

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

THE
MONTREAL MEDICAL JOURNAL.

VOL. XXII.

DECEMBER, 1893.

No. 6.

Original Communications.

THE GENERAL PRACTITIONER AND THE INSANE.*

J. V. ANGLIN, B.A., M.D., Asst. Supt. Protestant Hospital for Insane,
Montreal.

Mr. President and Gentlemen,—In this imperfect paper there is no pretension of attempting to bring before you anything new in connection with that branch of medicine in which I am engaged. Doubtless there have been introduced in recent years innovations for the amelioration of the insane that might be reviewed with profit. But the physician who can find leisure from the whirl of practice to learn of these things, has opportunity to do so in the ever-increasing literature that deals with alienistic themes.

My desire is to remind the general practitioner of some jottings touching his relations to the insane; to dust the corner of his memory where lie the psychiatric teachings of younger days, if he had such, for it is only within later dates that colleges have recognized the value in lectures on mental diseases.

As it is now the custom to relegate the sick in mind to institutions set apart for their cure and care, too often the doctor in general practice deems it unnecessary to trouble his mind with the mind's troubles. His lot is thus easier than his brother's, who gives his life to the insane work. For the mentally sick are liable to all the ills of the flesh as well, to which the asylum

* Read before the Canadian Medical Association, September 20th, 1893.

physician must attend. He cannot, therefore, neglect his surgery, for among his patients traumatism is common; parietic bones are fragile; there is a share of major operations. Indeed, the greatest triumphs of the art are in brain surgery. With medicine he encourages intimacy, for often diagnosis is obscure from inability to glean other than objective symptoms. His patient may be oblivious of pain or dumb to all enquiries. Sometimes, too, he must welcome the little stranger to a sad world, for not rarely the strain of pregnancy unhinges the mind.

Seemingly little as the general practitioner has to do with the insane, yet there is no one on whom falls weightier responsibility regarding them. With him rest questions whose decision may make or mar the life of the mentally afflicted. On him depend the diagnosis of a person's insanity, the advisement or administration of the adapted treatment, the certification of the mental condition in legal form if hospital surveillance is determined on. All of which considerations are of vital import, not only to the patient, but often to a circle of relatives, and, indeed, if carelessly undertaken, may rebound injuriously on the practitioner himself.

On these points we will enlarge, believing that they will interest you more than any recital of the advances in hospital methods, pleasurable as that might be. The diagnosis of insanity which may stagger the expert, and yet which in this country commonly lies with the general practitioner—of this we will give some hints further on, in discussing medical certificates.

Once convinced of a person's lunacy, the question a physician must poise in mental scales is, shall he advise *home* or *hospital* treatment? and he must decide quickly. If hospital care is essential, every day's delay lessens chances of recovery. Alienistic observers agree that insanity is more curable the earlier it comes under treatment. It is well to remember, however, that the doctor should only advise, advise as urgently as necessary, but let the friends assume all the responsibility of whatever course is followed. Indeed, in some cases, it is prudent to have writing to that effect. Now that insane hospitals are efficient to a satisfactory degree, in most cases it will be wise to

suggest transference to one of these. Nevertheless, there may arise cases so manageable that the medical man may have confidence in his ability to treat them himself, and results may justify this course. There may be those that for some good reason cannot be removed at once. There will be cases where friends will prove obstinate to conscientious counsel. Then the physician must endeavour to extemporize equipments essential to the hospital in the home, or, better, in some rural resort, for nearly always change of environment is advisable. But this can be properly done only for the few. The plan will be beyond the many. In any case but the mildest, two experienced attendants will be necessary, and other expenses will be heavy. Above all, the relatives take on themselves a responsibility often involving human life, that hospitals are more able to assume. Moreover, it will be difficult to restrict the liberty of the sufferer, who is not sick in his own eyes. In short, the treatment of patients at home is utopian. We believe the cases are few that will not have more hope of betterment in a hospital. This means no reflection on extra-mural skill, but the management of insanity is such that it cannot be well imitated in general practice. We are not blind to the fact that objections to hospitals hover round the stigma that families imagine will cling to the name if one of their number has been within asylum walls. This, alas! is our inheritance from the dark days when people had reason to look on these as lunatic prisons. But such times are only history, and it is our duty to help break down present prejudices. The asylum is now as free from objectionable features as the general hospital. There has been a revolution in treatment within the lifetime of many of you. The odium is lifting, and the hospital idea in the waning years of this progressive century is predominant. Even the ancient term, asylum, with its suggestions of custody, is in many places only a memory. Insanity is unveiled in its true character—a disease, and not a crime. Improvements have been going on, till to-day curative establishments are prepared to cater to the preference of wealth; institutions for the public are on every hand holding out remedial care, with every com-

fort that the appreciative can desire. The nurses selected are trained thoroughly, so that the attendant, as one puts it, is no longer a keeper, but the companion of the insane. Intelligence and tact have deposed brute force. Many an asylum corridor is as free of lock and bar as was the patient's home. The surroundings breed contentment. Occupation and amusement are made a constant study; for entertainment is found in our day as diverting as in the first authentic lunacy of history, when the melancholy monarch was "refreshed" by the strains of David's harp. It becomes medical men to keep informed in the strides asylum management is making. Knowing the merits of the modern institution, and that it is a potent instrumentality for good, we can recommend it as a desirable retreat for patients.

A physician will not be long in practice, however, without meeting some insane one whom he will have to attend temporarily or throughout his illness. A grasp of the principles of treatment for mental ailments may then be of service. While each case must be treated individually, there is much common ground. Change of scene and companionship is almost always advisable for your patient; perhaps a quiet journey or ocean trip. A nurse or two, qualified for the work, is indispensable. Relatives, often the best attendants in bodily suffering, make the poorest for the mental invalid, who is sure to do as he pleases with them. Often he dislikes most those whom in health he loved. How often we see a patient as docile as a lamb from the day he crosses the hospital threshold, who has been infuriate in his home. Ordinary sick nurses are little better than the sympathetic relation. They are prone to be awed by the wild fury of the maniac, or shocked by unlicensed language, much to the delight and encouragement of the lunatic.

With many of the insane, *sleeplessness* precedes or is concomitant with other manifestations. This insomniac condition brooks no delay, especially if the case is in its incipiency. The natural brain restorative is sleep. To produce it there is no catholicon. The ideal sedative is yet to be found. But some have merit. First and above all must we try to invite repose

by measures intrinsically harmless, as open air exercise pushed to pleasant muscular fatigue. A few hours' labour, or a drive for weaker ones, will often calm the brain storm and secure restoring slumber. A full meal will induce sleep in some, as we know from analogy. Then there is the hot bath (104°), which is surprisingly efficacious. These simple means will fail sometimes, and drugs be indicated, but we must beware that nature does not come to depend on them. Let us glance at a few that the alienist has proved useful. Alcohol is helpful where stimulation is needed as well as sleep. In small doses it will dissipate the wakefulness of anxiety. In larger quantity it will rarely fail in any case. Hyoscine has displaced its fellow, hyoscyamine, than which it is more uniform and certain. Hyoscine is indicated where there is motor excitement, and has been abused as the agent of chemical restraint. By its aid violence is calmed and loquacity ceases. It has advantages: its dose is small and tasteless, its action prompt, tolerance is slowly established, and no habit formed, as no pleasurable sensations ensue. Paraldehyde is preferred by some. It produces natural sleep, does not irritate the stomach; no headache follows its use. The unpleasant taste and odour to the breath are its drawbacks, and we find some have a repugnance for it. Sulfonal is successful often, and ordinarily safe. Its effects are lasting, though slow, but may be hastened if given in gruel or milk or water as hot as can be borne. An increased dose is not needed, the second acting better than the first. Our old friend chloral and the new chloralamide and trional have their advocates also. None of these will avail if the sleeplessness is caused by bodily pain. Then, and then only, is opium called for. I emphasize this because this drug is over-used. With some it is routine practice to prescribe it. It is useless and harmful in insanity, as it impairs digestion and bodily health, and thus combats the effects we most desire. The remedies mentioned are the popular sedatives, but their use must be deferred till other means prove futile. There is a temptation to over-drug the lunatic. It has happened that the ill effects of indiscreet medication have had to be eliminated before improve-

ment began. The people have great faith in their virtues. A question sure to be asked about an insane friend is: Does he take his medicine regularly? Neither will you have many cases before some sensitive relative will suggest: Can't you give him something so he won't know we're taking him to an asylum?

As with mental aberration there is usually found bodily debility, either as cause or result, consequently we run the gamut of the standard tonics, and find it the rule that mental improvement keeps pace with the physical. Cowper has said, and he ought to know,

"The frenzy of the brain may be redressed
By medicine well applied."

But there are other agencies to heal a mind diseased which the modern alienist places in the van of all the resources of the pharmacopœia. Such are the practice of hygienic teachings; the culture, employment and amusement of the patient; the application of mental therapeutics; in short, all things that tend to lift the patient out of his self-absorption and develop altruistic feelings. To describe them is to detail all that is embraced in the comprehensive term "Asylum Management," which is not possible. They will be rarely expedient outside.

Lastly, the nourishment of the patient must not have least consideration. Improvement often dates from the ingestion of a good meal. Many eat too little or not at all, and must be fed by the stomach tube. This forcible feeding should not be postponed. There is no special rule as to diet. Eggs and milk in abundance should form the basis. It must be borne in mind that maniacs will assimilate many times the amount of food needed in health. Whatever treatment is pursued, everything centres about an effort to build up the patient.

Finally, we come to the delicate duties that devolve on the profession in committing the insane to hospital. The hand of justice sets safeguards about the citizen's liberty, and forbids his being put under restraint without legal proceedings. It may seem waste time to say this, but some act as if ignorant of it, for insane have presented themselves at asylum doors with

only an informal line from an intrepid physician beseeching their admission. It is felony to detain any person without definite legal conditions. These may seem exacting, but the superintendent does not coin them, neither can he alter the laws of the land. Doubtless, over-stringent lunacy laws have delayed the restoration of many a curable case. Take Illinois, for example, where every suspect is dragged before a jury, no matter how ill, and made the butt of the court idlers. What is the consequence? The sensitive hesitate to seek the commitment of early cases of insanity, and have family troubles exposed. Nothing is gained, for sane people have been deprived of liberty under the system. Too many legislators would thus submit the sick in mind to the same ignominy as criminals.

In Canada, we are progressing towards the ideal we hope for, that holds liberty sacred, but still admits the insane to treatment without injurious delay. We are many steps from it yet, however, at least in Quebec. The only cases where we think strict formalities should be dispensed with are those where persons come of their own accord for admission, as they do sometimes to most superintendents. Such are usually genuine patients, seeking relief from symptoms recognized by themselves, the forerunners, perhaps, of serious mental disease. These should be allowed to enter as freely as to a general hospital. However, our duty is in the present, when it is obligatory that patients be admitted in a set way. Certain formal documents, correctly prepared, are requisite. Those who see many of these observe occasional errors, for which the fallibility of human nature is answerable. Some of the points commonly neglected will be noticed, in the hope that benefit may accrue to some case of "moping melancholy" or "moonstruck madness."

In our different provinces, the blank forms vary somewhat, but the essential features in all are based on the English statutes. Whatever else be wanting, a medical certificate is always required, and with it some history of the patient. When the friends of an insane person accept a physician's advice to adopt hospital treatment, the admission blanks should at once be pro-

cured from the proper authorities, usually an asylum superintendent. In making application therefor, such particulars of the case should be sent as the patient's name, sex, age and duration of disease. Acute attacks will be favoured, if there is any choice. When the blank forms are received, the doctor who wishes the best for his patient will exercise his medico-legal knowledge in supervising the preparation of all of them, that delay through mistakes may be avoided. Till the papers are correct, the patient will not be admitted. The various blanks are, as a rule, self-explanatory, and require only reasonable care as to details in filling them up. As to the medical certificate, practitioners often forget that the printed portion is fixed by law, and requires as particular attention as any. In this formal part, both the examiner and the patient must be designated precisely, and the date correctly inserted. These slight requirements are important to the identification of person and place. The lawyers set great store by them. It renders the document defective if there is any doubt as to who is spoken of. If ever you have to defend your certificate, nothing will create a more favorable impression for you than absence of negligence in attention to details.

In the body of the certificate must be written grounds on which the person is judged insane and suitable for confinement, and here there is a painful laxness in many cases. To fill this part will necessitate your examining the patient, for the basis of proof must be gathered from personal observation of his present condition. Knowledge of the past, and opinions of others, though valuable, can only be introduced secondarily. Hence is invalid this certificate, which I have seen, whose baldness is relieved only by, "Have seen him in previous attacks," or this example, "I am inclined to think he should be confined in a lunatic asylum, by the report which is given me by the members of his family." What a walk-over the prosecuting lawyer would have if these cases came to Court!

The prudent man will learn all he can of his patient's past and present character before interviewing him, but the opinions of interested parties must not bias his mind nor hurry a per-

sonal examination. There is the possibility of sinister motives. Make sure the patient is sober and uninfluenced by any "insane root that takes the reason prisoner." Not only should the doctor act in good faith, but he should ascertain why the relatives want the patient removed; still, that a man is dangerous is not the sole reason for seeking the restraint of a hospital. Modern English law regards necessary care and treatment sufficient ground for detention.

To gain access to an insane person is not always easy, and there may be actual danger in the attempt. It is the relatives' place, however, to protect the medical man, and if they will not try to do it, he is not called on to run any unusual risks. It is generally best to confront your patient undisguised. It is not necessary to volunteer information as to why you have come, but it is a mistake to deny you are a doctor. Deception may gain a point, but it will militate ultimately against his cure, and breed lack of confidence in those who have to deal with him in the future. Some patients' derangement will be evident at a glance, but it will sometimes require much tact to disclose the minds of others. Many lunatics have the cunning to conceal their foibles, especially if they suspect your object. Experienced men have withdrawn from more than one inquiry without detecting delusions that had existence. Someone has thrown out the hint that a man is likely to betray his lunacy if a question is thrust at him about his relations, and how they treat him. If others have suspicions of insanity in any case, the medical man should be slow to conclude that these are ill-founded. Much may hang on his decision. A renowned doctor said of an accused man that he saw no more insanity in him than in many people that walk the streets. Shortly after, the lunatic in question, without the shadow of provocation, murdered one of the foremost asylum superintendents Canada has known.

One is not expected to make a diagnosis of the form of insanity, but to set forth only such facts as will carry conviction to whoever may read them that the case is suited for confinement. The physician did not think of this who wrote, "He

is suffering from some mental derangement, which at the present time I can't easily diagnose." Modest, indeed, but very weak for a certificate.

