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CANADA

MEDICAL & SURGICAL JOURNAL

MAY, 1883.

Original Communications.

VIENNA LETTER—SYPHILIS AND ITS TREATMENT.

(From our Special Correspondent.)

VIENNA, April 10, 1883.

In addition to several large ambulatoriums, there are 400 beds in the general hospital of this city for the treatment of syphilitic cases. There are three professors in connection with this subject; two ordinary, Zeissel and Neumann, and one extraordinary, Auspitz. In addition, there are four privat-docents and six assistants.

Prof. Neumann is the successor of the late Prof. Sigmund. It is principally through the influence and efforts of the latter that Vienna presents such advantages for the study of syphilis. It is to him also that the profession are indebted for the modern and very simple method of classifying the various syphilitic skin eruptions. To many it may appear very strange that a physician should devote his lifetime to the study of a subject that appears when superficially viewed quite plain and simple. There is really however no subject, or group of subjects even, that requires such a general and accurate knowledge of the different scientific and practical branches of medicine as does syphilis. He who wants to know it well must be a good general surgeon, and especially must possess an intimate knowledge of the diseases of the genito-urinary system, and of the skin and mucous membranes. It is necessary also that he should be an accomplished physician, and in particular he should be thoroughly acquainted with the diseases of the nervous system.

In addition, if he wishes to conduct the treatment of his cases in a satisfactory manner, it is necessary that his knowledge of physiological chemistry should be considerable. In fact the general practitioner is the only man in the profession at the present who is truly fitted for this work.

The object of this letter is to give an account of the method pursued in the general hospital of this City in dealing with syphilis in its various stages. The treatment is essentially the same as that pursued by the late Prof. Sigmund. It differs in many points from that followed in England and America, which is that of the French school.

1st. *The Treatment of the Local Sore.*—The term *hard chancre* is now never applied to the local sore, for the simple reason that an infecting sore may be either hard or soft. These qualities do not depend on the nature of the poison, but on the anatomical structures of its seat. Where there is much connective tissue, as in the prepuce, the sore will be hard; but where there is little of this tissue, as in the glans, the sore is soft. The mineral acids, or the thermo-cautery are never used for the destruction of the local sore. The conclusion has been arrived at, that, after forty-eight hours from the time of infection, treatment of the local sore by escharotics is useless in preventing general infection. It can extremely seldom happen that an infecting sore will be seen by a physician as early as forty-eight hours. The treatment by removing, with the knife or scissors, infecting sores, has been given up here, for it was never found to be of any benefit in preventing the general infection.

The treatment of the chancre is always of the mildest kind. If it is an ulcerating surface iodoform is invariably used, and generally in the form of spray. One part of iodoform dissolved in six parts sulphuric ether sprayed on the surface of the ulcer, leaves a fine coating of the former intimately adherent to all parts of the surface. This method of applying iodoform is much better than simply dusting it on, on account of its adhering to the ulcerated surface better. After a few days use of iodoform, the sore takes on "healthy action," and when the

granulations are healthy, it is no longer advisable to use iodoform, but to employ in its place a 2 per cent. carbolic acid solution. When the chancre has healed, and there is left simply a nodule, the best application is one part of corrosive sublimate to fifty parts of water or a diluted mercurial plaster.

2nd. *The Treatment of the Second Stage of the Disease.*—Is it possible to prevent the secondary symptoms of syphilis? This question is answered distinctly in the negative here. It is considered certain that there are no known means dietetic, hygienic or medicinal that can prevent the infection of the system once the local sore has become fairly seated. Sigmund has found, from the observation of many thousand cases left untreated, that in forty per cent. the secondary symptoms are very slight, so slight that in quite a number of the cases they escape the patient's observation. The treatment of the secondary stage of the disease is not commenced until the particular form that it assumes is evident. If the patient has an excellent constitution and a good appetite, it is not considered necessary to give him either iodine or mercury, for it is claimed that robust health with a good appetite, and strict attention to personal cleanliness stand next to mercury and iodine as antidotes to the poison of syphilis. During the two to three years that the secondary stage is supposed to last the patient has two or more relapses, and as a relapse is always more difficult to get rid of, it is recommended when the first secondary symptoms are slight not to give either iodine or mercury, but to reserve these agents for a later period. If iodine is used for the first crop of secondaries, it will be found to have much less effect on the second or third crops, than if it had not been used during the first. This statement applies also to mercury. It is further maintained that this is true not only of the different crops of the second stage, but also of those of the third stage of the disease. If iodine is used for the treatment of the second stage of syphilis, it will be found to have much less effect over the tertiary symptoms than mercury, and if mercury is used for the secondary stage it will be found to have a less influence over the third stage than iodine.

As a rule the practice here is to give iodine during the secondary stage, when the symptoms are of a pronounced character. If they do not readily yield, or if the iodine is ill borne then mercury is given. Mercury is also given if the case is a particularly severe one. Iodine is considered to be as useful during the secondary as it is during the tertiary stage of the disease.

In either stage it is not like mercury a direct antidote of the poison, but acts indirectly by its favoring tissue changes, and increasing the resisting powers of the patient. Whatever preparation of iodine or mercury is used in the treatment of syphilis, only harm results if digestion is materially interfered with. This is a point of great practical importance, and one too often neglected. For the severer and more rebellious forms of the secondary stage, mercury must be used.

In scrofulous and tuberculous subjects it is very often found that neither mercury nor iodine have the wished for effect, until the patient has taken for some time iron or cod liver oil.

The rule that is generally followed here as to the choice between the iodides and mercury is to give the former in the moist and the latter in the dry secondaries. The division of the secondaries into dry and moist is considered to be one of great practical importance. It will always be found that the dry eruptions occur in the weak and badly nourished, while the moist occur in the strong and well nourished.

There are three methods in use in the administration of mercury: 1. Inunction. 2. Internal. 3. Hypodermically. The method by fumigation has been discarded.

Inunction is the method most commonly employed. It is certainly for the great majority of cases the most trustworthy. By no other method can we get the system so quickly under the influence of this drug. In gummata of the nasal septum, roof of the mouth, etc., where hours are precious in order to save the hard tissues from destruction, it should always be used. In syphilitic lesions of the nervous system (be the change from a circumscribed gumma, or from the blocking of an artery by cellular infiltration), where irretrievable damage

will happen in a very short time, the introduction of mercury into the system by inunction should always be a part of the treatment. Whatever else is given, mercury should never be neglected in these cases. To treat these cases with iodide of potassium alone as is often done is considered by Neumann to be only half treatment. After the third inunction mercury can generally be found in the urine, and after the fifth, there are distinct signs of stomatitis.

The following is the process followed in the inunction cure : The preparation generally used being a finely divided ointment made up of one part of mercury and two of lard. After a warm bath the patient commences the first day of treatment by rubbing the ointment into the external and internal surfaces of the legs. The surface over the tibia is avoided on account of the ease with which eczema is produced. On the second day, the inner surfaces of the thighs ; on the third, the sides of the trunk ; on the fourth the inner sides of the arms and forearms are rubbed by the patient ; and finally, on the fifth day, the rubbing is done by an attendant over the back, on each side of the spine and about a hand's breadth from it.

Only a small portion of ointment is taken at a time—a piece not larger than a pea—and this rubbed slowly until the parts are dry, the process being continued until the desired quantity has been used. It always requires half an hour, and often an hour before one drachm can be rubbed in. On the sixth day, the patient gets a warm bath, and on the seventh day he commences the rubbing again, and follows the same order as before. This process is continued until the symptoms disappear. In the secondary stage it requires from thirty to fifty rubbings for this end to be obtained. It is extremely rare to find a case in the second stage that resists sixty rubbings. A very important point in carrying out this form of treatment is to insist upon the patient keeping his mouth and gums clean. Unless this is done a severe stomatitis is apt to set in which necessitates the discontinuance of the treatment. The remedy above all others that is best for the prevention of a too severe or a too early stomatitis is tar—the ordinary *pix liquida*. When stomatitis

has set in, it is best treated by tar also. It is surprising how soon it affects a cure in even very severe cases of mercurial sore mouth.

A slight stomatitis is produced by mercurial inunction after the fifth rubbing. If a patient after ten or twelve rubbings has not slight salivation, with swelling of his gums and a coppery taste in his mouth, it is a certain proof that he has rubbed badly.

The rubbing of mercurial ointment into the skin is apt to induce eczema in some people, this and the fact that it takes up some time are the only objections to this method. The latter objections, however, can be got rid of by using a preparation made by mixing one part of mercury with two of green soap. The mercury should be so finely divided that it cannot be seen with a loupe. The addition of a very small quantity of glycerine helps to divide the mercury. From one to one and a half drachms of this preparation can be rubbed into the skin in ten minutes. It is as liable to cause eczema as the ordinary ointment.

3rd. *The Internal Administration of Mercury.*—No matter what preparation is used, it is apt to give rise to catarrh of the stomach. It is also a very inexact method, for we can never be sure what amount of the drug is absorbed. Calomel is used for children and weak persons. It is especially good in hereditary syphilis. It is usually given in the form of powders with sugar, and in doses for adults of from one-fourth to three-fourths of a grain three times daily. Corrosive sublimate is only used for adults. It is given either in pill form or solution in the usual doses.

4th. *Subcutaneous Injection.*—This method of introducing mercury into the system is also extensively used in Neumann's wards. It is only used however in the treatment of the secondary stage, and the slight forms of the tertiary stage. For the severer forms of the latter stage its action is too slow.

The preparation for hypodermic use is the formiamid. Its injection under the skin causes no pain. This preparation is made in Berlin, and was first recommended only a few months

ago by Liebreich of that City. It has been used in Neumann's klinik in over two hundred cases, and always with good results, and only once was its injection followed by the formation of an abscess. In every one hundred grains there is one grain of mercury.

Until recently, corrosive sublimate was extensively used for hypodermic injection. It answers very well, but it is apt to cause a burning sensation which lasts for two or three hours. It is very rare that its use in this way is followed by abscesses. The peptonate and albuminate of mercury first recommended by Bamberger are used also. Both preparations are free from irritating qualities, but as they require to be daily freshly prepared they are not likely to come into general use.

In using any preparation of mercury hypodermically it is very important, first, that the syringe used should be antiseptic; and, secondly, that the injection should be made into the subcutaneous cellular tissue, and not into the skin or muscles. The skin should be avoided on account of the danger of producing abscesses, and the muscles from the fact that they contain few absorbents. The back, three or four inches distant from the spine is the best situation for the injections.

In using mercury in any form it should be remembered that it is very slowly excreted. Considerable quantities can be found in the urine three weeks after any has been used. After a month's inunction treatment, it can be still detected eight months afterwards in the urine. Prof. Ludwig has several times found mercury in the urine of some of Sigmund's cases, three, four and five years after they had stopped using it.

There are three different preparations of iodine used here in the treatment of syphilis. They are the iodide of sodium, which contains sixty per cent., the iodide of potassium which contains eighty per cent., and iodoform which contains ninety-three or ninety-four per cent. of iodine. The iodide of sodium is better for children and weak persons. Iodoform is only used hypodermically, one part of iodoform dissolved in six parts of ether being the formula used. It does not give rise to any local reaction, and its injection is not painful. For mild cases twenty

injections will be sufficient, but for the severer forms fifty are often required. Iodoform is considered to be as useful as the iodide of potassium in either the secondary or tertiary stages of the disease.

THE STUART PERIOD FROM A MEDICAL STANDPOINT.

BY R. L. MACDONNELL, B.A., M.D.

[A Paper read before the *Athenæum Club*, Nov. 28, 1882.]

The physicians of the 17th century played an important part in medical history. Anatomy and physiology began with Harvey, rational therapeutics with Sydenham. Astronomy was beginning to be developed from astrology; chemistry from alchemy. It was pre-eminently the age of the anatomists and physiologists. The names of many parts of our bodies bear testimony to the extent to which these studies were carried by the men of that period. Thus, the circle of Willis, the foramen of Vesalius, the tubercle of Lower, the Malpighian tufts, all serve to keep these great names fresh in our memory.

Upon examining the records of the illnesses of the great persons of the past, one finds grand opportunity for the play of the imagination.* What effect would modern scientific treatment have had upon their diseases, and what result would their cure have brought about? How much longer would they have lived, and what effect would the prolongation of their lives have had upon subsequent events. Had Henry VIII. had a 19th century physician, the disease from which he suffered would not have descended to his unborn children. Catherine of Aragon might have been the mother of many Tudors, the Stuarts would never have been heard of, the Reformation postponed, and Henry himself would have been talked of to-day as a model father and husband.

Queen Mary's cruel disposition, if not the actual result, was certainly intensified by the disappointment which followed her

* A writer in the *Athenæum* (Sternberg), in 1856, thus puts it: "History has been done philosophically, statistically, comically, but never physically or psychologically. A medical Niebuhr, with a moderate share of impudence, might resolve every page of record into a simple diagnosis."

fruitless marriage. Sir Henry Halford thinks that a course of aloes and iron might have changed the course of events in England and Europe.*

A few ounces of quinine judiciously administered, and Oliver Cromwell might have lived to three-score and ten.

The principal physicians at the Court of James the First were Sir Simon Baskerville, Sir Theodore de Mayerne, Dr. Craig and Sir William Paddy. The great Harvey was appointed extraordinary physician to the king by reversion, but his services were not required at the court until the accession of Charles I. Of Sir Simon Baskerville little is known, beyond that he was a very fashionable doctor, and in high practice amongst the cavaliers. He was the physician of Archbishop Laud. Dr. Craig was an outspoken Scotchman, and we shall presently see how he got himself into trouble with the meddlesome old ladies who crowded about King James' deathbed. He was the son of a famous Scotch lawyer, was elected a Fellow of the Royal College of Physicians of London in 1604, and in the following year was admitted to the degree of Doctor of Medicine at Oxford. Dr. Craig was a very learned man. According to Wood (*Athenæ Oxonienses*, Vol. I., p. 469), he gave to Napier of Murcheston the first hint which led to his great discovery of logarithms. "He told him," says Wood, "among other discourses, of a new invention in Denmark by Logomontanus, as, 'tis said, to save the tedious multiplication and division in astronomical calculations. Napier, being solicitous to know further of him concerning this matter, he could give no other account of it than that it was by proportional numbers, which hint Napier taking, he desired him at his return to call upon him again. Craig, after some weeks had passed, did so, and Napier then showed him a rude draft that he called 'Canon Mirabilis Logarithmorum,' which, with some alterations, was printed in 1614."

