.

Amputations of the foot: primary—Chopart's, 16; recovered, 13; died, 3; Symes's, 2; recovered, 2; Pirogoff's, 4; recovered, 2; died, 2. Secondary—Chopart's, 8; recovered, 7; died, 1; Symes's, 4; recovered, 4 (1 unsuccessful, requiring subsequent amputation above the ankle-joint).

A vast number of additional operations are received, but without positive results, and therefore they have not been included in the above list.

We may well be satisfied with the results of these statistics, which, carefully excluding all doubtful cases, are compiled from those operations only that have reached a positive conclusion. A general summary of the above table shows that the mortality after 1,814 operations, including amputations, resections and disarticulations, amounted to 632, giving a death ratio of 34 per cent.

The only statistics on this subject from the Federal army we find in the *United States Army and Naval Journal* for November, 1863, which gives the amputation statistics for September, October, November and December, 1862, as follows:—Whole number, 1,342; deducting 516 under treatment January 1, 1863, 826. Of this number, 336 died; a mortality of 40 per cent.

The journal to which we owe the above observation gives the following table:—Whole number, 1,342; returned to duty, 100; furloughed, 25; deserted, 11; discharged, 350; died, 336; secondary operation, 34; under treatment January 1, 1863, 516.—*Richmond Medical Journal, and Confederate States Medical and Surgical Journal.*

HOSPITAL NOTES AND GLEANINGS.

Primary and Secondary Syphilitic Sores on the Eyelids.—It is very rare to meet with a primary syphilitic sore on the eyelid, though secondary ulcers are not unfrequently seen. In the first of the following cases there can be no doubt that the sore on the upper eyelid was a chancre. How inoculation could have been affected it is difficult to conjecture; but the combined facts of its syphilitic appearance, its indurated base, the enlarged gland behind the ear, the eruption over the body, and the rapid manner in which it healed under the influence of mercury, establish beyond a doubt its syphilitic nature.

Secondary sores on the eyelid are often difficult of diagnosis, as in many cases they closely resemble epithelial ulcers; but in cases of doubt a week or ten days' treatment with anti-syphilitic remedies will usually decide their true origin. A syphilitic sore generally commences close to the tarsal edge of the lid, which it partially destroys, leaving a notch which is somewhat characteristic. It will heal at the point where it first commenced, whilst it extends in the opposite direction; whereas in the epithelial sore there is no real repair of the ulcerated surface; it may scab over in one part, and become dry; but a reformation of healthy tissue seldom takes place. The previous history is a very material guide; but syphilis is so often vehemently denied by patients who have suffered from it, that reliance cannot always be placed on their statements with regard to it.

The four following cases are good and instructive examples of this form of malady:

CASE 1. Primary syphilitic sore on the upper eyelid of an infant, followed by a secondary eruption over the body.—J. F——, aged one year and ten months, came under observation on January 24th of this year, on account of a troublesome sore on the upper eyelid of the left eye, which showed no disposition to heal. The mother stated that it commenced a fortnight before Christmas as a pimple on the upper eyelid, at the inner side, and near its tarsal edge. The child scratched it, and it became a sore, which has increased to its present size.

Present state.—There is a large, somewhat oval-shaped sore, rather more than half an inch in length, and about a quarter of an inch in depth, extending into the tarsal edge of the lid, which has been partially destroyed and presents a sharp notch. The edges of the ulcer are indurated, and its surface is glazed. The mucous membrane of the upper lid is œdematous, and discharges mucco-purulent secretion. There is an enlarged gland behind the ear, and the whole of the body of the child is covered with roseola. The child appeared very feeble, and much out of

health. It was more than five weeks since the ulcer first appeared, and, although local application, had been used, not the slightest benefit had been derived. Ordered a grain of mercury with chalk night and morning, and dilute citrine ointment to the ulcer.

This treatment was continued until the 7th of February, when she was ordered to omit the powder in the morning, but to take one every night. The wound now speedily assumed a healthy action and began to cicatrize.

On Feb. 14th the sore on the eyelid was quite well, the rash over the body had entirely disappeared, and the child was much better in health and had grown much fatter.

Under the subsequent use of the syrup of iodide of iron, the child on the—of March was quite well, but was ordered to be brought to the hospital from time to time, to be under observation.

CASE 2. *Secondary syphilitic sore on the upper eyelid.*—Chas. T—, aged 49, admitted Nov. 22d, 1859, suffering from an ulcer on the upper eyelid at the inner part, and involving its free border. The sore was irregular in outline and somewhat oval in shape, healing in one point and extending itself at another. It commenced at the tarsal edge, at the point which now exhibits a deep notch. He states that he has never had syphilis, but the mucous membrane of his tongue is thickened and rugose, and presents all the appearance of syphilitic tongue. He was ordered iodide of potassium thrice a day, with Plummer's pill every other night, and to apply dilute citrine ointment to the sore.

By the 18th of December the wound was quite healed.

CASE 3. *Secondary syphilitic ulcer involving the inner angle of the eyelids.*—Sarah P—, aged twenty-three, married three years, applied at the hospital July 31st, 1860, on account of a large sore near the inner angle of the eye, which was encroaching upon the margin of both the upper and lower eyelids, close upon the caruncle.

