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CONTENTS.

Original Communications.

APPENDICTIS—OPERATION—DEATH ON THE TENTH DAY.

BY GEO. E. ARMSTRONG, M.D., Instructor in Surgery, McGill University; Surgeon to Montreal General Hospital.

F. S., aged 30, consulted me about April 15th for a chronic, persistent diarrhœa, from which he said he had suffered for about fifteen years. Loose, watery, mucus stools; colicky pains, and also a pain in right hypochondriac region. He had previously been under my care for diarrhœa in 1884 and 1885. For about six years I had not seen him.

On examination, I found the abdomen flaccid and compressible over the left two-thirds. The right third was tender and painful, and a hard, well-defined mass could be distinctly outlined in region of ascending colon. Pain first felt at beginning of year. I advised him to enter the Montreal General Hospital with the view of having further advice, possibly an exploratory incision. Has lost 13 lbs. in weight since January, 1891. During the next two weeks the condition of the right side changed very much. There evidently had started up a fresh and active inflammatory process; so much so that when seen in consultation by Drs. Geo. Ross and Shepherd on his admission to hospital the right side of abdomen and right lumbar region were so tender that anything like a satisfactory physical examination without an anæsthetic was out of the question. He walked with difficulty. He was considerably emaciated. Had never been confined to bed. He was a printer by trade. Had inflammation of lungs and scarlatina in childhood. Father died of gout at the age of 69; mother and one sister and one brother are alive and well.

On the 1st May, 1891, assisted by Dr. Shepherd, I made a lateral incision on the right side, over the tumor. On entering the peritoneal cavity I was for some minutes puzzled to make out what the condition of things was that I was to deal with. In the iliac region the omentum was closely adherent to the parietal peritoneum to the right of the cæcum and below. Above I could pass my finger around into the right loin and determine that the kidney was normally placed and not adherent to the tumor. The liver and gall-bladder could be also excluded. I then carefully separated the omentum from the parietal peritoneum to the right of and below the cæcum. The walls of the cæcum were thickened and covered with inflammatory tissue. The appendix was with difficulty recognized, as its walls were ex-

tremely thickened and œdematous, and its base of attachment to cæcum fully one and a half inches broad. I now carefully separated the adhesions on the right side of the cæcum which bound it down to the iliac fossa, when I came upon a sac whose anterior wall seemed to be made up of purely inflammatory tissue. Fluctuation in this sac was obtained, the needle of a large hypodermic syringe introduced, and thick pus withdrawn. I then enlarged the opening and evacuated nearly a pint of thick pus having a distinctly fæcal odour. On exploring this cavity it was found to extend downwards below Poupart's ligament, and above as far up as the diaphragm. The cavity was thoroughly irrigated with boiled water and two rubber drainage tubes inserted, one reaching to the upper and one to the lower limit of the sac. The abdominal wound was then closed with silkworm gut sutures.

On dressing the wound on the third day gas was noticed escaping, and on the fourth day fæcal matter escaped.

On the sixth day there occurred a marked elevation of temperature, and on examination of lungs, percussion dulness was found over right apex, extending down as low as lower border of third rib. There was increase of vocal fremitus, and loud course mucus râiles were heard over this area.

Death occurred on the tenth day after operation.

This case has many features of unusual interest; in some respects resembling a case reported by Dr. William Gardner. I am not at all sure that the case can correctly be entitled one of appendicitis. I regret that no autopsy was obtained to clear up the case. The history is rather one of chronic colitis, probably tubercular. There is no history of a recurring subacute appendicitis, much less of an acute attack. *He had never been confined to his bed before admission to the hospital.* At the operation the appendix was not, apparently, more involved than the posterior wall of colon. The pus was entirely retro-peritoneal. I think it quite likely that tubercular ulceration took place in the cæcum or appendix, or both; that there was excited in their peritoneal coverings an inflammatory action that resulted in the union of the vesical peritoneum of the cæcum or appendix with the parietal peritoneum beneath. The ulcerative action continuing, perforation occurred, and escape of pus or possibly a small amount of fæcal matter into the subperitoneal tissue, where suppuration continued until the large cavity described above was formed.

Society Proceedings

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 3rd, 1891.

F. J. SHEPHERD, M.D., PRESIDENT IN THE CHAIR.

Dr. Lapthorn Smith exhibited the following pathological specimens:—

1. *Small Cystic Ovary.*—The patient had been a sufferer for many years with pain in the left side and severe palpitation. Dr. Smith had tried every form of treatment without being able to give her any relief. He then concluded to operate. The appendages were removed, with the result of immediate improvement of her symptoms—the pain disappeared, and she was free from attacks of palpitation.

2 *Double Pyosalpinx.*—This patient was aged 33, married twelve years, and the mother of one full-grown child eleven years ago. Her labor had been difficult, and she had been in bad health ever since. She had recurring attacks of pelvic peritonitis yearly for the past ten years. For the last two years her menstruation had been profuse. On examination, the ovaries and tubes were felt bound down in Douglas' cul-de-sac, and were excessively tender. Removal of the appendages had been advised, and the operation was performed by Dr. Smith, assisted by Dr. Armstrong. The tubes, which were exhibited, were enormously distended with pus. Up to the present time the patient was doing favorably. Dwelling upon the causation, Dr. Smith mentioned the probability of a septic metritis and salpingitis following her confinement eleven years ago. The recurring attacks of pelvic peritonitis could be attributed to the oozing out

into the pelvic peritoneum of the pent-up pus in the over-distended tubes.

Dr. Shepherd exhibited the following

ANATOMICAL VARIATIONS.

1. *The left four-foot of a pig with six toes.*—The reproduction of the thumb was interesting, for the trapezium, which in the pig's foot is in a rudimentary condition, was here developed to its full size. In both the accessory toes there were three phalanges, thus differing from the ordinary first digit of the five-toed mammals with only two phalanges.

2. *An unciform bone* with the unciform process separate and evidently having an origin from a distinct centre, as there were no evidences of fracture.

3. *An Indian skull* with a well developed supra-occipital or rather inter-parietal bone, as is seen in many lower animals. The portion of bone above the superior curved line was separated from the rest by a suture running across from one lateral angle to the other.

New Methods in the Treatment of Granular Ophthalmia.—Dr. F. Buller followed with a paper of considerable interest on the above subject.

Discussion.—Dr. Foucher considered Dr. Buller's paper of interest to all, as it related to one of the severest diseases connected with the eye commonly met with. Before such remedies mentioned by Dr. Buller were adopted, cases presenting themselves for treatment in our hospitals increased in numbers owing to the inefficient methods then at the disposal of the specialists. The susceptibility of some individuals to trachoma more than others was difficult to explain. He had frequently noticed granular lids in patients with atrophic rhinitis. Was there any connection between these two diseases which somewhat resembled one another pathologically? Did tuberculosis predispose to granular opthalmia? In the treatment he considered jequirity of great value, as well as corrosive sublimate, in suitable cases.

Dr. Proudfoot had discontinued the use of inoculating with pus cases of granular opthalmia since the introduction of jequirity. He has been in the habit of using the freshly powdered bean. If within forty-eight hours there was no inflammation, he washed out the sac. He had also employed caustic potash with great care, neutralizing the effect with a weak solution of vinegar. He found corrosive sublimate in the strength of 1 to 5000 beneficial when used frequently.

Dr. Shepherd asked if sulphur had been tried in those cases where corrosive sublimate failed. It was known to act well in diseases of the skin.

Dr. Buller, in his reply, remarked that he saw no analogy between tuberculosis and trachoma. That trachoma was due to a specific diplococcus, cultures of which had been found to produce the disease. He was not aware that sulphur had been used in these cases. He considered scarification very valuable in recent cases with much swelling.

Stated Meeting, April 17th, 1891.

F. J. SHEPHERD, M.D., PRESIDENT IN THE CHAIR.

Chronic Ovaritis in Cases with unusual Nervous Symptoms.—Dr. Alloway showed specimens from three cases of chronic ovaritis. The ovaries and tubes exhibited were removed for the relief of unusual nervous symptoms. The first case was 30 years of age; three full-term children; menstruation had been very irregular. A year previous she had a trachelorrhaphy performed for laceration of the cervix, which improved her in general health for some months; but the following nervous symptoms remained and continued to become exaggerated: constant headache, vertigo, exaggerated hysterical symptoms, chiefly in the form of a feeling of irresponsibility for her acts, great cardiac excitability, insomnia, and pelvic pain. Since the removal of the appendages these symptoms have disappeared, and the patient has assumed altogether a different condition.

The next specimen exhibited by Dr. Alloway was the appendages removed from a lady 40 years of age. She had been married twenty-one years. Four full-term children; youngest 14 years of age. Menstruation had been very irregular, severe pelvic pain, constant vomiting, which seemed to be of a reflex character and unaccompanied by nausea, constant headache, hysterical attacks were very violent, requiring severe measures to suppress them, and were followed by these attacks of vomiting before mentioned. This patient had been under every possible treatment for years without relief. At the operation, the ovaries and tubes of both sides were firmly adherent to the pelvic wall, and were with much difficulty separated on account of the age of the adhesions. This patient has not had a single attack of vomiting since the operation, and in other respects is thoroughly restored to health.

The third specimen exhibited by Dr. Alloway was the appendages from a patient of 29 years of age, unmarried. Her principal symptoms consisted in an inability to digest ordinary food for the past two years, the smallest quantity causing intense gastralgia, followed by painful and loud eructations of gas and enormous distension of the large and small intestines, giving appearance to the so called phantom tumor. This tumor would gradually disappear towards evening, to reappear again the following morning accompanied by very loud borborygmus. This patient had had every possible form of treatment, including the washing out of her stomach; had lived on milk diet for months at a time without

any benefit. The appendages were removed and found extremely small and cirrhotic; they were formed of unruptured cysts and fibrous tissue. Since the operation this patient has had no distension of the abdomen nor dyspeptic attacks. She takes ordinary food without any inconvenience, and has no hysterical symptoms whatsoever.

Dr. Alloway said that he exhibited these specimens to show that hysterical symptoms accompanied by reflex phenomena relating to disease of other organs were really due to organic disease of the sexual organs; and that chronic ovaritis, due to past attacks of scarlet fever or smallpox, was invariably found on operation. This variety of disease was called by Tait exanthematic ovaritis, and was more prevalent than the profession generally suspected.

Uterine Fibroid Removed by Abdominal Hysterectomy.—Dr. Lapthorn Smith showed this specimen, which was about the size of the head of a new-born child. He said that he had performed this operation with great reluctance and only at the urgent solicitation of the patient and her friends. She was 35 years old, and had always had regular menstruation, but four years ago she had begun to flow profusely, and her periods became extended to fourteen days, gradually growing more and more profuse until she had to be tamponed and confined to bed. About two years ago she had ten applications of electricity in Minneapolis, according to Apostoli's method, but owing to her intolerance of it and the impossibility of introducing the platinum sound through the several sharp curves of the uterine canal she only received very small intensities, and the benefit was in proportion. She was, however, so much improved (losing about half as much blood and for about half the length of time that she did previously), that she returned to her arduous duties as principal of a school. After a winter's work she began to suffer again from dysmenorrhœa and menorrhagia, and when she placed herself under his care last fall she was losing for fourteen days every month. He was unable to introduce a platinum sound, and was obliged to invent an instrument for her case—namely, a soft elastic bougie covered with aluminium wire—which he was able to introduce a distance of 4½ inches, and by means of which he was able to go as high as 100 mm. She improved so much after fifty applicaions that the flow was only profuse for two days, and was over in five or six. She then went down to New Brunswick on a visit, where the periods continued to be less and less, and when she returned to Montreal a week ago she appeared in perfect health. Although all the cases which have improved under Apostoli's treatment had maintained their improvement, some after several years, yet Dr. Smith, on being asked, could not promise his patient that this would be the case with her. He advised her to return home, and if her improvement should not prove to be permanent, to return for operation next summer. The patient, dreading a return, requested that an operation should be performed immediately. Dr. Smith informed her that the only operation which would guarantee her against a return of the bleeding was a radical one—namely, the removal of the tumor with the uterus and its appendages, which he considered very little more dangerous than the removal of the appendages alone. Five days ago, with the assistance of Dr. Armstrong and of Dr. Spendlove (who gave the anæsthetic), he performed abdominal hysterectomy, removing the whole of the tumor and all of the uterus and appendages except a piece of the cervix, which was left for a stump. In order to lift the tumor out of the very small opening which he purposely made, he screwed into it a silver-plated cork-screw, which enabled Dr. Armstrong to litt it out without any effort. So far the temperature has not reached 100°, the only *contre-temps* being the oozing of about eight ounces of blood from the stump owing to the serre-nœud having gone to the end of its tether, so that he was obliged to place another serre-nœud around the first, which arrested the oozing. The stump came away on the fourteenth day, and there was every prospect of her making a good recovery.