To obtain facts on which to base an opinion, one should proceed in a methodical manner. Eye and ear should both be alert. The proof may have to be founded on a number of trivial discrepancies, any one of which would not justify a conclusion, but collectively might form weighty evidence. That practitioner is not blameless who delays making out a certificate till he finds proof of mental unsoundness in some outrageous act. In most cases he will look in vain for an exhibition of that "demoniac frenzy" which the populace attribute to every madman. The lunatic may superficially resemble his fellow-mortals, as did Shylock's Jew the Christian.

Without particularizing, one should observe carefully three things—the patient's appearance, his acts and his conversation. Mind can only be known as portrayed in conduct. Be not satisfied with one symptom; it is a weak certificate that hangs on a single statement. But such are commonly seen. Delusions and hallucinations should be sought for in all cases. They are not necessary to insanity, but if any are found, note them down as lucidly as possible, for nothing carries more weight with the legal fraternity. We must not snatch at statements haphazard, and call them delusions. Probable things may be delusions, and highly improbable things may not be. Thus, the certificate, "He says he is poor, he is financially ruined," was valueless in the case it referred to, because it was true the man's business had failed. But perhaps it was a modern failure.

It is always well to add, after stating a delusion, some such words as, "which is contrary to fact," or, "which I know to be false." This will not be necessary, of course, when a man says he is the devil; but when he is certified insane because he declares himself a poet, this needs qualification, for all poets are not insane, though genius and insanity may be allied. Perhaps this is not a fair example, for doctors may differ in their estimation of a poet; but supposing a man declares him-

self wealthy, when he is known not to be, this should be stated to be a delusion, for not a few men are rich. Hallucinations of hearing should be mentioned, if they exist, as a warning to others, for often the "voices" incite to crime. Any facts, indeed, that may serve as a guide to treatment should be detailed. Incoherence in speech is frequently noted, but it is a relative symptom, and would denote greater aberration in a scholarly man than in the uneducated. We must always remember that what points to mental disease in one may not in another; thus, the use of "perverted theological expressions" and obscene language might not arouse suspicion coming from the mouth of a heroine of the slums, but would suggest doubts of the sanity of a refined woman who indulges in them. Loss of memory is also a symptom that means more in youth than age, when the faculties naturally decline. If, after all efforts, the patient cannot be made to express himself, his taciturnity is not valueless. As a last resort, we may tell the man why he is undergoing examination. If he still maintains obstinate silence, this negative evidence is almost proof positive of insanity.

Having acquired all the information possible from the examination on which to ground an opinion, one may then cite any derived from previous acquaintance with the patient. Next may be inserted, in corroboration, facts ascertained from others, and it is always well to name your informant. Whatever you write down, assert only facts which you have elicited by searching enquiry. While conspiracies to incarcerate the sane are almost matters of history, yet the day may come when you will have to defend your statements, and this should engender caution. The most obvious case may prove the most troublesome. The long-headed practitioner will copy his certificate, and retain some fuller notes. These, to be of service, must be made at the period of examination. A certificate will be strengthened in proportion to the care shown in its construction. The facts should be written clearly, tersely and without comment. Make use of the patient's very words, if pertinent. Poor composition suggests negligence. Irrelevant sentences only weaken. Thus, the proof of a woman's insanity in a certain certificate grounded

on, "1st. Frequent births, 2nd. Close confinement to children," is not to the point; in short, is simply absurd as it stands. Statements that prove sanity ought to be omitted. Yet, frequently we see such phrases as, "He has no delusions," "He is not dangerous," "Talks quickly, but sanely," "Otherwise her mind is clear." Some facts are ridiculous, and to be avoided, *e.g.*, where a man is adjudged insane because of his "repeating poetry now and again," or "praying and singing hymns frequently." On such grounds the whole Salvation Army might be "run in." Perhaps the climax was reached in the certificate wherein the only fact alleged to prove unsound mind was, "He tells lies." Needless to say, this was not accepted as substantial ground.

The most common failing in medical certificates is setting down deductions without enumerating any facts on which they are based. These fall far short of the law's demands. For example, "Saw her at her home, and ascertained that she is insane," "Generally irrational in all her actions," "Perverted deportment and conversation." If the deportment had been described, and some conversation given, this skeleton would not be so apt to give the certifier trouble.

The form of history which accompanies the certificate should always have the supervision of the medical examiner, whether he signs it or not. While much of the information must be got from the relatives, still there are answers that should be moulded by a physician to be relevant. It may mean much in the treatment and prognosis of the case if the questions be conscientiously answered, to say nothing of their value as statistics. If more thoroughness were employed, there would be fewer "don't know's" and "can't say's" than now decorate this form, which often remains a blank, despite the use of ink. While all the questions are valuable, some of them are quite so, especially such as relate to when and how the disease manifested itself, and the number and nature of former attacks, if any. A correct reply to the query regarding suicide or homicide may save life. Yet, I have seen the doctor's certificate declare suicidal tendencies, and the question in the history of the same case as

to self-destruction answered with the much abused, but easily written, "No." Some description of the man as he was, in response to information sought as to habits of life, may bring out knowledge of inestimable worth, especially if it be shown there is now a departure from the normal in such matters as his affections, appetites, religion, temper and tastes.

Then there is the point as to heredity, about which such lies are told as must make the father of them hilarious. The friends cannot be trusted on this score. The doctor should quietly enquire from other sources as well, concerning the taint in the blood, and not only note insanity in the family, but also eccentricity, nervousness, and consanguinity in parents. Then, if you want the truth, as Clouston says, multiply what you get by two. It is well, also, to delve deeply to get at the cause of the trouble. The patient's friends seem to be rarely cognizant of it, for there is nothing about which the asylum physician is oftener asked by them, and he is the last one to come to, not having known the patient's life till he has crossed the hospital threshold. It may not be far to seek, however, if any hereditary blight exist, for very little will unbalance the predisposed. Do not snatch at effect for cause, as is too often done, to the injury of character. Masturbation and intemperate indulgence are more frequently the consequence of a diseased brain than physicians state.

One word more, and I have done. The general practitioner can do an incalculable amount of good for the cause of the insane if he gives proper counsel as to how the patient should be removed from home. I can't put it better than is done by Dr. Burgess in the advice he gives to those who seek admission for some friend to the hospital at Verdun:—

"In bringing a patient to the hospital, use force if necessary, but never deception, as it lessens the chances of cure by making him look upon the institution with dislike, and those in charge of it as alone responsible for his being kept there. Tell the patient frankly that physician and friends consider him *sick*, and that it is proposed to take him to a *hospital*, where his chances of being cured are of the best, and whence he will be taken out again as soon as well."

In these desultory sentences there have doubtless been pronounced numerous platitudes. The apology therefor is that the purport of this paper was to recall such fundamental teachings as each one of us should have imbibed from our Alma Mater before we were weaned, and which are so often forgotten, to the detriment of the insane.

It were more fitting, perhaps, in this jubilee year of the inauguration of asylums in Canada, that this Association should have been occupied with a retrospect of the semi-centennial period, a subject, however, within the province of the Nestor of the Dominion alienists, the oldest of McGill's living graduates, who still enjoys life in that city where he wrought so many reforms, whose benefits we are reaping.

Suffice it for me if from this reading there has dropped a hint that will revive any enthusiasm in those whose care has been styled the most noble branch of medicine. Suffice it if one word has been spoken that will lead to the better treatment and earlier restoration of some mind afflicted with the most distressing of ailments ere it must be said—

" It is too late : the life of all his blood
Is touched corruptibly, and his pure brain
Doth, by the idle comments that it makes,
Foretell the ending of mortality."

THE OKANAGAN VALLEY, B. C., AS A HEALTH RESORT.*

BY D. L. BECKINGSALE, M.D., VERNON, OKANAGAN.

The value of the Okanagan Valley as a health resort is scarcely known to the Canadian public, or even to the profession outside of British Columbia. This is no doubt to be in part attributable to its being isolated until within the last fifteen months from communication by railway with the outside world, when a branch line forming a junction with the main line of the C. P. R. at Siccamous was opened, the immediate result of which was the building of an excellent hotel at Vernon to accommodate the tourist and sport-seeking public; the climate, scenery, shooting of all kinds and fishing being undoubtedly the best in the Province. The elevation of the

* Read before the Canadian Medical Association, September, 1893.

Okanagon Valley, 1,250 feet, is sufficient to secure a dry, exhilarating climate, and although the mountains are very much in evidence, still the width of the valley is considerable, which prevents any feeling of being shut in from the world oppressing the resident or visitor. Canada's Governor, Lord Aberdeen, showed his appreciation of its many attractions by buying two extensive ranches in it some 35 miles apart from each other; as a tribute to the favourable climatic conditions he has planted a large acreage with the choicer kinds of fruit and hops.

A special feature of the district is the number and beauty of the lakes; Mara, Swan, Okanagan and Long Lakes have each their special attraction. The Okanagan is traversed daily by steamers, of which the Aberdeen is equal to any in eastern waters for convenience and comfort.

A peculiarity of the valley is the varying rainfall and average temperature within a short distance; thus proceeding from north to south the rainfall is considerably heavier and the seasons later at Enderly than at Vernon, 26 miles south, and at Vernon than at Mission, 36 miles south of Vernon, and the Mission climate again is drier and later than is the country to the south of it. The difference in the rainfall and seasons is not to be accounted for by the slight difference in latitude and altitude, but to local conditions, determined chiefly by the configuration of the land. The same conditions are found in the lateral valleys running east and west from the main valley. The advantages of these varying climates within easy reach is sufficiently obvious. The Okanagan Valley is almost entirely free from the winds and dust which prevail, more or less, in other parts of the upper country of British Columbia, thus rendering life more pleasant alike to the resident and the health seeker.

Meteorological observations have only been taken since the beginning of the year, which has been characterized by an exceptionally severe winter all over the Province. Speaking generally of the observations for the present year, the snow has never been more than a foot deep on the level ground and always dry. The actual snowfall is greater than this, but an occasional Chinook wind will remove several inches of snow in a few hours, leaving very little moisture. The winters are

sharp but pleasant, the dryness of the air causes the frost to be but little felt, they are much less severe than those of Manitoba and the North-West.

During January the reading of the thermometer ranged from 52° during the prevalence of a Chinook to 17° at 7 a.m.; 10° to 12° of frost was the average of the day temperature throughout January and February, but with occasional dips to a lower temperature, even to below zero; at night these low temperatures were naturally more prevalent. During March the temperature was rarely below the freezing point through the middle of the day; often during the winter a thermometer hung on a sunny day under a veranah with a southern aspect would record a summer temperature, while no perceptible thaw was noticeable outside. This peculiarity renders the climate specially suitable for invalids. Under the combined influence of Chinook winds and warm rains the snow quickly disappears in March.

The summers are characterized by hot days, frequently ranging between 80° and 90° in the shade, but the heat is never sultry and the evenings and nights always cool. A feature in the climate of especial value in phthisical and bronchial cases is the dense growth of pines with which the mountains on all sides are covered. This forest growth extends for hundreds of miles, and the result must be the impregnation of the air with those conditions from the conifers which have been so extensively adopted in the treatment of these diseases of late years.

This brief sketch of the country and climate will suffice to show that the Okanagan Valley is peculiarly well suited for that large class of cases with bronchial and phthisical trouble who are now sent to such climates as Colorado, the high Alps, Algeria and other bracing climates; and it is suited not to such cases only, but to all those requiring a bracing climate amid pleasant surroundings and with the advantages of a good hotel, who are recovering from debilitating diseases, especially from malarial fevers, and from all those complaints incident to overwork and worry.

As far as I have been able to learn no case of phthisis has originated among the white population of the Okanagan country, and is much less frequent among the Indian popula-

tion than in other parts of the Province. It was unknown among the Indians until they adopted sufficient of the modes of life of the whites to enervate themselves, chief among these may be mentioned their habit of over-heating their houses with stoves, which they use in place of the large open hearth formerly in use, and then standing listlessly about outside without putting on additional clothing, when there must often be a difference of from 50° to 60° between the inside and outside temperatures.

Among the several who have benefited by this climate may be mentioned a medical practitioner from the State of New York, but with Canadian qualifications, who came less than three months ago, then having phthisical symptoms and appearance, and who also had lost several near relatives from phthisis, a brother and sister as well as wife having died within the year. He has now lost all symptoms, has increased considerably in weight, and has determined to remain and live in the valley in the future, although owing to competition he does not expect to do as well professionally as elsewhere. Even cases of advanced phthisis, with all the appearances and signs of having cavities in the lungs, have had their lives prolonged beyond all reasonable expectation. While the advantages of the Okanagan climate are well known and appreciated in the coast cities of the Province, they are scarcely known outside its limits as they deserve to be; probably a greater tribute of appreciation could not be paid any climate than is paid to this from the fact of persons coming from Manitoba and the North-West to escape the rigors of the winter, and from the coast to escape the excessive wet, to settle in the Okanagan Valley.

The shortness of the time at my disposal must be my apology for this meagre sketch of a district which will be as well known as a health resort in the near future as any on the continent.

Retrospect Department.

QUARTERLY RETROSPECT OF SURGERY.

BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., ENG.

Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative Surgery, McGill University.

Surgical Treatment of Mastoid Disease and its Complications.—Prof. William Macewen, in opening this discussion at the meeting of the British Medical Association, held in August, 1893 (*Brit. Med. Jour.*, Sept. 9, 1893), said that in the majority of cases of infective diseases of the mastoid region, the infection travelled from the middle ear to the mastoid antrum and cells, and that it invaded, after destruction of the mucous membrane, the bone and dura mater and other membranes of the brain. In speaking of the proper place of operation, he said this was the suprameatal triangle. Here we could always reach the mastoid antrum, and could be free of the sigmoid sinus, and if only the upper and outer part was opened, the canal of the facial nerve, which lay on the floor of the passage between the antrum and middle ear, was avoided. After exposing the roof of the antrum, the ossicles were removed, and if there was an erosion the roof was fully opened up, granulation tissue removed from the dura mater, and the brain laid bare, and if necessary opened into. Abscess in the brain could be tapped in this region, but it must also be opened from above to remove sloughs of cerebral tissue, which could not otherwise come away. Where disease had spread to the sigmoid sinus, it was likewise dealt with. In all cases it was necessary to remove the focus of infective matter in the bone. In cases of infective thrombosis of the sigmoid sinus, he preferred to lay the sinus fully open, to turn out the contents, to separate the outer wall of the sinus, and to involute this membrane upon the inner wall of the sinus itself, retaining it in position by abundant powder of iodoform and boracic acid, and also by iodoform gauze. He preferred this method to ligaturing the internal jugular, because this did not wholly prevent the infective matter from getting into the lungs as it passed by the

large veins at the base of the skull from the interior and posterior condylar foramina, and so into the vertebral and subclavian. In cases where the internal jugular was involved, then he advised ligaturing, after all the infected tissue, bone, membrane, and vein, was removed. Prof. Macewen packs the part with gauze, and allows it to heal by granulation. He has operated in 80 cases of mastoid disease alone, and in those where the disease had been obliterated by operation he found a permanent cure resulting, but in those where the disease had spread into the petrous portion it was necessary to keep a permanent opening, which continued to discharge. In speaking of the complication of meningitis, in such cases at first he doubted the propriety of operating, but now does not hesitate to perform the operation, and in many with excellent results. In cerebral abscess there was no difficulty in performing the operation. It was a most satisfactory operation, because it was urgently required.