Present state.—The ulcer is larger than a sixpenny-piece, but irregular in outline. Its edges are inflamed and thickened. It has an unhealthy appearance, and although a portion of it has healed at its lower border, in the opposite direction it is extending itself upon the eyelids. She says she has never had syphilis; but she has lost the bridge of her nose, and is now suffering from a fetid discharge of the nostrils which she has had for the last six years. She has great hoarseness which came on about eighteen months ago, and has continued ever since.

Under the same treatment as in Case 2, the wound rapidly healed.

CASE 4. *Secondary syphilitic ulcer on the upper eyelid of four months' duration.*—George A— came to the hospital on Dec. 18th, 1860, with an

oval-shaped ulcer of the upper eyelid, involving the tarsal edge of the cartilage, and extending upwards on to the integument of the lid. Around the margin of the sore there was considerable thickening, and the surface of it had a glazed appearance. He had suffered from it for four months.

On Jan. 15th, 1861, the sore was quite healed under the same plan of treatment as in the two previous cases.—*Lancet*, May 6, 1865.

SUBCUTANEOUS LACERATION OF THE URETHRA IN ACTU COITIONIS.

FOLLOWED BY HEMORRHAGE AND EXTENSIVE ECCHYMOISIS. EVENTUATING IN URINARY FISTULA.

By LOUIS BACER, M. D., of Brooklyn, N. Y.

Surgical writers advert to lacerations of the fibrous sheath of the cavernous bodies of the penis, but I have not been able to ferret out a precedent case of the one which has lately come under my charge.

The patient, some thirty years of age, had, at about 7 o'clock in the evening, attempted several intercourses, when, on a sudden, he felt intense pain in his penis, which disqualified him to consummate the act. On examining himself, he found blood pouring forth from the urethra. His penis became immediately enlarged, and, with the adjoining integument, discoloured.

I saw the patient at one o'clock that night. He was very pallid and cold, and felt so exhausted from the loss of blood as to need copious stimulants. Penis, scrotum, perinæum, and inguinal regions deep-blue from extravasation of blood, and the integuments of the penis so much distended as to give the virile member a monstrous size. The prepuce, more especially, was almost raised to a blister, as we may find in dropsy, if not more so. At the junction of the penis with the scrotum, there was a circumscribed collection of blood, which, on pressure, would be discharged into the urethra. In addition to this, there was retention of urine.

To all appearance, the patient had sustained a transverse laceration of the floor of the urethra, about three and a half inches from its aperture.

The extravasated blood had partly diffused in the connective tissue, partly collected in a space below the wound, from whence the hemorrhage had taken its course through the urethra. Subsequently, the blood had in a measure coagulated and given rise to the circumscribed distension.

The insertion of the catheter was imperatively demanded, 1st, to relieve the bladder, and 2d, to prevent the urine from coming in contact with the wound of the urethra, thus causing urinary infiltration. For this purpose, the catheter should remain in situ. The execution was, however,

extremely difficult, for the prepuce overlapped the gland by more than an inch, and left scarcely space for the passage of the instrument; the orifice could, of course, not be brought in sight. Next, there was the wound, which is so apt to misdirect the point of the catheter. Nevertheless, after repeated and unsuccessful attempts which, however, affirmed my diagnosis in reference to the transverse laceration of the urethra, I at last effected a proper lodgment.

Directing the catheter to be retained, I left my patient in a comfortable situation, at about three o'clock a. m., anticipating no further difficulties in the management of the case; but in this I was doomed to disappointment.

It seems that a few drops of urine had found their way into the space alluded to, in spite of all precaution; the formation of an abscess was the consequence. The opening of the same disclosed a free communication with the floor of the urethra. For three weeks the catheter was used; during this time the abscess firmly closed. The discoloration had likewise disappeared, and thus it seemed as if the status ante had been re-established. From some cause or other, the abscess opened again, with the usual preliminaries, after a closure of some six weeks. A free division will yet be needed to conclude the trouble. Beyond the singularity of the injury, there is no instructive feature in this case.—*Philadelphia Medical and Surgical Reporter.*

MEDICAL CLINIC OF THE PHILADELPHIA HOSPITAL.

SYPHILITIC PHARYNGITIS AND LARYNGITIS.

On a former occasion I laid before you one or two cases of syphilitic laryngitis. The severity of this disease and its frequency in general practice is my only apology for presenting two interesting cases this morning. I wish you to become so thoroughly acquainted with the ravages produced by syphilis, and with the means of properly combating it, that you may never be at fault when called upon in civil practice.

Mary Ann S—, æt. 27, was admitted to the medical wards on the 21st of November, suffering from severe sore throat. A few months ago she was under treatment in the venereal wards, but now denies ever having had a chancre. A sudden loss of memory is a characteristic of nearly all the patients treated in that ward. I never saw but one or two after being discharged, who would acknowledge that they had ever had a chancre: but here we have the most conclusive evidence.

Upon opening her mouth you observe that the uvula, arches of the palate, and a part of the roof of the mouth have been destroyed; the

lower portion of the vomer has even been attacked by this ulcerative process.

This other case, the one on the table, is that of a delicate old female. Mary McB., æt. 62, Ireland, was admitted on the 16th of November. Her husband has been dead nineteen years. She also denies ever having had a primary sore. In this case the ulcerative process has not proceeded so far as in the former. She complains of severe pain "in her bones," restlessness at night, and loathing of food. You may observe that her face is covered with peculiar copper colored blotches, characteristic of a specific cause. The ulcers produced by syphilis in the pharynx or larynx, are usually stellated in form, small at first, and seldom attract attention until severe injury to the parts has been done.