Dr. Armstrong, dwelling upon reflex symptoms mentioned in Dr. Alloway's cases, considered that removal of the distal cause, when practicable, would necessarily tend to alleviation of the symptoms. Referring to hysterectomy, he questioned the propriety of submitting a woman to hysterectomy in cases where removal of the appendages would give relief. In the former the mortality was high, whereas in the latter the death-rate was low.

Dr. Mills said that the sexual organs played a great part in the reflex symptoms. The removal of the ovaries or testicles in an animal arrested its development. The moral, mental and even the physical life changed In man these changes were not so marked, yet we had sufficient evidence to show that a centre could be, as it were, thrown out of balance by over-stimulation of an afferent nerve, whereby the physical life became disorganized. He hoped that gynæcologists and obstetricians would be able to trace out the paths of these disturbances.

Dr. Alloway thought that the appendages in Dr. Smith's case might have been removed for a tumor of the size mentioned. He was of the same opinion as Tait in not performing hysterectomy when the appendages could be removed, which could be done in the majority of cases.

Necrosis of the Bladder.—Dr. F. A. L. Lockhart followed with a paper on this subject.

Dr. Johnston had been interested in reading an article on the above subject from Dr. Haultain of Edinburgh. He was not inclined to consider this a special form of necrosis of the

bladder in contra-distinction to other diseases of the bladder, such as diphtheria and cystitis, which are also a kind of necrosis.

Stated Meeting, May 1st, 1891.

F. J. SHEPHERD, M. D., PRESIDENT, IN THE CHAIR.

Dr. G. G. Campbell was elected a member of the Society.

Multiple Epithelioma of Œsophagus and Stomach.—Dr. Johnston exhibited this specimen, which had been obtained at the autopsy from a patient who had recently died in the hospital. It was a very unusual condition. Two epitheliomata were found high up in the œsophagus, whilst within the stomach, close to the œsophageal opening, was another tumor. The liver contained two large tumor masses and two smaller ones; the former were broken down in the centre. They differ in their microscopical appearances from those found in the œsophagus and stomach. The cells were not arranged in nests, but in alveoli. It was very difficult to say which was the primary tumor. But few of these cases had been reported.

Brain Tumor.—Dr. Johnston showed this specimen for Dr. Stewart. The growth was situated at the base of the brain, and occupied the position of the pituitary body, involving the optic nerves and optic commissure. The lateral ventricles were considerably distended, and covered with minute granulations produced by a thickening of the lining membrane from chronic distension. The tumor extended into the third ventricle. There were considerable areas of necrosis and fatty degeneration. From the microscopical appearance, the growth was pronounced a teratoid tumor, not uncommon in that region.

Dr. James Stewart remarked that the patient, whom he had seen, had been admitted to the hospital under Dr. Buller. He complained of failing vision, severe headaches, vertigo, and vomiting. There was double optic neuritis, which went on to complete blindness. He had ptosis of the right lid, and the head inclined to the right side. There was no history of syphilis. The symptoms were those of a gross lesion in the brain. Nothing pointed to the localization or nature of the tumor.

Cardiac Thrombus in a Case of Pneumonia.—Dr. Finley related that the patient from whom this specimen had been obtained was a man, 46 years of age, who, in 1889, had had a pleurisy which had lasted six weeks. On the 7th of February of this year the patient was taken ill with pneumonia. The fever disappeared on the tenth day, and he was apparently progressing favorably. A week later the patient was seized with a malarial-like attack. The chills were of a marked intermittent type, recurring at intervals of twenty-five hours. He had never had malaria, and had not lived in a malarial district. Dr. Finley was at a loss to explain their causes. The patient died from heart failure on 23rd March. At the post-mortem examination the right pleura was found greatly thickened. There was a localized pleurisy, with some effusion at the base of the right lung; the lung itself was in a condition of resolving pneumonia. Fraenkel's micrococcus of pneumonia was found. The examination of the heart was interesting from the presence of a large thrombus in the right side of the heart, which projected upward into the auricle; the valves beneath were perfectly healthy. Sections of the thrombus were made, but no bacteria were found.

Dr. Geo. Ross remarked that he had seen the patient on two occasions. At his first visit he had found him in one of those rigors mentioned by Dr. Finley, which was very violent, and very much like the chill of ague. At his next visit the patient was apparently well, pulse quiet, and temperature normal. There were physical signs of consolidation at the base of the right lung. The appearance of the ague-like attacks at a time when the patient should be recovering from pneumonia was very perplexing. The possibility of its being accounted for by septicæmia was negatived by his good condition in the intervals. Malignant or ulcerative endocarditis, which has often been mistaken for ague, could also be excluded from the absence of a heart murmur It was difficult to offer an explanation.

Ulcerative Endocarditis.—Dr. F. R England, who reported the case, remarked that the patient, a man aged 36, employed as a locomotive engineer, had been in good health until two and a half years ago, when he suffered from an attack of articular rheumatism with endocarditis, which kept him in bed for four weeks. There was at that time a soft blowing murmur transmitted down the sternum and upwards along the vessels into the neck. He recovered and remained well until the winter of 1890, when he suffered from a dry, harsh cough, which disappeared in the spring. The cough returned again last winter, and impaired his health considerably; he lost weight and complained of night sweats. The loss of a child about this time preyed heavily upon his mind. He persisted in going to his work until the 10th of March, when Dr. E. was called to see him. He complained of cough, great weakness, and pain in the left lumbar region on deep inspiration or movement. His temperature was 101°F.; pulse quickened. There was no evidences of disease in the heart or lungs. For six days of the illness the temperature ranged between 100° and 101°. The nervous prostration, the profuse sweats, together with the persistence and severity of the lumbar pain, lead Dr. England to believe that the trouble was probably

rheumatic. After the tenth day of the illness a harsh, double aortic murmur developed, with visible pulsation of the head and neck and smaller arteries. A congestive bronchitis appeared, and the patient became weaker and restless. The temperature varied between 99° and 101°; respirations 36 to 46, and pulse from 96 to 120 throughout the disease. No palpitation, or pain over the cardiac region, was at any time complained of. There were no rigors. Rheumatic pain and tenderness developed in the right shoulder, lasting for a few days. The patient died suddenly from heart failure on the forty-fourth day of his illness. Dr. Geo. Ross, who had seen the patient in consultation ten days before death, was strongly inclined to consider the case as one of malignant endocarditis.

Dr. Johnston, who exhibited the specimen for Dr. England, said the heart showed extensive acute endocarditis of three segments of the aortic valves, with large vegetations upon their free edges. Besides the recent endocarditis, the valves showed signs of old chronic endocarditis. Fusion of two of the segments of the valves had occurred, which was not uncommon in ulcerative endocarditis. A perforation was noticed directly in the middle of a segment with complete destruction of valve tissue at that point. The perforation was plugged with fibrin which prevented any leakage when water was poured upon the valves. This, Dr. Johnston suggested, might explain in some cases the disappearance of a murmer. The streptococcus pyogenes was found.

Dr. Geo. Ross considered the case of clinical interest. The prostration noticeable in this malignant disease was an important point. Another point was the different phases in the temperature curve; few diseases were so deceptive in regard to the temperature curve. Dr. England's report places another case on record where a heart already the subject of endocarditis subsequently becomes the subject of ulcerative endocarditis.

The Bacilli of Diptheria.—Dr. Wyatt Johnston exhibited cultures of the Klebs-Lœffler bacilli obtained from a case of diptheria. The bacteriological examination of the diptheritic membrane, as recommended by Roux and Yersin, was likely to prove of great practical diagnostic value in doubtful cases, as a positive diagnosis was possible within twenty-four hours. The appearance of the bacteria and their mode of growth were quite characteristic. Portions of membrane intended for examination could be sent dry in clean glass or between folds of blotting paper or cotton. In three cases of genuine diphtheria these characteristic bacilli were found in large numbers, while two other cases with a suspicious looking exudation on the tonsils were free from them, and proved to be simple cases of tonsillitis. One case where a peculiar fibrinous false membrane had formed in the nose, and a case of membranous conjunctivitis, were free from the diphtheritic organisms. Dr. T. M. Prudden's experience with what seemed to be cases of genuine diphtheria, where the bacilli were uniformly absent, was unique, and not borne out by his later results. It was probable that a certain proportion of primary acute inflammations of the throat, characterized by the presence of what was anatomically diptheritic membrane, was due simply to septic organisms, such as the streptococcus pyogenes.

Discussion.—Dr. A. D. Blackader had translated (some twelve months ago) an article on this important subject from *Le Journal de L'Enfance.* He had been surprised at the results obtained by Prudden on his first investigation for the Klebs-Lœffler bacillus. It was evidently the ptomaines which produced the poisonous effects.

Dr. Geo. Ross remarked that it was of great importance in doubtful cases to arrive at just conclusions. From recent work more than one disease was shown to be characterized by the formation of membrane In two cases which had recently come under his notice in the General Hospital, one was a young child with a suspicious-looking follicular tonsillitis which was examined for the Lœffler bacillus, but none were found; the other case was admitted for quinsy, and when first seen by him the patient had had rigors and complained of severe pain at the angle of the jaw, with difficulty of swallowing. The tonsils were considerably swollen, and a suspicious, small fibrous patch was noticed on the uvula. The next day the patch had extended, and he felt quite sure that the case was one of diphtheria. Dr. Johnston took a culture from the patient's throat, which showed the Lœffler bacillus abundantly. The most extravagant views were held upon the subject of diphtheria. Dr. Jacobi looked upon all cases of tonsilitis as diphtheria. The only way that such views can be positively disproved, will be by bacteriological examination.

Dr. Buller remarked that when true diphtheria attacked the conjunctiva, the local symptoms were very severe, and always sufficiently well marked to make easy the elimination of other diseases characterized by the formation of false membrane.

Dr. Birkett stated that a case which had come under his notice, and which had been mentioned in Dr. Johnston's report, had somewhat of a diphtheritic appearance. A yellowish, thick, pseudo-membrane was found loosely attached to the septum of the nose, which, however, could be removed without bleeding. The larynx presented a similar condition, and the tonsils were swollen. The patient evidently got well three weeks after, before the membrane disappeared from the cords. The Klebs-Lœffler bacillus was not found.

Dr. Wilkins referred to the difficulty, at

times, in the diagnosis of follicular tonsillitis from diphtheria, and *vice versâ*. A case which he had lately seen presented all the appearances and symptoms of a follicular tonsillitis, which he would have pronounced as such but for a small suspicious patch on the side of the uvula. The case proved to be one of diphtheria.

Dr. England mentioned the case of a child whom he had seen with a temperature of 101° F., glands swollen at the angles of the jaw, and both tonsils covered with white membrane. The case looked very much like diphtheria. In three days the membrane had all disappeared and the child was better. Another child in the same family was similarly affected, but in this case a large cervical abscess formed. The mother of these children was also taken ill shortly afterwards; membrane appeared on both tonsils, temperature rose to 101°F., and she was considerably prostrated. He questioned whether these were cases of true diphtheria, and was more inclined to consider them cases of septic sore throat, as mentioned by Dr. Johnston.

Stated Meeting, 15th May, 1891.

F. J. SHEPHERD, M.D., PRESIDENT, IN THE CHAIR.

Dr. G. Laforest was elected a member of the Society.

Combined Lateral and Posterior Sclerosis.—Dr. J. Stewart exhibited this case. The patient, a man aged 42, first showed symptoms of his trouble two years ago, in the form of weakness, stiffness, and difficulty in walking and standing, especially when the eyes were closed. When he came under observation two months ago, there was paresis of the lower limbs with marked ataxia and increased knee jerks. It was noticed, however, that in the course of the following month the knee-jerks gradually diminished, and were now completely absent. This was considered to be evidence pointing to the extension of the degenerative process from the postero-internal to the postero-external columns.