* Mary was bled frequently. "It appears, in Sir Frederick Madden's introductory memoir to the privy purse of Queen Mary, that she was bled very frequently, and that fees were paid again and again, and again, to the surgeon who bled her; till at last she grew so pale, as to convey, even to unprofessional eyes, a conviction that she labored under an internal organic disease."

Sir Theodore de Mayerne, who had the honor of being physician to four kings—Henry IV. of France, James I. and the two Charles of England—played a remarkable part in the medical history of the period. He was born at Geneva in 1573, and was the son of a Swiss Protestant. He was educated at Heidelberg and Montpellier. He soon became a lecturer on anatomy in Paris, and, at the same time, paid some attention to the study of chemistry. Dr. Mayerne was the first to use chemical remedies in his practice, and introduced the use of calomel to the profession. His success was so great that he was appointed physician to Henry IV. of France, and in 1606 was induced by Anne of Denmark to accompany her to London, where his remarkable talents soon gained his appointment to the post of chief physician in ordinary to His Majesty. Mayerne's success in practice and at court procured him many enemies. His foreign manners and style of speech exposed him to ridicule. Shakspeare, in the character of Dr. Caius in the "Merry Wives of Windsor," is supposed to be making fun of the French doctor. If 1606 be the date of Mayerne's arrival in England, and 1596* the date of the play, then Mayerne can scarcely be the person aimed at; nor do I see any allusion to Mayerne's career in the play. Mayerne's father was a literary man of some note in his day, and wrote a history of Spain. Nevertheless, Sir Theodore's foreign origin gave rise to many absurd reports regarding his career previously to his landing in England. Gideon Harvey, "their Majesties' Physician of the Tower and Fellow of the Colledge of Physicians of the Hague," in 1689, mentions Mayerne in terms the most contemptuous. Gideon relates the case of a patient who goes to consult Sir Theodore Mayerne, who is then living in retirement at Chelsea, a long way out of town in those days. Mayerne, he says, gave advice to this patient "without consulting the will and pleasure of God Almighty, an arrogance unheard of, and savoring more of the atheist (as too many of 'em are) than a pious physician." He accuses him, too, of prescribing a nostrum—"the great empirical medicine, from which his father, Turquetus (usually by the French nicknamed the Turk), had got great reputation by selling it publicly

* Chalmers.

on the stage, whom Sir Theodore, in his younger days, had attended in that employ." In a letter from John Chamberlen to Sir Dudley Carleton, Aug. 11th, 1612, Mayerne's appointment is mentioned as having given dissatisfaction. "Much envy was caused by Turquet's (Mayerne's) preferment, who hath £400 pension of the king, £400 of the queen, with a house provided him, and many other commodities which he reckons at £1400 a year."

Sir Theodore, for the benefit of posterity, left many published volumes on subjects connected with the prevalent dispute about chemical remedies. The most valuable of his legacies consists of records of the cases of the notable people who formed his *clientèle*. These entries in his diary are very interesting, in fact, as one of his biographers observes, might well be entitled, for the period they embrace, "The Medical Annals of the Court of England." There were 19 manuscript volumes, folio and quarto, exclusive of a volume relating entirely to the health and habits of James I. The later volumes, entitled "Ephemerides Anglicæ," relate to the disorders and cures of persons of quality of both sexes. The whole is written in very bad Latin, with a sprinkling of French words. Where the diseases are those of a nature not creditable to the moral antecedents of the sufferer, a *nom de guerre* is used. Thus Buckingham, who was constantly in trouble, is called "Palamedes," and Prince Charles is "Monsieur de la Fleur de Lys." Rochester ("Le Cardinal Joyense") is continually being treated for "debilitas," although he is described as being "admodum salax." Here is a portrait of the Marchioness of Buckingham:—

"Januarii 24, 1622. Madame la Marquise de Buckingham. Annum ætatis agit xix. Habitus gracilis, corpus *μονογραμμον*. Temperamentum ex sanguineo biliosum. Faciei color floridus. Mores compositi. Summa cum gravitate modestia. Vitium conformationis in spina dorsi. Gravida est et credit longissimum partus terminum fore diem Annunciationis B.V.M. 25 Martii."

Then again:

"Preparationes missæ ad Ser Walter Raleigh; parandæ pro Ser Roger Aston."

"My lord Duc de Lenox, Diarrhœa a liberiori victu."

"Madame de Hadingthon, Affectus hystericus et melancholicus."

The manuscripts which are now in the Sloane collection contain the histories of all his other patients, amongst whom were Lord Monteaule, Lord Arundel, Lord Clanricarde, Casaubon, Sir Henry Wotton, Arthur Brett, Oliver Cromwell, and very many others. His case-books show, too, that Mayerne's attentions benefitted alike man and beast. Nor was he above prescribing perfumes and cosmetics. In 1611, for Lord Hay, he compounded "odoramaenta et quæ ad ornatum," "Pasta ad manus dealbandas et emmoliendas." In 1617 the queen's black horse was seized with convulsions, and in 1636 the king's dogs were indisposed. Sir Theodore takes up his pen and carefully notes the line of treatment he thought fit to adopt: "Pro equo nigro Reginae epileptico." The history is complete, beginning with "equus est novem annorum," and ending "curatus fuit."*

Mayerne was the compiler of the first Pharmacopœia which was published by the Royal College of Physicians in 1618.

As a chemist, Mayerne had no equal. The results of his researches in his line were of benefit to art as well as to medicine. To both Van Dyck and Rubens he gave valuable information concerning the composition of paints and the use of the mineral colors. In the last chapter of Eastlake's "Materials for a History of Oil Painting" are numerous details as to colors and oils, brought out in a conversation between Van Dyck and Mayerne, and recorded by the latter. He gave valuable assistance to Petitot, his compatriot and fellow exile, who afterwards became the famous enamel painter.†

Mayerne attended Henry, Prince of Wales, in his fatal illness. From Sir Charles Cornwallis'‡ "Life of the Prince Henry," the following particulars concerning this remarkable fever are taken. The physician of the present day recognizes at once the now familiar typhoid fever, a disease in those days undescribed. From the very first it was said the Prince was poisoned. Rochester,

* These extracts from the Mayerne manuscripts are taken from Wadd's "Mems, Maxims and Memoirs," London, 1828, and from an article by Sternberg in *Athenæum*, 1856.

† M. F. Sweesters "Life of Van Dyck," Boston, 1878.

‡ To be found in the Somers Collection of Tracts, Vol. VI, p. 413.

afterwards Earl of Somerse, was at once suspected. People even hinted that the king was privy to the plot. Rochester was under suspicion because it was well known that he and the Prince were rivals for the favors of Lady Essex.* Typhoid fever was then a disease either new or not described. Many other cases of it occurred at about this time. In a newsletter written shortly after the death of the Prince, the fever is spoken of as being either a "bastard tertian or the ordinary disease of the time, wherewith all parts of the country have been much visited." Another writer of the period states that it was new to the physicians, and was thought by them to have been brought from Hungary. A short time afterwards, the Countess of Oxford died of the "new disease."*

The prodromata of the prince's fever made their appearance early in October, 1612. "Continuall headache, lazinesse and indisposition increasing, which, notwithstanding because of the time, he strove mightily to conceal." By the seventh day the disease was fully declared, and by the ninth began to assume a dangerous type. At this period the prince's body physician summoned Mayerne. The great error of bleeding the prince was committed. Mayerne was led to this step by the fact that bleeding of the nose had set in on the 20th day. This is a symptom of typhoid fever which we recognize to-day as an indication of extreme debility. Butler of Cambridge was called in at this stage. This extraordinary individual, of whom many amusing stories are told, acknowledged that the diagnosis puzzled him, and gave little hopes of recovery. Cornwallis speaks of Butler as "the famous physitian of Cambridge, a marvellous great scholler, and of long practise and singular judgment, but withal very humorous." John Chamberlen writes of him "that though he was otherwise but a drunken sot, yet he had a very shrewd judgment"; and in connection with his attendance upon the Marquis of Salisbury, "Butler of Cambridge" he says, "gave hard censure, but, thanks be to God, he proves a false prophet, and what for that and his other rude behavior was quite discarded." On the 22nd day of the fever there was delirium.

* Birch, "The Court and Times of James I."

The head was shaved and cupping glasses were applied to the back of the neck. On the following day, "a cocke was cloven by the back and applied to the soles of his feet, but in vaine." After the 23rd day all hope was abandoned. The king requested Mayerne to assume complete charge, but the responsibility was declined. The prince died on the 28th day.

My reasons for supposing this disease to have been typhoid fever are as follows:—1. The mal-hygiene of the period. 2. The time of year, the autumn. 3. The insidious nature. 4. The duration of the disease. 5. Headache, followed by delirium. 6. Bleeding from the nose. 7. The presence of diarrhoea.

According to the custom of the period, one not altogether extinct in these enlightened days, nostrums were sent to the prince with the compliments and recommendations of many distinguished persons. Sir Walter Raleigh, who lost a good friend in the young prince, sent from the Tower his famous fever cordial. The queen specially recommended it, since she herself had, in a previous illness, derived much benefit from it. No sooner was Prince Henry dead than the usual cry of "poison!" was raised. Strangely enough, it was rendered louder by an indiscreet word or two in the letter which Sir Walter Raleigh sent with his cordial. His words were, "it would certainly cure Henry of a fever, except in case of poison." So great was the public faith in this cordial, that the very fact of the prince's dying at all was looked upon as proof positive that he must have been the victim of a murderous conspiracy.

Sir Walter Raleigh was very fond of amateur therapeutics. In a letter from John Chamberlen to Sir Dudley Carleton in 1612, there occurs this passage: "The widow Countess of Rutland died about ten days since. Sir Walter Raleigh was slandered to have given her certain pills that despatched her."*

Mayerne was generally blamed for maltreatment of the Prince Henry. Butler is reported to have said that the patient should have been bled earlier and should never have been purged. The French physicians set forth hard censure; "they call him *temulentum, indoctum, temerarium, et indignum*, with whom no

* "Court and Times of James I." Birch. London, 1848.

learned physician should confer or communicate." A history of the case in French and in Latin was written by Mayerne, who procured from the king a certificate expressing the most perfect satisfaction with his conduct, and two others from the lords of the council and the officers and gentlemen of the prince to the same purpose. In Mayerne's case-book, the entries relating to the death of Prince Henry have all been torn out, most probably by Mayerne himself. Curiously enough, in connection with this fever of the Prince of Wales, I find in a recent publication of the St. Bartholomew's Hospital Reports an article by Dr. Norman Moore, entitled "An Historical Case of Typhoid Fever." The author considers that to Mayerne is due the credit of having been the exact describer of the earliest case of typhoid fever on record in England. Dr. Moore criticises the history of the case as written by Mayerne, and reduces it to the concise shape of a modern case report. The diagnosis, in the light of subsequent experience, is beyond a doubt. The autopsy is confirmatory of this view. The work from which Dr. Moore's history is taken is entitled "Theo. Turquet Mayernii Opera Medica." Ed. J. Browne, London, 1701. I do not think there is a copy of this book in America.

James I., at the age of 59, after having been subject to attacks of ague and gout at different periods of his life, met his fatal illness on the 12th March, 1625. On that day Mr. Chamberlen, in one of his letters, states that "the king was overtaken on Sunday with a tertian ague," and on the 16th Mr. Secretary Conway, in a letter to the Earl of Carlisle, speaks of "the sharp and smart accesses of his Majesty's fever, though a pure intermitting tertian, whereof this day early he had his seventh fit." Affairs went badly with the king. On the 12th night of the illness, the last sacrament was administered. He appears to have died insensible. There are several records of the examination of the king's body. The most rational one is that found in Nicholl's "Progresses of James I. Death resulted from a form of what is now called Bright's disease. One kidney was found to be much atrophied; two calculi were found in it. The heart was enlarged. Sir Simon D'Ewes records that "the greatness

of the king's heart argued him to be as very considerate, so extraordinary fearfull, which hindered him from attempting any great actions."

According to another account, the head was found so full of brains that they could not keep them from falling out, "a great mark of his infinite judgment," but his blood was "tainted with melancholy, and the corruption thereof the supposed cause of death." On the back of an engraving in the collection of Beckford of Fonthill, there is an account of this autopsy. Here it is stated that the spleen was enlarged. Death was really caused, then, by ague attacking a gouty man with damaged kidneys. A shilling's worth of quinine might have saved life.

Another very curious record of this illness was found written at the end of a Book of Common Prayer, in the library of St. John's College, Oxford. The author of it was Sir William Paddye, a physician of great name, one of the king's attendants. "Being sent for to Thibaulde butt two daies before the death of my soveraigne lord and master King James, I held it my christian dutie to prepare hym, telling hym that there was nothing left for me to doe (in ye afternoon before his death ye next day at noone) but to pray for his soule. Whereupon ye Archbishop and ye Lord Keeper Byshop of Lincolne demanded if his Majestie wold be pleased that they shold praye with hym, whereunto he cheerfullie accorded. And after short praier, these sentences were by ye Byshop of Lincolne distinctly read unto him, who, with eies (the messengers of his hert) lifted up into Heaven, att the end of every sentence, gave to us all thereby a goodlie assurance of those graces and civilie faith wherewith he apprehended the mercy of our Lord and onelie Saviour Christ Jesus, accordinglie as in his goodlie life he had publicuelie professed."

The attendants in this illness were Sir Theodore de Mayerne, Sir William Paddye, and Dr. Craig.