When a patient comes to you complaining of sore throat, and upon examination you find a peculiar eruption, copper coloured blotches, pain in the head or limbs, and an ulcer in the throat, no matter how small, make up your mind that there is a specific cause. Place him at once upon the internal use of the iodide of potassium, ten grains three times daily, and at bed time a pill of corrosive sublimate, one-eighth of a grain. The best gargle, as I mentioned in a former clinic, is that of Sir Charles Bell, viz.

R̄.	Hyd. chlor. corros.,	gr. ij.
	Sp'ts. rectificat.,	f. ʒ j.
	Tr. cinchonæ,	f. ʒ iiij.
	Mel. rosæ.	
	Tinct. myrrhæ,	āā f. ʒ j. M.

When the ulceration has proceeded so far as in the first case (Mary Ann), an operation might be deemed advisable. But, gentlemen, the truth requires that I should warn you against the operation.

Staphyloraphy consists in paring the edges of the cleft, passing ligatures, through them, and bringing them together. It has been performed by many distinguished surgeons, and in a few cases with gratifying success. Of late years the operation has fallen into disrepute, and I would not advise you to try it.

A few years ago I had a severe case of ulceration from syphilis; after having tried the usual remedies without success, I called in aid the services of a distinguished surgeon of this city, who at once advised an operation. It was immediately performed with but little inconvenience to the patient. The next evening I found that the stitches had given way and the gap was wider than ever.

As a last resort, I concluded to apply an ointment made by rubbing up Donovan's solution with lard, directly to the surface of the ulcer.

The resulting inflammation was terrific. I certainly thought that instead of benefiting my patient, I had indiscreetly placed him beyond hope of remedial aid. But in a few days the inflammation subsided, the ulcer healed, and my patient went away rejoicing. I have since repeatedly tried this same remedy with good results.

A peculiar huskiness of the voice frequently troubles the patient long after the disease has been subdued. It is owing to a change in the mucous membrane; a puffy condition of the lining membrane of the larynx.

I have often found serviceable in these cases the external use of collodion and ether, not to blister but to keep up a constant irritation.

R. Collodii, f. $\bar{5}$ j.
 Æther, f. $\bar{5}$ v. M.

At the same time administer internally

R. Potass chloras, $\bar{3}$ ss.
 Syr. scillæ, f. $\bar{5}$ ij,
 Aquæ, f. $\bar{5}$ j. M.

S. Teaspoonful occasionally.

—*Philadelphia Medical and Surgical Reporter.*

ON ANÆSTHETICS.

By J. M. CARNOCHAN, M.D., Surgeon in Chief to the State Emigrants' Hospital, New York, etc., etc.

I desire to present through the pages of the Medical and Surgical Reporter a general statement of the facts respecting three surgical operations which I performed, using nitrous oxide gas, administered by Dr. Colton, as the anæsthetic, and my opinion on the value of this agent as compared with chloroform and ether.

The first operation took place on the 22d of last July, and was the removal of the entire breast, and glands of the axilla, for cancer. The patient, a lady in feeble health, was suffering from disease of the throat and lungs and general debility. In thirty-five seconds from the time she began inhaling the gas, she was in a profound anæsthetic sleep. She remained insensible for sixteen consecutive minutes, until the operation was completed, and in forty seconds, from the time the bag was removed, awoke to consciousness without nausea, sickness, or vomiting, as is so often the case with the inhalation of chloroform and sulphuric ether.

The second and third capital operations occurred at the State Emigrants' Hospital, on the 2d of December, and consisted of two amputations of the leg. The time required to produce an anæsthetic sleep in the first

patient, a male adult, extremely debilitated and worn out by disease, was forty-five seconds; whole duration of the operation and influence, two minutes and a quarter. No nausea or unpleasant symptoms.

The third operation was on a boy of about 13 years of age. The time consumed in the inhalation, operation and recovery from the anæsthetic sleep was two minutes, the gas working equally as in the other cases, and the patient, after complete anæsthesia, awaking entirely free from unpleasant symptoms.

For minor operations, or for capital operations, such as amputations which when properly performed should require but a few minutes, I have no hesitation in stating that the nitrous oxide gas, as an anæsthetic, is far superior to either chloroform or ether. Insensibility is suddenly produced, and the patient recovers consciousness quickly, the operation being attended by no nausea or sickness, and without the dangerous effects often incident to chloroform and ether.

It is worthy of remark that the nitrous oxide gas approximates, in its chemical combination, to the composition of the ordinary atmosphere, and we may thus, inferentially, account for its more favourable influence. Whether it can be used in operations which from their nature require from half an hour to an hour's time, remains, till to be proved by actual experiment.

The duration of the anæsthetic influence in the case of the first operation, previously alluded to, is the longest on record; and I may here state that this is the first capital operation performed under the influence of the gas, since the great discovery of Wells of Hartford, twenty-two years ago, that a harmless sleep could be produced by a chemical agent, which could annul for the time being the greatest suffering. It is not at all improbable that had Wells lived and had the boldness to follow up his early successful experiments, chloroform and ether would never have been thought of as anæsthetics.

To G. Q. Colton is due the credit of reviving the use of this important agent, in the practice of dentistry, after a lull of twenty-two years.