Mr. Victor Horsley said that his experience in these cases coincided with almost everything Prof. Macewen had advanced. He would, therefore, speak on other points. For instance, in cases of simple *otitis media purulenta*, how long should antiseptic treatment be undertaken before the radical operation of clearing the tympanum and mastoid was undertaken? He suggested that one year would be a convenient limit, and that if the granulations had not subsided and if cicatrization did not occur within that period, the mastoid antrum should be laid open and the opening continued into the tympanum, so as to make one space of both cavities. In this way grave risks were avoided. As the operation was without risk, the question of hearing only was involved. This was already disordered, and he found after operation it often improved, often became perfectly normal and occasionally diminished to a slight degree. In cases of plugging of the sigmoid sinus, he advocated ligaturing the jugular vein, and believed Prof. Macewen's objections had no foundation, as was proved by the brilliant results of Messrs. Ballance and Lane.

Symptoms and Treatment of Septic Infection of the Lateral

Sinus, as Illustrated by Ten Cases.—Mr. Arbuthnot Lane read this paper before the last meeting of the British Medical Association August, 1893. (*Brit. Med. Jour.*, Sept 9, 1893.) From his great experience he arrives at the following conclusions: (1) That septic infection of the lateral sinus is always due to the extension of an inflammatory process from an abscess between the bone and dura mater, through the wall of the sinus, and, therefore, the symptoms of subdural abscess precede this infection.

(2) It is not easy to distinguish between subdural abscess and simple involvement of the dura mater, both having deep-seated pain and headache radiating from point of inflammation. In such cases the patient always received relief from operation, as one is merely a forerunner of the other.

(3) Subdural abscess may cause death by producing suppurative arachnitis, and by infecting the lateral sinus, pyæmia may result. The abscess often discharges itself through the antrum, tympanum, meatus, etc., but in every case, even if this takes place, opening of the antrum should be practised.

(4) In large subdural abscesses, besides the presence of deep-seated pain and radiating unilateral headache, there may be varying degrees of arachnitis. When the dura mater is inflamed, we have often neuritis; the degree of pain bears a direct relation to the degree of inflammation and its extent.

(5) The mastoid is not always tender in subdural abscess, especially in those cases where there are no mastoid cells, but in these cases, if the mastoid be sharply tapped with a pleximeter, pain and tenderness is at once felt.

(6) The infection of the lateral sinus depends on the situation of the subdural abscess. If in the posterior fossa, it may not be over the sinus at all. It rarely follows a first attack of inflammation of the middle ear.

(7) The symptoms of infection of the lateral sinus are in addition to those of subdural abscess. They consist solely of irregular, rapid fluctuations of temperature, and very often amounting to a well-marked rigor, though not always so.

(8) Secondary foci elsewhere are not necessarily accom-

panied by actual thrombosis, severe inflammation of the wall of the sinus, causing only an opacity of the interior, may be sufficient to produce secondary foci.

(9) Septic thrombosis often goes on unnoticed until too late, mastoid tenderness and swelling not being a necessary accompaniment. It would seem that the less extensive the thrombosis the more virulent are the symptoms of septic infection.

(10) Ligature of the vein and sinus in septic infection, apparently without thrombosis, may not stop the progress of secondary foci, even though coagulation takes place in the sinus, and this is owing to the extension of the septic process along the petrosal sinus to the cavernous sinus.

(11) When extensive thrombosis exists, it does not seem necessary to remove the whole proximal and distal portions of the clot.

(12) The presence of secondary foci does not preclude the chance of recovery, provided the supply of septic emboli be stopped.

(13) However advisable it may seem to ligature the internal jugular vein beyond the limit of the thrombosis, there is no evidence to prove that the complete removal of the distal portion of the clot is necessary or that leaving it will injure the patient.

(14) In spite of the variations in the activity and characters of the conditions which result from septic infection of the lateral sinus, it would seem that the most scientific and certain measure to adopt, in every case, is, after opening the antrum, which is a necessary antecedent of every operation of this sort, ligaturing the internal jugular vein and clearing out the subdural abscess, to remove as much as possible of the proximal portion of the clot, then the whole distal portion, or, if there be no thrombosis, to slit up the sinus beyond the limits of the abscess wall and plug it with gauze and iodoform. Mr. Lane reports ten cases with two deaths—a most admirable result.

Mr. Hugh E. Jones said that Mr. Ballance, in a paper written on this subject (*Lancet*, 1, 1890) some time ago, held that it was very unlikely mischief would extend from one lateral sinus to the other, but Dr. Newton Pitt had collected 22 cases.

In 4 the clot extended into the longitudinal sinus, in 3 into the opposite lateral sinus, and in one case into all the sinuses. Mr. Jones reported a case where there was partial occlusion of the torcular Herophili. He said the question, therefore, presented itself, Is it worth while to cut off one avenue for the extension of the mischief, whilst another, quite as open, remains unclosed? Mr. Jones' plan is: (1) Expose the sinus as near as possible to its junction with the torcular, compress it there so as to control the hemorrhage completely; (2) Clear the septic clot in the usual way; (3) Scrape out the whole of the interior from the compress to the sigmoid flexure of the sinus, and plug with antiseptic gauze.

The papers and discussion on Mastoid Disease and its complications are most interesting, and are of great value. Many cases are left to die unrecognized, and others, although recognized, are relieved too late. Such cases usually in this country come under the care of specialists, and perhaps it would be as well, after the antrum had been opened and the disease still progressed, going on to brain abscess and septic infection of the lateral sinus, that the general surgeon should be called in. Perhaps it would be better that in all acute cases the surgeon should be associated with the specialist from the first. Mr. Horsley's suggestion that if, after a year's treatment, the suppurative middle ear disease still continued, then the antrum should be opened and the diseased structures removed, is a most excellent one and should be made a note of by otologists.

Surgical Treatment of Cerebral Tumours.—At the meeting of the British Medical Association above referred to, Mr. Victor Horsley, in opening the discussion on cerebral tumours (*Lancet*, Aug. 12, 1893), spoke first of the treatment of the patient previous to operation; secondly, of the objects for which surgical interference should be undertaken; and thirdly, of some fresh points in the technique of the operation. In many cases there was great obscurity, and the existence of a cerebral tumour was overlooked; in other cases there were grounds for suspecting the existence of a tumour. No one would operate in any case unless there was reasonable localization of symptoms, divided

into those of over-action, such as contraction of muscles, exaltation or perversion of sensation, and want of action, such as progressive motor and sensory paralysis. Three symptoms had been called cardinal symptoms, viz., optic neuritis, headache, and vomiting; but one or more of these cardinal symptoms might be absent, and the surgeon must not wait for them before operating. The leading feature for guidance, Mr. Horsley thought, was the progressive character of the symptoms. Treatment by drugs should not be prolonged beyond six weeks, unless there was a striking improvement. The only cases susceptible of undergoing cure were those of gumma and tubercle. He insisted on the necessity of employing surgery, not as a *dernier ressort*, but as a primary means of cure. With regard to the second point, the objects of surgical interference were the removal and cure of the neoplasm. Glioma and glio-sarcoma were distinguished by their liability to recurrence, and in advanced cases he had frequently declined to operate. Most cases recur, but life is prolonged by removing those recurrences. Even if it were impossible to remove the tumour, it was possible to relieve the symptoms. By opening the skull the agonizing headache could be removed, and optic neuritis and atrophy might disappear, and vomiting would cease with the headache; convulsions might be mitigated. But the operation might produce loss of power, this, however, would be more than counterbalanced by the advantages mentioned. As to the third point, as to the best method of opening the skull. It had been observed that where positive cranial tension already existed, the mere pressure of the trephine might produce immediate failure of the heart's action. It was, therefore, important to remove bone without pressure, and this could be done by a saw running at a great pace. He had given up the circular saw, and showed a linear cutting instrument. The only drawback was the vibration due to the velocity. He objected to the osteoplastic method of raising a flap of bone. It was not a good method in the interests of the patient. From close observation in adult and child, he was sure that the pericranium has no osteogenic power, and consequently it was of no moment whether it was retained

in contact with the bone or not. In cases where the dura mater had been affected, it had to be cut away, and it was not possible to replace the bone. Where bone was to be replaced, the practice of American surgeons of returning large portions of it should be followed, and it should not be cut into small pieces. In certain cases, tamponing the wound in the brain, as recommended by Bergmann, might be of great service. Fatal shock might be prevented by dividing the operation into two stages, the bone being removed at one operation, and at a second one, performed after a few days' interval, the dura mater might be opened and the tumour removed.

Prof. Macewen agreed with Prof. Horsley on the great advantages to be derived from palliative operations. The two areas of the cerebellum had been freely opened by him, with great relief, absolutely regarding pain, and, to a great extent, the paralysis. With regard to the reimplantation of bone, he reimplanted the whole bone if it was from a young subject, but if from an older person the bone required to be detached into smaller portions, as if one part was not well nourished, grave mischief resulted in attempting to remove the diseased part.

Intestinal Obstruction.—At the meeting of the British Association, Mr. Page (*Lancet*, Aug. 12th, 1893) opened a discussion on the above subject. By acute obstruction he meant "total arrest of the passage of fæces and flatus." In strangulated hernia the treatment is obvious, and herniotomy is successful in proportion to its early performance, and he said great damage was often done by taxis. When no hernia can be found, the seat of the hernia must be within the abdomen, and treatment must be similar. It is not always possible to say that the symptoms are due to strangulation or to some acute inflammatory process due to suppuration, gall bladder, peritonitis, or typhlitis. To treat the acute inflammatory attack by taxis and repeated injections of air and fluid would lead to disaster. Mechanical obstruction or perforation are best treated by abdominal section, and it is impossible often to tell the cause of obstruction or peritonitis without opening the abdomen, and the earlier the operation is done the better the chance of success.

Mr. Hutchinson spoke in favor of taxis in hernia and intestinal obstruction, and after taxis for hernia recovery was the rule. Operation was attended by risk, and the opening of the sac in hernia had a special risk. No comparison could be made between herniotomy and opening the sac and opening the peritoneum in a healthy state. The inflamed sac of an inguinal hernia could not be laid open with impunity. In advocating taxis he was not apologizing for delay. The patient application of taxis was very different from delay, and if he applied ice he waited to see the effect. He used forcible taxis as much as his fingers permitted, but he used it carefully, steadying the neck of the sac until his hands were tired. He had then asked another surgeon to continue taxis, and had gone on tiring the hands of his surgical colleagues until the hernia was reduced. Acute intestinal obstruction could not be defined, and he objected to Mr. Page's definition of it. There was no one lesion that could be associated with any definite symptoms, and though there were a few cases in which operation might be necessary, yet they were so mixed in their symptoms, and they were so indistinguishable, that he thought it wise to let the few cases go. The risk was far greater if the abdomen was opened. His point was to try abdominal taxis thoroughly, and he could mention a dozen cases where success followed this method of treatment.

His plan was to give chloroform and hold the patient up by the legs, and to shake him to give him enemata, and to push the intestines from side to side vigorously. He stated that there were many cases of intestinal obstruction, whether band or twist, where the bowel might be replaced by abdominal taxis. In the London Hospital he did not know of more than a single case in which laparotomy had been successful. If abdominal taxis failed, he thought the chance of patient was much better if abdominal section was not undertaken.

Mr. Morison objected to Mr. Hutchinson's doctrines and practice. He did not attempt taxis, but performed immediate herniotomy. Of 100 cases of herniotomy, only one died of peritonitis.

Mr. Rivington thought that Mr. Hutchinson altogether undervalued the operation of abdominal section. The fact that operations were not successful in the London Hospital was that they were performed too late. The cases often did not come under the surgeon's care until the time had passed when a successful issue might have been expected from operation. He fully recognized the value of manipulation, and had relieved several cases by kneading the abdomen under chloroform and by enemata. Operation ought to be performed within the first 24 hours. If taxis and enemata failed, the surgeon should proceed to operate without delay. When a number of cases of operation within 24 hours are put on record, it would be fair to compare the results with those obtained by abdominal taxis and delay.

Dr. Newman said that two years ago, in Glasgow, there was a similar discussion, with equal diversity of opinion, but the conclusion arrived at was that patients with intestinal obstruction should be admitted into the surgical wards. He had made many necropsies as pathologist for 10 years, and had never met a case in which the operation had caused the death of a patient. The abdomen might be safely opened to make a diagnosis, and the advantages of early operation were shown well in reference to the surgery of the kidney. His experience from the post mortem table was that more cases died from the want of operation than from the operation itself.

It seems strange to hear at this time a discussion taking place as to the advisability or not of abdominal section in cases of intestinal obstruction. On this side of the Atlantic it is regarded as ordinary practice, and the only trouble is that surgeons, as a rule, get the cases too late, or operation is refused until the patient is *in extremis*. As time goes on, these cases from the first will be treated surgically, and the public will be educated to the fact that the operation is always performed in the best interests of the patient, and will offer no further objections to early exploratory incision. At present, in a case of strangulated hernia, the surgeon is called in from the first, and the patient and friends not only do not

object, but seek operation. So should it be in acute intestinal obstruction.