Again there was meddlesome interference with the medical men, which in this case was a cause of great trouble to all concerned. Everybody had an infallible remedy to offer to the king. The Buckingham party, including the duke's mother, anxious to meddle in everything about the court, brought suspicion upon

themselves by secretly applying a plaister to the king's wrists without the consent of the physicians. This was done injudiciously at the wrong time. It was put on before the paroxysm began. It should have been done just as it was declining, and then by the *post hoc* argument they might have claimed the honors. Unfortunately, the king got worse, and just at the time they had made up their minds to remove the noxious thing, the fit began to decline, so that the doctors were quick enough to claim that the improvement was due to its removal. The sons of Æsculapius then refused to continue the treatment. Promises of good conduct having been made, they saw his Majesty through his fifth, sixth and seventh fits. Again dissatisfied with the progress of the case, the Buckingham's applied their plaisters, but the patient grew worse, and it is a matter of history that the Royal Chirurgeon had to get out of his bed to remove it. Dr. Craig was particularly incensed at these proceedings, and, according to Dr. Fuller (Church History), "he uttered some plaine speeches, for which he was commanded out of court." The Duke of Buckingham secretly administered a julep, after which the king was said to have grown rapidly worse. This interference with the medical men cost Buckingham much trouble. Dr. Geo. Eglisam, one of the King's Scotch physicians, publicly charged him with having poisoned his master. In the impeachment of Buckingham, his accusers did not forget this affair. The 13th count of the impeachment (Howell's State Trials, Vol. II, page 1318) is entitled "His transcendant presumption in giving physic to the king," and it is therein set forth that "he did un- duly cause and procure certain plaisters, and a certain drink or potion to be provided for the use of his said Majesty, without the direction or privity of his said Majesty's physicians, not prepared by any of his sworn apothecaries or surgeons . . . did produce such ill effects that some of the sworn physicians did altogether disallow thereof, and utterly refused to meddle with his said Majesty until these plaisters were removed."

(To be continued.)

NOTES ON HARELIP.

BY T. G. RODDICK, M.D.,

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(Abstract of a paper read before the Medico-Chirurgical Society of Montreal.)

Almost the only excuse I can offer for presenting so commonplace a subject before the members of the Society is, that I have had an opportunity of treating some twenty-five cases of this deformity in both hospital and private practice, and hence have been enabled to lay down for my guidance certain rules, which are not always clearly defined in books, but which may assist in guiding others whose opportunities have been fewer and less varied.

A word, in the first place, as to the etiology of harelip. Perhaps not more than twelve per cent of all the cases are really hereditary. I have noticed, moreover, in this connection, that the line of transmission is seldom direct, the rule being to skip one generation entirely. Thus a man with harelip will have a large family, none of whom inherit his deformity; but probably several grand-children will be afflicted. Now and then the line is still less direct, the impression coming from a distant branch of the family tree. As to the influence of maternal impressions in producing deformities of this kind, I think something may be said in its favor, although my belief in this direction is not nearly so strong as that entertained by many observers. One of the most striking illustrations of this impression as a cause of harelip came under my notice in connection with a case on which I operated about two months ago. The mother stated that during about the fourth month of pregnancy she was living in one of the villages on this island, and one day visited the house of a neighboring farmer. Here she was confronted by a grown girl having a very hideous harelip. The impression made was instantaneous and abiding, and the child was born with what had originally been a severe form of harelip, but a considerable amount of healing had taken place *in utero*, as shown by the scar present. Fergusson (Sir William) used to think that a very slight peculiarity in the mouth of either parent was often the cause of

harelip. The following rather ridiculous story was told me by the mother of one of my cases operated on some two years ago. She said that while she was carrying the child, at about the third month, her husband, without her consent, had his moustache shaved off, exposing a very bad set of teeth. She was very much annoyed at this, and could not help upbraiding him constantly. The child was born with a complete harelip, and the husband is blamed to this day for having shaved.

As to the occurrence of other malformations (not including cleft palate) in the same individual, I know of only one case where club foot was also present. I have, however, repeatedly seen congenital deformities in other members of the same family. I show you now the photograph of a girl of eighteen years, on whom I operated successfully for double harelip, and who had congenital alopecia, the scalp being covered here and there only by a few downy hairs. In a case of harelip, which Dr. Alloway requested me to see with him a short time ago, there was marked cyanosis, due doubtless to non-closure of the foramen ovale. Owing to this, and the fact that an anæsthetic could not be given with safety, the operation was deferred and fortunately, too, as she died soon after.

Now as to the operative measures for the correction of this deformity: First, at what age should the operation be undertaken? This is often a very difficult question to answer; but will usually depend on the condition of the child, and the amount of deformity. There are two very serious objections to an early operation, namely, the very friable and lacerable condition of the tissues which allow the sutures to cut out too rapidly, and again the fact that young infants bear the loss of blood very badly. Then an equally grave mistake could be made in deferring the operation too long, or until dentition sets in. I think the following rules may be safely followed in these cases: Where cleft palate complicates the harelip, and the child feeds with difficulty, the operation may be performed between the fourth and sixth week; where the harelip is uncomplicated, the operation will do best if deferred to the third month. I am aware that the operation has been often per-

formed at a very early date, owing to the urgent solicitation of friends, but I think no surgeon should allow anything of the kind to warp his better judgment. The responsibility really rests with himself, and in the event of a failure the parents will very seldom be found willing to share it.

I always give an anæsthetic, and prefer ether to chloroform even in the infant of a month old. It may be a little more troublesome, but can be given as fearlessly as in the adult. I am not among those who believe that chloroform can be given with impunity to children. My experience may be singular, but I have witnessed alarming symptoms more frequently in them than in grown persons, and I believe the chief explanation of the comparatively infrequent fatal results in children lies in the fact that they are so much more readily handled than adults during the efforts to resuscitate.

I notice that many surgeons prefer scissors to the knife in paring the edges of the harelip fissure. I used them in one case only, but have never ceased to regret it. They bruise the tissues, and in that way interfere with primary union. Besides it is next to impossible for one to save the parings when scissors are used. They may, however, be employed with advantage in separating the lip from the underlying gum. A narrow bladed knife—an ordinary tenotomy knife in fact—will be found to answer the purpose best. When one is not provided with a skilled assistant, hemorrhage may be readily controlled by applying on either side of the fissure a pair of dressing or Pean's forceps, the blades being compressed by applying an elastic band to the handles.

As to the sutures employed, I use in all cases the hare-lip pin and cat gut, excepting in the very simplest form where wire may be substituted for the pin. In order to support the pin and at the same time exercise a sort of splint-pressure on the sides of the fissure, I have been in the habit of using flat leaden discs, perforated in the centre, and of the size and shape I show you, taking the precaution to pad them on the lip side with lint or rubber tissue. Prepared in this way it will be found that the needles will not cut the tissues of the lip, and can, if neces-

sary, be left *in situ* a much longer time than without the discs. Thus in persons over a year old I constantly leave the pins in till the third or even the fourth day.

In cases of harelip complicated with cleft palate, not only is there a wide gap in many cases between the two portions of the jaw, but the longer portion, or that having attached to it the intermaxillary process, will be found to overlap the other often to the extent of three-quarters of an inch. Now while an operation for the closure of the entire cleft is not practicable in a child of only a few weeks old, much may be done to lessen the gap, and place the parts in a better position for a subsequent staphyloraphy. Thus I invariably break down the projecting portion to the level of the other, either by the pressure of my thumb, or, when the bone is too firm, by deliberately fracturing the jaw with a chisel opposite about the canine tooth of that side. The edges of the two portions are then pared and held together by means of a strong silver wire passed through at a distance of at least half an inch from either edge. This wire is left in for about a month, when it will be found that the line of the gum is perfect, and the cleft through the hard palate has been lessened to a degree often astonishing. More than that, this narrowing process will continue often for many months, so that by the second year the fissure will sometimes be found to have almost closed. I show you here a pair of forceps, having broad smooth blades, with which the projecting portion of jaw can often be broken down when the thumb fails.

Next as to the treatment of double harelip and the management of the median tubercle or intermaxillary bone. I have had two cases only of this kind. The soft parts have to be treated in very much the same way as in the single variety, but care must be taken not to draw the skin covering the tubercle too far down towards the edge of the lip, otherwise the point of the nose will become flattened, and an unsightly appearance be given to the person. This occurred in my first case, and I was obliged to free the nose by a subsequent operation. This intermediate portion should be utilized simply to complete the columna, the point only entering into the formation of the

lip. As to the management of the intermaxillary bone, this may be dealt with in a variety of ways. The most expeditious method, of course, and that advocated by many surgeons, is to remove it altogether. This, however, causes the lip to fall in, and gives the patient a peculiar expression. The process should then if possible be preserved; this can be done by simply breaking it away from the vomer and pushing it back into the gap between the two lateral portions of the jaw. Should the space not be sufficiently large to receive it, the edges of the cleft may be pared away, and the process held *in situ* by means of a wire suture.

In the after treatment of harelip I have never found it necessary to employ Hainsby's truss or any apparatus of that kind. The application of straps of Mead's rubber plaster, made broad over the cheeks, and approximated across the lip by lacing with thread, will be found necessary in a few cases only. Great care should be taken, however, not to make the plaster crossing the lip too wide, as I have known it to cause the upper portion of the wound to gape by pressing on the nostril above.

A word in conclusion on the method of feeding the child. The majority of surgeons recommend that the child be put at once to the breast. This may answer very well, and doubtless is the best practice when the nipple of the mother is small, prominent, and readily grasped by the child; but on the other hand I have known serious mischief to follow persistent endeavors on the part of the mother to push a large nipple into the tender and contracted mouth of the child after the operation for harelip. Hence in all cases it is better, safer perhaps, to feed the child with the spoon, at least for the first forty-eight hours after the operation.

CASE OF CONGENITAL DEFORMITY OF THE HANDS.

BY JOSEPH WILLIAMS, M.D., BOSTON, MASS.

A recent obstetric case has furnished me with an example of a deformity which seems worthy of mention. There is nothing to note in regard to a supposed cause in the personal or family

histories of the parents; the pregnancy was normal and the child perfectly developed, with the exception of the hands.

In each hand there are only three metacarpal bones, the first and the fifth being wanting. The second, third and fourth digits are normal. The little finger in each hand has its articulation with the outer side of the head of the fourth metacarpal, and is set so closely to the adjoining phalanx of the fourth digit that there is probably an articular facet on the latter. As if to remedy this deformity as much as possible each little finger curves so as to form nearly a semi-circle, the extreme end of which touches the ulnar side of the fourth digit. The wrists seem unusually long and flexible; but whether there is any increase in the number of the carpal bones could not be satisfactorily made out.

The most visible deformity, however, is in connection with the thumbs. On the left hand there is no trace of a thumb; there is no cicatrix or irregularity on the radial side of that hand. On the right there was a thumb whose shape is best compared to that of the human stomach, the larger end being attached to the hand by a very narrow pedicle, while the more pointed extremity carries a diminutive nail. The mass measures 22 m.m. in length and 10 m.m. in greatest diameter; the pedicle is 5 m.m. long and of a uniform diameter of 2 m.m., and is so flexible that the thumb rolls about with the least movement. At the wish of the parents I removed this thumb. The pedicle contained blood-vessels but no bone or cartilage; the thumb possessed its two phalanges, the proximal one being rudimentary.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

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Necrotic Breaking-down of a Uterine Myoma during Pregnancy, by Dr. Krukenberg, assistant physician to the Gynecological Clinic at Bonn. This is the title of a paper in the last

number, (Bd. XXI, Hft. 1, *Arch. f. Gyn.* 1883.) The author begins by stating that necrosis of a uterine myoma during the puerperium is not rare. During pregnancy at the most, oedematous infiltration of the tumor occurs. Most of the cases of gangrene of fibroids have occurred shortly after labor. Such an occurrence at this time is not to be wondered at. The copious supply of blood during pregnancy leads to rapid growth, and after its termination conduces to rapid regressive changes. The author reports the following case. He has been able to find only one other on record, Cappie's, published in the *Obstet. Journal of Great Britain*, 1874; Vol II., p. 303. The following is a brief account of the case reported by Krukenberg: The patient, aged 43, had always menstruated regularly and painlessly, and had been sterile during the two years that she had been married. The menses last appeared in the beginning of March. She remained in fair health till June 10th, when immediately after defecation without difficulty, she was seized with a severe rigor lasting five minutes, and accompanied with most violent pain in the hypogastrium. She could with great difficulty be got to her room. The physician in charge treated her for inflammation of the bowels; the pain subsided after two days, but she was obliged to keep her bed till the end of June. No vomiting, fainting or giddiness. The circumference of the abdomen increased. At the end of June patient was much better, but still had pain in the right iliac region. She was then admitted to the Clinic. Abdomen was enlarged; palpation painless, percussion showed absence of ascites; in the lower part of the abdomen were two tumors, that on the right was hard, that on the left firm and elastic. They were separated by a furrow, both were smooth. On auscultation, uterine souffle was heard in the right hypogastrium. Foetal heart sounds inaudible. Dr. Veit, chief of the Clinic, could not arrive at a positive diagnosis; probably the patient was in the fifth or sixth months of pregnancy. Extra-uterine pregnancy seemed excluded. Probably the tumor on the left side was the gravid uterus, and that on the right a myoma. It was too firm for an ovarian tumor, and the line of separation between it and the uterus was not distinct enough.

About the first of August the left-sided tumor or enlargement had increased; the dividing line or furrow had become very indistinct; foetal movements could be felt, and foetal heart sounds were now audible. Morning temperature normal; in the evening, high fever, 39.9 Cent., but there was little regularity about the temperature; other organs healthy. These facts suggested suppuration somewhere. An irregular but increasing temperature continued. On the 11th August a severe rigor. Conditions otherwise unchanged. Opening the pus cavity seemed the only chance of saving life. The propriety of this course seemed assured by the history of an attack of peritonitis, whereby it was hoped that adhesion of the parietal peritoneum to the visceral layer had occurred. Next day, Aug. 12th, Prof. Veit with antiseptic precautions made an exploratory incision, but was completely disappointed in his expectations; there were no adhesions to obliterate the peritoneal cavity, only clear fluid escaped; no separation of the tumor or furrow could now be seen; the tumor mass felt much more like the gravid uterus than anything else, but harder on the right side than the left; the wound was closed. Eleven hours later labor set in, and at the end of five hours the foetus enclosed in its membranes was expelled. The membranes healthy, the liquor amnii slightly turbid; foetus recently dead, not macerated; to the right and above the uterus could be felt a hard tumor of the size of the fist; no abnormal escape of blood or pus; during the following day the belly became tender and tympanic; occasional vomiting, delirium, herpes labialis, left sided parotitis; lochia fetid, scanty, containing no pus; general condition was of typhoid character. Death occurred on the 18th Aug., six days after the exploratory incision. At the autopsy, purulent depots in the parotid gland and kidney; general peritonitis; ureters dilated to the size of the little finger. From the pelvis rose a tumor of the size of a child's head; from this two smaller myomata projected. On removing the parts from the pelvis, in the left side of the uterus, there lay an interstitial myoma about eight centimetres in diameter; its capsule averaged one centimetre in diameter; to the right and behind, it was very

much thinned, and at one spot completely absent. By this opening the capsule communicated with a collection of soft, broken down tissue and pus, part of the tumor was also softened.