The value of a safe anæsthetic agent, which can be used without anticipation of danger by the patient, is a great boon to suffering humanity, and I have related thus minutely its action in my own cases, in the belief, that if similar favourable results are met with by others, the nitrous oxide gas will supersede all other anæsthetics now in use.

VARICOSE VEINS.

Maisoneuve, writes the correspondent "J." of the *Chicago Medical Examiner*, gave me the statistics of his operations for the cure of var-

ose veins, by injections of per-chloride of iron. He reports 365 operations, 364 cures, and one death. In the fatal case, the tr. of iodine was used by mistake for the per-chloride of iron. A surgeon of large experience, who has had good opportunity to observe his cases, expresses some doubt as to all the others being cures. The operation, if carefully conducted, seems to be safe, and is probably as successful as any other.

ENLARGED SPLEEN REMOVED BY EXCISION.

Mr. Spencer Wells exhibited to the Pathological Society (Nov. 21, 1865) an enlarged spleen removed by excision the day before the meeting. The patient was going on tolerably well when Mr. Wells saw her (thirty hours after operation) on his way to the meeting. When removed it weighed six lbs. five ounces, but as nine ounces of blood had drained from its vessels, it now weighed five lbs. twelve ounces.

It was eleven inches long, eight broad, and three to four thick. It appeared to be simply hypertrophied, though some spots on the surface appeared like commencing amyloid or lardaceous change. It was not cut into, however—as being the first case in which the operation had been done in this country, it was to be sent to the museum of the College of Surgeons. Mr. Wells added, that when Mr. Nuan showed a large spleen in that room two or three years ago, and he (Mr. Wells) had suggested that the patient's life might possibly have been saved if the spleen had been removed, Dr. Wilks had approved of the suggestion, and he (Mr. Wells) determined to try what could be done if he met with a suitable case. Soon afterwards he attended a lady, with Dr. Jenner, who had a very large spleen; but there was such extreme leukæmia coexisting, that operation was never seriously thought of. The lady died near Bristol, and Mr. Clarke, of Clifton, who examined the body, was specially requested to do so with reference to the removal of the spleen. He informed Mr. Wells that it was done quite easily, and that, in his opinion, all the bloodvessels might have been easily secured. Mr. Wells afterwards saw cases of enlarged spleen with Dr. Budd, Dr. Boulton, of Horncastle, and Dr. Gill, of Bow; but in these cases they were the result of intermittent fever, and not in a state of health to render a hazardous operation necessary or justifiable. At length the patient whose spleen was before the society consulted him six weeks ago. She was married, 34 years of age, and the mother of two children. She had only been ill about a year, and the tumour had only been discovered six months. Its growth had been slow at first, but very rapid lately. Mr. Wells prescribed bromide of potassium and quinine. This proving useless, iron was given;

and this being equally useless, excision was proposed, and Dr. Jenner consulted, who said she was dying, that medicine could do no good, while an operation did offer the "shadow of a chance" of success. Upon this, the patient and her husband desired that the trial should be made. Mr. Wells found the operation quite easy. An incision, seven inches long, was carried along the outer border of the left rectus abdominis, and the spleen was turned out very easily. The vessels were secured by silk ligatures, which were cut off short and returned. There was very little bleeding. The patient had recovered from the shock, there were as yet no signs of peritonitis; and, if she should recover from the operation, all that we know of removal of the healthy spleen in dogs, and in man accidentally by wounds, led to the hope that the absence of the spleen might be tolerated and a good state of health regained.

Dr. Crisp said the case was a very interesting one, but he did not think it was parallel with cases of removal of spleen from dogs. He had, he said, never seen a healthy liver with such a spleen. He thought the liver had more to do with blood formation than the spleen had.—*Medical Times and Gazette*, Dec. 2, 1865.

Midwifery and Diseases of Women and Children.

THE OTORRHŒA OF CHILDREN.

Clinical Lecture by PROF H. RODGER, at the Hospital for Sick Children in Paris.

"I have presented to you, gentlemen, five little patients suffering from otorrhœa, and I take this opportunity to give you my views of this disease. The discharge from the ear is only a symptom, just as the discharge from the urethra, the mucous sputum from the air passages, etc.; its causes are very various; it may be owing to a simple irritation or inflammation, but it may also be based upon a very serious organic lesion in the interior of the ear and its nearest vicinity, and then, of course, lead to a very different prognosis and treatment."

(After recapitulating the details of these cases, Professor Roger continues:)

"These five cases present, as I have already indicated, all the different species of otorrhœa occurring in children, namely: 1. Acute Otitis; 2. Chronic Otitis; 3. Otorrhœa, or simple or ulcerative inflammation of the mucous membrane of the meatus auditorius, consequent upon some disease of adjoining parts or the tissues surrounding the meatus. These

different species we will now consider more closely according to their causes, symptoms, prognosis and treatment.