Dr. James Stewart read the notes of a similar case which had been under his observation at the Montreal General Hospital for a period of some weeks two years ago. The patient was 43 years of age, and presented the characteristic symptoms of combined lateral and postero-internal sclerosis. The patient died from erysipelas.

Dr. Finley, who performed the post-mortem, was able to demonstrate the existence of degeneration of both the lateral (crossed pyramidal) and postero-internal fibres.

Dr. Roddick inquired as to the cause.

Dr. Elder asked, if a case be seen early, what symptoms would lead to a diagnosis between postero-lateral sclerosis and tabes?

Dr. Stewart, to Dr. Roddick's question, replied that the patient had a history of syphilis, which he believed to be the cause. To Dr. Elder he answered that in tabes the knee-jerk was invariably lost, besides the presence of the Argyll-Robertson pupil, and lightning pains.

Pericarditis.—Dr. Finley exhibited this specimen for Dr. Wilkins. The pericardial sac contained a large quantity of pus. The inner surface was covered with lymph and some fibrinous adhesions between the visceral and the parietal layer. The outer surface was also involved. The left lung was found glued to the pericardium. The endocardium was healthy. The chief point of interest was that the lesion was primary, there being no history of Bright's disease or rheumatism.

Appendicitis.—Dr. Armstrong read a paper on this subject from a case in practice.

Discussion.—Dr. Hingston was doubtful as to the case being one of appendicitis. He had seen more than one case of appendicitis, when on the eve of an operation there would be a discharge of the pus. He thought that in such cases the pus emptied more frequently into the bowel.

Dr. Johnston had found pus in the retro-peritoneal region, the result of an appendicitis,—a large peri-nephritic abscess which he believed at first to be connected with the kidney, but on careful dissection, a narrow sinus was found leading down to a perforated appendix which lay behind the cæcum.

Dr. Shepherd had seen the case reported by Dr. Armstrong and was still of the opinion that the case was one of appendicitis. The appendix had been found bent on itself and closely attached to the posterior wall. It had perforated beneath the iliac fascia and extended upwards.

The late E. H. Trenholme, M.D.—The following resolution of regret was proposed by Dr. Hingston, seconded by Dr. Armstrong, and carried:—

"That this Society has learned with regret of the death of Dr. E. H. Trenholme, for many years a useful and active member: That it records its sense of his ability as a gynæcological surgeon and as an original observer."

Prof. Keen selects the following points for the passage of the needle in the operation of paracentesis. In paracentesis thoracis the place of election is between the eighth and ninth ribs in the line of the axilla. In paracentesis abdominis the needle should enter in the middle line, the patient being in a sitting posture and the bladder having been previously emptied. In paracentesis pericardii the patient should be in the recumbent posture and the needle should enter at the fifth interspace in front, due regard being had for the heart and large vessels.—*Col. and Clin. Record.*

Progress of Science.

THE PRESENT STATUS OF ABDOMINAL SURGERY. *

By Joseph Price, M.D., Philadelphia, Pa.

The progress of abdominal and pelvic surgery has so far advanced within the last decade, that, from occupying a doubtful position both as to practicability and justifiability, it is now recognized as holding easily the vantage ground of both refinement and attainments. It has vanished opposition and won over its opponents; it has grafted its exact methods of procedure upon all other branches of surgery, and so lent its refinements to their advantage; and lastly, it has, by overthrowing traditions and fables of surgery, given valuable aid in the line of therapeutics in determining where surgery must begin and medicine end in a line of diseases hitherto considered almost entirely outside the domain of else than physic.

I have deemed it fitting to discuss this subject here at this time because, here in the person of Ephraim McDowell in Rockbridge county, abdominal surgery was born more than a century ago. Born in Virginia; buried in Kentucky; his resting place is marked by a shaft of Virginia granite; but the monument of his fame is everlasting, though the inscription thereon be effaced and the granite crumble in that dying womanhood and suffering humanity, to the end of time, must rise up and call his genius blessed, that has delivered them.

The question is often propounded at the present day. "To which branch of surgery must be accorded the first place? which branch is most indebted to the others for its advancement? in which are the most difficulties to be anticipated during the progress of an operation?" Now, it is easy in any specialty to set up and defend a number of points, from which it would appear that this or that specialty may claim prominence. It is easy for the general surgeon to say that in the vast variety of accidents and pathological processes met variously in the body, the difficulties of general surgery are easily in the van. The argument is however fallacious, for though the number of organs and parts dealt with by the general surgeon may, for the sake of arguments, be granted to be greater, nevertheless, the relations of these parts, on the average, is not so intimately concerned in the vital processes, as those of the abdomen. To ligature an artery, carotid or femoral outside of the body, easily exposed and kept so, is an altogether different matter from tying a vastly smaller one in the pelvis. The methods of procedure in all the ordinary surgical operations, major or minor, are for the most part a matter of accepted method from the well-known relations of the parts. In abdominal and pelvic work, however, routine—except in reference to instrumental preparation and cleanliness—is not possible, for no operation can be taken as a type of any other, and the complications of one cannot be estimated by the accidents of another. The only thing to rule out failure is to be prepared absolutely for anything, from complete packing of the pelvis to control hæmorrhage, to the resection of intestine, removal of kidney, or the uterus.

With this understanding of abdominal surgery, it is not difficult to see that what promises to be the simplest operation may turn out the most difficult, and that the terms are only of an average; the requirements of this branch of surgery are *facile princeps* in requiring a special training and its difficulties especially its own. To say that a general surgeon without such training can do such work, is to argue that he can just as well do eye work or brain surgery. That now and then a general surgeon has excellent results in this special work, is no more argument than special surgeons are not required in it, than to hold that because Blind Tom has mastered the technique of music without lesson or instruction, he is not an idiot, and there is no science of music. It is clear then that the work of abdominal surgery is distinctive. Let us now consider briefly the procedures pertaining to it, and the approved methods of dealing with the many pathological conditions encountered.

We may start with *pelvic abscess*. Here the radical abdominal interference is especially to be compared with the old (and by some still followed) method of vaginal puncture. Vaginal puncture is a dangerous procedure, in that it cannot be told what organs are involved in the abscess wall. The abscess again may be multiple, and therefore, puncture will only open a single cavity, and may leave three or four untouched, and the difficulty of the case be left unsolved. To say that these abscesses are often outside of the peritoneum is no argument against the abdominal operation at all, for if this is true, careful manipulation may evacuate the pus entirely without opening the peritoneum. Again, it is to be remembered that nearly every case of so-called pelvic abscess takes its origin from a diseased tube or ovary. This being the fact, it is apparent, that the absolute removal of the focus of the disease is the only way of effecting a cure. The tediousness of the healing process by the method of puncture, is so well appreciated in even the most uncomplicated cases that this alone is a most telling argument against it.

At the present time, *operations for the removal of cancerous or myo-fibromatous uteri*, are claiming especial attention, for the reason that when first originated these operations were regarded with especial disfavor on account of their primary mortality. It is not my purpose to

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speak especially of the removal of the uterus for cancer, but to consider the operation as necessitated by myomatous or fibro-cystic tumors. Experience has amply shown that this latter operation, carefully performed, so as completely to shut off the peritoneal cavity from the surrounding tissues, a technique which must be freed from every loophole of error, is at once the key to the operation and the salvation of the patient.

Another feature of the operation is the use of the clamp, or serre-nœud, as the great essential in the instrumental technique of the operation. This fact is especially interesting from the fact that certain sentimental surgeons at once insist upon the barbarousness of the instrument, and claim that if the operation is to stand, an intra-peritoneal method of treating the stump must be devised. The line of argument in a life-saving operation that would insist upon the abandonment of an instrument simply because, from their ultra ideas of refinement, it is "barbarous" we suppose would refuse succor in a storm, because the boat savored of fish. Plainly to the clamp belongs the credit of giving to hysterectomy its acknowledged position as a justifiable surgical procedure. By its use I have now completed a series of *twenty-seven hysterectomies without a death.* The course of the operation was smoother than the average ovariotomy, and gave me less concern, because I had the danger point under my eye all the time. I am morally sure that if hæmorrhage occurs I shall see it, and when seen, it is easily controlled. Herein lies the value of the clamp, and at this stumbling-block the intra-peritoneal methods of dealing with a stump often as big as a thigh must be uncertain and therefore dangerous. To say that suture and ligature, inasmuch as they control hæmorrhage elsewhere, will do it here, is to argue without a due appreciation of the facts, or a very limited experience; and just here the general surgeon falls short. There are many stumps that will not safely hold a ligature, and even when they do, the danger from after shrinkage is so great that it is not by any means certain that the ligatures employed will not altogether fail.

The *method of making a stump* is one not to be easily described, nor is it uniform. Each stump must be made according to the exigencies of the case. The general rule is to free the bladder, save the peritoneum dissecting out the tumor until sufficiently free to engage it with the clamp. The after technique involves the closure of the pelvic peritoneum, and the embracement of the stump by the parietal peritoneum so as to close off the peritoneal cavity absolutely.

Following closely in importance for the relief of uterine fibroids of a myomatous nature is the *removal of the appendages.* When this is possible, the relief afforded is, in most instances, immediate and permanent. It must not be premised, however, that the removal of tubes and ovaries, in cases of uterine fibroid, has its counterpart in the operation under the simpler pathological conditions. In the latter, it is often the easiest of the easy operations; in the former, it frequently becomes a most serious undertaking—often is impossible, eventuating in hysterectomy in cases where such a conclusion was considered the remotest of contingencies, if considered at all. This is another illustation of the complexity of abdominal work. The mortality in removal of the appendages in uncomplicated cases of fibro-myomata should be about *nil.* The mortalities of dabblers in abdominal surgery have no right to be considered. Closely related, in a clinical light, as dealing with the uterus, are the *Porro Cœsarian operations.* These, of course, have an obstetric relation, and in many points must be so considered, so far as their necessity is concerned. The average obstetrician is however, far from being prepared to perform either of these operations; and hence they will fall, in most cases, into the hands of the abdominal surgeon. As an operation of utility—*i. e.*, accomplishing its purposes and removing a chance for the necessity of re-operating, the Porro is to be preferred. In addition, with the perfected method of doing hysterectomy, it is, I believe in competent hands, much the safer operation, though, so far as statistics are concerned, this is, perhaps, open to question; but, all things considered, as I have shown in a previous paper, the Porro operation should be the safer operation, and I have no doubt it will ultimately be so recognized.

The *Cœsarian section*, simplified and perfected to conform with the modern surgery of the abdomen, is outside of the unfavorable conditions for perfect suture of the uterus—a simple operation —so much so that it has been sought after as a cheap means of advertisements of late years in many cases in which it was not at all justifiable.

Ectopic pregnancy may be considered at this time as related indirectly with the uterus. That is, there are uterine symptoms in connection with it. These are not, however, in any sense pathognomonic of pregnancy, and may be simulated by various pelvic pathological conditions. So far as the diagnosis is concerned, I shall not argue the question further than to say that out of an operative experience of over thirty-eight cases in which its existence was proved in every case beyond question. I have so often been deceived or in doubt, that I cannot, for an instant, agree with those who insist upon exact and positive diagnosis in this most serious of the abdominal pathological conditions. I have not, it is curious to remark, observed a so-called intra-ligamentous variety of this condition, and, accordingly, am somewhat skeptical as to its frequency and the correctness of the pathology advocated by Hart and Carter, as shown by

frozen sections. I may be in error as to this but believe the matter should be further investigated before it is considered settled. As to operation, this should be done at once when the condition is discovered; and, if strongly probable, exploratory incision should be made. The earlier the operation, the safer it is. Delay, for the sake of saving the child, I regard as illogical, unless it is clearly felt to be also more safe for the mother.

As to the *method of dealing with the placenta*, this is perhaps not settled. In all cases, when at all possible from the nature of its attachments, it should be removed. When this cannot be done, of course there is nothing else to do but leave it under conditions as favorable as possible. It should be emptied of its blood, made as dry as possible, the cord cut close and tied, and the abdominal cavity closed.

The peritoneum will probably digest it, which, thanks to its vast absorbent power, will likely, in most cases, with clean operation, remove what would otherwise negative the operation.