Gartner's Canals.—Dr. J. Kocks, privat-docent of Obstetrics and Gynæcology at the University of Bonn, in a paper in the 20th volume *Archiv f. Gyn.* (1882), draws attention to two follicles which open more or less close to the posterior margin of the orifice of the female urethra; their length varies from a half to two centimetres. Kocks believes that they are the homologues of the ejaculatory ducts of man, of which in the female they are the embryonic remains. Gartner discovered these in ruminants and swine, but hitherto their existence in other animals has not been announced. They are evidently the same as described by Dr. Skene of Brooklyn in a paper, "Anatomy and Pathology of two Important Glands of the Female Urethra," published in the *American Journal of Obstetrics* for April 1880. In this paper Dr. Skene very fully describes the structure and diseases of the gland; they are liable to inflammation, in most cases occurring as extension from vulvitis or vaginitis. Skene has pointed out that the follicles when inflamed give rise to annoying symptoms, and require special treatment; curative applications, as tincture of iodine or solutions of nitrate of silver, must be applied within the follicles by fine probes coated with cotton, or if this fail they must be slit up like a sinus or fistula. In the healthy condition of the parts the openings of the follicles are within the orifice of the urethra, but when inflamed they cause an eversion of the mucous membrane to such an extent as to make them visible.

Professor Böhm of the Rudolf-Stiftung Hospital, Vienna, in a more recent number (Bd. XXI., Hft. 1, of the *Arch. f. Gyn.* 1883) also points out the frequency of inflammation of these glands, and asserts that he has seen it in virgins, prostitutes and married women. From my own experience I can confirm the above statements with reference to the existence of diseases of, and necessity for special application of remedies to these follicles. Neither of the German observers give any credit to, or even mention Professor Skene's observations.

On the Diaphoretic Treatment of Puerperal Eclampsia, with Hot Baths.—Our readers will remember that in a previous report I embodied a *resumé* of the results obtained by this method of treatment at Prof. Gustav Braun's Clinic, Vienna. Dr. Carl Breus, his assistant—the writer of the previous article—again appears in the last number (Bd. XXI, Hft. 1 of the *Arch. f. Gyn.*, 1883) with a report of eleven other cases, treated in the same way; of these eleven only one died, the other ten recovered—as the author remarks excellent results in such a serious disease. It will be remembered that the procedure consists in placing the patient in a bath of a temperature of 38° C., and gradually raising it. After the bath the patient is wrapped in warm sheets and blankets to encourage perspiration. This method of treatment in no way interferes but rather favors the carrying out of other indications for treatment; such as chloroform inhalation, chloral hydrate enemata, etc. A sketch of the history of each case is appended. Of the eleven cases in four the eclampsia occurred in the beginning of labor; in two after long duration of the first stage; once during the expulsion of the child, and four times after labor. The fatal case was syphilitic; was brought late to the Clinic for treatment, and had had many convulsions. She was, moreover, also probably in a condition of septic poisoning when brought in, as death was not caused by the eclampsia but by pelvic phlegmon and peritonitis four days after delivery, when the evidences of kidney affection had become very much diminished. This series affords a better showing for the treatment than the first series of six cases, of which one died. To sum up, of seventeen cases two only died. One only of the deaths being due to convulsions, the other as just related to puerperal peritonitis. Experience of the treatment has shown that it in no wise exposes the patient to the danger of premature labor. In two cases in which convulsions came on before the end of the full period of gestation, and which were treated by the baths and other diaphoretic procedures, labor did not come on till the end of full time.

Further evidences of the fact here stated are afforded by the

results of preventive treatment of several cases of œdema and albuminuria in pregnant women at the Clinic. In one notable instance a primipara, æt. 26, with bloody, highly albuminous urine, was transferred in the 8th lunar month of her pregnancy from Bamberger's Clinic to the Obstetrical Clinic for treatment. She was so dropsical that she could scarcely turn in bed, and suffered from intense dyspnoea from œdema of the bronchial mucous membrane and hydrothorax, aided, of course, by the normally lessened descent of the diaphragm by the gravid uterus in advanced pregnancy. She was treated with hot baths and packing. For more than ten weeks she was thus treated—forty-five baths in all having been thus given. The first baths markedly relieved the dyspnoea, lessened the œdema, and markedly reduced the quantity of albumen and blood in the urine. When on one occasion the baths were suspended on account of diarrhoea, the distressing symptoms returned. The patient was delivered spontaneously of a living child. The only interference being bilateral episiotomy, or incision of the perineum, rendered necessary by the œdema of the vulva. She died, however, later of an attack of pleurisy in Bamberger's Clinic, to which she had been removed for further treatment of her nephritis.

Shall Carbolic Oil or Vaseline be allowed to retain our confidence as a reliable Disinfectant Lubricant in Obstetrical practice?—Fehling of Stuttgart discusses the question in a recent number of the *Cent. f. Gyn.* Mixtures of carbolic oil or vaseline have been used for several years, and are still much employed for such purposes. Koch's recent researches are pertinent to this question, and tend to destroy confidence in the parasiticide properties of carbolic acid. He found that anthrax bacillus and its spores could be kept in carbolic oil for more than three months and retain their vitality. He also found that these spores retained their vitality as long in carbolic oil as in olive oil. Bacteria, moreover, are found, and continue to develop, in catgut preserved in carbolic oil. The most important lessons to be derived from these facts is that the disinfectant power of carbolic oil upon the fingers must be very slight, insufficient, and therefore dan-

gerous to rely upon, if, as in the Prussian Handbook for Midwives, it is the only one recommended. An important advantage, however, from the use of carbolic oil for such purposes is that it protects the examining finger from the infection of poisons, such as cancer, syphilis, and foetid endometritis. For several years since he has used carbolic oil, Fehling has experienced none of the irritant or poisonous effects of these poisons on his own hands. Previously he very often suffered in this way. Carbolic oil, then, must not be relied upon to the neglect of thorough disinfectant washing of the hands of the obstetrician with the 5 per cent. watery solution of the acid. Fehling recommends, in preference to carbolic oil, the paraffine ointment of the German Pharmacopœia, with an admixture of 4 per cent. of carbolic acid. An ointment has this advantage over oil, that it does not drop on and so stain the clothing.

Effects of Hystero-Trachelorrhaphy on Fertility and Parturition.—This operation has been shown to be of the utmost value in the treatment of so many of the diseases of women, and is so frequently performed that the question of its effects on fertility and parturition may now be put with a fair expectation of receiving a definite answer. Within the last few months the obstetrical journals have contained articles and reports of discussions at meetings of societies, bearing upon it. Dr. P. J. Murphy of Washington, surgeon in charge of Columbia Hospital for Women, has a paper on this subject in the *American Jour. of Obstetrics* for January, 1883. After a brief introduction, he gives a *resumé* of all the cases whose history he could find in the library of the Surgeon-General. He found only 11 cases of pregnancy there reported. He therefore, and, as I think, without sufficient warrant, concludes that (1) the repair of lacerations of the cervix is usually followed by sterility; (2) that the character of the labour is severe and protracted, and that, in a large proportion, laceration occurs a second time; (3) that in order to ascertain the benefit of surgical interference in such cases, an examination should be made several months after the operation to determine the condition of the cervical canal and, if conception has taken place, the condition of the cervix following delivery.

At the meeting of the Obstetrical Society of New York for October 3, '82, Dr. J. B. Hunter related the case of a woman on whom he had performed the operations for a severely lacerated cervix and for a completely lacerated perineum. The child was born at full time, and weighed seven pounds. Neither cervix nor perineum gave way, although he believed the perineum had a narrow escape. He mentioned the case because so many physicians feared a reproduction of the injury at delivery after operations. This was only one of several which he had seen in which no injury was done to the repaired laceration at subsequent labors.

Dr. Skene of Brooklyn, who was present, said that he had seen several cases of successful delivery without injury to the repaired cervix and perineum. In some others in which laceration took place, it was only slight or partial, and was not complete in any. He could readily understand why [this should be so, for with the development of the uterus during pregnancy, the compensation of normal tissue would be so great and the scar tissue so insignificant that there could be no more reason why laceration should occur than in a case in which it had not happened before.

Dr. Hanks said that in one of the first cases he ever operated on for laceration of the cervix, the operation was done at the Woman's Hospital of New York. He delivered the patient 18 months afterwards without any injury to the cervix. Since then he had had several cases, without relaceration.

Dr. C. C. Lee had operated in a case of double cervical laceration so extensive that very little of the true cervical tissue remained after its repair. An excellent result was obtained. He was particularly interested in this case, the laceration was so extensive. The woman was young, and expected to bear more children. She became pregnant. His associate, Dr. Swasey, attended her in her confinement, but no laceration whatever occurred. Dr. Lee examined her very carefully himself, but found no traces of anything of the sort.

Dr. B. F. Baer of Philadelphia, at the meeting of the Obstetrical Society of that city, Feb. 1st, '83, read a paper on the

“ Analysis of 27 Operations for the Restoration of the Lacerated Cervix Uteri, with special reference to the effect on Sterility and Labor.” He admitted the force and truth of a statement made by Dr. Herman of the London Hospital during a discussion in the Obstetrical Society of London following the reading of a paper on “ Trachelorrhaphy, or Emmet’s Operation,” by Dr. Playfair. Dr. Herman said : “ The American literature on the subject consisted mostly of general statements. Few writers had published cases, and they were mostly complicated ones.” Dr. Baer next referred to the conclusions of Dr. Murphy, embodied above, and admitted the truth of his conclusion that repair of lacerations of the cervix uteri is usually followed by sterility ; but he believes that the truth is not properly expressed, and that Dr. Murphy ought to have said that in those cases in which sterility followed the operation, that condition also preceded the repair of the cervix in most of the cases, either as a result of the laceration or of its consequences on the uterus and its appendages ; and that the operation did not cause the sterility, but failed to cure it. Of Dr. Baer’s 27 cases, 6 were widows or had passed the menopause, and are therefore to be excluded. Of the remaining 21, 13 had been sterile 5 to 16 years previous to the operation, and probably must be classed as beyond the possibility of becoming pregnant. In the remaining 8 cases, pregnancy had occurred within 5 years, but abortion occurred in 5. These figures, as Dr. Baer well remarks, give abundant proof of the ill effects of the lesion and its results, subinvolution, chronic hypertrophy, cellulitis, öophoritis, etc., on fertility.

The statement that sterility usually follows as a result of the operation is not correct, if it be properly done ; the os uteri not made too small, and the union obtained is primary, the minimum of cicatricial tissue remaining to interfere with the normal resiliency of the cervix. Other reasons for sterility in such cases adduced by Dr. Baer are the histological changes in the uterus and its appendages, due to frequently recurring abortion, and the fact that in the majority of cases trachelorrhaphy has been performed long after the receipt of the lesion, because the operation is new, and there were many old cases. The author appends

short reports of cases selected from the twenty-seven, illustrating the points he makes in his paper. In the discussion which followed, Drs. Albert Smith, Githens, Montgomery, Cleemann, Wharton Siukler and others, each reported cases of pregnancy and labor at full term, in the great majority without laceration of the cervix, following Emmet's operation. Here then, is a mass of testimony opposed to the prevailing idea in the mind of the general profession, to the effect that the operation causes sterility, or that, if pregnancy occur, laceration of the cervix will be reproduced. The point is of considerable importance. There is no doubt that many women are deterred by the advice of their physicians from submitting to a necessary operation until some of the more important secondary consequences of the lesion; such as chronic congestion or inflammation of the uterus and its appendages have set in, when the case is often rendered incurable.

Secondary Puerperal Hemorrhage.—At the meeting on January 18th, 1883, of the New York Academy of Medicine, Dr. P. F. Mundé read a paper on this subject. He said that the majority of obstretical authorities scarcely refer to the possibility of alarming uterine hemorrhage occurring as late as several weeks after confinement. He reported a case in point. The hemorrhage did not occur until sixteen days after confinement. The child had been hydrocephalic and was delivered with the cephalotribe; hemorrhage occurred, the placenta was adherent, and the anterior lip of the cervix torn. She was feverish, and the lochia were offensive, the secondary hemorrhage was arrested for a moment by the intra-uterine injection of hot water, but it returned. Dr. Mundé then cleared out a mass of clots from the dilated vagina and distended uterine cavity, washed out the uterus with hot carbolized water; then introduced a tubular speculum, and through this with a long cervical syringe injected half an ounce of pure tinct. iodine into the uterine cavity, which caused neither pain nor shock. The patient was excessively blanched and weakened, but contrary to all expectations she slowly recovered, and five weeks later was completely convalescent.

The causes of Secondary Puerperal Hemorrhage Dr. Mundé enumerated as follows:—Constitutional: hemophilia, mental emotion, functional diseases of the liver, incautious use of stimulants, sudden assumption of the erect position. Local: Irregular or inefficient contraction of the uterus, clots in the uterine cavity, portions of retained placenta or membranes, retro-flexion of the uterus, laceration of the vagina or vulva, laceration or erosion of the cervix, inflammatory ulceration of the cervix, malignant disease of the cervix, pelvic cellulitis, inversion of the uterus, premature sexual intercourse, loaded rectum. To these he added distended urinary bladder. Besides these, malarial poisoning was a well recognized cause of secondary puerperal hemorrhage. General febrile disturbances were also causes of secondary metrorrhagia. Another cause, so far as he had been able to learn, spoken of by Winckel only, was disease of the inner surface of the uterus, chiefly endometritis. Dr. Mundé believed that his case belonged to that.

Secondary Puerperal Hemorrhage may occur as late as four, five or six weeks after delivery. For treatment he recommended injection, or swabbing the uterine cavity with tinct. of iodine, and if necessary the use of the vaginal tampon.—*American Journal of Obstetrics, March 1883.*

Martin's Operation is for the removal of uterine fibroids. It consists in performing laparotomy, causing the uterus to protrude through the wound, incising its wall opposite to the tumor, shelling it out and removing it. The uterine wound is then sewed up with numerous closely set sutures, and the abdomen closed in the usual way. A case of this operation is published by Dr. Möricke in a recent number of the *Zeitschrift für Geburtshülfe und Gynäkologie*. It occurred to him while in temporary charge of Prof. Schröder's wards during an illness of the latter. The patient, aged 35, had suffered from pain and hemorrhage, and was very anæmic. The uterus was about the size of one four months pregnant. The cervix admitted the finger, and by it a broad-based tumor could be felt springing from the anterior wall of the cavity. Ergotin internally and curetting of the endometrium did no good. After the opera-

tion there was fever, and on the 10th day pelvic exudation could be felt. On the 48th day foetid pus was discharged from the vagina. After this the fever abated, and on the 76th day after the operation the woman left her bed. The fever, however, again returned; the patient wasted and died 111 days after the operation. At the autopsy peritonitis with sero-fibrinous exudation; a collection of pus in each broad ligament; almost complete involution of the uterus, and a healthy endometrium. Dr. Möricke thinks Martin's operation is an ideal one, and strongly recommends it.