Infectious Appendicitis.—Dr. Robert T. Morris, of New York, in a most interesting paper on the above subject, read before the Pan-American Medical Congress (Annals of Surgery, October, 1893), says that Appendicitis is an infectious exudative inflammation of the appendix vermiformis cæci, originating in any local cause for displacement of the secondary epithelium of the mucosa of the appendix, and progressing by bacterial invasion into the rich layer of adenoid tissue, which is under compression. Bacteria once having penetrated the adenoid tissue, remain there and develop for an indefinite time with widely varying degrees of rapidity. The natural course of the inflammation is protracted, and marked by slow erosion of the mucosa and adenoid tissue, caused by the pressure of exudates and infiltrates. A more rapid destructive process follows, passive choking of the inner tube within the outer, when exudation into the adenoid tissue is excessive. The most rapid destructive process occurs when the muscular sheath, irritated to the point of spasm, contracts firmly down upon the swollen inner tube. Incidents in the course of the disease are: (1) Infection along the lymph channels from the appendix to the colon, causing typhlitis, perityphlitis, paratyphlitis, and cæcitis. (2) Extension of thrombosis along the veins of the appendix, resulting in mesentric thrombo-phlebitis, pyle-phlebitis, portal embolism, and abscess of the liver. (3) Local peritonitis from direct infection of peritoneal investment of the appendix. (4) General peritonitis from infectious thrombi in the veins of the portal system, and from poisoned peritoneal exudates. (5) Local abscesses in sub-peritoneal connective tissue. The layer of epithelium which guards the adenoid layer against infection is easily injured by foreign bodies or fæcal concretions, especially when violent exercise or a blow causes forcible impact of the mucosa against such bodies. Dr. Morris believes many acute attacks of appendicitis follow the efforts of parturition. Wherever the mucosa is injured this is likely to occur. Thus it is occasionally a complication of typhoid fever or dysentery

or cholera. The epithelium of the mucosa of the appendix being once destroyed, infection and necrosis are always possible and imminent, though the process might take years to develop. The outside of the appendix may be normal in appearance, when its mucous membrane is necrosed. When the peritoneum becomes affected, there is a process of suppuration, with falling off of infectious products, then bacterial changes, and finally perforation and general peritonitis. The most painful cases, as well as the most severe, are those in which there is a spasm of the muscular coat. The "exudates in the tissues being crowded" to the end, the appendix has a bulbous appearance. In cases where the exudate is over the iliac arteries the pain is also great, owing to the strong pulsation of these vessels. If, in addition to this, the large nerves of the pelvis respond to irritation with neuralgia, the condition of the patient is deplorable. Infection from the appendix to the walls of the cæcum and colon, in mild cases, may cause a constipation from inhibition of peristalsis, or a diarrhoea from the irritation of ptomaines. The infection may be so insidious as to cause perforating necrosis of the colon several inches away from the appendix, when the appendix is outwardly perfectly normal. There is apt to be an area of thrombosed veins, however, extending between the bowel and the necrotic area. This involvement of the neighbouring parts has been variously named typhlitis, perityphlitis, etc., but in all such cases the focus of infection can be traced to the appendix. Bilious vomiting is not always present in appendicitis, but in all acute cases is characteristic of reversed peristaltic action. Dr. Morris classifies four kinds of relapsing appendicitis. (1) Cases in which the poisoned peritonæum of the appendix responds in various mild exacerbations of local peritonitis. Colic is not a marked feature of these cases, and the septic symptoms are not important. (2) Cases in which the muscular coat of the appendix is excited to the point of spasm from time to time. Colic is the most salient symptom, but septicæmia is not severe or persistent. (3) Cases in which small or larger portions of the inner tube slough and cause marked septicæmia, until the sloughs have decomposed enough to escape

into the bowel. (‡ Cases in which a chronic abscess cavity fills in exacerbation, and empties by slow absorption at irregular intervals, and where persistent septicæmia is the chief symptom. In all cases of infectious character, operation should be early. In the simplest cases, an incision only one inch and a half long, following the line of the aponeurosis of the external oblique muscle, was required. The anterior longitudinal band of the colon should be looked for and followed to the appendix, which latter should be drawn out, and the mesentery tied with catgut. The outer tube is now stripped through with scissors, very close to the cæcum. The inner tube is then ligated with a strand of eye silk well down into the cæcum, and the stump of the inner tube cut short. The peritonæum around the stump is scarified until pink serum exudes, and then closed over the stump with three or four Lembert sutures of catgut. If the ligature escapes, it will go into the lumen of the bowel, and give no further trouble. The wound of the abdominal wall is closed with silkworm gut sutures, which include peritonæum, transversalis fascia and transversalis and internal oblique aponeurosis, the knots being cut short, to remain permanently. The external oblique aponeurosis must have its own row of sutures, and the skin closed with very fine catgut. In severe cases a larger incision is necessary, the patient in such cases being in the Trendelenburg position. In the severest cases, with abscess and extensive induration, the incision should be four inches and a half long, and the cavity should be cleansed with saline solution and peroxide of hydrogen, and then packed with gauze.

Dr. Morris reports 48 cases, with four deaths in cases where there was a large amount of exudate and pus. In all cases, even where the adhesions are extensive, Dr. Morris advocates separation and removal of the origin of the disease, the appendix.

I have made an extensive abstract of Dr. Morris paper, on account of its suggestiveness, and although not agreeing with him in every point, still his paper affords much material for thought, and throws much new light on the more chronic and milder forms of the disease. The pathology is almost too good

to be true, and fits most exactly into the symptoms and lesions for which an explanation is sought.

Radical Cure of Hernia by the Implantation of Bone.—Thiriari, in *Le Mercredi Médical*, May 24th, 1893, describes his method of radical cure for hernia by the implantation of a decalcified plate of bone. After carefully isolating the sac to above the internal ring, he then ligates and resects it. On being released the stump disappears within the abdomen. Between the peritonæum and abdominal wall a plate of decalcified bone is inserted; this is held in place by the sutures which pass through the edge of the orifice and unite the pillars. The size of this plate is larger than that of the opening, and varies from 3–5 c. m. long, the same in breadth, and 3–12 m. m. in thickness. The canal is closed with catgut sutures, and then the edges of the skin wound brought together, and drainage put in or not. The author has practised this operation 25 times in the last eight months, and has as yet no relapses. In one of his earlier cases the plate was discharged in 15 days one-third the size; the patient, notwithstanding, was cured and remains so. The author claims that as the plate disappears, it is gradually replaced by cicatricial or fibrous tissue which effectually plugs the opening and prevents recurrence (quoted in *Univ. Med. Mvg.*, Sept., 1893). This operation is not likely to prove one that will take a permanent place in the radical cure of hernia, for, cicatricial tissue has been proved conclusively to be gradually absorbed and not to be depended upon to prevent recurrence of hernia. The time elapsed (eight months in the oldest cases) is too short to enable the author to pronounce such a decided opinion as to the value of his operation.

Gangrene in Strangulated Hernia—Resection versus Anus Præternaturalis.—*Conclusions from Cases.*—H. P. Zeidler, of St. Petersburg, has treated this subject in an exhaustive manner. (*Centralblatt f. Chirurgie*, January 23rd, 1893.) The paper gives the histories of 289 cases in which primary resection was performed for strangulated hernia, and 287 where an artificial anus was made. In the first group 142 (49½ p.c.) died, and in the second 213 (74.22 p.c.). From the first

series 20 cases and from the second 74 cases are excluded, because definite cause of death was not stated, and the result is that in the first group of cases (resection) 25.65 p.c. died from causes independent of the operation, and 28.64 p.c. in the second group (artificial anus). Death due to resection directly occurred in 19.66 p.c.; due to formation of anus præternaturalis, 36.65 p.c.

A contra-indication to primary resection is the presence of diffuse peritonitis, especially when combined with collapse. If collapse is absent, resection is not absolutely contra-indicated. The greatest danger in resection is the occurrence of gangrene of the sutured intestine; the next greatest is peritonitis, due to infection of the sac. The sutures in resection should always go through healthy tissue, and unless the condition of the patient is very good, a radical cure should not be attempted.

In the formation of an artificial anus nearly all the dangers exist which are present in primary resection, and, also, in addition, certain dangers which are absent from the latter. The only advantages are shortness of operation and rapid and complete emptying of the intestine. This operation can be made use of temporarily, since Riedel has shown that the anus præternaturalis can be closed after a day or so by an early secondary resection, namely, in such cases where primary resection is contra-indicated on account of severe collapse, or on account of the impossibility of placing the sutures in entirely sound tissues where the gangrene is not absolutely determined. The formation of artificial anus as an exclusive treatment of gangrenous hernia should be given up.—(Condensed from the *Annals of Surgery*, Sept., 1893).

Hernia of the Vermiform Appendix.—A Report of 41 Cases.—Dr. Briège, of Breslau, has collected a series of 41 cases, 20 inguinal, 15 femoral, and 16 variety not stated. In 26 cases operation was performed; 16 cases were entirely cured, two were cured, but had a fistulous opening remaining, five died, and in three the result is not stated. From a study of these cases, Dr. Briège comes to the following conclusions:—

(1) Hernia of appendix vermiformis is more frequent than is generally accepted.

(2) It is impossible to diagnose with certainty a hernia of the appendix. Where there are present the symptoms of an incarcerated hernia in the right inguinal or femoral region, one should think of the possibility also of a hernia of the appendix.

(3) A hernia of the appendix may produce more or less severe complications, inasmuch as the appendix is so frequently the seat of pathological processes.

(4) This form of hernia demands early operative interference, because of the threatened complications which may arise from the appendix.

(5) This operation must, almost without exception, consist of resection of the appendix. The appendix must not be returned unless absolutely normal.—(*Archiv. für Klin. Chir.*, Bd. xlv., Hft. 4. Quoted in *Annals of Surgery*, Sept., 1893).

I have seen only one case of strangulated hernia which included the appendix, and in this the symptoms were most urgent, the pain being especially severe. I operated within eight hours of the onset of the symptoms, and found in the inguinal canal a piece of small bowel and an appendix much swollen and congested from constriction. The bowel was of rather dark color. Both structures were returned, and the case did well. This was six years ago, and the patient, when seen recently, had no return of the hernia, the cure being radical, although the only operation was simply cutting off the sac and closing the external wound.

Extirpation of a Tumour of the Liver.—Bergmann says (*Verhand. der Deutsch Gesell. f. Chir.*, XXII. Kongress, 1893) most operations on the liver are done for echinococcus, in which a portion of the liver can rarely be removed. Langenbuch removed a lobe in 1888, with good results. Syphiloma of the liver is most frequently the excuse for removing a portion of the organ. In the early part of last year Von Eiselsberg removed a large carcinoma of the liver. In a case of carcinoma of the gall-bladder, Hochenberg removed the disease with the neighbouring portion of the liver. The largest tumour of the liver ever operated upon with good result was by Lücke.

The tumour operated on by Bergmann was a round, very movable mass, situated on a level with the umbilicus, in the middle line. It seemed to be in connection with the liver, and presented symptoms of an echinococcus of that organ. It was small and of uniform consistency, and liver brown in colour. It was easily drawn through the wound, and was found attached to the liver by a pedicle 10 c. m. long and $\frac{1}{4}$ c. m. thick. The pedicle was cut off, the larger vessels ligated, and the remaining controlled by sponge pressure. The tumour was found to be a "tubulous gland adenoma," a variety of tumour closely allied to primary liver carcinoma and the hyperplastic adenoma.—(Quoted in *Annals of Surgery*, Nov., 1893).

Laparotomy for Perforating Ulcer of the Stomach.—Kriege (*Berlin Klin. Woch.*, No. 49-50, 1892) reports the case of a man, aged 41, seized with collapse in the course of ulcer of the stomach, on whom he performed laparotomy. A median incision gave exit to some gas and some of the stomach contents. The intestines were slightly injected. A transverse incision was made, and the gastro hepatic omentum torn through, but the ulcer was not seen on either the front or back wall of the stomach. The incision was then prolonged to the right, and an opening the size of a pea found 3 c. m. from the cardiac orifice. It was closed with sutures, and gauze left in for drainage. Recovery was rapid, and patient was out of bed in 15 days. This operation had been done previously only seven times, without a single success, but in most of the cases there was marked peritonitis. In such cases early operation should be performed. The perforation will usually be found near the cardiac end. In the first few days after operation the patient should be fed entirely by the rectum, and morphia should be given to relieve pain.—(Quoted in *Univ. Med. Mag.*, Oct., 1893).

Barling (*Birmingham Med. Review*, Vol. XXIV., No. 181, p. 129) reports the successful treatment of a case of gastric ulcer, with perforation and peritonitis, by abdominal section. He had operated previously in two other cases unsuccessfully. The first case was one of latent gastric ulcer in a girl aged 22,

presenting symptoms of peritonitis. The abdomen was opened six hours after the onset of the acute manifestations. The source of the perforation could not be found at the operation, and death took place 24 hours later. The autopsy disclosed a perforating gastric ulcer in the anterior wall of the stomach, nearer the cardiac than the pyloric end of the stomach.

The second case occurred in a girl 20 years old, with a previous history of gastric ulcer. Symptoms of peritonitis developing suddenly, the possibility of perforation was considered, and the abdomen was opened. At about the middle of the anterior wall of the stomach an opening with indurated margin was found. Five Lembert's sutures were introduced, the abdomen flushed and then closed, a drain having been introduced. Death occurred 30 hours after the operation. The autopsy revealed well marked peritonitis, especially in and around the portal fissures, and about a pint of purulent fluid escaped from the abdomen. The anterior perforation was found to be closed effectively. A second ulcer which had almost perforated was found on the posterior wall.

The third case occurred in a domestic 29 years old, who was suddenly seized with severe abdominal pains, vomiting and faintness. She had previously suffered from epigastric pain and vomiting, though she had never had hematemesis or melena. The acute symptoms had set in a day after the ingestion of a heavy meal with a feeling of something having given way in the abdomen. Peritonitis soon set in, and the diagnosis of perforation from gastric ulcer was made. Under appropriate treatment the girl did fairly well for a number of days, until pain was complained of in the left hypochondriac and lumbar regions, soon followed by swelling in the left hypochondrium. Under treatment the symptoms again subsided, but the condition of the patient appearing precarious, abdominal section was decided on. An incision was made over the swelling in the left hypochondrium, and a small abscess found behind the stomach and evacuated. The patient doing badly after the operation had been in progress ten minutes, a drainage tube was introduced into the abdominal cavity and the wound speedily

closed. Rather contrary to expectation, the case did well. Further progress was complicated by phlebitis in both legs, but recovery ultimately ensued.

The author recommends, before closing the perforation in the stomach, the passing of a drainage tube into the stomach through the orifice of perforation, and evacuating any fluid present, and afterwards the abdomen should be drained by two tubes, one placed *in situ* close to the perforation and the other introduced into the abdomen immediately above the pubes.—(*Med News*, Nov. 11th, 1893.)