"1. *Acute Otitis*.—If a child runs out of doors during a cold wind, or happens, while somewhat heated, into a cold draught, it acquires—sometimes a severe cold with headache, sometimes a catarrhal angina with cough, or else a like inflammation of the meatus auditorius, etc. Sometimes, even, the child takes all these together, or in succession: coryza, angina, otitis. When the latter sets in, the child awakes soon after falling asleep, or in the middle of the night, with pretty lively fever and complains, if it is able, of pain in the region of the ear. Generally, such pain is acute and sometimes very violent. The child cannot sleep, cries, and if it is not yet sufficiently intelligent, nothing will pacify it, and all our endeavours to find the cause are fruitless. If the pain in the ear is not so severe as to make the child put its hand to it, we have not a single sign from which to surmise the seat of the trouble. The pain will then be sought for in the abdomen, and colic be thought of since neither cough nor dyspnoea is found, and the expression of the face as well as the undisturbed intellect will not allow us to think of a cerebral affection. If we happen to examine the child's ear, we discover perhaps a little redness and swelling in the external meatus, so that it seems narrower, as it were. At the same time the inner membrane of the meatus is dry and extremely sensitive to the touch. Deglutition is painful, and if angina be present, this pain is still greater. The pulse is pretty active, the skin hot, with thirst and loss of appetite.

"These symptoms continue for about two or three days; the pain gradually becomes less continual, appears in paroxysms, and radiates to the other ear, especially when an angina is combined with it. Sometimes this simple otitis really affects both ears, but this is rare. At all events, the severe pain is accustomed to abate in a few days spontaneously, the child becomes calmer, and we then discover upon the pillow on which its head rested, or in the nightcap, a greenish spot caused by a discharge from the ear; this discharge consists at first of but a few drops of purulent matter, but it is accompanied by difficult hearing or deafness—a fact which is more easily discovered in older children than in those quite young. In many cases, however, the pain remains very acute and lasts longer than the period mentioned. The discharge which sets in does not diminish the pain, and is sometimes more, sometimes less profuse. We may, in such a case, be tolerably certain that the inflammation has progressed to internal parts of the ear, and need not be surprised if under these circumstances congestion supervenes

"When a discharge from the ear has once shown itself, the diagnosis

is manifest; but before this sign appears, it remains in doubt, especially when the attention of the physician has not been called to it by some circumstance. It is impossible to know whether the cutting of teeth, especially of molars, is not the cause of the pain, or if the angina, if such coexists, which may have affected the Eustachian tube, be not to blame; in any case, a close examination of the mouth and throat will give the clue.

“ However that be, the disease can terminate—1, in recovery, which takes place after 2–4 weeks, the discharge becoming gradually milder and less copious; or 2, by passing into a chronic state, which engenders an otorrhoea of long duration, and not unfrequently a consecutive alteration of the membrana tympani also.

“ The treatment is rather simple. In the acute period local remedies are applicable, especially emollient cataplasms, or the introduction of a few drops of oil of almonds into the meatus, or even of a drop of laudanum. When the intense pain has subsided, two or three injections daily of a tepid infusion of elder in milk, *Decoct. Papaveris*, *Decoct. Althææ*, etc. But if the pain continues very severe, and if there is reason to suppose that the middle and internal ear participate in the inflammation, two or three leeches may be applied to the mastoid process and the bleeding from the bites continued for some time. A little later, when purulent discharge from the ear has begun, recourse may be had, according to circumstance, to aromatic or to astringent injections decoctions of cinchona, of *folia juglandis*, of rhatany with milk and lime-water, etc). The injections must be made freely to cleanse the meatus continually, so that the secreted matter may not, by remaining too long, increase and keep up the irritation. The cure is assisted by the use of derivatives, especially irritating foot-baths, simple sinapisms to the calves of the legs, etc.

“ 2. In *Chronic Otitis*, repeated injections of water merely are made to free the meatus thoroughly from all pathological secretions. The diseased membrane is then treated, by smaller injections, with astringent or even caustic fluids (acetate of lead, sulphate of zinc or copper,) which are allowed to remain in the ear by closing its external orifice with a little cotton. If there is reason to believe that the membrana tympani is perforated, it is well to be cautious in the use of these injections.

“ 3. *Secondary, or consecutive, Otitis* is that which follows upon other diseases, or is developed in their course. Sometimes it originates during a simple catarrhal inflammation of the throat by continuation through the Eustachian tube into the middle ear. But it occurs especially in the course of eruptive fevers, so in small-pox by the development of

pustules in the meatus, in measles, scarlet fever and typhus. In these cases the otitis begins during the height of the disease, and in the course of measles more rapidly than in the others. In scarlet fever it is produced by inflammation in the vicinity, and scarlatina is next succeeded in point of frequency of the occurrence of otitis by typhus. In the latter it is chiefly congestion by which deafness is suddenly produced, and it is well known with what rapidity difficulty of hearing or deafness supervene in severe cases of typhus; it is the same congestion which in this disease produces splenization and hepatization of the lung.

“The symptoms of secondary otitis are not very conspicuous, however characteristically the symptoms of the main disease may show themselves. The ear-ache is usually not severe and does not engage the attention of the physician; perhaps he recognizes the otitis by accident, perhaps only when discharge from the ear is present. As slow and indeed insidious as the approach of this inflammation, is also its course and duration—all consecutive inflammations, especially of mucous membrane, taking generally a chronic course. The discharge from the ear becomes permanent, is usually profuse, at times less so; the secretion collects in the meatus or tympanum, and is very fetid and irritating; the membrane, which lines the meatus and the exterior of the membrana tympani, gradually undergoes an alteration by the chronic inflammation, the continual moisture and the irritation. It is softened, swelled and becomes the seat of fungous proliferations or ulcerations. The inflammation may continue upon the periosteum, and even to the bone, and lead to caries, perforation of the membrana tympani, destruction of the ossicula auditus and thus cause irremediable deafness. It may be asserted that the majority of cases of real deafness have their origin in secondary otitis; and variola, measles and scarlatina chiefly are to blame in this respect.