Total Extirpation of the Uterus through the Vagina for Cancer.—This operation continues to be frequently performed, especially in Germany. It seems to have almost entirely displaced Freund's abdominal operation. At last year's German Medical Congress of Physicians at Eisenach, Olshausen reported that he had performed total extirpation of the uterus twenty-three times. Of these, three were not completed; one on account of rectal, and two on account of vesical adhesions. One case had a vesico-vaginal fistula as a sequel, and another an intestino-vaginal fistula. Of the remaining twenty cases six died. In nineteen there was carcinoma of the cervix; in three sarcoma of the body of the uterus. In one case the operation was performed on account of myoma of the posterior wall of the cervix. Of the survivors of the operation, in three the disease reappeared, and of these two died. In the last ten he had employed the elastic ligature exclusively, with carbolic acid irrigation, drainage tube in Douglas' pouch, and iodoform gauze. At the same meeting Martin reported that he had made thirty-one operations, in five of which all the diseased tissue could not be removed; of the twenty-six others four died. His method was to commence by opening the posterior vaginal cul de sac, and then to ligate the tissues to be divided, thus avoiding loss of blood. He employs drainage. He admitted that as regards return of the disease the operation was not successful. Of all his cases only one remained a year and a half free from the disease. At the same meeting Keyelmann stated that he had never seen a case of permanent cure of carcinoma obtained by extir-

pation. He therefore thought it ought to be reserved for cases of adenoma. Olshausen, Veit, Rinecker and Martin were, however, opposed to this view, as they have all seen cases in which long continued or permanent relief has been maintained. The experience of Martin as just given scarcely warrants the assertion on his part.—*Centralb. f. Chir.*, Jan. 20, 1883.

Reviews and Notices of Books.

Medical and Surgical Aspects of In-Knee (Genu-Valgum): Its Relation to Rickets, its Prevention, and its Treatment with and without Surgical Operation.—By W. J. LITTLE, M.D., F.R.C.P., assisted by G. MUIRHEAD LITTLE, M.R.C.S. Illustrated with upwards of 50 figures and diagrams. New York: D. Appleton & Co., 1882. Montreal: Dawson Bros.

This compact and neatly gotten up little work of one hundred and sixty pages, is especially deserving of notice from the fact that its Senior Editor, Dr. W. J. Little, is well known to be the pioneer of Orthopædic Surgery in England. He himself was at one time a patient of the great Stromeyer, having suffered in early life from one of the varieties of talipes. The work is dedicated by the authors to Prof Gross, "the Father of Surgery in America," in grateful acknowledgment of the reception accorded them during a recent visit to the United States.

The intention of the book seems to be chiefly to disprove some of the ordinary conceptions regarding the pathology and treatment of genu-valgum. Thus many surgeons of eminence have long contended that *enlargement* of the internal condyle is pathognomonic of in-knee. Whereas Dr. Little maintains that the external condylar part of the femur, and the external articular portion of the tibia are damaged and shrunk in this deformity, thus giving rise to the characteristic appearance of knock-knee. Much space is taken up to prove the rachitic origin of in-knee, a fact which few surgeons will question; although a non-rachitic variety is recognized and fully described. While the latter usually requires mechanical treatment only,

the rachitic form has to be reached often mainly through the constitution.

The surgical treatment is divided by the author into two parts: that which consists in manipulations and application of suitable contrivances, and that which consists of more abrupt means, such as tenotomy, forcibly straightening under anæsthesia, and osteotomy. Dr. Little makes the remarkable statement that he has never met with a case of in-knee that did not recover by the help of instrumental means alone. He deprecates the practice of performing osteotomy at all in young children, and in the case of adolescents even he thinks that the operation is justifiable only where adequate skillful instrumentation has been tried in vain. He, however, gives due credit to Macewen and others for their brilliant successes, and admits frankly that the Listerian system of antiseptic surgery has divested osteotomy of many of its dangers, and made it a really brilliant operation.

The book is neatly printed, and the woodcuts are very creditably executed. It is evident that the authors have spared no pains in its preparation, and we can strongly recommend it to those of our readers who may be interested in orthopædic work.

Trichinæ; their Microscopy, Development, Death, and the Diagnosis and Treatment of Trichinosis.—By W. C. W. GLAZIER, M.D., Assistant-Surgeon Marine Hospital Service, U.S. Seventeen woodcuts; pp. 20. Illustrated Medical Journal Co., Detroit, Mich. Price, 25 cents.

This little pamphlet, closely printed, gives a very full and reliable account of the life history of the formidable flesh worm, and of the symptoms produced by it. The material has been judiciously selected from the best authors, chiefly German, and there is nothing to lead one to suppose that the author has had any experience either in the investigation of the disease or the parasite. We believe, however, that Dr. Glazier has made some important researches into the prevalence of Trichinæ in American pork, and if he had given us a review of the disease as it exists on this continent, he would have added materially to

the value of the book. To those who do not possess special monographs this one will prove servicable, and we can commend it as containing a full *résumé* of the subject.

Experimental Pharmacology : A Handbook of Methods for Studying the Physiological Actions of Drugs.—By L. HERMANN, Professor in the University of Zürich. Translated, with the author's permission, with notes and additions, by ROBT. MEADE SMITH, M.D., Demonstrator of Physiology in the University of Pennsylvania. With thirty-two illustrations on wood. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

The more demonstrative all courses of lectures become—and this is the tendency of the age in the teaching of medicine—the more will students feel the want of a reliable guide to assist them in carrying on their examinations, by which they can confirm the observations they may make in the class-room. It has not yet been competent for any of our native schools to give practical demonstrations of the actions of drugs—we hope it soon will be—and when this comes, and our students before making these observations for themselves—and better still now in anticipation of this—we can highly recommend this book as furnishing all the necessary guidance with full directions, with reference to apparatus required, methods of procedure, etc., for investigating the actions of all important drugs upon muscles, nerves, glands, etc., and the functions of circulation, digestion, respiration, nutrition, etc. It has been edited with great care, and is well illustrated.

The Diseases of the Liver with or without Jaundice, with the Special Application of Physiological Chemistry to their Diagnosis and Treatment.—By GEORGE HARLEY, M.D., F.R.S., F.R.C.S., Physician to University College Hospital, etc. Illustrated by colored plates and wood engravings. Philadelphia: P. Blakiston, Son & Co. Montreal: Dawson Bros.

This work of Dr. Harley's upon these important disorders is

constructed upon a plan rather different from most of the systematic books on the same subject. The chemistry, physics and physiology of the liver form one of the early chapters, which is full of good teaching upon topics which make up the foundation for a correct understanding of the disturbances of this organ in disease. Much valuable information is to be obtained from the "general remarks on the signs and symptoms of Hepatic Disease," and on "treatment of Hepatic Disease." These are followed by a short account of that every day condition so universally called "biliousness," in which chapter many suggestive practical hints will be found. Jaundice is treated of in all its forms at very considerable length, its etiology receiving special attention. Abscess, cancer, hydatids, etc., are then treated of in order, and the affections of the gall-bladder have a section to themselves. From the known ability of the author, and the fact that he has for many years made a special study of the physiological chemistry of the excretions, renders his present work a valuable addition to the literature of this subject.

The Pharmacopœia of the United States of America.

Sixth decennial revision. New York: Wm. Wood & Co.

The sixth decennial revision of this important work made its appearance last November. The committee of revision being composed of almost equal numbers of medical men and pharmacists, it may be readily inferred that the interests of both were well discussed. The work appears to be a compilation of all medicines of any repute in the various States of the Republic; many of the remedies added are to us in Canada but little tried, but articles used with any degree of frequency by physicians of each State appear to have been accepted by the compilers.

The work of revision could have been no easy task, when we consider that 256 new articles have been added and 229 discarded, 106 of the latter being pharmaceutical preparations. It is with pleasure we see added such useful and, in many cases, well tried articles as salicylic and hydrobromic acids, pilocarpine, iodoform, chrysarobin, and many others that we could mention, yet we regret that so useful a manner of administering remedies,

as by suppositories, should have received so little attention ; all the suppositories of the former edition (nine in number) have been excluded. Five of the glycerites have also suffered the same fate, including the preparation of tannic acid. One great change we notice is that of giving the quantities by their relation to each other, instead of by weights and measures, thereby adopting the metric system where an opportunity offered,—a very useful one when well tried, and one that might be readily adopted in the now talked-of new revision of the British Pharmacopœia. Two new classes of preparations have been introduced—that of dry powdered extracts and triturations. The latter will be found very useful, and could be advantageously increased in number, but the compilers have provided for this by the introduction of a standard formula for all triturations—one grain of the active ingredient in each ten grains of the trituration.

The dry powdered extracts, or, as they are called by the compilers, “abstracts,” are eleven in number ; they are introduced to “supply a demand which has arisen for dry powdered extracts,” but whether they will prove of that advantage which is evidently expected is open to doubt. The process, similar in the first stages to that for the preparation of fluid extracts, is both expensive and laborious, and when complete, one grain of the result will only represent two grains of the crude drug, or two minims of the fluid extract. Among druggists there has long been felt a demand for officinal recognition of dry powdered extracts of known strength, extracts corresponding as nearly as possible to the pilular extracts of the pharmacopœia. Such extracts are now prepared in many large establishments for the sake of convenience in dispensing, such as Powd. Extract Aloes, Belladonna, &c.

Upwards of thirty fluid extracts have been added, showing the esteem in which this form of preparing drugs is held by the profession ; the strength of these are made of a definite standard, 100 grammes of the crude drug making 100 cubic centimetres of the fluid extract. Strange to say, elixirs, so popularly used and many so elegant in their preparation, and having their origin in the States, are, with one exception, entirely omitted.

Cotton-seed oil takes the place of olive oil in the liniments. Except in the case of Lin. Camphoræ, camphor being more readily soluble in that oil, the advantage of the change is doubtful.

The compilation of tables of "thermometric equivalents," "percentage and specific gravity," "saturation," and others, will be found very useful, and too much cannot be said in praise of them. We notice the omission of all processes for the manufacture of chemicals, the physical characteristics only being described, and tests for their identity and purity being given. This is in accordance with the general principles laid down on page 22 to be followed in revising the work, and on the next page is another of these rules that "all doses shall be omitted." Whether this be a wise rule or not is open to grave doubt. For our part we think that the compilers of the Pharmacopœia—the text-book of both medical men and druggists—should be the responsible persons to lay down the doses of each article. These articles have each passed in review before them; many of them do not appear in works likely to be in the hands of students, and to such the Pharmacopœia has always been the harbour of refuge.

On the whole, we may certainly say that the work is the best yet produced, and deserves at the hands of physicians and druggists an impartial trial.

Books and Pamphlets Received.

A MANUAL OF AUSCULTATION AND PERCUSSION, EMBRACING THE PHYSICAL DIAGNOSIS OF DISEASES OF THE LUNGS AND HEART, AND OF THORACIC ANEURISM. By Austin Flint, M.D. Third Edition; revised. Philadelphia: H. C. Lea's Son & Co. Montreal: Dawson Bros.

HANDBOOK OF MEDICAL ELECTRICITY. By A. M. Rosebrough, M.D., Toronto.

MANUAL OF GYNÆCOLOGY. By D. Berry Hart, M.D., F.R.C.P.S., and C. A. Barbour, M.A., B.L., M.B. Vol. II. New York: Wm. Wood & Co.

THE TEMPERANCE LESSON BOOK. A SERIES OF SHORT LESSONS ON ALCOHOL AND ITS ACTION ON THE BODY. By Benj. W. Richardson, A.M., M.D., LL.D., F.R.C.S., etc. Thirty-eighth Thousand. London: The National Temperance Publication Depot.

TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION. Vol. XXXIII. Philadelphia: Times Printing House.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 2nd, 1883.

T. G. RODDICK, M.D., 1ST VICE-PRESIDENT, IN THE CHAIR.

Dr. Trenholme exhibited a *fibro-cystic tumor of the uterus*. The patient, a well-formed, healthy girl, 39 years of age, has always had good health. About eight years ago she discovered a tumor in right side, which slowly increased for five years, when it took on rapid growth. It became smaller after each menstrual period till the last three years; since then has never diminished at all. At this time she noted that the tumor moved in one night from the right side to the middle of the body. The result of several careful examinations was that there were two tumors. The one on right side being lowest and most firm to the touch, and fluctuation not felt. The left, the larger, was felt to be moveable from the other and fluctuation was felt, but not distinctly. A well-marked sulcus existed between the growths; both were of even general contour. Per vaginam the os was found to be high up, and, so far as the finger and sound could indicate, showed the lower growth was uterine, and probably sprung from back part of the uterus. The sound could be introduced with much difficulty only $2\frac{1}{2}$ inches. The left tumor it was thought might be ovarian, and, if so, could perhaps be removed, and thus afford relief to the great sufferings of the patient, and which she said were at times dreadful to endure, and of late rendered her life so miserable that she willingly subjected herself to the operation, though she was more than well apprised of the risk she ran, and was told that she was as likely to die as to recover,—the probability of recovery (should the uterus require to be removed) being about equal. After preliminary attention to the state of bowels, etc., assisted by Drs. Hingston, Rebillard, Gardner, Armstrong, Young, Henderson and Wood, the operation was begun at noon on the 19th February, and lasted two hours fifteen minutes. The nature of the growths were now apparent, and the amputation of the stump was followed by considerable bleeding, and

some vessels secured with difficulty. Hemp ligatures were used internally, except one silver suture to close the os internum. The outer wound was secured by deep silver wire sutures, superficially by horse hair. The patient soon recovered consciousness, and though vomiting supervened she made a gallant fight for life, but died on the 5th day, in the evening, from exhaustion, due to uncontrollable vomiting. The temperature and pulse were little above the normal till toward the end of life.