Resection of the Rectum, with Transverse Separation of the Sacrum.—Levy proposed, more than three years ago, a method of resection of the rectum, the prominent features of which included the proposition to (1) Leave intact the lower or external anal sphincter; (2) To preserve the coccyx; (3) To avoid injury to the levator ani. He has recently modified this procedure as follows:—An arch-shaped incision is made through the skin and fascia, over the lower end of the sacrum. This is located a finger's breadth above the points of the cornua of the coccyx. Laterally it is continued upon either side to a point 5 c.m. from the tuberosity of the ischium and parallel to the course of the gluteus maximus. Below the fourth sacral foramen the incision is carried to the bone. The lateral muscular fibres are separated by a blunt dissector until the lateral edge of the great sacro-sciatic ligament is reached. This is carefully divided upon a grooved director. A chain saw is now introduced in front of the sacrum, a special elevator being used to separate the soft parts upon its anterior surface. The chain saw is passed between these bones. The flap of bone and skin is now drawn downwards, the coccygeus and sacro-sciatic ligaments being still further divided if necessary. The pudendo-hæorrhoidal and fourth sacral nerves are not injured by this procedure. In case an insufficient amount of space is afforded, the osteo-plastic flap may be divided longitudinally.—(*Berlin Klin. Woch.*, No. 13, 1893. Quoted in *Annals of Surgery*, Oct., 1893).

In a letter to *Annals of Surgery*, Sept., 1893, on the

“ *Priority of the Operation of Intra-Cranial Neurectomy*, Krause, of Altona, states he first performed the operation on Feb. 23rd, 1892. He has operated on five cases. His method of procedure is as follows: After making the flap of scalp and bone in the temporal region, the cranium is opened and the dura mater stripped from the base of the skull. The root of the arteria meningea media is next ligated and divided, and then the third and second divisions of the fifth nerve in their entire extent, from the foramina ovale and rotundum to the ganglion Gasserii, are freed. Next the dura mater is lifted back from the nerves with the elevator, and the nerves are lifted away from the underlying bone. This isolation is carried as far back as the ganglion itself, indeed until the ganglion is brought into view. The second and third divisions are now divided with a pointed tenotome at the foramina rotundum and ovale. The Gasserian ganglion is now seized transversely in its posterior part by Thiersh's nerve forceps. By careful twisting, the entire trifacial root is brought away. In all five cases recovery took place, and since then there has been no return of the pain.— *Annals of Surgery*).

Contribution to the Treatment of Cleft Palate.—Kuester has operated in 22 cases, of which 13 were females and 9 males, varying from $3\frac{1}{2}$ to 36 years. The last 10 patients were all cured by a single operation. He operates with the head down, using Langenbeck's method, and anæsthetizing the patient. He modifies the freshening of the edges, in that he pierces the middle of the uvula by a two-edged knife and forms a flap extending on both sides to the posterior border of the hard palate. In this manner the velum palati and the uvula are lengthened and broadened, so that they are easily applied to the bony surface. He avoids further cutting through the velum and severing the tensor palati, but rather does he incise the velum only so far as to cut the nasal mucous membrane with a button bistoury where it passes over into the soft palate from within outward. In applying the sutures to the uvula, a silk thread is passed through and held to act as a guide and to oppose tension. The whole operation took from one-half to

three-quarters of an hour. The sutures are painted with iodoform collodion, and a tamponade of iodoform mull employed in cases of profuse hæmorrhage, and then only for a few minutes. He rejects Wolff's method of making lateral incisions, with employment of silver wire sutures to relieve tension, as disadvantageous and favouring lateral defects. Daily irrigation of the nose is also unnecessary. The operation in two sittings is only justifiable in cases of very broad fissure. To avoid gangrene of the margins of the wound, he has used in several the tertiary silver wire suture. Healing of the wound can be much accelerated by painting it with tincture of cantharides. Speech training should precede the operation, and two cases treated thus succeeded in obtaining ideal speech. Out of the other seven, five had normal speech.

Kuester is of opinion that it is not advisable to operate as early as possible, for he does not consider it dangerous to life, and the nasal, pharyngeal and laryngeal catarrh which often complicate rapidly retrogress, even in later life. He looks upon the fifth to the seventh year as the most appropriate time to interfere.—(*Wiener Med. Presse*, No. 18, 1893. Quoted in *Annals of Surgery*, Aug., 1893).

Correspondence.

OUR LONDON LETTER.

To the Editors of THE MONTREAL MEDICAL JOURNAL.

DEAR SIRS,—An important and valuable addition to the facilities offered in London for the study of the various medical and surgical affections, in which the skin is chiefly concerned, has recently been made by Mr. Jonathan Hutchinson, in the form of a private museum. Having leased a large house at the top of Portland Place, he has built a considerable addition, and has here arranged his extensive collection of drawings and water colour sketches of the numerous interesting cases of skin disease that have come under his observation during a long life of practice, both in the London Hospital and in private. Here, amongst others, are many of the original pictures from which

the Sydenham Society's plates, so familiar to those who have paid special attention to this branch of medicine, are taken. Here, too, is being arranged by his secretary an extensive series of some two hundred volumes, each of which is to contain all the magazine articles and extracts for many years back of some one particular disease, so that each, it is hoped, will furnish an almost complete history of the affection of which it treats. This series will, as may be imagined, prove invaluable to anyone anxious to find out, rapidly and easily, the cases previously reported of any particular affection in which he may be interested, as well as the more important papers, articles, monographs, etc., referring to it. At the present time Mr. Hutchinson is giving here a weekly lecture, in connection with the post graduate course, now under way, on one or other of the subjects, such as lupus, syphilis, etc., to which he has so successfully devoted time and thought.

It was my good fortune to be present recently at a private exhibition of a series of microscopic slides, prepared in Dr. Unna's laboratory at Hamburg, and at present on their way to Paris, where they will doubtless be criticized by the members of the Dermatological Society, to whom they will be shown. These slides show the cocci, which Dr. Unna has called marroccoci, on account of their mulberry-like grouping, and which he believes to be the efficient cause of seborrhœic eczema. These cocci flourish in the horny layer and in the follicles, and are found in enormous numbers in seborrhœic conditions of the skin and scalp. Injected under the skin, they seem to die, and are incapable of exciting suppuration. Apparently they require oxygen in order to flourish and multiply successfully. Pure cultures have been obtained, and in one case, it is said, a slightly vesicular eruption has been produced by inoculation. On the other hand, precisely similar cocci are obtained in small numbers by scraping the healthy skin, which would seem to indicate that they merely multiply with exceptional rapidity on an exceptionally favourable soil, perhaps aggravating an already morbid condition, and probably modifying its clinical appearance. Further investigations and experiments are being made,

and no doubt more definite information will be obtained and more definite results arrived at ere long. Meantime, there is no doubt of the existence of the cocci in large numbers, and Dr. Unna is to be congratulated on the admirable manner in which he has succeeded in staining them in the horny layer.

The paper read before the dermatological section of the British Medical Association, at their annual meeting, by Dr. Byron Bramwell, on thyroid "feeding" for psoriasis, attracted a good deal of attention at the time, and has now been published in the *British Medical Journal* (Oct. 28th, 1893). His methods have already been tried in several of the London hospitals, with somewhat varying results. As yet it is probably too soon to say whether this treatment will prove to be of permanent value, or will merely take rank, in a year or two, amongst the innumerable recipes, popular and fashionable for a time, but soon falling into neglect and disuse. Dr. Bramwell's results are certainly remarkable as illustrating once more the rapid effect of injecta on the cutaneous surface, and seem to point to another long step away from Hebra's dictum as to local origin and treatment of skin affections, and a nearer approach to the position so long and so consistently maintained by the French school. It must not be forgotten that thyroid gland, in whatever form administered, is a remedy to be used only with supervision and care. In some patients it is responsible for distressing and even alarming symptoms.

RANKINE DAWSON, M.D.

London, Nov. 1st, 1893.

Reviews and Notices of Books.

A Text-Book of Ophthalmology. By Dr. ERNEST FUCHS, Professor of Ophthalmology in the University of Vienna. Authorized translation from the second enlarged and improved German edition. By A. DUANE, M.D., Assistant Surgeon, Ophthalmic and Aural Institute, New York. One royal octavo volume of 788 pages, with numerous illustrations.

As a text-book this work already stands in high repute in Germany, and the second edition, from which the translation is made, is even more elaborate and complete than the first. The reader cannot fail to be imbued with the feeling that the author is giving the results of a ripe experience, coupled with a profound knowledge of his specialty. It is more particularly in pathology that this work excels, and indeed this part of the subject is not treated so fully in any recent work on ophthalmology, with the exception, perhaps, of one or two "Systems" of ophthalmology only to be found in the libraries of those who use such works as books of reference. In the several divisions of the work the anatomy and physiology of the eye are elaborately discussed. It would perhaps not be of less practical value if this feature were omitted, since every student or physician is, or ought to be, familiar with these subjects from the study of text-books other than those which are supposed to deal with diseases and their treatment. It is a question whether the same amount of space devoted to the detailed description, the classical aspects of the subject would not make the book more acceptable to the ordinary reader. For instance, the part of this work which deals with the errors of refraction cannot be perused without conveying the impression that the refractive errors are a matter of minor importance, to be disposed of by the application of a few simple rules; but every ophthalmologist knows by daily experience that they constitute the most difficult and exacting part of his work, and therefore call for close attention to minute details, such as can never be included in general rules or abstract principles. The same remarks will apply to the chapter on affections of the ocular muscles, a subject which is indeed most intimately connected with the errors of refraction. In

all other respects this work is one of the best of its kind now before the profession.

A Guide to the Examination of the Urine. By J. WICKHAM LEGG, F.R.C.P., formerly Assistant Physician to St. Bartholomew's Hospital, and Lecturer on Pathological Anatomy in the Medical School. Seventh edition. Edited and revised by H. LEWIS JONES, M.A., M.D., M.R.C.P., Medical Officer in charge of the Electrical Department in St. Bartholomew's Hospital. Price, 3s. 6d. London: H. K. Lewis, 136 Gower street. 1893.

This work is arranged on an excellent plan. It commences by giving a scheme to be followed in making a systematic examination of the urine. As each test is mentioned, the page is given on which is the detailed account of the method of its performance. The descriptions are concise and easily understood, and altogether it is a most useful book for ordinary clinical work. It would be an improvement if the exact proportions were given of the standard copper solution required in the volumetric examination for sugar in the urine.

Transactions of the Medical and Chirurgical Faculty of the State of Maryland. Ninety-fourth Annual Session, held at Baltimore, Md., April, 1892; also Semi-Annual Session, held at Rockville, Md., November, 1891. Baltimore: Griffin, Curley & Co.

This volume contains the minutes of the meetings and the reports of the various committees. An important report is that of the committee appointed to devise means for lessening the amount of blindness from curable diseases. The following circular letter was prepared by them, and a copy sent to each midwife in Baltimore:—

“The undersigned practicing physicians of Baltimore were appointed by the Medical and Chirurgical Faculty of Maryland to take measures tending to diminish the blindness in our city and State. About *one-third of the blind* in our Blind Asylums have lost their sight through a disease which is common among the newly-born. This *fearful disease*, which causes so much suffering and unhappiness, *can be prevented by proper care. It can nearly always be cured and sight saved if*

treatment is begun early and kept up. The disease shows itself by redness and such swelling of the eyelids that the baby cannot open its eyes; the eyes discharge yellow matter. The disease usually begins during the first few days of life. This disease will often cause incurable blindness in forty-eight hours, unless properly treated.

"We ask you to impress upon the mothers you attend *the great danger of delaying treatment.* Do not let them waste valuable time in using breast-milk, chamomile tea, quince water and other home remedies, for *a day lost may rob the infant of its sight.* Insist upon sending the child, as soon as the disease begins, to a physician, or, if the parents are unable to procure one, to a dispensary,

"You can do much towards *preventing* the disease by thoroughly cleansing the child's eyes immediately after it is born. Wash the eyes carefully with fresh, warm water and a piece of perfectly clean soft linen. Do not use water or linen which has been used on other parts of the body, but wash the eyes first of all. You will assist greatly in the important work of diminishing blindness:

"1. By washing the eyes of the newly-born as described above, in order to prevent the disease from attacking them.

"2. By instructing the mothers whom you attend concerning the *importance of watching the eyes closely during the first and second weeks.*

"3. By calling attention to the *dangers of the disease, and the great urgency of prompt medical treatment.*

"HIRAM WOODS, M.D., *Chairman,*

"GEORGE H. ROHE, M.D.,

"J. EDWIN MICHAEL, M.D.,

"HARRY FRIEDENWALD, M.D.,

"Committee."

The address of the President, Dr. William H. Welch, Professor of Pathology in the Johns Hopkins University, is given in full. It is entitled "The Etiology of Acute Lobar Pneumonia, considered from a Bacteriological Point of View," and, as might be expected, is a masterly review of the subject. The volume closes with lists of the Presidents from 1799 to 1892 and of the active members of the association.

Hernia: Its Palliative and Radical Treatment in Adults, Children and Infants. By THOMAS H. MANLEY, A.M., M.D., Visiting Surgeon to Harlem Hospital, Consulting Surgeon to Fordham Hospital, Member of New York Academy of Medicine, American Medical Association, New York State and County Medical Associations, International Medical Congress, Pathological Society, etc. Philadelphia, Pa.: The Medical Press Co., Limited, 1725 Arch street. 1893.

In this work Dr. Manley takes the middle ground between those who claim that intelligent surgical intervention will cure all cases of hernia, and those who deny any good results from operative interference. He begins by classifying hernial cases, with a view of showing which are legitimate subjects for surgical intervention and which are not, and also of indicating the proper methods of dealing with each. The first important fact he calls attention to is that, contrary to popular impression, the diagnosis of hernia is frequently far from easy, and he proceeds to point out more than one condition which may be mistaken for a *rupture*, as the disease is incorrectly called in common parlance. The author calls attention to several errors in infantile hygiene, and strongly deprecates the use of a tight binder around the abdomen in infants. He devotes a chapter to the treatment of hernia in infants by means other than operative. In his description of the trusses, he declares himself to be in favour of the circular spring truss, although he acknowledges that, if properly made, it is beyond the means of many patients. The hank truss is mentioned, and commended as being cheap and effective, but precise directions for applying it are not given, and unless properly applied it is useless. The fourth chapter closes the first part of the book, that devoted to the consideration of hernia in children, and is taken up by the consideration of the varieties of hernia in which operative interference is to be recommended. In the second part, the various palliative methods in which hernia in the adult may be treated are discussed. In the third part, a history of the origin and progress of surgical intervention is given, and also the anatomy and mode of production of the various forms of hernia. The fourth and last part of the book is devoted to the operative methods of dealing with hernia, and in a systematic way all are in turn described.