“The treatment of secondary otitis does not differ much from that of the primary; but specific local remedies, such as astringent and caustic injections, must be employed sooner and more energetically, together with the internal use of tonic and antiseptic remedies.

“Properly, a fourth form of otorrhœa ought to be mentioned here, which occurs frequently in children and may be regarded as specific. In children, suffering from eczematous or impetiginous eruptions, e. g. crusta lactea, a purulent and very fetid discharge from the ear is produced, either immediately or after the eruption has been transferred to the mucous membrane of the meatus. The consequences in such a case can be very serious, and we must combat them energetically. The treatment consists in fomentations and injections, at first of mild and depurating, afterwards of astringent or even caustic lotions. At the same

time internally those remedies, which are commonly employed against chronic eczema and impetigo in children.

“To this class, also, belongs serofulous or tuberculous otitis. It is chronic from its beginning, but instead of progressing from without inwardly, the inflammation takes the reverse course. Usually it is the consequence of caries or necrosis of the mastoid process or the petrous bone. It then forms an abscess, which empties outwardly by perforating the membrana tympani, and a continual discharge of an offensive pus mixed with detritus of bone results, which in the course of time brings the mucous membrane of the meatus to a state of ulceration.

“In caries of the petrous bone, symptoms also appear which show an affection of the neighbouring parts of the brain, more especially of the facial nerve. In the latter case we observe, at the same time with the offensive otorrhœa, a paralysis of the face. A little girl, which we have in the Hospital at present, had measles six months ago, and an otorrhœa remained, which was not cured. Gradually the little one lost her appetite, became emaciated, had alternately diarrhœa and constipation, and finally swelling of the cervical glands. Lately, only, the mother discovered a kind of distortion of the face of her daughter and brought her to us. She looks very pale now, is poor and feeble, and has very conspicuous glandular tumors on the neck under the lower jaw, and at the same time the right half of the face is immovable, without expression, and the paralysis distinctly observable on the lids of the right eye and the depressed angle of the mouth. What is the cause of this condition? The supposition of caries of the temporal bone near the middle or internal ear explains all these symptoms; it explains also the paralysis of one side of the face by the alteration the facial nerve has probably suffered in its passage through the said bone. The swelling of glands, and the exploration of the chest (by which a blowing respiration is detected, with dull sound in the apex of the right lung,) point decidedly to a tuberculous diathesis and leave hardly a doubt but that the suspected osseous lesion, whereupon the otorrhœa and paralysis are based, is of serofulous origin.

“What prognosis have we in such cases? Without doubt a sad one; for the local disease, as well as the general diathesis and especially the tuberculosis of the lungs, lead us to expect nothing favourable. The strength of the patient will sink more and more, the local lesion will gradually affect the brain and cause a fatal meningitis. (The child really died soon after.) What is possible to be done is simply to cleanse the meatus continually, and this must be done very cautiously. The internal treatment is directed against the tuberculous diathesis.”—*Translated for the St. Louis Medical and Surgical Journal.*

Canada Medical Journal.

MONTREAL, JANUARY, 1866.

WE may reasonably suppose that our Government have determined on not affording asylum accommodation in or near the city of Montreal. And now that a late member of the Government has been suddenly converted into an Asylum proprietor, by the purchase of Dr. Douglas' share of the Beauport Asylum by Mr. ex-Commissioner of Crown Lands Cauchon, we may presume that a person possessing at least the sympathies of his former colleagues will be able to bring such pressure on the members of the Executive as will crush out all the feeble attempts to do justice to this section of the Lower Province in respect to this question.

We hope that Mr. ex-Commissioner of Crown Lands Cauchon will, as plain Mr. Cauchon of the Beauport Asylum, post himself up on the question of cubic space, and not be led into the error, as was the case with his predecessor, Dr. Douglas, of asserting, before an assembled concourse of *savans*, that his patients have each 300 cubic feet of breathing space. But perhaps our present proprietor will ignore all such low and ill remunerative questions which involve the health and lives of the unfortunates, but which are of very little importance after all, because he has embarked a certain amount of capital in the concern, simply regarding the return likely to accrue, and not caring whether the inmates have 10 cubic feet space or 10,000. These *minor* points he is not expected to debate. There is an imperative duty imposed on us, as public journalists, to repeat the oft-told tale of over-crowding, which, in spite of the increased accommodation in the Beauport Lunatic Asylum, still appears to exist. In the last report of the Prison Inspectors, Mr. Ferres, one of the inspectors, says, in regard to the Beauport Asylum: "I was somewhat taken by surprise to observe that it was accompanied, even while works were advancing, with a continued addition to the numbers, so that *when it was fully completed*, (the italics are ours), the same and indeed worse over-crowding still remained."

With regard to cubic space, Mr. Ferres states that he and Mr. Meredith took the measurements of all the rooms then occupied as dormitories, and found that many of these did not afford more than 350 cubic feet of air to each patient, and none of them over 500 cubic feet. These are incontrovertible facts, and not to be got over by mere newspaper assertion to the contrary.