The following morning, fifteen hours after death, Dr. Osler kindly made the *post mortem* examination. The following are his notes: Abdomen distended. Union at the lower and upper portions of the incision, and of the skin in the middle portion. Coils of intestines reddened and sticky, but no lymph over the membrane. There is no peritoneal effusion. Parietal layer is reddened from recent sub-peritoneal extravasation. Last part of ilium adheres slightly to the abdominal walls. On left side of the pelvis the ligated broad ligament is seen; its surface is rough and irregular, and not covered with any membrane. By the side of the rectum is a space containing dirty bloody fluid. The stump of the uterus adheres to the rectum. The walls of the pelvis are in good clear condition. Stomach, liver and kidneys healthy.

A committee consisting of Drs. Gardner, Osler and Armstrong, was appointed to examine the tumor and report to the Society.

Dr. George Ross spoke of the importance attached to investigation into the cause of death in cases of abdominal operations. He had recently had a conversation with Dr. Thomas in New York, and agreed with him in the opinion that patients may die from septicæmia without the signs of high temperature, chills, etc., from an overwhelming dose of poison being absorbed,—the symptoms in those cases being more like those of hemorrhage.

Leucocythemia.—Dr. G. Tillerie Ross reported the case. (See page 532.)

Dr. Geo. Ross spoke of the rarity of this disease in this city and

in America, as compared with other countries; he had only seen one case in the Hospital in ten years, but has seen others in private practice, whereas several cases of the rarer Hodgkins' disease had come under his care.

Dr. Osler said the late Dr. John Bell was the first to report a case in Canada. The points of special interest in the case just reported, were the enormously distended heart and venous system. As there were no adhesions it might have been a good case for removal of the spleen. A successful operation was recently performed in Italy.

Dr. Smith mentioned a case of leucocythemia under his care, which had been considerably relieved by treatment, in which iron and arsenic were employed, together with generous diet and inunctions of mercury.

Dr. George Ross said the remarkable temporary improvement seen in blood diseases could not be always attributed to treatment. Sometimes in pernicious anæmia, such an improvement may be noticed as to make one think that an error in diagnosis had been made till they relapse and terminate fatally. He had lately such a case in the Hospital. Under arsenic and iron, the patient got well enough to resume work, but returned to the Hospital and died. He has also noticed this temporary improvement in Hodgkins' disease.

Dr. Roddick exhibited a photograph of a child shewing *recurrence of lymphadenomatous glands* after removal by him.

Stated Meeting, March 16th, 1883.

T. G. RODDICK, M.D., VICE-PRESIDENT, IN THE CHAIR.

Dr. Osler exhibited the following pathological specimens:—

Membranous cast of Windpipe and Bronchi.—An unusually extensive cast of the air passages taken from a patient of Dr. Blackader's who died of diphtheria. Tracheotomy had been performed, but death took place from the gradual filling of the bronchi with the exudation. The glottis was completely occluded, and the membrane was so firm and consistent that it was removed entire from the rima to the tubes of the 3rd dimension, the tracheotomy orifice perforating it about $1\frac{1}{2}$ inches below the rima.

Chronic Bright's Disease.—The patient had been ill for six weeks with dropsy and other signs of chronic renal trouble. The fluid in the peritoneum and pleural sacs was milky, and a specimen of it was shown by Dr. Ross at a former meeting. The kidneys were large, pale and smooth; cortices swollen, and presented many opaque areas of fatty degeneration. Examination showed the interstitial tissue to be also somewhat increased, and many of the Malpighian bodies were atrophied.

Aneurism of Pulmonary Artery in small cavity.—Taken from patient with chronic phthisis, who had had profuse hæmoptysis, which had been checked, but death followed in 48 hours from exhaustion. In the upper part of the right lower lobe there was a small cavity filled with clots, and projecting from the wall was an aneurism the size of a large pea. This had ruptured, and was filled with pretty firm clots.

Dr. Osler called attention to the frequency of these small aneurisms, and to the fact that the fatal hæmoptysis in chronic phthisis is very often due to their rupture.

Acute Tuberculosis of Lung and Spleen.—A. M., aged 26, under care of Dr. Geo. Ross, admitted into hospital with symptoms suggestive of some low form of blood poisoning, with severe pain and tenderness in right side of abdomen. No physical signs of lung or heart trouble. A year before, had symptoms of chest trouble, apparently recovered from, with exception of loss of weight and night sweats. While in hospital he failed rapidly, with irregular temperatures. One week before death, physical signs began to develop over front of left chest, slight dullness, feeble breathing, and fine râles; this condition soon extended over the whole of both lungs, increasing rapidly in intensity. At autopsy, lungs crepitant, except at apices, where they are firm; both organs universally stuffed with miliary tubercles, largest in upper lobes, making small caseous nodules size of split peas. This condition most marked at apices, in which are seen small old cavities. Spleen three times normal size, presenting numerous miliary tubercles in its substance. Kidneys average size; through cortices are several small scattered tubercles. Under the microscope, in spots, a good deal of proliferation of

epithelium is seen in the tubes and around the Malpighian capsules. Liver normal. Brain not examined. Careful examination showed no sign of disease in right side of abdomen.

Lead Poisoning.—Dr. Girdwood read the reports of two cases occurring in the practice of Dr. Groves, Carp, Ont. The first was that of a widow, aged 34, who sent for the doctor November 30th, 1880. She was suffering from pain in abdomen; no tenderness on pressure. Appetite bad, much thirst, foetor of breath, tongue coated, constipation. Treated her for colic. Was seen again in three days. Pain worse. Now found blue line on gums. Diagnosed lead poisoning. After much trouble, the source was traced to the well, or rather the pump. Six months before, a large piece of lead had been placed on the valve to weight it down, and the water, being very pure, acted upon the lead and made a solution. Other members of the family had been slightly affected by it. All recovered completely after the cause was removed. The second case was a Mrs. C., aged 37, who sent for Dr. Groves. Oct. 19th, 1882. She complained of abdominal pains, also pains in the back and limbs; had been so affected for two weeks before sending for the doctor. Her tongue was heavily coated with a dark fur; blue line on gums; inside of cheeks bluish-black; countenance anxious; face pale, subicteroid. Abdomen slightly tympanitic; no pain on pressure. Pain in abdomen was paroxysmal and lancinating in character, and seemed to shoot into the back and down lower limbs. Complained of metallic taste, foetor of breath, and annoying eructations. No appetite; bowels constipated. Urine scanty and dark-colored. Extensors of forearms paralyzed. Wrist-drop more marked on right side. Was much emaciated; raising head off pillow caused nausea. Pulse 120; temperature 102°. Treatment: Gave first a brisk purgative, and left mixture of Potass. Iodid. v grs. three times a day, and Chlor. Anodyne to relieve pain. After examining the well, cooking utensils, etc., at last came across a jar of vinegar, which was examined, and found to contain a large percentage of lead acetate. On breaking the jar, a rounded elevation was seen on the inside of its bottom. This prominence was eaten into by the vinegar. The jar and

vinegar had been purchased on October 4, '82. After questioning, he found his patient had partaken largely of this vinegar. In connection with these cases, Dr. Girdwood said: Dr. Groves sent me, in December last, a sample of vinegar which he wished me to analyse for lead, stating that he had a case of lead poisoning. I examined the sample of vinegar, and found it to contain 2.01 per cent. of acetate of lead. He also sent me a piece of broken pottery, which he informed me was a portion of the bottom of the stone jar which had contained the vinegar. I found this jar had been glazed with litharge, or oxide of lead, and that it had been acted upon by the acetic acid and the whole surface eroded. In these two cases of lead poisoning there is considerable interest in the sources whence the lead was taken into the system, and these point to the necessity of being constantly alive and searching all possible and impossible causes or avenues by which poison may be introduced into the system. In the first case, the danger of storage of water, more especially water which is pure, in leaden cisterns or carried through leaden pipes is brought prominently out. Had the water contained any sulphate, an insoluble sulphate of lead would have been found, which would have been inert. In the second case, the necessity of greater care in guarding food of all kinds from contamination is shown. Had this sample of vinegar been adulterated, as it frequently is, by 3 per cent. of sulphuric acid, this case of poisoning would not have come to light, because the sulphuric acid would have formed an insoluble sulphate, which would have stayed further action. But from not having any sulphuric acid in it, the acetic acid gradually acted on the oxide of lead and dissolved it. Another point of interest is the fact of increased temperature and increase of pulse, symptoms which I fail to find recorded in authors who speak of the symptoms of poisoning by lead. They also exhibit the cumulative effect of the poison, the gradual introduction of the poison, at last producing the set of symptoms which lead to the diagnosis of lead as the poison. And the poison acting on the liver preventing the secretion of bile and all the train of symptoms indicating hypochondria, depression of spirits, fear of impending danger, being well marked, especially in the latter

case. And the gradual diminution of the symptoms after the cessation of the cause. These cases also determine, as far as they go, that the amount of lead sufficient to produce these symptoms is eliminated from the system in the course of two or three weeks. It is a pity that the urine in these cases was not examined, so as to ascertain the exact period at which it ceased to appear, and so have given a little more definite criterion of the time it takes to eliminate lead from the system. I scarcely see what steps can be taken legally to prevent a recurrence of these accidents; but it will be well to diffuse the knowledge that lead used for water storage, especially in a country where good soft water is common, is liable to be dangerous. And that it is customary to use lead in the glaze of common earthenware, and that such a practice is fraught with danger to the public.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Two Cases of Colotomy.—Although this operation is very frequently performed at the present time, it is not easy to obtain a description in the books which will serve the purpose of a useful guide to the surgeon who is about to undertake his first case of this kind. The best description in the English language is furnished by Allingham, so far as the writer is aware, and he is freely quoted by Bryant. A painstaking and accurate account is given by Koenig. Allingham's rules are: to make an incision beginning one and one half inches to the left of the first spine below the last rib, and running five inches obliquely downwards and forwards across the space between the last rib and the crest of the ilium. Some writers content themselves with saying that the middle of the incision should correspond with the highest point of the *crista ilii*. The length of the incision is occasionally given as three inches. This is about the length of that drawn in Bourgey's plates of Amusat's operation. Packard, in the American edition of Holmes, considers this length sufficient. It is his custom, he informs me, to begin the incision at the depression made by the edge of the quadratus lumborum muscles. Inasmuch as the bowel lies at

the edge of the muscle, this would bring the objective point near the beginning of the preliminary incision and not under the centre, as it should be. Moreover, some anatomists affirm that the depression supposed to be caused by the quadratus is really produced by other muscles. Allingham calls attention to the fact that it is sometimes quite difficult to find the bowel, and gives as a guide the direction to draw a line from the anterior to the posterior spinous processes, to extend a line vertically from a point one half inch behind the centre of this line, and it will be found to lie directly over the bowel. The bowel may be opened in the groin according to Littré's method, and modern surgery has deprived this operation of its principal danger, the opening of the peritonæum. Another method of getting at the colon, described by Fine, consists in making a vertical incision from the eleventh rib to the crest of the ilium through the abdominal walls and opening the colon within the peritonæum. The precautions sometimes given not to open the bowel in these operations until it has become glued to the lips of the incision seems hardly necessary.

The first case was that of a German girl, twenty-three years of age, who entered the Massachusetts General Hospital with symptoms of disease of the rectum of one year's standing. She was suffering great pain in defecation, and a digital examination showed the lower rectum to be almost completely obstructed by an indurated growth. The patient was etherized a few days later, and the constriction relieved by an incision which completely divided all tissues between the anus and coccyx, including the lining of the bowel and skin. Great relief followed, but in a week or two the symptoms of stricture returned, and it was found that the disease had already extended above the incision. Colotomy was performed on May 24th, Allingham's directions being carefully followed. The bowel was found without difficulty, was caught up by two loops of thread, and the incision stitched together around it. The colon was then opened, and after a very abundant faecal discharge had taken place was stitched to the edges of the opening left for that purpose. The operation was done with antiseptic precautions, as a slight

attack of erysipelas had followed the previous operation. Drainage tubes were inserted at each end of the incision, and a dressing of oakum folded in carbolized gauze was placed over the wound and changed as often as necessary. Except a slight erysipelatous blush lasting a few days recovery was uninterrupted, and the patient was discharged from the hospital June 24th, with the wound entirely healed. There was no inconvenience from leakage from the bowel, although occasionally a small amount of faecal matter escaped with the morbid discharges from the rectum. There were two natural movements from the bowel daily, and there was complete relief from the previous suffering. During the summer the patient reported herself at the hospital. The movements continued to be well-formed and regular. The disease continued to progress, and she died on January 1st, having been obliged to resort to opiates only a few days before death.

Colotomy was performed in the second case for congenital absence of the rectum. The child, a patient of Dr. W. A. Dunn, was born two days before, and all attempts to open the bowel through the anal orifice were unavailing. The so-called paradox of M. Huguier occurring to my mind, namely, that in infants the sigmoid flexure is in the *right* groin, I selected that position, found the distended bowel without difficulty, and evacuated a large amount of meconium, relieving the enormously distended abdomen. All symptoms were speedily relieved, the child nursed well, and the wound healed without any indications of unusual inflammation. A progressive emaciation soon set in, which continued in spite of the baby's ability to nurse well, and death occurred on the fourteenth day. Unfortunately, Dr. Dunn was unable to procure an autopsy and settle the point whether the ascending or descending colon had been opened. Taking into consideration the fact that it has been shown that the position of the sigmoid flexure described by Huguier is found in a comparatively small percentage of cases, and that when the ascending colon is opened marked emaciation occurs, as has been pointed out by some writers, it seems quite possible that the ascending colon was opened in this instance, although the

rapid and abundant discharge of fæces made it seem probable at the time of the operation that the opening had been made near the fundus of the cul-de-sac.