Dr. Manley's book will be read by all with much pleasure and profit, as giving as short an account of the subject as is consistent with clearness. Indeed, this conciseness is a feature of the book to be much commended. It is a work that the general practitioner as well as the surgeon will find useful.

A System of Genito-Urinary Diseases, Syphilology and Dermatology, by various authors. Edited by PRINCE A. MORROW, A.M., M.D., Clinical Professor of Genito-Urinary Diseases, formerly Lecturer on Dermatology in the University of the City of New York, Surgeon to Charity Hospital, etc. With illustrations. In three volumes. Volume II.—Syphilology. New York: D. Appleton & Co. 1893.

The second volume of this work is now published, and is devoted to the consideration of the various manifestations of syphilis. The first article is by Jas. Nevins Hyde, on the history, etc., of the disease, and in this he reviews the evidence adduced regarding the date and point of its origin. The etiology of syphilis is given by John A. Fordyce, and he details the methods which have been pursued in endeavouring to find the germ which, in the opinion of most modern pathologists, is the cause of the disease. He also takes up the question of the possibility of inoculation of the lower animals, and answers it, from the evidence he brings forward, in the negative. L. Duncan Bulkley writes on the modes of infection, and goes into the subject as fully as the space at his disposal allows. Primary syphilis is by Edward Beniet Bronson, and constitutional syphilis by Joseph Zeisler. The editor takes up syphilis of the skin, and illustrates his paper by some excellent plates, both coloured and uncoloured. Syphilis of the appendages of the skin is by Samuel Alexander. Syphilis of the mucous membranes is by Chas. W. Allen; of the joints, muscles, etc., by Frank Hartley; of bones by W. R. Townsend; of the upper air passages by John Noland Mackenzie; visceral syphilis by W. T. Councilman. James P. Tuttle writes on syphilis of the rectum and anus, and has another paper on chancreoid of the same parts. Syphilis of the genito-urinary system is by Eugene Fuller, while the nervous system is by B. Sachs, and inherited syphilis of the nervous system

by William N. Bullard. The eye lesions, both acquired and inherited, are written on by Chas. Steadman Bull, and the ear by J. Orne Green. Hereditary syphilis is by F. R. Sturgis; diagnosis and prognosis by Hermann G. Klotz; treatment by J. Wm. White, and its relation to public health by Samuel Treat Armstrong. Chancroid is by Edward Martin.

The articles are very ably written, and the subject is gone into most extensively, and evidence is freely brought forward to support the conclusions which are arrived at. The illustrations are numerous and good, and altogether the volume is a most valuable addition to the literature of the subject.

A Treatise on the Science and Practice of Midwifery. By W. S. PLAYFAIR, M.D., LL.D., F.R.C.P., Physician-Accoucheur to H. I. and R. H. the Duchess of Edinburgh; Professor of Obstetric Medicine in King's College; Physician for the Diseases of Women and Children to King's College Hospital, etc., etc. Sixth American from the eighth English edition, with notes and additions. By ROBERT P. HARRIS, A.M., M.D., Honorary Fellow of the American Gynecological Society, and of the Philadelphia Obstetrical Society, etc. With five plates and 217 illustrations. Philadelphia: Lea Brothers & Co. 1893.

Playfair's midwifery is so well known, and has been used by so many generations of students, that any praise of it is superfluous. The present edition sustains the reputation gained by the work, by embodying all the advances made in the art of obstetrics. Besides, it has the advantage of notes by Dr. Harris, thus giving American as well as British views. These notes are enclosed in brackets, in order not to interfere with the original text. Many new plates are added, and much new matter. Thus, symphyseotomy comes in for favourable notice, as also does the Cæsarian section, as giving good results when performed with antiseptic precautions. Extra-uterine pregnancy and its treatment by operation, and puerperal fever, are also viewed in a different light, on account of the advances made in asepsis and antiseptis. The work is most complete, and cannot be too highly recommended.

Gaceta Medica, Revista Ecuatoriana de Medicina, Cirugia y Farmacia.

We have received the October number of this journal, which is published in Guayaquil, Ecuador. The editors are Drs. Samuel Mora, Emilio G. Roca and César Borja. This is a new publication, the first number appearing in June last. The articles contained in this number are:—School of Agriculture and Botanical Garden, Analysis of drinking water, Surgical treatment of scirrhus of the mamma (illustrated), Legal medicine and toxicology, Studies in national jurisprudence, and a selection from the *Journal de Médecine et Chirurgie Pratiques* on animal vaccine. The journal is printed in Spanish, and is an excellent publication, keeping well in touch with the Old World as well as the New.

Society Proceedings.

PROVINCIAL BOARD OF MEDICINE.

The half-yearly meeting of the College of Physicians and Surgeons of the Province of Quebec was held on Wednesday, the 27th September, 1893, in the rooms of the Medical Faculty of the University of Laval, Quebec.

In the absence of the President, the Hon. J. J. Ross, M.D., who was unwell, Dr. L. J. A. Simard, Vice-President for Quebec, took the chair, at 10 o'clock precisely.

The Governors present were Drs. F. W. Campbell, Vice-President for Montreal; A. G. Belleau and A. T. Brosseau, Secretaries; A. Dagenais, Treasurer, and J. M. Beausoleil, Registrar, A. Vallee, W. A. Verge, C. S. Parke, A. A. Waters, Leonidas Larue, C. E. Lemieux, Côme Rinfret, L. T. E. Rousseau, P. M. Guay, Alfred Morissette, J. M. McKay, R. Craik, J. B. McConnell, the Hon. D. Marcil, J. B. Gibson, P. Cartier, R. Latraverse, H. Cholette, P. J. L. Bissonnette, F. Paré, Thos. Larue, F. J. Austin, E. C. P. Chèvrefils and L. A. Plante.

The minutes of the last meeting were read and adopted, excepting that it was resolved to add the words "not sworn" (*pas assermenté*) opposite the name of Mr. Lucien Miller, graduate, who is there inscribed as having his license; Dr. Beausoleil, the Registrar, having it still in his possession.

Letters from the Hon. J. J. Ross, M.D., and Dr. J. H. L. St. Germain were read, regretting their inability to be present at the meeting, on account of their being too unwell.

As some of the members of the Board had suggested that the examiners for the preliminary examination should meet together some days in advance, to come to an understanding relative to the questions to be put at the examination, a letter from the Rev. Mr. Laflamme was read, asking the advice of this Board on the subject. It was decided that a meeting was unnecessary.

Dr. J. B. McConnell was named a member of the Board, representing the Faculty of Medicine of Bishop's College, in the place of Dr. James Perrigo, who has resigned.

The reports of the assessors of Laval University (Quebec and Montreal) were read and adopted.

The reports of the examiners for the preliminary examination were read and adopted.

Thirty-one candidates presented themselves, and ten were admitted. The following are their names:—Messrs. J. H. L. Pagé, W. S. Picotte, Ashton Kerr, Edgar Cassegrain, Arthur Lucier, D. Romuald Picard, Oswald H. Létourneau, Fred H. Wainwright, Wm. Kerr Brown and Jos. B. A. Poliquin.

The following Bachelors were admitted to the study of Medicine, after having been sworn on their respective diplomas:—Messrs. Alfred Simard, B.L., C. Eugene Parrot, B.S., Wilfred Lamay, B.S., Achille Comptois, B.A., Henri Larue, B.S., F. H. Pelletier, B.A., Achille Boisvert, B.A., Henri Lafleur, B.S., Joseph Pageau, B.S., Marc Rudeau, B.L., Arthur Poirier, B.A., Elias Groulx, B.L., George Cartier, B.S., F. X. Massicotte, B.A., Calixte Ethier, B.L., Ernest Primeau, B.S., F. X. Duplessis, B.S., Olivier Tourigny, B.S., H. Lennon, B.A., L. J. A. Noisieux, B.S., Elzéar Duguire, B.S., Hormidas Deschambault, B.L.

The report of the Committee on Credentials was read, recommending that the license be given to the following graduates, who received it, after having been duly sworn on their respective diplomas:—

Laval University, Quebec.—Michel Thomas Blais, Louis Alfred Frechette, F. X. Jules Dorion, Gustave Bacon, Joseph Eugene Mathieu, Albert Alphonse Jobin.

Laval University, Montreal.—Aurèle Nadeau, François

Plourde, Jos. George Elzéar Miville-Déchêne, E. R. T. Larue, L. O. Bournival, J. T. Arthur Gauthier, Isidore Laviolette, Henri Lesage, L. Z. Lajoie, L. A. Lacombe, O. C. Milot, G. E. Landry, F. X. Renaud, G. C. F. Schiller, Jules Jehin-Prume, H. Denis, Victor Geoffrion, Pierre Barrette, J. E. Gervais, R. Dazé, Zénophile Beauchamp, J. P. Gagnon, Eugene Lafontaine.

McGill University.—J. W. A. Seguin, J. W. Lawrence, T. P. Shaw, J. A. Henderson, W. J. Deeks, P. H. Phillemore.

Edinburgh University.—Walter Scott.

On the motion of Dr. Dagenais, seconded by Dr. Guay, it was resolved that Mr. F. X. Lemoine DeMartigny should be allowed to take the oath upon presentation of his diploma of Doctor of Medicine of Laval University at Montreal, which is not ready to-day.

The Committee on Credentials makes this further report:—That Messrs. F. X. Plouffe and J. A. Lapierre, who were lawfully admitted to the study of medicine in September, 1889, and who have presented a diploma of Doctor of Medicine dated in April, 1892, that is to say, obtained before the fourth session; that they shall only obtain their licenses on proving that they have followed the course of medicine during their fourth year, and by undergoing a further examination before this Board.

These two gentlemen having obtained from Dr. Hingston a certificate of attendance at the indoor and outdoor clinic of Laval University during their fourth year, it is resolved that they be allowed to undergo the professional examination.

Mr. A. G. Ferguson, of Vancouver, admitted to the study of medicine in 1884, and graduated in 1887 at Queen's University, makes application for a license.

Proposed by Dr. Dagenais, seconded by Dr. Rousseau, and resolved that this Board does not accord a license to Mr. Ferguson without an examination.

Mr. Eugene Ferron, undergraduate, is also referred to the Committee of Professional Examination named by the President.

The meeting adjourned at 12.15 to 1.30 p.m.

AFTERNOON MEETING.

The President *pro tem.* took the chair at 2 p.m.

The Examination Committee reports that Messrs. Ferguson, Plouffe and Lapierre have successfully passed the professional examination before the special committee appointed by the Board, and that the license be given to them. Mr. Ferron is refused.

In the absence of Dr. St. Germain, confined to his house by illness, Dr. Bissonnette laid on the table a series of amendments to the projected Medical Bill, but, as a large number of propositions of very great importance are before the chair, he did not press the reading of these amendments at present, but hoped that in the month of May next Dr. St. Germain would be able himself to explain the advantages offered by these amendments.

Dr. Dagenais gave notice that at the next meeting of the Board he would propose:—

1. That the members of this Board shall receive for each day's attendance the sum of ten dollars and their travelling expenses.

2. That the President be authorized to administer the oath to those who take their license and their degree the day before the meeting, after the session of the Committee on Credentials.

3. That the two Secretaries, the Registrar and the Treasurer receive annually a fee of two hundred and fifty dollars.

4. That Bachelors who have a right to their matriculation without examination have the oath administered to them, either at Montreal or Quebec, at least eight days before the meeting of the Board, by one of the Secretaries, who shall make a report at each meeting of the number and the name of these Bachelors.

Dr. Bissonnette asked the following questions:—

1. Have the Secretaries forwarded to each licensed physician a copy of the Statutes and Rules of the College?

Reply.—No. There only remain twelve or thirteen copies.

2. Have the Secretaries forwarded to each licensed physician the reports of the proceedings of each sitting of the Board, containing also the names of those newly admitted to degrees and licenses, and of midwives?

Reply.—No, because no copies remain of the medical register. For the last year and a half the reports of the meetings have been published in the *Union Médicale*, and Dr. Guay adds that all the members of the Board receive this journal.

3. Has the medical register, giving the names of all physicians licensed and not licensed in the Province of Quebec, been published and distributed among the members of the profession?

Reply.—Dr. Beausoleil, the Registrar, replies that he is about to prepare an alphabetical table of the names of all licensed physicians, and that then the statutes and rules, as well as the proceedings of the meetings, will be regularly distributed.

It was then unanimously resolved that the Board authorizes the Registrar to have printed an extract of the register giving the names of all licensed physicians in the Province.

Dr. Beausoleil read the following report of the Committee on Medical Legislation:—

PROVINCIAL BOARD OF MEDICINE.

COMMITTEE ON MEDICAL LEGISLATION.

Mr. President and Members of the Provincial Board of Medicine:

I have the honour to present to you the report of the Committee on Legislation appointed by you at the half-yearly meeting in May last.

Your Committee sat on the 7th of June and on the 5th of July last.

The labours of our Committee have been directed towards the creation of a Provincial Board of Examination, with the object of obtaining reciprocity of licensing with Ontario, of protecting the profession, and of gaining information.

After considerable discussion, Dr. Rottot, delegate of the Medical Faculty of the University of Laval at Montreal, suggested to the Committee to think over the following proposition, seconded by Dr. Chèvrefils:—

1. To augment the powers of the Assessors of the Medical Faculties of the Province.

2. To increase the number of the Assessors *pro rata* to the number of Committees of Examination of the Medical Faculties, up to a complement of six.

3. To permit the Assessors of the Medical Board to interrogate those candidates whose examination has appeared to them to have been unsatisfactory.

This proposition, submitted to the Universities and to the Faculties of Medicine, has resulted in the following replies:—

UNIVERSITÉ LAVAL, }
 QUEBEC, 16th June, 1893. }

DR. SIMARD, Professor Université Laval:

SIR,—In reply to the enclosed communication of the Committee on Medical Legislation, Monseigneur the Rector desires me to say that Laval University has no objection to the Assessors interrogating the candidates at the examinations of Bachelor of Arts and of Doctor of Medicine.

With respect, I remain, &c., &c.,

J. C. K. LAFLAMME,
 Secretary Laval University.

Dr. Rottot makes known the position of the Faculty which he represents as follows:—

SCHOOL OF MEDICINE AND SURGERY OF MONTREAL, }
 MEDICAL FACULTY OF LAVAL UNIVERSITY, MONTREAL, }
 MONTREAL, 1st July, 1893. }

DR. BROUSSEAU, Secretary to the Provincial Board of Medicine, Quebec:

MR. SECRETARY,—In the event of Dr. Rottot, representative of the Medical Faculty of Laval at Montreal, being unable to be present at the meeting of the 5th July of the Committee on Medical Legislation, and to make a report in the name of the Faculty, I beg to inform you officially that the motion Rottot-Chèvrefils, adopted by the aforesaid Committee, has been submitted to the Laval Faculty of Montreal on the 15th and 20th June, 1893, and has been adopted.