In all of these operations so far referred to, it must be remembered that there are no hard and fast lines of treatment invariably to be followed, step by step, in every case. A knowledge of the expedients and resources of all complications will bring in variations that are valuable and indispensable for the successful accomplishment of their surgery.

In all cases of prolonged operation, especially in threatened shock and after hæmorrhage, and in the presence of pus or debris, the value of *flushing out the abdomen with moderately hot water* is beyond question. In puerperal peritonitis, such procedure comes in as a valuable adjunct in removing the pus and relieving shock. This latter operation is still in its infancy, so far as its appreciation is concerned. Abroad it has not met with success, according to Mr. Bantock; but along with drainage, and an early appreciation of its presence, there is much to be hoped in this line. The point especially to be urged is that, in cases already in collapse, only sufficient be attempted temporarily to save life.

After operation, it may be required to put the patients in a sound condition, but this should not be undertaken until there is reasonable assurance that they can endure it. The ideal surgery is the surgery that saves life, and not that which records a technically complete operation, followed by a death certificate.

In these operations, characterized by overwhelming quantities of pus, it is noticeable that there is no need whatever of the use of antiseptics. Pure water, fresh from the tap, or if possible distilled, thoroughly cleanses the abdomen, the temperature falls, the pulse slows down, and the Listerien system of germicides is, once for all, proven absolutely needless, so far as abdominal surgery is concerned.

In all abdominal surgery, it must ultimately be accepted that *germicides are useless*, and may be harmful. The same may be said of opium, except in cases in which the opium habit has already been acquired.

As to the time for entering upon the operations for the various conditions referred to, it is now an axiom of surgery not to delay longer than to establish the fact that operation will be necessary at some time. This once granted, the earlier such operation is done the fewer will be the complications, and all the dangers attending operations will be diminished or avoided. There will be a shorter anæsthesia, shorter operation, less handling of the parts, less shock—surgical and dynamic—and quicker convalescence. There will be less need of drainage, because of the fewer complications. In complicated cases with adhesions, and where fringes of cicatricial tissue are necessarily left, the value of drainage is to be insisted upon. Cases do the better for it, have a more uninterrupted convalescence, and are more comfortable generally than where it is omitted. The *drainage tube* should be kept clear and clean, emptied frequently, and removed when the discharge is serum.

From my own experience, I must regard with disfavor what certain operators express concerning the tube as the result of ignorance of its proper handling, or of those cases that require it. To its use I certainly ascribe the recovery of many cases that would otherwise have been failures.

As to the *details of all operations*, they should be as exact and simple as possible. All sponges and instruments should be counted before and after operation. No hand except those of the operator, assistant and nurse should approach the trays or touch an instrument under any circumstances whatever. The incision should be closed accurately and firmly without being strangulated by the ligatures. Care should be taken that the skin edges do not invert, and thus prevent union. Before opening the peritoneum, all hæmorrhage should be checked by pressure forceps, and when once the peritoneal cavity is reached, the work should be as quickly and expeditiously done as is consistent with thoroughness. No operation should be undertaken without full preparation for any possible complication. In ligaturing the pedicle in ovariotomy, the double surgeon's knot is by all odds to be preferred to any other. It gives greater certainty of constant pressure, and carries with it less danger of slipping, as I can readily demonstrate.

The *after treatment* of these cases is marked by no special features, except to insist on absolute abstinence from food or drink until the stomach is entirely settled. The liquid diet is begun in small quantities, butter-milk being an excellent *initiative*. If there are signs of tympany, a saline purgative will usually afford prompt relief; or, if this is not well borne small doses of calomel will have the same effect in relieving the distension.

As a preparatory treatment for the operation, I insist upon rest in bed for at least twenty-four hours, and free purgation. When this is done, there is much less danger of tympany subsequent to operations The patient should remain in bed for at least three weeks, and should wear a bandage for at least a year. This will obviate in most cases, the complication of hernia.

A word as to the *electrical treatment of pelvic disease in women.* To those who have followed out the claims of the electricians, it will be evident that many of their cures depend entirely upon the correctness of their diagnosis. When we consider the absolute impossibility of making an exact diagnosis in the pelvis or abdomen, we are justified, in the light of exact surgical experience and of our own failure, to doubt the perfection attained by these men, the most of whom have never seen inside of an abdomen. If we doubt their diagnosis, what, then, must we say of their cures?

A wide field of discussion is still left open in reference to the surgical affections of the spleen, liver and kidneys, and also of the gall bladder.

Generally, the same teaching and arguments apply to these as to the operations already considered. Where they are divergent, it is due to the anatomical relations of the parts, the same general principles underlying all.

LECTURES ON VENEREAL DISEASES.

On the use of injections in gonorrhœa.—Before speaking of the proper and legitimate use of injections in the treatment of this complaint, I wish just to refer to the so-called abortive treatment by means of strong solutions of nitrate of silver, or some similar substance, by which it is claimed that a severe but simple form is substituted for the specific inflammation and thus the duration of the disease is materially shortened. I mention this plan of treatment only to condemn it in the most emphatic terms as being both uncertain and dangerous. While, perhaps it can not be said that this plan of treatment *never* succeeds in its aim in cutting short the attack; still it may most safely be asserted that it does so only in a small minority of the cases, that we never can tell whether it is going to succeed or not, and that there is always danger of producing the most disastrous results.

I know of one patient who contracted a gonorrhœa about eight years ago; he went to a physician who promised to cut it short in a few days, and administered an injection in his office. The pain was so intolerable that the patient fell down on the floor as if shot through the heart and remained in a condition of syncope for a short time. The resulting inflammation was most intense and the discharge very profuse, amounting to many ounces in the twenty-four hours. But it was not of short duration as he had been led to expect, but continued day after day, and finally resulted in a severe cystitis from which the patient has never entirely recovered to this day. And I know another patient who, from a similar treatment, nearly as long ago, contracted the most severe and inveterate strictures for which he has undergone several operations without complete relief. With such results before our eyes and the uncertainity as to when they may be repeated, it seems to me that we are not justified in subjecting a patient to such a risk, especially while milder means are almost sure of success and are free from such fearful risks.

Injections properly used, however, have always and deservedly held a high character in the treatment of gonorrhœa. The proper period for their application seems to be toward the close of the stationary period or when the discharge is beginning sensibly to diminish in quantity. When used at this time and of proper strength there seems to be no real danger of their producing stricture or other bad consequences as claimed by some. Indeed stricture is much more likely to be caused by allowing the inflammation to go on unchecked, as it results from the deposit of inflammatory material in the sub-mucous connective tissue which is more in proportion to the duration than the severity of the case.

The syringe used should be made of hard rubber, as glass syringes in addition to their destructability are most always unevenly blown, which gives rise to an irregular and uncertain discharge of the contents together with leakage of a part from the side of the piston rod; and metallic syringes are incompatible with many of the substances used, which act chemically upon the pewter or other metal and are acted upon by it as well.

With regard to the many forms found in the shops offered for sale for this purpose, almost any of those with a blunt or short nozzle will answer the purpose, the best of all in my opinion being that known as the hard rubber syringe, No. 1, A. Syringes with a long and pointed nozzle are to be avoided. It is also essential that the syringe should work easily with one hand. The patient should make water just before using his injection, as this act clears the urethral canal to a reasonable extent of the pus that may be present and permits the injection to come directly in contact with the inflamed mucous membrane. Having slightly warmed his injection material, which should never be used cold, and filled his syringe, taking care that all air is expelled, the nozzle of the syringe is introduced well within the meatus, but not crowded as far as it will go, and the lips of the meatus compressed laterally by pressing them together, rather than by pressing them against the syringe. The injection is then slowly and gently introduced, the syringe with-

drawn, but the meatus still compressed, retaining the injection for about thirty seconds when it is allowed to flow out. This which constitutes the whole of the act in most cases may be repeated two or three times a day, bearing in mind that a weak injection used twice a day will do more good than a strong one used once. At a later period in the case when the inflammation has reached the deeper parts of the canal, after introducing it the injection may be made to distend the whole urethra by passing the finger along the urethra from before backwards. This pressure however, should not extend beyond the peno scrotal angle, less the injection be forced into the protastic sinus or even into the bladder itself.

With regard to the substances used as injections in gonorrhœa, their name is indeed legion and it would be a useless labor to enumerate even half of them, as no doubt all that can be accomplished by this method of medication may be done by a judicious selection from a few out of the multitude of articles that have been from time to time recommended.

No doubt more harm than good is often done by using injections of too great strength in the vain hope of thus expediting the cure. It is a good rule never to employ any injections strong enough to produce severe pain and even a moderate degree of smarting if it lasts more than about five minutes may be taken as an indication that the solution is too strong.

Too frequent changing of the remedy used is also to be deprecated—time enough should be given for the remedy to have ample opportunity to produce its effect.

On the other hand a change is sometimes desirable when a given injection has been continued several days without any perceptible result; for it is to be borne in mind that no remedy used in medicine will produce exactly the same effect in every individual, so that our best and most generally successful prescription may fail when we least expect it.

Sometimes indeed, it is well to omit all treatment of this kind for a time and then upon beginning again the remedies will have a better effect.

Perhaps of all substances used as injections in gonorrhœa, the salts of zinc are most extensively employed and on the whole give the best satisfaction. The sulphate seems to be the general favorite, but I much prefer the acetate, and the following is my favorite formula:

R.—Zinci acetatis	grs iv–viii
Tinct. catechu	ʒ i–ji
Aqua rosæ	℥ iv

M. S. To be used two or three times a day.

Sulphate or sulpho-carbolate of zinc in similar proportions with or without the tincture catechu is also an excellent injection.

R.—Quiniæ sulph.	grs ji
Acid sulph. dilut.	M vj
Aqua	℥ i

Is highly recommended by many but, I have had no personal experience with it.

R.—Pulv. aluminis	grs v–x
Aqua	℥ i

Is a good astrigent injection, but I prefer a solution of tannin of about the same strength. Tannin it should be remembered is apt to stain the linen and the patient should be forwarned of this fact.

R.—Zinci permanganitis	gr ¼–ii
Aqua	℥ i

Is a good injection in chronic cases.

The salts of iron are excellent astringent injections and would no doubt be more frequently used but for their staining the patient's clothing. Bumstead speaks highly of the liquor *ferri persulph* half a drachm to six ounces of water in the later or gleety stages of gonorrhœa.

Insoluble substances such as oxide of zinc, calamine, subnitrate of bismuth, etc., suspended in water with a little mucilage are recommended by many writers, but I have never tried them nor do I feel inclined to do so.

I have recently received a written communication from Dr. F. P. Wilson, a well known and successful practitioner, of East Toledo, highly extolling Marchand's peroxide of hydrogen, and from its reputed action upon suppurating surfaces generally, I should think much might be expected of it. I shall certainly give it a trial. It may be used full strength or diluted, according to circumstances.

Ricord, the celebrated French surgeon, was very partial to his red wine injection, which was simply claret diluted with one or two parts of rose water, gradually increasing the strength, being careful of course to use the same brand of wine all the time, until in some cases the pure wine alone was used.

A very good injection that perhaps might be used to advantage oftener than it is, is tea, using simply the infusion of green or black tea as it is prepared for the table. It is a very efficacious and agreable remedy, according to those who have used it; it may be said that it is nothing but a simple tannin injection, but it certainly seems to possess some properties that a solution of tannin alone does not, and in some cases seems to be more efficacious.

Medicated bougies made of cocoa butter or gelatine are in no respect superior to injections, if indeed, they are not much inferior, and are dirty, inconvenient and not altogether free from danger. They have nothing whatever to recommend them unless it is novelty, but that is enough for some people.

In cases of chronic gonorrhœa where the discharge is limited to the deeper portions of the urethra, it has been recommended to make localized injections by means of a catheter syringe, the injection to be administered by the surgeon himself and confined as nearly as may be to the portion of the urethra supposed to be diseased.

The same results have been sought to be obtained by means of medicated ointments administered by capped or fluted sounds, often of very ingenious mechanism, but doubtful efficacy. It may fairly be doubted whether either of these methods possess any real superiority over injections administered in the ordinary way. Many of these cases of chronic discharge are kept up by the existence of stricture or protastic irritations. In the former case treatment of the stricture is essential to a cure, and in the latter, constitutional treatment, and oftentimes cessation of all treatment with a protracted vacation and complete change of scene and surroundings is the best plan.