In looking up the literature of this subject after the operation, the proposition of McLeod struck me most favorably, and that is, to perform abdominal section when the rectum is wanting, free the end of the bowel from its connections, and, having emptied it, bring it down and stitch it to the anal opening. This is certainly a severe operation, but it seems to me preferable to all other alternatives. The treatment of cancer of the rectum deserves a word in connection with the case first reported. In this neighborhood it has been the custom to adopt chiefly an expectant method, the stricture, if marked, being relieved by the passage of bougies; in England colotomy is almost universal; in Germany extirpation is largely resorted to. A linear division of the stricture, which I have performed in a number of cases, brings only temporary relief. A radical operation can, of course, only be attempted with reasonable hope of success in the earlier stages of the disease, but it is important to recognize the fact that the terrible suffering peculiar to cancer in this locality can be greatly relieved by an opening in the bowel at some point above.—*Dr. J. Collins Warren in Boston Med. & Surg. Journal.*

Electricity v. Hangings.—A contemporary, in drawing attention to a proposal of Mr. Lane Fox in a recent issue of the *Zoophilist*, to employ a form of apparatus known to electricians as the micro-farad condenser for the destruction of worn-out horses and domestic animals, takes the opportunity of drawing attention to the barbarities attending the present use of the long drop in judicial executions: and also suggests that “far less contrivance and money than were expended on the Peltzer case would suffice to arrange a murder by electricity, which would in all respects resemble a death by the visitation of God,” by which we presume is meant a death from natural causes. Murder is so much a fine art, or at all events an application of science, in the present day, that this suggestion—perhaps not a novel one—might well have been spared, even in

the pages of a medical journal, where it is little likely, we hope, to catch the eyes of would-be murderers. We believe that should murder by electricity ever be practised, the resources of medicine and science will prove equal to the detection of the agent employed. The accidents that may be expected to result from the extension of electric lighting, will doubtless soon afford medical men the opportunities of becoming familiar with the appearances resulting from death from electricity. Mr. Lane Fox's proposal is a humane one, but we question whether it will meet with serious recognition. It is applicable to horses and pet animals only; and is inapplicable to animals the flesh of which is to be used for food. The plan is too complex, and involves, in killing a horse, the following elaborate preparations: the fitting of an iron plate into the stable-floor, and the connection of this with the negative pole of a condenser formed of alternate layers of tinfoil and tissue paper soaked in paraffin. The condenser is then to be charged from an ordinary coil to its full capacity, so as to be capable of producing a one-inch spark. The animal to be killed is to have its head, feet, and legs sponged with salt water, and is then to be placed on the iron plate, and touched on the head by a brass knob attached to an insulating handle, and connected with the positive pole of the condenser, when it at once falls dead. Death is asserted to be painless. Probably it is so; but of this we know, and can know, nothing. Our readers will perhaps be of opinion that by this method it would be more troublesome and costly to kill a worn-out cab-horse than to hang a criminal; not to speak of the operation being by no means devoid of danger to the operators. The feasibility and advisability of judicial executions being carried out by means of electricity is one, nevertheless, which is well worthy of consideration; and certainly, now that executions take place in private, and the criminal at the moment when the drop falls becomes immediately removed from the view of all but the executioner, there are additional reasons why the mode of carrying out the dread capital sentence of the law in Britain should be revised. Not to go back to earlier atrocities, the scenes at the execution of the man Taylor, at Wandsworth, and

of Myles Joice, at Galway, respectively, are reported to have been of the most revolting description. It would appear that the long drop (the length at present used is stated to be 9 feet) does not bring about instantaneous death; and causes, sometimes, perhaps, prolonged and unnecessary suffering. It is, then, well worth consideration whether the use of electricity, or the simpler mode of strangulation recently proposed by Dr. Hammond, of New York, should not be substituted for the present system. Dr. Hammond's method has the advantage over the electrical, that we have the personal voucher of a man of his high reputation that the sensations of the strangled man, up to the moment when unconsciousness supervenes, are rather pleasurable than painful. So long as execution is required by our law, it behoves the authorities to carry out the sentence in a manner as little revolting, and as painlessly, as is possible.—*Brit. Med. Journal.*

Kairine.—In the attempts to produce quinine, synthetically, now making in Germany, various new products which have been employed medicinally, have been brought forward. Although a true quinine has not thus far been accomplished, a near approximation to it has been made. Quinoline or chinoline is one of these. Recently, however, Dr. Fischer (*Berliner klin. Wochen.*, No. 45, 1882) has produced a phenol, to which he has applied the term *kairine* for short, although its true name is *oxy-quinoline—methyl-hydride* in chemical language. The salt which has been employed medicinally is the hydrochlorate. It has no irritant qualities, and in the normal state causes no obvious disturbance. All the members of the phenol group are antiseptic and antipyretic. The antipyretic stands in a nearly constant ratio to the antiseptic action. This fact is strongly suggestive, for if the power to destroy the organisms of disease or septic ferments, is the source of the antipyretic action, it is in a high degree probable that the febrile action is a consequence of the multiplication and growth of germs or ferments. The action of antiseptics lends support to the parasitic or zymotic theory of the infectious diseases.

Besides kairine, there have been introduced kairoline, and in

addition to resorcin, quinoline and pyrocatechin, all members of the phenol group, and all possessed of antiseptic and antipyretic effects. We are confident that the time is not distant, when that most valuable of all antiseptics and antipyretics—quinine—will be produced in the laboratory of the chemist.—*Med. News.*

Woman Attached to a Tumour.—A recent number of the *Medical Record* contains engravings from photographs of a woman who was afflicted with a tumour weighing eighty pounds. It was attached to the abdomen, and the picture shows the patient in a sitting posture, holding in her arms and on her knees a large bundle, which formed her undesirable appendage. After much entreaty from the poor woman that an operation for her relief might be tried, the surgeons of the Cincinnati Hospital finally consented; and Dr. N. P. Dandridge performed the hazardous work with great skill, being assisted by Dr. E. W. Walker and the hospital staff, in the presence of the medical class and a large number of neighboring physicians. But the shock to the patient was very profound, and her inherent strength not sufficient. She survived a week after the operation. This was a subcutaneous fatty tumor, one of the largest ever known. It was thirty-five inches long and sixty-seven and a half inches in greatest diameter—nearly as large as a barrel of flour.

Cure of Squint without Operation.—In the early stages of a convergent strabismus, before the internal rectus muscle is permanently contracted, Dr. Boucheron (*Schmidt's Jarbucher*, January 17, 1883) claims that a cure is possible without operation. He states that, as a convergence is caused by efforts of accommodation for near objects, if we take away the power of accommodation, squint will not occur. He maintains a constant mydriasis by the instillation of atropine night and morning. A cure is usually obtained in two or three weeks. If atropine is not well borne, other mydriatics, such as duboisia, may be used. In nine cases of intermittent strabismus the author obtained eight cures by this method.—*Medical Record.*

CANADA

Medical and Surgical Journal.

MONTREAL, MAY, 1883.

CHANGES IN MCGILL.

We have already announced that Prof. Wright has resigned the chair of *Materia Medica* in McGill College. It will be remembered that, during the past session, considerable friction was found to exist between the professor and his class. A settlement of grievances was finally arrived at after some trouble, and the students attended till the session closed. No doubt the resignation has been to some extent induced by the knowledge of the reigning discontent. It must be regretted that such circumstances should have arisen in connection with one who has been so long connected with the school, and who in the past has done such good service on many occasions in its cause. The vacancy created has been filled by the Faculty recommending the name of Dr. James Stewart, of Brucefield, Ont. This recommendation has been approved by the Board of Governors of the University, and only awaits the sanction of His Excellency the Governor-General. It is believed that the very best possible selection has been made. Dr. Stewart has for many years taken great interest in all matters pertaining to the subject of drugs and their actions, and has been a frequent contributor in this department to the Medical Societies and Journals of papers which have excited attention and shown marked ability. He is at the present time in Vienna, where he has been taking a special course upon practical experimental therapeutics. From our personal knowledge of Dr. Stewart we think his success as a teacher is assured, and that the Faculty is to be congratulated upon his acceptance of the office.

Still another of the older members of the Faculty of McGill

College has resigned, viz., Prof. MacCallum, who has so long and so successfully presided over the department of Obstetrics. An extended and important private practice had been making such calls upon both the doctor's time and energies, that he found it to be impossible to continue longer the rather laborious work of daily teaching. Dr. MacCallum has now taught midwifery with much success for the past 15 years, besides having the care of the University Lying-In-Hospital. The Faculty part with regret from an able and zealous colleague who has ever faithfully performed all duties entrusted to him by the University, and it is expected that he will be named Emeritus Professor. This chair will in future be divided into two parts, the one including Obstetrics and the diseases of infants, and the other Gynæcology. The former department will be undertaken by Dr. A. A. Browne, who has for some years acted as Dr. MacCallum's assistant for practical demonstration in the Lying-In Wards, and as Lecturer in the summer session. Dr. Browne is at present in Europe intending to devote himself to the special study of obstetrics in London and Vienna during several months.

Prof. Gardner, who has hitherto held the chairs of Medical Jurisprudence and Hygiene, has resigned these, and will become Professor of Gynæcology. He has recently renounced general practice and devotes himself entirely to the special treatment of women. He is well known to the readers of this Journal through his quarterly compilation of the recent writings on Gynæcology.

Dr. Geo. Wilkins, for several years professor of pathology in the medical department of Bishop's College, has accepted the chair of Medical Jurisprudence. He is recognized as an experienced lecturer, a good microscopist, and an energetic investigator. It is confidently anticipated that a thorough and interesting course will be given from this chair.

Dr. Richard MacDonnell, assistant Demonstrator of Anatomy, will, in addition to these duties, be made Lecturer on Hygiene.

CHANGES IN THE SCHOOLS.

KINGSTON.—Dr. Saunders, to take Clinical Surgery ; Dr. McCammon, Clinical Medicine ; Dr. W. H. Henderson, Histology and Curatorship of the Museum.

BISHOP'S COLLEGE, MONTREAL.—Dr. Wood, transferred from Chair of Chemistry to that of Pathology ; Dr. Armstrong, from Chair of Anatomy to that of Physiology. Dr. Young takes Chemistry. Dr. Trenholme, the original Professor of Midwifery and Diseases of Women, has joined the school again as Professor of Gynæcology. Dr. Foley, the Asst. Demonstrator of Anatomy, succeeds Dr. Armstrong. Dr. McConnell, the Lecturer on Botany, takes Materia Medica ; and Dr. H. L. Reddy has been appointed Professor of Therapeutics.

WESTERN UNIVERSITY, LONDON, ONT.—Dr. Wishart has been appointed Professor of Clinical Surgery ; Dr. McGuigan, Registrar ; W. Saunders, Esq., Treasurer ; Dr. Arnott, Representative in the Ontario Medical Council ; and Drs. Arnott, Waugh and W. Saunders, Executive Committee.

MEDICAL EXAMINATIONS.

The following completes the list of examinations in Canadian Universities and Examining Boards :—

QUEEN'S UNIVERSITY.—M.D.C.M.—W. G. Anglin, C. Clancy, J. Cryan, L. Davis, H. M. Freeland, D. C. Hinkey, J. F. Kidd, G. S. McWhie, A. McMurphy, T. A. Moore, T. A. Page, R. S. Smith, W. Young.

VICTORIA UNIVERSITY.—M.D.C.M.—J. M. Jackson, R. Hearn, A. D. Watson, H. S. Clerke, W. Cuthbertson, E. M. Hewish, J. S. Draper, S. S. Stewart, J. E. Case, W. Jaques, F. P. Drake, A. L. Brown, Augusta Stowe, C. S. Grafton, George Wyld, J. J. Wild, C. E. Cochrane, J. H. C. Willoughby, Wm. Kennedy.

TORONTO SCHOOL OF MEDICINE.—*Fourth Year*.—W. J. Robinson, (Scholarship) ; J. M. Jackson, (Honors).

Third Year.—R. Hearn, (Scholarship) ; J. W. Clerke, (Honors).

Second Year.—L. Carr, (Scholarship) ; H. Bascom, J. H. Hoyell, (Honors) ; J. G. Sutherland, G. A. Carveth, W. A. Goodell, J. S. Freebourne, J. R. Harvie, C. W. Hunt, A. C. Krick, and D. Ellis.

First Year.—D. R. Johnston, (Scholarship) ; 39 candidates passed the first year's examination.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—*Final for License*.—W. G. Anglin, F. D. Bates, R. W. Belt, W. D. M. Bell, J. Bray, M. K. Collyer,

H. B. Casgrain, H. S. Clerke, T. E. Case, W. H. Carleton, C. W. Chafee, J. Cryan, W. Cuthbertson, W. J. Derby, F. P. Drake, W. F. Dickson, W. J. H. Emory, W. F. Freeman, R. M. Fairchild, R. S. Frost, J. B. Gullen, C. M. Gordon, J. E. Hansler, R. Hearn, R. Hislop, D. C. Hickey, J. M. Jackson, W. Jaques, J. F. Kidd, F. Krauss, W. J. Lepper, T. D. Meikle, J. A. Meldrum, S. W. McConochie, A. McMurchy, E. B. O'Reilly, J. C. Rattray, W. A. Ross, T. H. Robinson, W. J. Robinson, E. A. Spilsbury, Augusta Stowe, F. H. Sowers, J. D. Wilson, J. B. Whitely, E. R. Woods, J. W. Ray.

Primary.—W. D. M. Bell, G. A. Bingham, J. A. Burgess, F. Beemer, Elizabeth Beatty, W. M. Brown, G. A. Carveth, J. A. Couch, J. D. Courtenay, F. A. Cane, G. A. Cherry, J. M. Cochran, H. S. Clerke, T. E. Case, C. W. Chafee, W. J. Derby, P. A. Dewar, J. S. Draper, H. Duff, J. E. Elliott, D. W. Everts, T. E. Eede, W. J. H. Emory, R. M. Fairchild, J. Fergusson, G. Fierheller, W. A. Goodall, W. J. Gunne, C. M. Gordon, H. H. Hawley, E. F. Hixon, A. R. Harvie, J. H. Howell, C. W. Hunt, J. Herald, A. R. Hauks, Fred. Harkin, E. A. Hall, W. S. Harrison, R. Hislop, D. C. Hickey, G. L. Johnston, D. O. R. Jones, F. H. Johnston, A. B. Kinsely, C. A. Krick, J. H. Knight, F. Krauss, H. D. Leitch, A. D. Lake, R. J. Lockhart, J. R. Logan, T. W. Murray, H. S. Martin, D. Minchin, Alice McGillivray, M. C. McGannon, T. Owens, J. O. Orr, J. J. Paul, J. R. Phillips, J. W. Patterson, G. F. Palmer, W. N. Robertson, R. F. Ruttan, J. C. Rattray, R. L. Stewart, S. Stewart, J. G. Sutherland, Elizabeth Smith, J. E. Sterling, C. Trow, H. E. Webster, A. B. Wilson, J. A. Watson, G. S. Wattam.