With respect, I beg to remain, &c., &c.,

H. E. DESROSIERS,
 Secretary,

E. M. & C. of Montreal, Fac. Med. Univ. Laval.

Dr. R. Craik reported verbally that McGill University refused to give to the Assessors of the Medical Board the power to interrogate the candidates at the examination in Medicine.

Dr. McConnell, representative of Bishop's College, reported

that it had been impossible to have a meeting of the Faculty, but that he was under the impression that his University would oppose any increase in the powers of the Assessors.

On the proposition of Dr. Gibson, seconded by Dr. Brosseau, the Committee approved of the proposition Rottot-Chèvrefils, and referred it to the Medical Board at its semi-annual meeting of September.

The votes in favour of this resolution were:—Hon. Dr. Marsil, Drs. Rottot, Brosseau, Chèvrefils, Simard, Gibson and Beausoleil. Against this resolution:—Drs. Craik and McConnell.

It was then proposed by Dr. Brosseau, seconded by Dr. Chèvrefils, That in the event of the motion Rottot-Chèvrefils not being carried, Dr. Simard be requested to forward to the Committee of Legislation his proposition relative to the facilitating of reciprocity of license between this Province and that of Ontario.

This proposition reads as follows:—

Whereas, it appears that the Board of Medicine of the Province of Ontario would be disposed to accord reciprocity to the diploma of licenciates of the College of Physicians and Surgeons of the Province of Quebec, provided that this diploma shall have been obtained by an examination held by the Board of Physicians and Surgeons of the Province of Quebec.

And whereas, in consequence of the uniform formula of the diploma of the license of the Board of the Province of Quebec, those who have already passed, or who shall pass, an examination before the said Board, would not be able to prove *prima facie* their right to such reciprocity.

Be it resolved, that the formula of the license of this Board shall for the future indicate if it has been conferred upon the presentation of a University diploma, or if it has been given after an examination before this Board.

And moreover be it resolved to ask the Medical Board of Ontario, and of the other Provinces, reciprocity for those physicians of the Province of Quebec who are of the latter class—that is to say, those who have passed their medical examination before this Board.

The whole respectfully submitted.

DR. D. MARCIL, President.

DR. J. M. BEAUSOLEIL, Secretary.

Proposed by Dr. Beausoleil, seconded by Dr. A. Dagenais, and unanimously resolved that the report of the Committee on Legislation be adopted.

Proposed by Dr. Beausoleil, seconded by Dr. Dagenais; and resolved that the Secretaries of the Medical Board be authorized to sign an agreement with the authorities of the Universities to put in operation the Rottot-Chèvrefils resolution, adopted by this Board, which reads as follows:—

“To permit the Assessors of the Medical Board to interrogate those candidates whose examination shall not appear to them to have been satisfactory.”

In case of the motion Rottot-Chèvrefils not being carried, Dr. Beausoleil proposed, seconded by the Hon. Dr. Marcil:—

1. That it is in the interest of the public to assure to the people of this Province a medical service worthy of confidence.

2. That it is the duty of the Council of the profession (Medical Board) to assure itself of the scientific proficiency of the candidates for the diploma of practice (license).

3. That every endeavour to obtain the exercise of this power of control has been frustrated by the opposition of the Medical Faculties.

4. That all efforts towards reconciling the interests of the Universities and those of the public and of the profession having been fruitless (in consequence of the refusal of certain Faculties to conform to the motion Rottot-Chèvrefils).

5. That this Board considers that it is the duty of the Government to take in hand the interest of the people in general, and of the profession in particular.

6. That a new legislation be adopted, so as to give to the corporation of the College of Physicians of this Province the control of the entry of its future members (admission to practice).

Dr. Beausoleil, Registrar of the College, read, clause by clause, the notice of motion given by him at the semi-annual meeting of last May to the Board.

Proposed by Dr. Beausoleil, seconded by Dr. Dagenais, and Resolved (1), That the fee for the certificate of admission to study shall for the future be twenty dollars (\$20), in place of ten dollars (\$10).

Resolved (2), That the fee for the Provincial license shall be forty dollars (\$40), in place of twenty dollars (\$20).

Resolved (2 a): That the regular fixed meetings of the Board of Governors shall be held the first Wednesday in July and the last Wednesday in September of each year; the meetings in July in the city of Montreal, and those in September in the city of Quebec.

Resolved (3), That the following subjects shall be part of the programme of the examination for admission to the study of Medicine:—Botany, Chemistry, Elementary Physics and Intellectual Philosophy.

Resolved (4), That the medical studies be modified in the following manner:—1. Normal Histology. 2. Descriptive Anatomy. 3. Practical Anatomy. 4. General and Special Physiology. 5. Hygiene. 6. General Pathology. 7. Medical Chemistry, Theoretical and Practical. 8. Internal Pathology. 9. External Pathology. 10. Materia Medica and Therapeutics, Practical Pharmacy. 11. Obstetrics and Pathology of Early Infancy. 12. To have been present at at least twelve confinements at a maternity hospital, and to have followed a course of clinical obstetrics of forty-two lessons, or two courses of twenty-four lessons. 13. Medical Clinics and Surgical Clinics, three courses of eight months, or four courses of six months, in an hospital containing at least fifty beds for each of the subjects. 14. Medical Jurisprudence. 15. Instruction at the Morgue. 16. Mental and Nervous Diseases. 17. Diseases of Children or Pædiatrics. 18. Gynæcology. 19. Histology, Pathology and Bacteriology. 20. Operative Medicine and Minor Surgery. 21. Medical History and Medical Ethics. 22. Ophthalmology and Otology. 23. Rhinology and Laryngology.

That the professional examination made by the Faculties and the Board shall be conformed to the above programme.

Resolved (5), That in place of two Assessors to the Faculties of Medicine, the Board shall name not less than two and not more than six Assessors for each Faculty.

That in future the Board shall only supply Assessors for the annual examination of each Faculty.

That in case of any Faculty wishing to have the services of the Assessors for a supplementary examination, notice must be given thirty days beforehand to the Secretary of the section to which it belongs, and remit the amount of the fees to the said Assessors.

The Assessors shall have the right to be reimbursed for their travelling expenses, and moreover a fee of ten dollars (\$10) for each day that they are detained by their duties.

Resolved (6), That it shall be part of the duty of the Assessors to be present at the examination of each student. Before proceeding with an examination, the Assessor shall enter in a book *ad hoc* the names and surnames of each candidate, the date of his certificate of admission to study, the title of each subject for which he has a certificate of attendance, and he will note in writing his observations in such a manner as to show cause for his report. The notes of the Assessors shall be the property of the Medical Board.

Resolved (7), That the Assessor shall only hear the examination of such candidates as shall have fulfilled the following conditions: For the primary examination he must have a certificate of admission to the study for the space of at least two University sessions in a Faculty of Medicine recognized in this Province, conformably to the regulations of the College of Physicians and Surgeons of the Province of Quebec.

The primary examination shall include Normal Histology, Descriptive and Practical Anatomy, Bacteriology, General and Special Physiology, Hygiene, General Pathology, Medical Chemistry Theoretical and Practical, and Practical Pharmacy.

Any candidate who shall have failed in Anatomy or Physiology shall have to undergo the entire examination afresh.

Resolved (8), That the final examination shall include Internal and External Pathology, Materia Medica and Therapeutics, Obstetrics and Pathology of Early Infancy, Medical Jurisprudence and Toxicology.

No candidate shall be admitted to the final examination without having passed his primary examination to the satisfaction of the Assessors of the Provincial Medical Board.

Resolved (9), That the following subjects of special instruction shall be part of the examination questions in the practical examination:—Mental and Nervous Diseases, the Diseases of Children, Pathological Histology, Gynecology, Operative Medicine and Minor Surgery, Ophthalmology, Rhinology, Otology and Laryngology.

No candidate shall have the right to pass this final examina-

ation before the Assessors without he shall have studied in a University during at least four sessions, starting from the date of his certificate of admission to study; so as to have in all points conformed himself to the statutes, rules and regulations of the College of Physicians and Surgeons of the Province of Quebec.

Resolved (10), That in giving notice of the date of their annual examination, the Faculties shall also inform the Secretary of the section to which they belong of the names of the candidates for examination, both primary and final.

Resolved (11), That the Assessors shall only be required to go to the Faculties when these latter shall be ready to pass consecutively all the students who shall have entirely conformed to the requirements of the statutes and regulations of the College of Physicians and Surgeons of the Province of Quebec.

Proposed by Dr. Beausoleil, seconded by Dr. M. Guay, and resolved that Dr. J. A. Duchesneau, of Terrebonne, be named a member of this Board, to replace the late Dr. W. Prevost.

Proposed by Dr. Beausoleil, seconded by Dr. Dagenais, that the resolution adopted by this Board in May, 1892, concerning admission to the study and to the practice of medicine enters this day fully into force, without consideration for the permits to study obtained before 1892, and that the Secretaries of the Medical Board inform all the medical corporations of the Dominion of this rule.

That the present resolution shall only be applicable to those Provincial Boards of Medicine with whom the Board of this Province has not established reciprocity of license.

Unanimously adopted.

Proposed by Dr. Brosseau, seconded by Dr. Beausoleil, and resolved that the following names be added to those of the former Assessors:—Drs. J. Gauthier, H. Cholette, A. R. Marsolais, F. Paré, J. Girouard, P. J. L. Bissonnette, W. Grignon, J. A. Duchesneau, J. M. Beausoleil, E. P. Lachapelle, Côme Rinfret, C. S. Parke, W. A. Verge, P. M. Guay, Thos. Larue.

On the motion of Dr. Guay, seconded by Dr. Brosseau, a vote was passed thanking Laval University for the gratuitous use of their rooms.

The meeting adjourned at 4.15 p.m.

—*Translation of the Official Report in l'Union Médicale.*

THE MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, May 12th, 1893.

JAMES STEWART, M.D., PRESIDENT, IN THE CHAIR.

Large Scrotal Hernia.—Dr. ARMSTRONG brought before the Society a man suffering from an enormous hernia. It had been gradually increasing for the last twenty-four years; a truss had never been worn. The sac seemed to contain the greater part of the small intestines, and the ring was large enough to admit the fingers to the knuckles. Dr. Armstrong intended to transplant the cord and close the opening.

Dr. SHEPHERD referred to a similar case upon whom he had operated several years ago. The sac contained all the abdominal contents, except the stomach and rectum. The testicle, which was cystic, was removed, and the canal completely closed. There has been no return.

Macroglossia.—Dr. SHEPHERD showed an infant of six months suffering from an extreme degree of macroglossia. The tongue projected about two inches from the mouth, and great difficulty was experienced in feeding the infant. He proposed to remove the tongue with the ecraseur.

Poisoning by Sulphate of Copper.—Dr. WYATT JOHNSTON exhibited the stomach of a man aged 28 who had committed suicide by drinking nearly a quart of a saturated solution of sulphate of copper from a battery jar in the electric works, where he was employed as a night watchman. Death occurred in an hour and a half. The stomach and intestines had externally a leaden-blue colour, and contained a large amount of pale grayish-green flocculent fluid. The mucosa had the appearance of having been tanned, and was stained a deep green colour. Chemically, the contents of the stomach were found to consist of basic or sub-sulphate of copper. Heart muscle and liver parenchyma looked opaque and grayish. No examination for copper was made of these organs.

Dr. W. F. HAMILTON said that the patient had been admitted to the General Hospital shortly before death. Large quantities of warm water and mustard failed to produce emesis. He seemed to suffer from extreme pain and difficulty of respiration, owing to a quantity of mucus in the throat.

Extremities were cyanotic; superficial capillaries were markedly dilated. There were some mucous and watery stools.

Dr. MILLS asked if there was any evidence along the course of the vessels and lacteals to indicate whether the salt had been absorbed into the blood.

Dr. JONSTON replied that there were no signs to indicate that absorption had taken place; no naked-eye changes in the blood.

Localized Tuberculosis of Ascending Frontal Convolution.—Tuberculosis of one Suprarenal.—Dr. ADAMI exhibited the drawing of a brain recently removed by him, presenting a peculiarly rare localized tubercular lesion, affecting the centres for the movements of the upper limb and neck of the left side.

The patient, a woman of 28, phthisical and a morphine maniac, a patient of Dr. Stewart at the General Hospital, had for two days before death suffered from repeated attacks of an epileptic nature, in which there were convulsive movements of the left upper extremity and the neck, so that the head became pulled down to the left and the face turned partly to that side. These movements were executed with great rapidity, as many as 145 contractions of the extremity being recorded per minute.

At the autopsy there was found old phthisis of both apices, and extending from there a condition of acute tubercular broncho-pneumonia, miliary tubercles of relatively large size being scattered all over both lungs. Both the kidneys and the liver presented similar tubercles, while the medullary substance of the right suprarenal contained caseous tubercular foci of large size. The left suprarenal had a grey softened medulla, but was not tubercular.

A condition of great interest was exhibited in this brain. Careful examination and section revealed no tubercular affection save at one spot—an area a little over half an inch in diameter, situated upon the right ascending frontal convolution, at either apposed side of a fold forwards in that convolution, at the level of the sulcus which separates the superior from the middle frontal region of the brain. Here miliary tubercles surrounded the surface vessels, and the tubercular process extended along the sheaths of the branches given off from these and formed small wedge-like masses, passing through

the grey to the outer surface of the white matter. Dr. Adami pointed out a tubercular lesion of such small dimensions affecting so distinctly one group of associated movements was almost, if not quite, unique. He called attention to the fact that this case supports Ferrier's conclusion reached by experimental research that the area for the movements of the neck passes backward to the ascending frontal, and overlies or intermingles with the areas for movements of the upper extremity.

Recto-ovarian Fistula.—The same case presented another rarely recorded condition. Upon removal of the pelvic organs *en masse*, it was found that both ovaries were situated low down in the cavity, and were there bound to the vaginal end of the uterus by firm old inflammatory adhesions. They were fibroid and contracted. The fallopian tubes curved downwards to them and did not present such extensive evidence of inflammatory disturbance. It is to be noted that the left tube was not at its extremity in close attachment to the ovary.