Some further remarks on these chronic urethal discharges will be presented when we come to treat of gleet.

TREATMENT OF SPECIAL SYMPTOMS.

Chordee.—Owing to the hyperæmic condition of the organ and nervous erethism or sensibility, which is present more or less in all cases of gonorrhœa, there is an increased tendency to erections, especially when the patient is warm in bed. These are at all times painful, but especially when there is exudation of inflammatory lymph in the corpus spongiosum, which prevents its expanding with the copora cavernosa, but instead of which it remains as a rigid, sensitive chord below and between these bodies, so that when they expand in erection it is severely dragged upon, causing the penis to curve downwards and giving rise to intense, often excruciating pain. This symptom which is known as chordee, is sometimes quite a prominent one, causing by far the greater part of the patient's suffering and demanding special treatment.

In some cases coming on just as the patient is sinking off to sleep, and being repeated as often as sleep comes on, it deprives him almost entirely of his necessary rest and is quite a serious affair.

When severe, chordee is often a very difficult symptom to combat. The patient should persist in his lowering regimen, a brisk saline cathartic may be repeated from time to time, bathing the penis in water as hot as can be borne several times during the day is also useful; the best method of accomplishing this is to immerse the organ in a cupful of hot water, moving it briskly about in the fluid, to which a little watery extract of opium or fluid extract of belladonna may be added with advantage.

The patient should most sedulously avoid all sources of sexual excitement, not go to bed until thoroughly sleepy, sleep in a well ventilated room and be but lightly covered with bedclothes. He should avoid lying on the back and empty his bladder just before retiring.

Sometimes a warm bath or hip bath at bedtime is useful.

Among the drugs administered for this symptom, lupuline has a high reputation but it has to be administered in large doses.

R.—Lupulini ʒ jss
Fiat pilulæ, No. xx.

Of these from four to six may be taken at bedtime the first night; if this does not answer, eight or ten the following night and even fifteen at a dose have been recommended.

Many patients can not or will not take so many pills; the fluid extract or tincture may be given, but in large doses are apt to upset the stomach. Bromide of potassium in a full dose not less than half a drachm at bedtime, well diluted, is often successful. Sometimes it does better combined with twenty grains of chloral. The trouble with the bromide in such large doses repeated night after night is that it is apt to set up gastric irritation. Should these remedies fail, a full dose of opium may be given, which acts better in combination with camphor.

Vesical Irritation.—In some cases there is very great ardor urinæ with frequent micturition and vesical tenesmus, in short all the symptoms of severe irritation of the bladder, although real cystitis is rare. In these cases the prescription of benzoic acid and biborate of soda already mentioned is often very useful.

The copious use of demulcent drinks such as flax seed tea is also to be recommended; it should not be made too thick and slimy; should be sweetened and flavored with lemon—in short, be made agreeable so that the patient can take large quantities without offending the stomach. A thin, soft, hot poultice laid over the hypogastrium at bedtime, as also a hip bath before retiring are of use.

When the patient is very frequently disturbed during the night, suppositories of cocaine, or opium and belladonna are indicated.

Belladonna is itself a sovereign remedy in vesical irritation, but the trouble is that in doses large enough to be efficacious, it is apt to blur the sight and give rise to other symptoms which alarm the patient.

Lymphangitis.—A not very frequent symptom is inflammation of the fine lymphatics of the penis. The organ becomes unusually swollen, red, tender and painful; and there is often a quite considerable febrile reaction. The patient should be confined to bed and the very best

local application is the cold rubber coil. The penis is completely covered with thin rubber tubing coiled around it, through which cool (not cold) water is kept constantly running night and day. In this most admirable of all methods of applying cold locally, we have two means at our disposal of regulating the effect produced; viz., by varying the temperature of the water used, and the rapidity of the stream. If this can not be procured, the next best means in my judgment is enveloping the penis in soft rags wet with the old fashioned lead and opium wash. This is said to be an incompatible and unscientific prescription; that may all be, but it is a very comfortable and useful application, nevertheless.

In these cases there will sometimes be slight enlargement and tenderness of the inguinal lymphatics, which are best let entirely alone, as they never suppurate unless provoked to do so by irritating applications.

Retention of Urine.—In every case where the inflammation is at all severe the caliber of the urethra is necessarily diminished somewhat by the swelling of the mucous membrane. This sometimes, either from exposure to the cold, some imprudence or without assignable cause, increases to such an extent as to produce complete retention of urine. No doubt there is also a marked spasmodic element as well in these cases.

An effort should be made by a prolonged hot bath and a full dose of opium to get along without the use of the catheter, and it will very often succeed. But if it does not the catheter should be used with the utmost care and gentleness. A Nelaton's soft catheter is the best instrument to use and once will generally be all that will be needed.

Gonorrhœal Cachexia.—In a few cases of severe and protracted gonorrhœa that I have seen the patients have become very much emaciated and anæmic, and so extremely low spirited and melancholy as to be reduced to the very verge of suicide.

This condition seems to me to fairly deserve the title of gonorrhœal cachexia and is very often obstinate and rebellious to treatment. No doubt it may be brought about or intensified by injudicious persistence in a lowering plan of treatment and by profound gastric disturbance, the result of the various medicines used in the treatment of the complaint.

Such patients should be put upon a full and generous diet, and in some cases a little good wine may be allowed. This, with complete freedom from business and cares of every kind, a sea voyage or a prolonged sojourn by the sea shore, or at some mountain resort, is worth more than any drugs. All special treatment should be suspended at least and it will often be found not necessary to resume it.—*J. H. Pooley, M. D., in Toledo Medical Compend.*

ABSTRACT OF THE REPORT OF THE COMMITTEE ON GYNECOLOGY.

By O. O. Burgess, M. D., Chairman, San Francisco.

The Treatment of Fibroid Tumors of the Uterus.—The speaker, alluding to the brilliant progress in gynecology of the past year, said that this had been mainly in the direction of surgical methods and procedures, while with one notable exception the non-surgical methods of treatment had fallen behind. The vast increase in our knowledge of pathology of the pelvic organs, together with a corresponding increase of diagnostic skill, have rendered possible surgical achievements unparalleled in brilliancy and in the results conferred upon suffering womankind. But have they correspondingly improved our methods of treatment of the earlier stages of pelvic diseases by which they may be arrested and cured before surgical interference becomes a necessity? A pus cavity in a tube or ovary, freshly removed from the living subject furnishes ample justification for its removal and is a tribute to the pathological knowledge and diagnostic skill of the operator. But does it suggest any new method of treatment for the processes that led up to that condition? With the exception of some valuable improvements in the use of electricity there has been but little advance in the non-surgical methods of treatment of diseases of the pelvic organs.

The remarkable perfection and success of surgical methods attracts attention and discussion, and has a tendency to lead to an overzealous resort to them, while more conservative measures are not followed by the same enthusiasm. We are apt to forget that operations are always fraught with dread and terrible anxiety to the patient and her friends, whilst many of them are mutilating and by no means free from danger to life. Success sometimes leads to an extension of the limits of surgical interference which is not justifiable. If operative zeal were confined to the repair of torn services with a view to the cure of any and every ill that may befall a woman there would be less to say; but when it comes to the removal of any or all of the pelvic generative organs upon insufficient indications, or before other promising methods of treatment have been fairly tried, it is time to raise a protest and to enter a plea for a more careful study and pursuit of conservative measures. There should be a few exceptions to the rule that no mutilating or dangerous operation is justifiable so long as the possibility of success by other methods remains undemonstrated. Many of us will admit that we have sometimes been carried along too hastily and too far, and have done operations that were afterwards regretted. He knew himself that he had done things that he would not do again under the same circumstances.

These introductory remarks have a direct

bearing upon the chief subject of this paper, the treatment of uterine fibromata. There are but three methods that need claim our attention at this time: (1) The electrical method of Apostoli. (2) The operative method by removal of the uterine appendages. (3) The radical surgical method by complete removal. Apostoli's method by galvano-chemical cauterization naturally claims consideration first because of its important bearing upon questions of operative interference. He defines it "as a galvano-chemical cauterization of the uterus, vaginal, intra-uterine or parenchymatous and always monopolar." It differs from the older methods mainly in that the dosage is made precise by the introduction of galvanometers of intensity which furnish the exact measure of the current passed through the uterine tissue. In the use of high intensities (50 to 250 ma.) by means of the abdominal electrode of moistened clay, the former being the highest used until Apostoli's improvements were introduced. In better localization by direct application of the active pole through the vagina to the uterine cavity, or into the fibroid growth when the uterine cavity cannot be entered. In a more scientifically exact knowledge and appreciation of the topical effects of the two poles, the positive pole is hemostatic directly by coagulation or indirectly by the formation of contractile cicatrices, and is therefore indicated in hemorrhagic fibromata. The negative pole is fluidizing, producing temporary congestion without direct hemostatic effect. It is more stimulating to the circulation of the uterus and hastens the regression of the tumor, relieving amenorrhea and dysmenorrhea much more rapidly than the positive. Apostoli's differs essentially from all other methods of electrical treatment, and its results are not to be measured by those obtained by other means. When failure is reported, it is frequently the fault of the operator rather than the method. Thus the most striking results the speaker had yet obtained were in a case of interstitial fibroid that had been treated for a long time by electricity without benefit. Close questioning revealed the fact that an electrode had never been used in the uterus or even in the vagina.

The effects of Apostoli's treatment may be divided into two classes, the anatomical and the symptomatic. Among the former are: (1) Arrest of growth. (2) Regression. (3) Mobilization of fixed tumors through absorption of adhesion. (4) Pedunculization by extrusion of intramural growth outward toward the peritoneal surface or inward toward the uterine cavity. (5) Radical cure (rarely) by complete disappearance of the tumor by absoption or by its extension into the uterine cavity and its delivery therefrom. The symptomatic effects are: (1) Arrest of hemmorhage. (2) Suppression of pain and dysmenorrhea. (3) Suppression of reflex troubles. (4) Prompt and marked improvement in the general health is invariable, and as a rule is speedily felt. It is due primarily to the tonic effect of the current, and secondarily to relief from pain, hemorrhage and distressing reflex symptoms. Arrest of growth is usually prompt and almost constant. Reduction in size of tumor, although sometimes rapid, is usually slow, and is variable in the extent of retrogression secured. With arrest of hemorrhage, relief from pain and all reflex disturbances and restoration to health and activity and the patient may be called symptomatically cured. It is true that even this is not always secured, but it is rare to see a suitable case that is not more or less benefited by it. Finally, if surgical interference becomes necessary, the patient is in better condition for operation locally and generally. Failure is due sometimes to a faulty application of it, and occasionally to intolerance of sufficient dosage. Experience proves that great intolerance is often due to conditions, such as active pelvic inflammations, closed pus cavities, etc., it thus becomes a valuable diagnostic agent.

These statements as to the value of Apostoli's method are based not only upon his own very valuable and extensive reports of cases, but upon those of many other eminent gynecologists in all parts of the world. The number of cases treated has now become very large and more than sufficient to prove or disprove the efficacy of the method. Twenty different observers, in various parts of the world, reporting 2112 cases, although not equally successful, have satisfied themselves of the efficacy of the treatment. Drs. Thomas and Skene Keith have not done a single hysterectomy or castration for more than two years, and are enthusiastic enough to say that they never expect to do another. Of the speaker's own cases, ten in number, it was rather premature to speak. They were all of recent date and still under treatment. The results, however, already obtained, have been highly satisfactory. Hemorrhage has been arrested in all, pain lessened and suppressed, and the general health invariably improved. Notwithstanding the array of evidence in favor of Apostoli's method, the fact remains that it is rejected by many, indeed, perhaps by a majority of those interested in the treatment of fibroid tumors of the uterus. The reasons for this are various. With some it arises from prejudice, apathy, or a lack of personal knowledge of the results of treatment; others have tried it and have not been satisfied, but the most serious opposition comes from surgeons filled with operative zeal and the pride of success.

The chief arguments advanced are that the treatment is slow, painful, tedious to both physician and patient, and not at all sure of even partial success. That at best the cure is only symptomatic, and even then not permanent, the

tumor still remaining as a standing menace. By some it is denounced as dangerous. Most of these objections have already been answered. As to the dangers, it is sufficient to state that out of the large number of cases cited there has been just four deaths, or .0018 per cent. Even these were due more to the faults in the operators than in the method, and are not likely to occur again. The conclusions to be drawn are that Apostoli's method is not only worthy of trial, but that it should always be tried before resorting to surgical methods, which though more speedy and radical, are always mutilating and dangerous to life.