There are many other facts of which we are cognizant, with regard to this Asylum, such as the fact that the system of ventilation in the building is most defective, the dormitories open into corridors, receiving light and air from them. The air breathed by the inmates in the upper stories having already been breathed by those occupying the rooms underneath; there is no direct means of ventilating each room independently, and the light is borrowed light, supplied from the corridors or passage ways. This is certainly a sad picture of the only Lunatic Asylum in the Lower Province of Canada. As we said before, we presume that Mr. Couchon, having the sympathies of his former colleagues, there will be no lack of funds; and we have no doubt that if the \$2.75 per week is not sufficiently remunerative, an increase can easily be obtained. In fact, we, in Lower Canada, have no Insane Hospital; the establishment in Quebec is nothing more than a large boarding house, as has been pointed out by Mr. Inspector of Prisons, T. J. O'Neil, in the last report before referred to—"Beauport Asylum may, therefore, be regarded rather in the light of an extensive boarding house than a public institution."

Of this system of private institutions, under government inspection, we have somewhat to say, but as it is rather foreign to the subject under discussion, we can only condemn the principle as unjust to the community, and not likely to be of benefit to the inmates. Of the necessity for an Asylum, devoted to the treatment of the Insane in Lower Canada, there is no question, no such institution being in existence. In proof of this great want, we can give a case which came under our observation in the village of St. Scholastique, about thirty-six miles from Montreal. On a recent occasion, we visited the temporary jail in that place; the building was originally a farm-house, built of wood; there we found confined in a cell, not as large as a horse's stall, an unfortunate being who was so violent that he had to be locked up. The cell was dark, ill ventilated, noisome with the exhalations and excretions of its unfortunate occupant, who was wallowing in his filth, to remain there—if in mercy death does not put an end to his misery—until room can be made for him, either at the Beauport Lunatic Asylum, or at the "miserable make-shift at St. Johns." This case is one of acute mania, the result of injury, a portion of a building having fallen on his head. It is

really to be regretted that his brains had not been knocked out with his wits—as death, in our opinion, would be far preferable to the miserable existence to which he is condemned, and which is likely to become a permanent and settled mania, as in his present condition, he is deprived of all chance of recovery, from the very nature of his surroundings, as well as the absence of all attempts at treatment. Mania, to be treated at all with a chance of benefit, must be treated early in the attack. We ask, is this a single instance? We fear not; indeed we know that cases of acute mania have been retained in the cells of our city prison, until the period has passed when the chance of benefit could have followed judicious treatment. So long as there are no means at hand for the proper care and treatment of this class of disease, so long may we anticipate a repetition of such cases; and, as a result, the necessity of support, by the people of Canada, of a class of incurables who, had proper means been at hand, might have recovered from their malady, and returned to the industrial population.

These are questions of serious moment, to be taken up and gone into with a heart and will by the philanthropist and political economist. There is no need shirking the question; it will have to be considered before long; but delay is dangerous, nay, it is worse—criminal. Communities as well as individuals are answerable for their acts; and no single act of injustice passes unrecorded and unpunished, while there is a God above us who gives us the means and teaches us how to employ them.

PROFESSIONAL REMUNERATION.

After we had written the article under the above head, which appeared in the December issue of the Journal, but before the number had reached our subscribers, the question of regulating and equalizing the fees of physicians and surgeons practising in Montreal, was brought forward at a regular meeting of the Medico-Chirurgical Society, and a brief discussion thereon took place. It seemed to be the general opinion of the members present, that, considering the high price of every necessary of life, some slight increase in the amount of professional fees should be made; but, *above all*, that there should be a good understanding among the profession, as to what should be charged for professional services, and the agreement adhered to. We have so freely expressed our views upon this subject that we will not again enter at length upon it; yet we cannot but feel that this matter is one of the very highest importance to the profession, and one concerning which action should have been taken several years ago. We are aware of the delicacy of the subject, and of

the many difficulties which surround it, yet we cannot see but that it may be approached, and, with care, all these difficulties surmounted. The question will again, we believe, be brought forward at the next (January) meeting, when we hope the elder members of the profession will be present, and give utterance to their views.

At the same meeting of the Medico-Chirurgical Society the adopting of a code of medical ethics was suggested. We heartily approve of the suggestion, and hope to be able to write upon this subject in our next issue.

THE LATE S. C. SEWELL, M.D., L.R.C.S., EDIN.

It is with deep regret, and sympathy for his afflicted widow, that we announce the death of Stephen Charles Sewell, M.D., &c., which lamentable event took place at his residence, in Ottawa City, C.W. Dr. Sewell was a son of the late Solicitor General for the Lower Province, and nephew of the late Chief Justice Sewell, of Quebec. He studied in Edinburgh, and during his pupilage was elected President of the Royal Medical Society of that city. He commenced practice in Montreal about the year 1836 or 1837. In 1842 he was elected Lecturer on Materia Medica McGill University, and Attending Physician Montreal General Hospital, which posts he held up to the year 1848, when he resigned, and left our city. In 1850, on his return to Montreal, he again became attached to the faculty of Medicine McGill College, and to the Staff of the Hospital, and lectured on Clinical Medicine up to the year 1852, when he removed to Ottawa.