COLLEGE OF PHYSICIANS AND SURGEONS, P. Q.—*Final for License.*—H. A. Lafleur, E. H. Blackader, Wm. G. Stewart, A. W. Gardner, — Beique, Wm. Christie, Robert Kirkpatrick, Joseph Langlois, George C. Stephen, A. Couturier, Alex. Corvie, Theo. Mayrand, C. V. Poitras, Joseph F. Triganne, Adolphe Guy, Chas. J. Edgar, Jos. Edge, J. G. Lamarche, Paul Briere, L. J. A. Mignault, Joseph Cinq-Mars, Henri Marchand, J. B. Richard, Thos. C. Blondeau, C. A. Dugas, Geo. W. Lecombe, Damase J. Page, Edmond Bittner, Wilfred Joyal, L. Rochette, Honore Garceau, Alphonse Hudon, Elzear Lebreque, Charles V. Marsil, Joseph Michaud, Pierre Pelland, and Pantaleon Pelletier.

PHARMACEUTICAL ASSOCIATION, PROVINCE OF QUEBEC.—The examination for certificates was held on the 25th April, when the following gentlemen were successful:—

Major Examination.—Chas. E. Scarff, Alph. Davidson, Ed. Leonard, Alexis Robert, Ernest G. Swift, and Adhelm Dugal. One candidate failed.

Minor Examination.—A. E. Holden, L. Flanagan, Joseph H. Nault, R. A. Kerry, A. R. Reid, F. Baker, J. L. Beaudry, W. Purchard, M. B. Rice, and E. F. G. Daniel. The first two tied. Seven candidates failed.

The Board of Examiners is constituted as follows:—Alex. Manson (chairman), H. R. Gray, J. D. L. Ambrosse, H. F. Jackson, R. McLeod (Quebec), F. E. Gauvreau (Quebec), and Wm. Ahern, Secretary and Registrar.

—For the vacant positions of Resident Medical Officers in the Hospital, left by the retirement of Drs. MacDonald, Duncan and McLean, there are four candidates, all members of the graduating class of '83 (McGill),—Messrs. Gray, Hopkins, Gardner and Henry. The examination for the positions took place on Monday the 7th, and election will be held on the 17th, at the annual meeting of the Governors.

—Of 77 candidates at the preliminary examination of the College of Physicians and Surgeons for entrance to the study of medicine in the Province of Quebec, held on the 9th inst., 37 passed, 27 were rejected, and 13 rejected on certain subjects. During the past three years there has been a good deal of dissatisfaction in certain quarters at the large proportion of rejections at this examination, often much larger than on this occasion. We feel sure that it will do good, and in time the students will come up better prepared. We have been told by one of the examiners that the French students are most frequently *plucked* in French and the English students in English.

—We have received a copy of the report furnished to the Provincial Health Board, by Dr. Smellie of Prince Arthur's Landing, on the epidemic of small-pox on the Nepigon section of the C. P. R. The disease broke out early in January, and of twenty-five attacked—19 men on the Road and 6 persons in Prince Arthur's Landing—five died. A rigid quarantine was established and maintained until April 2nd, when the men in the infected camps were thoroughly washed, supplied with new outfits, and the camps burnt. Dr. Smellie took the disease early in the outbreak, and his assistant, Dr. McCammon, proved equal to the occasion.

—Mr. Barwell, the accomplished surgeon of Charing-Cross Hospital, has of late been strongly advocating the employment of white lead paint in the treatment of erysipelas, having had some half-dozen cases in which it was used with the most gratifying results. He does not lay claim to any originality in connection with this method of treating erysipelas, but simply revives an old remedy employed by Mr. French some twenty years ago.

The paint is applied by means of an ordinary brush, and seems to act simply by excluding the air. Mr. Barwell has not found it necessary to employ internal treatment of any kind. In some of the cases the urine was tested for lead, but the results were invariably negative.

Obituary.

JOHN A. STEVENSON.—The profession of London, Ont., has lost one of its most active members by the death of this gentleman on the 28th ult. He was the son of Judge Stevenson of Simcoe, Ont., entered McGill College in 1869, and graduated in 1873. He began practice in London with Dr. Fraser, and quickly won the confidence of the profession and the public. Last year, when the Medical Faculty of the Western University was organized, he took a very active part in the promotion of the new school, and was the Lecturer on Therapeutics and Secretary of the Faculty. He overtaxed his energies, and symptoms of pulmonary disease became manifest. Dr. Stevenson married a daughter of Vice-Chancellor Proudfoot of Toronto, and his wife and two children are left to mourn his loss. To them and to his brother, Dr. R. A. Stevenson of Strathroy, we extend our sincere sympathy. The class of '73 has lost one of its most popular members.

JOSEPH A. WHYTE.—Dr. Whyte was a native of Charleston, S.C. After having served on the Confederate side through the American war, he came to Canada and studied at McGill College, where he graduated in 1870. He subsequently, in Edinburgh, received the qualification of M.R.C.S. He practised first at Sherbrooke, and for the past five years in Montreal. He had for some time suffered from heart disease, of which he died in this city on the 25th April, at the early age of 40 years. His kindly disposition made him many friends, and his death will be heard of with regret by many of his old classmates.

ALEXANDER CHISHOLM.—We regret to have to record the death of this promising young physician, at Alexandria, Ont., on the 6th inst. He was a native of Lochiel, Ont., entered McGill

College in 1874, and graduated in 1878. After practicing a short time he went to Great Britain and took the diplomas of the Edinburgh Colleges, and on his return settled in Alexandria, where he rapidly acquired a large practice.

SURGEON-GENERAL BARNES—died at Washington on the 5th ult., aged 66. He was a graduate of the University of Pennsylvania, and entered the army in 1840. His name will ever be associated with three great undertakings—the Medical and Surgical History of the War of the Rebellion, the Army Medical Museum, and the Library of the Surgeon-General's Office.

B. H. LEPROHON—of Joliette, Q., died on the 24th ult. after a long and painful illness. He was an *alumnus* of the Victoria School, and for many years had been Sheriff of the county. He was a cousin of Dr. J. B. Leprohon of this city.

WILLIAM FARR—the celebrated statistician, and for many years author of the Registrar-General's Returns, died in London on April 10th, aged 76.

Personal.

Robt. C. McCorkill, M.D. (McGill, '82), has left for Edinburgh.

M. O'B. Ward, M.D. (McGill, '75), left for France on the 28th ult.

H. J. Harrison, M.D. (McGill, '83), left for Edinburgh on the 12th.

G. A. Dearden, M.D. (McGill, '83), has commenced practice in St. Paul, Neb.

F. S. Muckey, M.D. (McGill, '83), sails to Paris on the 27th to continue his studies.

Arch. McLeod, B.A., M.D. (McGill, '83), is attending the Polyclinic School, N. Y.

J. J. E. Maher, M.D. (McGill, '83), has opened an office at 455, 2nd Avenue, New York.

E. J. Laurin, M.D. (McGill, '81), has moved from Virginia City to Deer Lodge, Montana.

Thomas Gray, M.D. (McGill, '79), of Brigus, Newfoundland, has gone to Europe for an extended course of study.

Dr. Arthur A. Browne left on the 7th for Europe, where he will visit the chief Lying-in Hospitals and Obstetric Clinics.

In political circles it is rumored that Dr. Orton, of Fergus, will succeed the Hon. Mr. Pope, as Minister of Agriculture.

And. Stewart, M.D. (McGill, '83), left for London on May 1st to join the Canadian contingent at the London Hospital.

H. J. Burwash, M.D., (McGill, '79), Professor of Clinical Medicine in the Northwestern University, Minneapolis, has joined the Benedicts.

W. L. Gray, M.D. (McGill, '81), of Pembroke, Ont., left for Vienna on the 10th. He purposes spending a year abroad at the chief hospitals of Europe.

R. B. Struthers, M.D. (McGill, '83), has left for Liverpool, Eng., to join the Allan S. S. Co., having received the appointment of Surgeon to one of the ships.

W. T. Duncan, M.D. (McGill, '82), and T. N. McLean, M.D. (McGill, '82), for the past year resident medical officers in the Montreal General Hospital, have gone West.

John A. MacDonald, M.D. (McGill, '80), who has been one of the resident medical officers of the Hospital for the past three years, has begun practice in the city at 1 Belmont street.

Andrew Henderson, M.D. (McGill, '80), late House Surgeon of the Montreal General Hospital, left on the 18th April for Calgary, N.W.T., where he has taken up land and intends also to practice.

Mr. Lamirande, the collector for the C. P. & S. of Quebec Province, has moved his office to 63 St. Gabriel Street. This gentleman is a candidate for the Inspectorship of Anatomy in the Montreal District.

Dr. Bucke (McGill, '62), Supt. of the London (Ont.) Asylum, was in town for a few days last month, the guest of his old classmate, Dr. Trenholme. He has been instructed by the Ontario Government to examine Mann, the L'Original murderer, and give evidence as to his mental condition.

Medical Items.

—The Ontario Medical Association meets in Toronto on the 6th of June.

—The American Medical Association meets in Cleveland on the 5th, 6th and 7th of June.

—Virchow's *Archiv*, now in its 92nd volume, appears in improved paper and type.

—An old feud: The feeling between ague and quinine is exceedingly bitter.

—Cotton wool saturated with equal parts of chloral and carbolic acid, and allowed to dry, is a cure for toothache.

—A mill pond in Indiana is said to be good for three hundred cases of chills and fever a year, and furnishes two drug stores a pretty fair support.

—An old lady who lives in Massachusetts heard that Mr. John Bright was going to visit America. "Well," said she, "I hope he won't bring his disease with him."

—The attendance in the present summer session of McGill Medical Faculty is larger than in any previous year. With three exceptions, all the final students have returned.

—Talk of the days of blunderbuss prescriptions being over! The following is taken *verbatim* from a prescription recently dispensed by a Lower Province druggist from one of the most eminent local practitioners :--

R Pot. Bromide, Pot. Chlor., Pot. Iodid., Pot. Acetas, Pot. Bi-Carb., Ammonia Chl., Ammonia Bromide, Ext. Calombo, Ext. Gentian, Ext. Taraxaci, Ferri Pyrophosphas, āā ʒij; Syrup Ferri Iodide, Tinct. Valerianas Amm., Dil. Phosphoric Acid, āā fl. oz. j; Pepsine, gr. xxx; Tinct. Cannabis Indica, Tinct. Digitalis, āā fl. oz. ss; Syrup Calcii Lacto Phosphas, Glycerine, Syrup Tolu., Tinct. Cinchona co., āā fl. oz. ij; Liq. Arsenicalis, fl. dr. ss; Tinct. Arnica, fl. dr. ss; Ext. Nux Vomica, gr. x; Ext. Conii, Ext. Belladonna, Ext. Hyoseyami, gr. vi; Chloro-

formi, gtt. x ; Quinine, ʒj ; Alcoholis, q.s., fl.oz. xvi. M. Sig. Shake and take two teaspoonsfuls after each meal three times a day in a glass of milk.

SIR T. SPENCER WELLS.—The great honor of a baronetcy has been conferred upon Mr. Spencer Wells. This announcement will be received with the greatest approval by the profession throughout the world. The profession and the public are under an enormous debt to Sir Spencer Wells for his life-long labors in their interest, and this mark of honor from his Sovereign does something to repay it.

AMERICAN LINT.—We have received a sample of surgeon's lint from Messrs. Seabury and Johnson. We understand that they have just established the first lint-works on this continent. The specimen before us is particularly good. Compared with the ordinary commercial article, its superiority is easily observed. It is beautifully white, very soft and fluffy, and tears readily in any direction. Druggists would do well to bring this manufacture under the notice of their customers.

FEHLING'S TEST TABLETS.—A specimen of these articles has been furnished us by Mr. H. R. Gray, chemist. They are from the manufactory of John Wyeth & Bro., and form the most convenient possible sugar-test one can have. Each tablet is to be dissolved in a given quantity of water, which then gives the officinal (U.S.P.) solution of Potassio-cupric Tartrate. They are said to be very reliable, and to keep well.

ICDOFORM AND THE DIAPYCNOSIS OF LEUCOCYTES.—Binz (Virchow's Archiv) reports a series of experiments which go to show that iodoform has a similar effect with quinine, carbolic acid and eucalyptol, in checking the diapycnosis of white blood corpuscles. He holds to the opinion that diapycnosis is due to a vital property of the leucocyte and not, as Cohnheim and Hering maintain, to an alteration in the wall of the vessel. He is inclined to think that it fastens itself to the vascular wall, which it digests at the point of attachment and thus makes for itself a passage. This digestion properly is due to the peptone

which is found in pus corpuscles and to the presence of which the liquefaction of pus is due. Iodoform destroys the action of this peptone, and thus prevents diapidesis, by the liberation of iodine. Its action in this regard is identical with that of iodides of potassium and sodium, the former of which is, because of this property, regarded in Germany as a successful agent in the treatment of croupous pneumonia. By thus preventing diapidesis of leucocytes it prevents the formation of pus, the corpuscles of which have their origin in the white blood-corpuscles which find their way through the parietes of the blood vessels.

REMONSTRANCE OF AN ASYLUM SUPERINTENDENT.

On the suggestion of a doctor that those who associate with the insane transmit the disorder to their offspring.

Dear Doctor, I beg you—I pray you—don't tell us
That you really believe in an insane bacillus!
That in mingling with patients we're breathing an air
Full of germs of mad phrenzy and hopeless despair;
That, although our own minds may seem perfectly sane,
Parasitical growths will forever remain
In our system, infecting the blood and the brain;
So that if, by good luck, we ourselves don't go mad,
The child will inherit the germ of its dad!

Already, in truth, are our troubles enough,
Without being told this nonsensical stuff;
In peril from blows, in peril from flurry,
In peril from fire, in peril from worry,
In peril from Lunacy Board and Committee;
Are these not sufficient, dear sir, in all pity?
Forbear then to talk, I beseech you, until I
Have time to examine these wretched bacilli.
But if you insist on such growths diabolic,
Please send me a box of mental carbolic.

Y.

—The value of the CHEMICALLY PURE hypophosphites in the treatment of consumption and similar diseases has of late years been very generally recognized. Dr. McArthur of Lynn, Mass., has prepared a chemically pure syrup containing these salts, which has been used with great success, and has received the endorsement of many prominent physicians. Full particulars furnished—to *physicians only*—on application.—*Boston Journal of Chemistry.*