As to the second method of treatment, by castration, there is not much to be said at this time, probably there are few cases capable of relief by this method that could not be better relieved by electricity; indeed, galvano-cauterization has cured several cases after castration had failed. Still this operation will always hold a place where myomotomy is considered unnecessary or too difficult and dangerous.

Finally as to the third and last method, that of removal. Since removal of the tumor does not necessarily involve hysterectomy, the term myomotomy, which has been used to indicate the removal of the tumor with or without the whole or a part of the uterus, seems a very judicious one to employ as a designation of this method. During the past few years improvements in the *technique* have resulted in a steady decline in the mortality, until some operators declare that in their hands myomotomy is no more fatal than ovariotomy. The result of this has naturally been to expand the limits of its indications. It is not strictly true that the mortality of this operation has been brought so low except in a few short and exceptional series of cases. In 56 cases recently reported by Leopold, there were 12 deaths (21.4 per cent.), while according to Vautrin the general mortality of hysterectomy in 39 per cent.

It is a fact that a large percentage of uterine fibroids require no treatment whatever. If the tumor causes no symptoms it does not need any treatment, and many of us have seen cases go on for years without serious inconvenience. There is another and a large class of cases in which treatment is absolutely demanded, and here electricity stands between the patient and the knife. Thus Leopold, who does not believe in electricity, found it necessary to operate on 140 out of 400 cases, while the Keiths and Sir Spencer Wells have found electricity to do away with the necessity of operation. I believe that Apostoli's method is sure to make its way, and that the time will come when the following rule of practice will be observed: "Myomotomy shall be considered unjustifiable except in cases in which electricity has failed, or to which it is inapplicable."

TREATMENT OF ECZEMA IN CHILDREN.

In the *Revue Mensuelle des Malades de l'Enfance* for August, 1890, Sallfeld gives the following treatment for eczema: Some interesting considerations are presented concerning the treatment of eczema in children, which differ essentially from those which are usually adopted in adults. Of all varieties of local eczema which are developed under the influence of external causes, the most important in children, in the author's opinion, is intertrigo. It is particularly common in fat children, and is frequently located near the margin of the anus, in the inguinal folds, in the folds of the neck, and in the vicinity of the chin. Intertrigo thus localized is readily cured by the use of bland and inert powders, but if the disease includes large portions of the surface of the body, the local treatment should be supplemented by change in the diet, and if diarrhœa exists, it should be energetically treated as well. If the skin is the seat of an intense inflammation, cold compresses should be used for several days which have been moistened with a mixture composed of equal parts of a five-per-cent, solution of boric acid and the officinal solution of subacetate of lead, an ointment of boric acid being used after the former preparation has been discontinued. If the skin is very moist it should be dried with a suitable absorbent powder before using the ointment. In the treatment of eczema of the face and scalp which is so common in fat children it is well to diminish the quantity of nourishment, to eliminate fatty materials from the diet, and to combat habitual constipation with appropriate enemata. The crusts upon the head and face should first be softened with olive oil, and after they have been removed the surface should be anointed with following ointment:

℞.—Boric acid, 45 grains
Zinc oxide, 75 "
Vaseline, } of each 450 "
Starch, } —M.

If there is generalized eczema of a scrofulous character, the organs of digestion must be carefully interrogated, and if the alimentation is insufficient, it must be supplemented with cod-liver oil combined with phosphorus or arsenic. The local treatment should be limited to the use of vaseline inunctions, followed by the use of bland powders upon the skin. Applications of tar preparations should be avoided, as they only irritate the skin

The following formula may be used with advantage:

℞.—Ammoniated mercury, 30 grains
Peruvian balsam, 75 "
"Wilson's ointment", 450 " —M.

—*Archives of Pædiatrics.*

THE VARIETIES OF HYDROCELE.

Duplay mentions a large variety of hydroceles which may be encountered in the inguino-scrotal region, together with the means of differentiating them. It is an easy matter to distinguish the so-called "hydrocele by infiltration" from hydrocele with effusion, since the former is simply an œdema, and is not accompanied with fluctuation and transparency, while the tissues retain the imprint of the fingers. More difficult is the diagnosis between encysted hydrocele of the testicle and epididymis and vaginal hydrocele. The differences here consist in the variable connections which exist between the sac and the testicle. The effusion in hydrocele of the tunica vaginalis entirely surrounds the testicle, and the latter occupies a postero-inferior position, and is a little internal to the tumor. This is the rule, but it is well to remember that in cases of inversion of the epididymis the testicle is found in front of the effusion. In encysted hydrocele there is a cyst which takes its origin between the testicle and the epididymis, either on a level with the head of the latter, or a little lower. This cyst increases in volume, little by little, until it conceals the testicle, but it always remains attached to the head of the epididymis by a point more or less constricted, as large as the thumb or two thumbs, and it is always possible to outline the gland, which is impossible when it is enveloped by an effusion.

It is necessary to distinguish several varieties of vaginal hydrocele, and to describe separately congenital hydrocele, and hydrocele in Dupuytren's pouch. In the fœtus there is nothing in the tunica vaginalis, and it is at the time of the descent of the testicle that a prolongation of the peritoneum is dragged down, constituting the serous cavity. Congenital hydrocele is that in which the peritoneo-vaginal prolongation is not separated from the large abdominal cavity. The liquid which the sac holds is then very easily reducible, and returns into the abdomen very rapidly when the passage is large. If, on the contrary, the passage is small, it may require some time to return all of the fluid. Hydrocele in Dupuytren's pouch is a second variety of congenital hydrocele. It is easy to confound this variety with bilobar hydrocele. The latter is that in which, owing to the resistance of the fibrous tunic of the pouch, a bridle is formed which divides the sac into two portions. Hydrocele in the pouch is a variety in which the peritoneo-vaginal conduit, instead of becoming obliterated after the passage of the cord, is closed only in its upper portion, this closure completely shutting off communication with the peritoneal cavity. If, under these circumstances, an effusion occurs into the tunica vaginalis, it will divide into two portions, the one occupying the cavity which extends from the base of the sac to the orifice of the canal, and the other an intra-canalicular dilatation. Occasionally the peritoneum is pushed back, and it then forms a subperitoneal sac, which may be felt in the iliac fossa. In some cases, vaginal hydrocele runs even to the external orifice of the vaginal canal.

Of hydrocele of the cord there are two varieties: in one, the cavity presents itself above the line of the cord, and evidently consists of the non-obliterated remains of the peritoneo-vaginal canal. It is seen as a small, resistant, transparent tumor, at a point more or less elevated above the passage-way of the cord. Some cysts of this kind at times descend to the lower portion of the pouch, and it is then possible to confuse them with ordinary hydrocele. On the other hand, the obliteration of the peritoneo-vaginal canal may take place in its lower portion, all the upper portion remaining patulous, and forming a serous cavity which may be taken for an hernia or an effusion. In this variety, which is very rare, the effusion descends along the inguinal canal, and forms a transparent, reducible tumor. This is, if we adopt the name given by Chassaignac, a peritoneo-funicular hydrocele.

Finally, there is hydrocele of the hernial sac, which may extend the length of the inguinal canal, and even reach to the base of the pouch. The hydrocele is a serous cavity filled with liquid; sometimes the intestine and omentum are absent, and there is no communication with the peritoneum, but at other times an organ is found in the sac which should be in the abdominal cavity. Hydrocele of the hernial sac does not descend to the base of the scrotum, and it is easy to recognize it. Nevertheless, the diagnosis between it and peritoneo-funicular hydrocele, or cysts of the cord, may be quite difficult.—*L'Union Médicale,—Med. News.*

LINIMENTS FOR PRURITUS.

La Semaine Médical gives the following liniments for pruritus:

℞.—Pure resorcin,	1 drachm
Glycerin,	2 drachms
Water,	4 ounces

Mix and label "To be Used Externally;" or,

℞.—Menthol,	3 drachms
Glycerin,	2 drachms
Water,	4 ounces.—M.

This is to be labelled "Use Externally." and is to be shaken before using.

Finally, the following mixture may prove of value:

℞.—Ichthyol,		1 to 3 drachms
Glycerin,		2 drachms
Alchol, Water,	of each	2 ounces.—M.

Use externally. *Med. News.*

TREATMENT OF SEAT-WORMS.

Success in the treatment of cases of seat-worms depends upon the prolonged and constant use of a vermifuge or some active vermicide. The worms are generally attacked by means of injections, suppositories, or ointments. Of the injections, a favorite prescription is a solution of common salt in the proportion of 1 to 5. Sometimes sugar and water may be used, and an infusion of absinthium is employed by some French practitioners. Still others employ simply cold water. It is said that West and Barthez recommended astringent injections composed of the perchloride of iron and lime-water, as follows:

℞.—Lime-water, 6 ounces
Perchloride of iron, 10 drops.—M

And also,

℞.—Lime-water, 4 ounces
Decoction of marshmallow, 1 ounce.—M

For the same purpose Trousseau prescribed suppositories of tannin made up as follows:

℞.—Tannic acid 15 grains
Cocoa butter 1 drachm.—M

Other physicians have employed injections of asafœtida, and many have found the following treatment useful:

℞.—Alcoholic extract of senna leaves, 30 grs
Boiling water, 4 ounces

Make an infusion and sweeten with syrup of wild cherry, 4 drachms. This may be given to an infant of four or five years as a laxative, and if it does not act may be followed by from a half to one drachm of the sulphate of magnesium. After this an injection may be given composed of 1 ounce of powdered quassia chips to 1 pint of water, or of carbolic acid in the proportion of from ½ to 1 drop to 4 ounces of water. An emulsion of calomel may be employed composed of calomel 3 grains and mucilage of flaxseed 4 ounces.

Guersant is said to employ sulphuretted potash 2½ drachms, water 4 ounces; while Rossbach finds naphthaline of great service, and administers it as an injection as follows:

℞.—Naphthaline, 15 grains
Olive oil, 1½ ounces

This quantity may be doubled or tripled in adults. Sometimes he prefers to use naphthaline from 2 to 10 grains and decoction of marshmallow 6 ounces. If the worms inhabit the lowest portion of the intestine it may be well to follow the treatment of Cruveilhier, viz,—to employ mercurial ointment or to rub into the anus an ointment composed of calomel 8 grains and cocoa butter 1 drachm.

Trousseau is said to employ the following suppositories:

℞.—Calomel 1 drachm.
Vaseline 3 drachm.

When the worms inhabit the higher portions of the rectum they will probably resist all therapeutic measures unless they be attacked through the stomach. Under these circumstances it may be well to employ calomel and santonin, of each ½ grain, which is to be administered early in the morning in order that the calomel may act by evening. This dose is the proper one for a child of two to three years. *Revue Générale de Clinique et de Thérapeutique.—Medical News.*

TREATMENT OF TYPHOID FEVER.

The *Revue Général de Clinique et de Thérapeutique* gives the following method used by Teissier in the treatment of typhoid fever. Morning and night a powder composed of 5 grains of alpha-naphthol and 3 grains of salicylate of bismuth is given. In addition four cold injections are used, at intervals of twenty-four hours, with the object of increasing diuresis. After the mid-day injection he prescribes the following tonic and antipyretic mixture:

℞.—Extract of cinchona, 1 drachm.
Sulphate of quinine, 15 grains.
Tincture of valerian, 1 ounce.—M.

Teaspoonful at a dose.

Teissier also applies cold compresses to the head and abdomen, and the patient is allowed 10 ounces of Bordeaux wine and one and a half pints of milk or broth in the twenty-four hours. He employs alpha-naphthol in preference to beta-naphthol because the latter is very much more poisonous; thus, to produce poisoning in a man of ordinary weight it is necessary that twice as much alpha-naphthol be given as of beta-naphthol. In consequence it is possible to give larger doses of alpha-naphthol without danger, and obtain thereby a greater degree of intestinal antisepsis. The cold baths which he recommends augment, in his opinion, the elimination of toxic substances in the urine, and the naphthol stops their production in the intestine.—*Med. News.*

CHOLAGOGUE POWDERS FOR HEPATIC COLIC.