Dr. Sewell has contributed several papers of value to medical periodicals, and in the pages of our Journal he published, from time to time, the results of his observations. In manner he was kind and affable; as a lecturer he was clear and painstaking. His views on medicine were sound; and though perhaps not brilliant as a teacher, yet he possessed that gentlemanly deportment which endeared him to his pupils. As a practitioner, he possessed a pleasing manner which inspired confidence. His death, though not sudden, was unexpected. Although his health had been failing for several years past, yet no serious apprehensions were entertained of a fatal result, until about a week before the event.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

The first annual meeting of this Society was held on the 15th of January, when the following gentlemen were elected office-bearers for the ensuing year: *President*, William H. Hingston, M.D., L.R.C.S.E.

Vice-Presidents, R. Palmer Howard, M.D., L.R.C.S.E., J. L. Leprohon, M.D.; *Treasurer*, Hector Peltier, M.D., Ed.; *Secretaries*, E. Lemire, M.D., W. Wood Squire, A.M., M.D.; *Council*, Drs. Fenwick, Robert Craik, F. W. Campbell, Dagenais, Ricard.

MEDICAL NEWS.

The number of medical students attending the London schools this year is 1022, being an increase of 41 over last year. At the Provincial schools there are over 241 students, being an increase of 2. — Dr. James A. Easton, Professor of *Materia Medica* in the Glasgow University, died recently of apoplexy. He was an able practitioner, and thoroughly conversant with *Materia Medica*. — John Moses Galignani, of Paris, has lately built and endowed at Paris an hospital for the English poor of that city. It contains twenty-five beds, and is placed under the direction of an English Sister of Charity. Two English surgeons have undertaken to give gratuitous attendance. — According to Professor Simpson, Messrs. Duncan, Flockhart & Co., the well known manufacturers of Chloroform in Edinburgh, prepare daily 7000 doses, — counting two drachms as a full dose—thus making 2,500,000 doses a year. — A surgeon's assistant lately poisoned a young lady at Salisbury, England. He subsequently committed suicide by drowning himself in a warm bath. — Dr. Littlejohn, of Edinburgh, warns the public against the use of "Pharaoh's Serpents," as they are called. These toys are compound of sulphocyanide of mercury. The inhalation of some of their products of combustion is highly dangerous; viz., cyanogen, sulphurous and sulphuric acids, bisulphide of carbon, and mercury in vapour. The mass left after combustion is organic matter called "mel-lor." — Dr. Hammond, late Surgeon General of the Federal Army, has gone to Europe, in charge of a grandson of the late John Jacob Astor, of New York. He receives for his services \$10,000 in gold for six months, with all his expenses paid, and should he be detained longer than the time specified, is to receive \$3000 per month for the remainder of the term employed. — Her Majesty has been pleased to confer the title of a Baronet of the United Kingdom on William Fergusson, Esq., F.R.S., Professor of Surgery to King's College, London.

The following are the only medical officers, in a list of those now living, who were present at the battle of Trafalgar:—Deputy Inspector General Peter Sutler, then surgeon of the *Swiftshure*; and surgeon P. Lyon, then assistant-surgeon of the *Royal Sovereign*.

Dr. Chambers, of Kingston, New York, was beset by two stout highwaymen, in a lonely part of the road, a few nights since, and his money demanded. The doctor said: "Well, if I must give up my money, I had better do it." So he quickly took off his glove, and putting his hand into his side pocket, he drew out—not his pocket-book—but a neat revolver, and bringing it to bear in an instant, he shot one of the robbers dead. The other ruffian then fired at the doctor, but the ball went harmlessly through his hat. The doctor then took his turn again and wounded the fellow severely. He then rode back to Kingston and made known the facts, but on returning the wounded man had escaped.

Anak the Anakim, the French Giant, has been introduced by Professor Anderson at St. James' Hall, London. The following are his dimensions: Circumference of the head, 2 ft. 3 in.; length of humerus, 1 ft. 9½ in.; length of radius, 1 ft. 5½ in.; circumference of fore-arm, 1 ft. 4 in.; round the biceps, 1 ft. 3 in.; circumference of middle finger, 3½ in.; breadth of hand, 5¼ in.; length of femur, 2 ft. 6¼ in.; length of tibia, 2 ft. 1 in.; length of foot, 1 ft. 4 in.; round the chest, 4 ft. 6 in.; across the shoulder, 2 ft. 1 in.; height, 8 ft.; length of outstretched arms, 8 ft. 1 in.; weight, thirty stone, (420 lbs.) The giant's physical strength is at present unknown. He can lift 600 weight, and is daily growing more powerful.

HEROIC DOSES OF ACETATE OF LEAD IN UTERINE HÆMORRHAGE.

At a recent meeting of the Medical Society of Southwestern, New York, the proceedings of which are recorded in the *Buffalo Med. and Surg. Journal*, Dr. C. K. Irwin, of Dunkirk, read a paper on "Acetate of Lead in Uterine Hæmorrhage in Heroic Doses." He recommends its use in doses of one, two, or three drachms, which, he states, are as free from danger as if given in doses of so many grains, and with the effect of controlling the hæmorrhage, completely, in an instant. Dr. Irwin, in his practice, has always used the acetate of lead in these large doses, without having lost a patient from hæmorrhage of the uterus. It is not necessary to confine its use to cases of full period, or where the placenta has been delivered, as its action will be to cause immediate expulsion of the contents of the uterus, and it can be used in cases of violent hæmorrhage from polypus, hydatids, abortions, retention of placenta, or almost any case requiring prompt and heroic action for the suppression of uterine hæmorrhage, except in cases of placenta previa.