In the *Revue Général de Clinique et de Thérapeutique* the following treatment for the relief of hepatic lithiasis is given, based upon the fact that Binet and others have found that the benzoate and salicylate of sodium act as cholagogues. The nux vomica in the prescription aids in regulating the bowels and in relieving anorexia and dyspepsia.

℞.—Benzoate of sodium, } of each 75 grs.
Salicylate of sodium, }
Powdered nux vomica 7 " —M.

This is to be divided into 20 powders, of which the patient should take 1 three times a day for two months.

CHLOROFORM.

I will conclude by giving a series of "practical conclusions," derived from studies of the subject by experiment upon animals, which do agree with observations upon the human subject. And I consider it a matter of no slight congratulation that they were presented at the late International Congress by one of our countrymen, Professor H. C. Wood, in his address on Anæsthesia. They have been lately published in nearly all the journals, but they will bear repeating. The closest examination fails to detect any flaw in them, or to find any point which is not supported and which cannot be substantiated by clinical records:

1. The use of any anesthetic is attended with an appreciable risk, and no care will prevent an occasional loss of life.

2. Chloroform acts much more promptly and much more powerfully than ether, both upon the respiratory centres and upon the heart.

3. The action of chloroform is much more persistent and permanent than that of ether.

4. Chloroform is capable of causing death either by primarily arresting the respiration, or by primarily stopping the heart, but commonly (sometimes) both respiratory and cardiac functions are abolished at or about the same time.

5. Ether usually acts very much more powerfully upon the respiration than upon the circulation, but occasionally, and especially when the heart is feeble, ether is capable of acting as a cardial paralyzant, and may produce death at a time when the respirations are fully mained.

6. Chloroform kills, as near as can be made out, proportionately four or five times as frequently as does ether.—*J. C. Reeve, M. D., in Med. News.—Columbus Med. Jour.*

SWEATING FEET.

The following may be tried when alum, belladonna, etc., have failed (*Brit. Med. Jour.*):

1. Wear low shoes, wool socks, and dust the feet over twice a day with iodol; they will soon be as hard, sweet and comfortable as one could wish. 2. Wash the feet at night with very hot water, put on white cotton socks, and immerse the feet, thus covered, in methylated spirit poured into a basin; wear the socks all night; they will soon dry in bed. During the evening wear cotton socks and common felt slippers, and keep the socks constantly saturated with spirit. In a week the cure will be complete. The best ventilated boots are made of stout canvas.

℞—Liq. plumb. diacet., Acid. carbolic, } aa ʒ ij,
Aquæ, ad ℥ ij.

M.—One tablespoonful to be mixed with a pint of warm(ish) water, and the feet to be washed every morning and dried with a soft towel.

3. Wash the feet night and morning with soap and water, and after careful drying, sponge them over with the following lotion:

℞—Plumbi acet., ℥ j,
Acet. destil., ℥ j,
Sp. vini. methylat., ℥ ij,
Aq., ad ℥ xvj.
Sig—Ft. lotio.

NOVEL TREATMENT OF INGROWING TOENAIL.

Dr. Puerckhauer recommends a novel, simple and at the same time competent treatment for ingrown toenail.

A forty per cent. solution of potassa is applied warm to the portion of the nail to be removed. After a few seconds the uppermost layer of the nail will be so soft that it can be scraped off with a piece of sharp edged glass. The next layer is then moistened with the same solution and scraped off. This must be repeated until the remaining portion is as a thin sheet of paper, when it is seized with a pincette and lifted from the underlying soft parts and severed from the other half. The operation does not require more than half an hour's time, is painless and bloodless, while the patient is delivered from his suffering without being disabled even for an hour.—*Pittsburgh Med. Review.*

AN EARLY ATAXIC SIGN.

Weiss, of Vienna, says that an early symptom of locomotor ataxia is an inability on the part of the patient to walk backward, while as yet, and in other ways, he may be able to walk with firmness and rapidity. Perron, of Bordeaux, has also, as we stated several weeks ago, recently suggested an early diagnostic sign, which is simply a modification of the Romberg test—namely, causing the suspected ataxic patient to stand upon one leg, instead of two, with the eyes closed. If the patient shows a tendency to fall, it may be inferred that the spinal trouble has begun which will lead on to locomotor ataxia, even if the Romberg test fails, as it not infrequently does in cases that are not well advanced.—*Columbus Med. Jour.*

THE TEN COMMANDMENTS OF ABDOMINAL SURGERY.

1. The arrest of hæmorrhage. 2. The avoidance of mechanical irritation. 3. The guarding against infection. 4. The proper apposition of the edges of the wound. 5. The provision of necessary drainage. 6. To apply gentle pressure to prevent exudation. 7. To give perfect physiological rest. 8. To secure the best possible position of the parts to promote comfort and healing. 9. To provide for hygienic surroundings. 10. To attend to the patient's general health.—*Dr. Griffiths.—Southern Practit.*

BIBLICAL MEDICAL ETHICS.

"Honor due the physician and why?"—*The book of Apocrypha, Ecclesiasticus, chapter xxxviii.*

"1. Honour a physician with the honour due unto him, for the uses which ye may have of him, for the Lord hath created him.

"3. The skill of the physician shall lift up his head, and in the sight of great men he shall be in admiration.

"4. The Lord hath created medicines out of the earth; and he that is wise will not abhor them.

"12. Then give place to the physician, for the Lord hath created him; let him not go from thee, for thou hast need of him.

"13. There is a time when in their hands there is good success.

"15. He that sinneth before his maker, let him fall into the hands of the physician."

Medical men will recognize the above clipping, but fearing the laity might not read understandingly a short explanation is given. The books of Apocrypha are considered spurious scripture (hermaphrodite) by Protestants. The book of Ecclesiasticus is supposed to have been written by Jesus the son of Sirach and is termed, "the prologue of the wisdom of Jesus." This book was written about two hundred years before Christ.

The Apocrypha is contained in many of the Protestant bibles.

These sayings, probably, give a fair estimate of the medical man, as held by the laity in those days. It is to be noted that he was called a physician and not "Doc." The reason assigned for this honor, however, "the uses ye may have of him," will not bear close scrutiny from a moral standpoint; but it represents the spirit of the people of to-day.

The last clause of the first verse forever settles the vexed question of the origin of doctors, "for the Lord hath created him." The skill of the physician then as now marked his success. He must possess ability in some direction or he cannot succeed. If he has merit, somebody will appreciate it whether it is in the line of our liking or not. The world appreciates success and extends the helping hand. "And in the sight of great men he shall be held in admiration." The fourth verse should be pondered by skeptics in medicine. It is not the part of wisdom to abhor medicines. The practitioner who fails as a rule to get results from the medicine he administers should turn a searching gaze within himself and often he will discover the reason of his failure.

The twelfth verse no doubt means to set a plate for him at table, for he is tired and hungry with his long ride or much labor and waiting, and to remember him on pay day. The second sentence, "God has created him," drives the truth of his origin home and clinches it.

"Let him not go from thee," do not put him out of mind; do not banish him from your thoughts—keep him in hailing distance—an unexpected event may occur at any time. The period of gestation is up and you had better speak to him in time. Do not let him go off on the train to Jerusalem or Damascus, but engage his time and pay him.

Verse thirteen says "There is a time when in their hands there is good success." There were times when they were not successful. People would die. The physician would at one time be on Pisgah's Mount and again in the Slough of Despond. A bad run of cases making him wish it was the other fellow's; his rival's luck. Wishing he had stuck to the farm or workshop. Wondering if he had not missed his calling. But this will not do; he arouses himself from his dispondency; at it again, and good success crowns his efforts. In those days the physicians blistered and bled, gave strong drastic cathartics and turpeth mineral. Cauterized with the hot iron using no anæsthetic. The physician was the go-between, middle men as it were, between the Creator and the other fellow, giving color to the mooted question of the physician's origin, for verse fifteen says, "He that sinneth before his Maker let him fall into the hands of the physician."

ITCHING OF JAUNDICE.

For the itching of jaundice, Prof. Da Costa advised sodii bromidum with antipyrin internally, with the following ointment externally:

℞ Menthol, gr. xx.
Alcohol, 1 oz.
M. Sig. For local use.—*Weekly Med. Rev.*

Rheumatism.—Audhouri recommends the following syrup:

℞. Potass. iodid, gr. lxxx;
Sodii Salicylat. ʒv;
Syrup aurant. cort., ʒx;
M. Sig. ʒss. to ʒj. daily.
—*Medical News.*

PERSONAL.

Drs. Robert Craik and George Major sailed for England on July 1st in the SS. "Lake Ontario."

Dr. W. Grant Stewart left for Liverpool on July 4th per Allan SS. "Polynesian." He purposes being absent about two months.

Dr. T. Rodger, head surgeon of the Grand Trunk Railway, who has for the past seven weeks been dangerously ill with erysipelas, is now, we are pleased to be able to say, considered out of all danger. We trust ere long to see him quite recovered.

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MONTREAL, JULY, 1891.

THE CONSERVATION OF ENERGY.

Although a chapter on this topic is generally to be found in text books on physiology, there are still doctors who do not understand the meaning of the term. Of such is a recent contributor to a medical journal who claimed to have made the startling discovery that workers and especially brain workers might increase their capacity for work indefinitely, simply by drinking a certain amount of strong black coffee, at the end of a hard day's work, and thus be enabled to keep on working all night with renewed vigor. We don't exactly remember what he told his readers to do next morning, but suppose he would tell them to take more coffee. We hope that no one who read his article did anything but smile, as we did, but if any are disposed to follow his advice, nothing could be more diastrous to health. To deprive oneself of all the sleep we can take is little short of madness; indeed to the latter it often leads. One cannot do without sleep very long without paying the penalty with compound interest, and the penalty is generally exacted in the form of insomnia. Insomnia is one of the marks of an over wrought or worried nervous system, while being able to sleep soundly for from six to nine hours is a fair test of a healthy nervous system. The only sure treatment for insomnia is to undo as much as possible the wrong that has been done of robbing nature of her rights; stop mental work, spend twelve hours a day in bed and the other twelve in physical work or recreation. The man who would increase his powers of work with coffee, cocaine or any other stimulant is every bit as stupid as one who would expect to restore his tired horse by means of an extra heavy whip instead of the needed rest.

BRITISH MEDICAL ASSOCIATION—MONTREAL BRANCH.

Dr. Ernest Hart, the able and energetic editor of the *British Medical Journal*, honored our city with a visit the other day on his way from the East. At his request a meeting of the profession was hurriedly called to discuss with him the advisability of forming here a branch of the British Medical Association. On the evening of June 19th some thirty medical men assembled in the rooms of the Medico-Chirurgical Society. Dr. Shepherd, as president of the Society, was called to the chair.

Dr. Hart gave a very interesting address, referring first to his trip round the world, and especially to his sojourn in Japan, where he spent much time in studying the history of medicine in that remarkable country. He then went on to state that it was the desire of the Council of the British Medical Association that colonial branches should be formed on the same lines as the so-called "Provincial Branches" at present so universal in Great Britain and Ireland, and which have been found such a source of strength to the mother association. The doctor stated that among the advantages accruing from membership and the annual payment of $5.25 were included an *entrée* to the Metropolitan House in London, which afforded many of the privileges of a club, and the receipt of the *British Medical Journal.* He further proceeded to explain that local branches had a large latitude for autonomous government, organization and development according to their various

needs. They might hold their meetings once a year or once a month, as they pleased, and either in one centre or various centres they might meet either as the whole branch or in sections according to locality. Where societies were numerous and well developed they were not in any way interfered with, nor had it been found in the oldest settled communities that the prosperity of any local institution was in any way interfered with. Thus no local jealousies arose, and while the Association fulfilled its great purpose of uniting the whole profession of this great empire in bonds of friendship and brought them constantly into touch with each other it aimed at fulfilling only such local needs as were found to require supplementing. He concluded by expressing his gratification at the unanimous and cordial manner in which the proceedings had been taken.

The following resolutions were then moved and carried unanimously:—

Moved by Dr. Hingston, seconded by Dr. Geo. Ross: "That this meeting of members of the medical profession, resident in Montreal, cordially sympathizes with the work of the British Medical Association in bringing the members of the medical profession throughout the whole extent of the British Empire into direct union and frequent intercommunication for the purpose of promoting mutual friendship, advancing scientific knowledge, and furthering the general interests of the medical brotherhood; and that it will use its best efforts to promote the extension of the membership of the British Medical Association throughout the Province of Quebec."

Moved by Dr. George Armstrong, seconded by Dr. J. Chalmers Cameron: "That it is desirable that a Montreal branch of the British Medical Association be constituted, and it is hereby constituted, subject to the sanction of the Council of the British Medical Association, its laws and by-laws."

Moved by Dr. Girdwood, seconded by Dr. Wilkins: "That the following gentlemen be, and they are hereby appointed, officers of the Montreal branch, pending sanction by the Council of the Association: President, Dr. Hingston; 1st Vice-President, Dr. Geo. Ross; Treasurer, Dr. James Perrigo; Honorary Secretary, Dr. J. C. Cameron. Other members of Council—Dr. T. G. Roddick, Dr. F. W. Campbell, and Dr. Geo. Wilkins, with power to add to their number."

Dr. Cameron and Dr. Perrigo at once proceeded to enter upon their functions, and twenty-six of the gentlemen present signed forms of application to be admitted as members of the Montreal Branch of the British Medical Association. Dr. Cameron, hon. secretary of the branch, will be glad to have the names of other intending members throughout the city and province in order that as full a list as possible may be at once forwarded to the Council of the Association for election at their next meeting. We wish the branch every success.

BOOK NOTICES.

EXAMINATION OF WATER FOR SANITARY AND TECHNICAL PURPOSES, by Henry Leffman, M.D., Ph.D., Professor of Chemistry in the Woman's Hospital College of Philadelphia, and William Beam, M.A., Demonstrator of Chemistry in the Pennsylvania College of Dental Surgery. Second edition, revised and enlarged, with illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street, 1891.

As the starting point of many acute diseases depends upon the contamination of water by sewerage, bacteria or some chemical substance, any information leading in the direction of making less difficult the means of discovering these deleterious ingredients must be very acceptable. Such is the purpose of this little book, viz., to act as an aid in making the analysis of water. The contents are divided as follows: History of Natural Waters; Analytical Operations; Interpretation of Results; Biological Examinations; Purification of Drinking Water; Identification of Source of Water; Technical Applications; Analytical Data.

MEDICAL JURISPRUDENCE AND TOXICOLOGY. A Text-Book, by John J. Reese, M. D., Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania; late President of the Medical Jurisprudence Society of Philadelphia; Honorary Member of the New York Academy of Anthropology; Corresponding Member of the New York Medico-Legal Society, revised and enlarged. Philadelphia: P. Blakiston, Son & Co. Price, cloth, $3.00; leather, $3.50.

This is the third edition of this volume, and it has been carefully edited and revised so as to bring it up to the present day. Much new material has also been added. This call for a third edition (to quote from the preface), within two years of the last issue is not only flattering to the author, as an

evidence of the kindly estimate placed upon his book, but is especially gratifying as an indication of the increasing interest bestowed upon the subject of Medical Jurisprudence by students and practitioners of both the professions of Medicine and Law throughout the country. Simplicity of style, conciseness and directness of purpose have rendered it one of the best guides extant to the study of legal medicine. Every physician should have a copy of a work of this nature, as the question of medical jurisprudence is one on which doctors and lawyers must fully post themselves, for they are liable at any time to be called upon as experts or counsel. The author explains thoroughly, in the opening chapters, the duties of the physician in medico-legal cases. He describes the observations he should make, the proper method of arranging and preserving such information, and to what, and how, a physician should testify in court. He points out the difference between the position occupied by the physician who is a witness merely as to facts, and his who is called to give expert testimony. Of the two, very different questions are to be asked, and Dr. Reese denounces the methods of cross-examination now so much in vogue. Then follow chapters upon the signs of death, and the detection of the immediate cause, and directions to be followed in making a post-mortem. Chapters on poisoning, feigned disease, pregnancy, criminal abortion, rape, insanity, and malpractice bring the book to a conclusion.

FEVER: ITS PATHOLOGY AND TREATMENT BY ANTIPYRETICS. Being an essay which was awarded the Boylston Prize of Harvard University, July, 1890. By Hobart Amory Hare, M.D., B.Sc., Clinical Professor of Diseases of Children and Demonstrator of Therapeutics in the University of Pennsylvania; Physician to St. Agnes's Hospital and to the Children's Dispensary of the Children's Hospital; Laureate of the Royal Academy of Medicine in Belgium and the Medical Society of London, etc. 12mo, pp. 166. No. 10 in the Physians' and Students' Ready Reference Series. Price, $1.25. Philadelphia and London: F. A. Davis.

The book before us comprises the pathology of fever, together with a thorough knowledge of the remedies referred to under clinical observation. This little volume is, without doubt, the best summary of the effects and utility of the antipyretic group of remedies recently discovered hitherto published. It is a most scholarly treatise on which the profession in general need the latest and most thorough researches. The author has executed the task of supplying this much needed treatise in a manner which leaves nothing to be desired. It deserves a widespread circulation and careful study.

No. 9 IN THE PHYSICIANS' AND STUDENTS' READY REFERENCE SERIES. Medical Symbolism in Connection with Historical Studies in the Arts of Healing and Hygiene. Illustrated. By Thomas C. Sozinskey, M. D., Ph.D., author of "The Culture of Beauty," "The Care and Culture of Children," etc. Philadelphia and London: F. A. Davis, Publisher. 1891. Price, $1.

This is a most valuable little book to physicians and others interested in the mythological aspect of early medicine. The historical features of the volume are of great value, as it gives us a glance at the progress of the science of healing from its earliest beginnings. Medical symbolism is something of which very little is commonly known. This little book puts the subject before the reader in a very attractive form. As an archæological contribution to medical literature it is especially valuable. We have read the work with the greatest pleasure, and urge every one interested in such matters to procure a copy.

AUSCULTATION AND PERCUSSION, by Frederick C. Shattuck, M.D., Professor of Clinical Medicine in Harvard University. Detroit, Mich.: Geo. S. Davis. 1890. Price, 25c.

This little monograph forms part of the Physicians' Leisure Library Series and is certainly on a topic of great interest. Auscultation and Percussion are the most important means of physical diagnosis, and it therefore behooves all to be familiar with the many ways by which they can be made to subserve the interests of the doctor. Shattuck has written a practical work and one that will be useful to any one who will read it no matter how well versed in physical diagnosis he may be. The plates, after Weil, showing the position of the various organs of the thorax and abdomen are excellent. The chapter headings are: The Lungs in Health; The Lungs in Disease; The Physical Conditions and Diseases of the Pleuræ and Lungs; The Heart in Health; The Heart in Disease; The Pericardium; Thoracic Aneurism; Physical Exploration of the Liver, Spleen, Stomach and Pancreas.

MANUAL OF THE DOMESTIC HYGIENE OF THE CHILD. For the use of students, physicians, sanitary officials, teachers and mothers. By Julius Uffelman, M.D., Professor of internal medicine at the University of Rostock. Translated with with the author's permission, by Harriott Ransom Millinowski, edited by Mary Putnam Jacoby, M.D. New York and London: G. P. Putnam's Sons. Price, $1.75.

Those most interested, namely, mothers, should gladly welcome this work to the household, as at this time of the year when the "heated term" is upon us, nothing is more important, towards securing the child's continued health and welfare, than good hygienic surroundings. It is the professed object of this publication to add the more intelligent mothers to the other classes for whose instruction Prof. Uffelman's book was originally written. The editor has, to this end, interpolated many explanatory notes in brackets, thus modifying the technical phraseology of the work, and bringing it within the range of those possessed of a good, non-technical education. The chapter on "play" is certainly one of the best in the book; it brings out the subject in the most scientific as well as the most sensible manner, and if largely read, as we hope it will be by Canadian mothers, will do much for the benefit of the rising generation.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, Consisting of Original Treatises and Reproductions, in English, of Books and Monographs selected from the latest literature of foreign countries, with all illustrations, etc Contents: Influenza Associated with Nervous and Mental Diseases, by Dr. Van Deventer; Technic of Ling's System of Manual Treatment as Applicable to Surgery and Medicine, by Arvid Kellgren, M.D.; Antipyresis, by Prof. Dr. Arnaldo Cantani; Some Urinary Disorders connected with the Bladder, Prostate and Urethra, by Reginald Harrison, F.R.C.S. Published Monthly. Price, $10.00 a year, single copies, $1.00. June, 1891. New York: William Wood & Company.

A Compend of Anatomy and Physiology, illustrated by the New Model Anatomical Manikin, including a key, a glossary of medical terms, and incidental notes on pathology. Edited and compiled from standard works by M. C. Tiers. New York: Fowler & Wells Company, 775 Broadway. 1891.

NEWS ITEM.

Higher Medical Education.—For some years past even the poorest medical schools in Canada, without any endowment whatever, have adopted the compulsory four years course, which we have always respectfully recommended to our confrères in the United States. It is with especial pleasure therefore that we have received an announcement from the University of Pennsylvania informing us that it is the first in the United States to take this step. On reading between the lines we think we see the influence of our own Canadian, Dr. Osler, who was for some time connected with the University of Pennsylvania.

Higher medical education is the true interest of the public and of the medical profession. Nothing concerns more directly every individual member of the community than that our medical men shall receive a thorough and practical education. In all civilized countries except America from five to seven years are devoted to this purpose, although their students enter the medical schools with better preliminary education than the vast majority of ours enjoy. In each European country there are only a few schools privileged to confer medical degrees, so that it is easy to maintain a high standard. But in this country there are hundreds of medical schools intrusted with this great power and high responsibility. Keen competition keeps down the standard. Until a few years ago it was the rule that only two years' study was required. Conscience revolted at this shocking laxity, and a few schools advanced their standard and established a three-year obligatory graded coures of medical study. It was done in the face of much opposition, but it was done successfully, and to-day no medical school has any standing which has not adopted the three-year course. It was known to all who had studied the subject that this advance was but the first step. The number of subjects to be taught has increased; the methods of medical instruction have grown exacting and thorough; above all it is felt that no student should receive a degree which empowers him to enter on the most responsible work of practicing medicine unless he has had ample bedside instruction in every branch of his profession. It is simply impossible to do this in a three-years' course. Students are overworked in the attempt. The more complete the facilities possessed by any school the more evident has it become that one more advance must be made to enable the student to profit by his opportunities and to become a well-trained physician. The old cry is still raised that there were eminent doctors in former days who had studied only two years, and that those who graduate now with three years training succeed well in their profession. But every one who advances this argument knows how specious and hollow it is. It is universally admitted by the public and the medical profession alike that it is impossible to-day to give a thorough medical education in less than four full years of actual work in lecture-room, laboratory, and hospital.

The Medical Department of the University of Pennsylvania is the oldest and most distinguished medical school on this continent. The stand taken by this school more than fifteen years ago in lengthening the term and raising the standard of medical study produced the most conclusive effect, because it was at ended with such brilliant practical results. Ever since that time its graduates have distinguished themselves by unequaled success in all professional competitions. The advance was effected only by great sacrifices and exertions on the part of the Faculty. All high-grade, scientific education is costly and demands great facilities and increased labor. So it will be again. The school which puts into operation a full four-year graded course of medical study must be ready to meet increased outlay and lessened income from students' fees for some years at least. But what is resigned in mere pecuniary profit will be many times over compensated by the lasting influence for good exerted.

At the meeting of the Board of Trustees of the University of Pennsylvania, held May 21st, Dr. Pepper made an offer of $50,000 towards an endowment fund of $250,000, and of $1000 annually towards a guarantee fund of $20,000 annually, for five years, conditioned upon the establishment of an obligatory graded four-year course of medical study. This was accompanied by a communication from the Medical Faculty, pledging themselves to carry out this proposal, and to enter upon the four-year course in September, 1893. It was also reported that the members of the Medical Faculty had themselves subscribed $10,000 annually for five years to the endowment fund. The Board of Trustees expressed warm approval of the proposed advance in medical education, but postponed their assent until the success of both funds had been demonstrated.

The approaching completion of the fine Laboratory of Hygiene, built by Henry C. Lea, Esq., will render the medical facilities of this school unequaled. It is to be hoped that the necessary pledges will be secured promptly, as the interests of the entire community are deeply involved in the success of this great advance, which will enable medical students to obtain a thorough practical education in every branch of their profession.