Upon attempting to cut away the left ovary a fistulous track, containing foul-smelling contents, was opened, and upon passing a sound into this, it emerged into the rectum at a point about $3\frac{1}{2}$ inches above the anal orifice. The ovary lay curved over the blind end of this fistula, which was $1\frac{1}{2}$ inches in length. There had been so much inflammatory change all around the fistula, that it was not possible to recognize microscopically anything but firm fibrous tissue in this region; however, macroscopically, the rather thin upper wall of the fistula, seen from above, was in direct connection with and indistinguishable from the rest of the ovary, while, clinically, there was the history of acute ovarian disturbance several years previously. Hence it may safely be inferred that this was a true recto-ovarian fistula.

Not a few cases of tubo-ovarian abscess bursting into the rectum are on record, but here the tube was not implicated, and Dr. Adami held that the fistula could only be explained as the consequence of an acute suppurating oöphoritis or peri-oöphoritis with rupture into the rectum. The patient had complained of no recent ovarian or rectal trouble; the fistula, as its walls showed, must have been of long standing.

Dr. WILLIAM GARDNER had never met with a condition of

recto-ovarian fistula as described. Ovarian abscess without involvement of the tube is extremely rare.

Dr. STEWART said that the case was unique as a demonstration of the location of the motor areas.

White Sarcoma of the Retina.—Dr. BULLER exhibited the specimen and gave the history of the case. The patient, a woman, aged 49, had a subacute glaucoma of some standing in the right eye. A year and a half ago she became suddenly blind. The other eye was absolutely healthy, so he had come to the conclusion that this was not a case of ordinary glaucoma, but that the blindness was due to some cause antecedent to the glaucoma. The lens had become quite opaque, thus precluding ophthalmoscopic examination, and making the diagnosis difficult. He, however, counselled enucleation, which was done. On making an equatorial section a round growth was seen on the fundus, which proved to be a white sarcoma, a condition of great rarity. The rest of the eye was in a fairly healthy condition; the detachment of the retina had not become complete.

Thoracic Empyema.—Dr. ALLAN read a paper on this subject, dealing with the surgical treatment.

Dr. SHEPHERD thought that ordinary cases following pneumonia got well after aspiration. But in cases where incision into thorax, with removal of one or more ribs, is performed, the operation gives great satisfaction. He never washes out the cavity except when the pus is foetid, as he considers it unnecessary to introduce foreign matter.

Dr. MCGANNON said that there was a great difference of opinion about washing out the cavity. Some say that the procedure causes shock, but he thought shock might be due to hæmorrhage. A weak solution of peroxide of hydrogen could never do harm, and might be of great service.

Dr. STEWART had recently seen three cases of pneumonic empyema, and none had been successfully treated by aspiration.

Stated Meeting, May 26th, 1893.

DR. JAMES BELL, 2ND VICE-PRESIDENT, IN THE CHAIR.

Dr. ARTHUR BEERS was elected a member.

Exophthalmic Goitre.—Dr. J. B. McCONNELL presented before the Society the patient, a woman 45 years of age, married 25 years, 4 children, the youngest being 5 years. The trouble began in the summer of '91, when she began to suffer from a spasmodic cough, which seemed to arise in the throat, and was associated with a great deal of palpitation. During the winter following she got rid of the cough, but the palpitation grew worse. During the summer of '92 the palpitation was so bad that she could scarcely lie down. She noticed the swelling of the thyroids first about Christmas, '92, and they have grown gradually larger ever since. In the spring of '92 she first observed some brown pigment spots on different parts of her body; since then they have appeared on the hands, the shoulders, the inner sides of the thighs, and somewhat less marked on other parts of her body. Associated with these pigment spots are patches of leucoderma. The exophthalmos is not as yet very well marked; it is becoming more so, however, seeming to be following the other two cardinal symptoms. She has also suffered from marked tremor, which has been a little better of late, several days' rest seemingly having rendered it quieter. Her pulse ranges from 90 to 120, and is very irregular.

Examination shows the heart to be considerably enlarged; the apex beat is considerably to the left of the normal point.

It is a very typical case of Graves' disease. The pigmentation, however, does not appear to be a very common complication. In Pepper's system of medicine it is not even mentioned; Osler, however, speaks of it as one of the complications of this disease.

There is no anaemia, although she is emaciated and somewhat pale; the corpuscles number 5,200,000 to the cubic millimetre.

Dr. ADAMI remarked that pigmentation was very common in the cases of this disease he had seen, in a country where Graves' disease appeared to be particularly common, Lancashire. It was looked on there as the fourth cardinal symp-

tom. Pigmentation is interesting as showing the nervous nature of exophthalmic goitre, and brings it into relation with more than one disease in which there is some affection of the sympathetic system. Addison's disease is another of these.

Dr. LAPHORN SMITH extolled the use of the galvanic current in the treatment of the disease, comparing it to quinine in malaria and mercury in syphilis. He cautioned moderation in the turning off or on the current, remarking that the sympathetic nature of the trouble is shown by the tendency of the patient to faint or turn pale under even the slight shock thereby incurred. A single sitting often reduces the size of the tumour quarter of an inch. A lady afflicted with this trouble, and in whom the tumour is so large as to obstruct breathing, had been accustomed to come to him yearly for several years, just to have it reduced, it growing again in the interim. The strength of the current used varies from 10 to 15, and rarely up to 20 milliampères. No puncture was ever made, simply an electrode large enough to cover the surface, and to effect this it is better to make it concave. Clay or absorbent cotton answer very well for its manufacture.

Dr. KIRKPATRICK related the history of a case where the galvanic current had been used with results corresponding to those of Dr. Smith. The patient usually stood 10 milliampères, commencing with 5, and gradually increasing. In the *Medical News*, a few months ago, a case was mentioned where the Faradic current had been used with equally gratifying results. On the other hand a case occurred in the General Hospital some time ago, where the constant current had been used without any result. Probably, after all, it is only in a certain number of cases where it is of use.

Dr. McCONNELL asked on what principle galvanism is used in this disease. The enlargement of the thyroid is a secondary phenomenon. It seems to begin in some affection of the sympathetic, a vaso-motor paralysis localized to a certain extent; in this way the heart is primarily affected. Goitre and other symptoms seem to be secondary and not essential, from a causative point of view. Have they applied the current with a view to reduce the enlargement, or has the sympathetic been galvanized?

Dr. L. SMITH thought galvanism acts as a powerful tonic to the sympathetic. He believed that the beginning of the disease is a paralysis of the vaso-motor nerves in the thyroid, resulting in a hyperæmia of that gland. Galvanism acts by renewing the tone to these vessels, and the fainting, etc., which are observed to follow a too sudden application of the current, are due to the too rapid tightening of the sympathetic in the brain, the blood being thus temporarily cut off.

Cases of Cystic Diseases of the Ovaries.—Dr. ADAMI had recently received for examination a very interesting series of cases of disease of the fallopian tubes and ovaries, and brought some of them before the Society in order to invite discussion upon the subject of ovarian cystomata.

Case I. Chronic Salpingo-öophoritis.—The two tubes and ovaries exhibited were obtained by Dr. Alloway from a woman aged 38 years, who had been married 11 years. She had been twice pregnant, the last pregnancy occurring 11 years ago, when there was evidence that she suffered from septic peritonitis. Upon examination before operation the uterus was found contracted, the ovaries and tubes enlarged, fixed and acutely tender and painful upon pressure. Dr. Alloway operated upon May 22nd, and upon exposing the parts found extensive delicate veil-like adhesions binding the ovaries to the surrounding organs; firmer adhesions bound the ovaries to the outer ends of the tubes. These numerous adhesions complicated the removal.

Left ovary and tube: The tube was tortuous and $\frac{3}{4}$ in. in diameter. The walls appeared firm and greatly thickened, but upon section the reverse was found to be the case, for the tube was greatly dilated and thinned in its outer half; the smaller and narrower proximal half alone showed thickening of the walls, while the dilated region was filled with thick, almost solid, inspissated pus, which presented no cell structure, but only granular and fatty débris. There was almost complete stenosis of the uterine extremity of the tube; the ovarian extremity was completely occluded and was distended, all indications of the fimbriæ having disappeared. Upon the outer wall of the tube, close to the ovary, there was a small white body of the size of a No. 12 shot; this, when opened,

was seen to be a cyst filled with similar inspissated cell débris, but unconnected with the lumen of the tube. The ovary, which was of fair size, presented in the substance of its inner half a cyst as large as a pea. This possessed a well-marked capsule, and was filled with similar fatty cell débris. Apparently this was the remains of an enlarged and suppurating graaffian follicle. The outer half of the ovary was almost entirely formed of a corpus luteum, with thickened sinuous walls and firm central area containing blood pigment.

The right tube presented a condition similar to that of the left. It was enlarged and tortuous, and its occluded extremity was adherent to the ovary. There was the same almost solid cheesy material filling the thinned and distended outer half; no trace of the fimbriae could be determined, either externally or coiled within the tube. Immediately below the tube and to its outer end was a cyst with contents similar to those of the tubes and cysts already described. The outer wall of this cyst was in direct contact with the ovary, and it was a question as to whether this was of ovarian or ligamentous origin. The ovarian tissues could not be traced into its walls, and this, together with the position, favoured the latter view. The right ovary, like the left, contained a small cyst filled with cell débris and an old corpus luteum, and neither attained to the dimensions of those in the left ovary.

The well-formed veil-like adhesions, the nature of the contents of the tubes and abscess cavities, the complete disappearance of the fimbriae, all indicate a peculiarly long-standing condition, as also did the history and sterility of eleven years' standing, but the most instructive feature of the case is the series of cysts here presented, for these masses of semi-solid fatty material, surrounded by definite capsules, may quite rightly be described as cysts. Clearly there had been a tendency towards the formation of chronic suppurative foci, not only in the tubes and ovaries, but also around them, so that we have cysts of inflammatory origin (1) in the ovaries themselves, starting in the corpora lutea, (2) in the broad ligament, (3) upon the outer wall of the fallopian tube, and (4) in the fallopian tubes; for these have become occluded, and each with its lumen distended by old inflammatory products, may be looked upon as cystic.

Case II. *Pedunculated Sub-peritoneal Fibro-myoma: Cystic Graaffian Follicles.*—Here was a sub-peritoneal fibro-myoma attached to the posterior portion of the uterus by a ligamentous membrane, which allowed it to be quite distinct and separable from the uterus. The ovaries in this case also showed evidence of disease. The right one was of fairly normal size; on section a cavity with a sinuous wall was seen; this cavity is certainly nothing other than a large corpus luteum which has undergone cystic degeneration and is now being absorbed. So that here is another form of cyst of the ovary. In the last specimens we had to do with a cyst which resulted from the suppuration of a Graaffian follicle, or corpus luteum; in this one we have a corpus luteum which, instead of undergoing its normal course of enlargement, followed by atrophy, has increased abnormally (it was at least 30 millimeters in diameter). The blood first poured out had become absorbed, and was replaced by a fairly clear fluid, and only now, judging from the sinuous capsule, was absorption taking place. The left ovary in this case showed two other cystic conditions. One appeared to be a comparatively recent corpus luteum, the blood pigment still being in it, with little crystalline masses of hæmatoidin, the centre being a clear cystic space. The second was a simple cyst partially filled with semi-solid broken down cell matter, the rest of the cavity being filled with clear fluid.

Case III. *Multilocular Ovarian Cyst of Great Size: Cystoma Proliferum Glandulare.*—This case, sent by Dr. Gardner, is interesting on account of its great size, and from the fact that upon first sight it appeared to be one huge single cyst, completely filling up the lower abdominal region. There were, however, towards the lower and hinder portion a few small cysts connected with it, corresponding, it would seem, to the region of the original ovarian tissue, and upon the anterior wall could be felt three or four hardened areas, or "plaques," the largest being several inches in diameter. Upon opening the large cyst and removing the mucoid material contained, these flattened plaques could be seen projecting slightly into the interior. The specimen had been sent in order to determine the nature of these thickenings of the wall.

Waldeyer has divided the ovarian cyst-adenomata into two classes, which, it must be admitted, are not sharply separated, for a very large proportion of ovarian cysts, if carefully studied, must be placed under both of his headings. These are: (1) that of the "cystoma proliferum papillare," in which the connective tissue of the wall of the mother cyst undergoes great proliferation, forms papillomatous projections, and the papilla, covered by a layer of epithelium, and coming into contact here and there, form thus the secondary cysts; (2) In the second class, or that of the "cystoma proliferum glandulare," it is the columnar epithelium lining the mother cyst that is the more proliferous, and that dipping down into the underlying connective tissue, there form follicles, which, becoming occluded, develop into the secondary cysts. Now, the plaques in this specimen, when examined microscopically, are seen to be composed of a relatively small amount of fibrous stroma, enclosing very numerous small follicles and cysts lined by a single layer of columnar epithelium, tending to invade the capsule of the mother cyst. Hence to this extent the tumour must be classed as an adeno-cystoma of the glandular type.

We have, therefore, in the series of examples brought before the Society, a not uninteresting series of the main forms of cystic growth in the ovary, the dermoid cysts alone being deficient. We have the Graaffian follicle, which, owing, it would seem, to coincident inflammation in and around the ovaries, forms a corpus luteum of great size and aberrant course, becoming either the seat of inflammatory change itself, so that the cavity contains, eventually broken down cell material, puriform debris, or again becoming a cyst of moderate size filled with clear fluid. And again, we have a very fair example of the form of multilocular ovarian tumour of the more important type clinically, with regard to whose etiology there is still divergence of opinion.

Are the multilocular ovarian cysts, the cyst-adenomata, also developed, like the simple cysts above described, from Graaffian follicles, or have they another origin? The fact that the columnar epithelium lining them is of a simple type, that they and the tumour which they form are of an embryonic type, and that coincident with this more or less embryonic nature

the tumours are of fairly rapid growth and incline towards malignancy, are, on the whole, against the view that they develop from mature Graaffian follicles. And with Waldeyer and Malassez it is generally held that they are developed from an earlier stage: that just as the Graaffian follicles themselves originate from processes or follicles growing inwards from the epithelium covering the surface of the foetal ovary, so these tumours arise from similar ingrowths in later life; and Malassez has seen such ingrowths from the surface, resembling a cylinder epithelioma. On the other hand, Ritchie states that he has observed the ovum or its remnant in the smaller cysts of a multilocular tumour, and these smaller cysts, like the Graaffian follicles, have limpid contents; while Galabin has seen processes similar to a cylinder epithelioma starting from Graaffian follicles, and not from the surface. There is, it appeared to Dr. Adami, no inherent improbability that the adenomatous growth should start from the adult (glandular) follicles, just as adenoma or carcinoma of the mammary gland is supposed to start from adult gland tissue in the mamma.

The matter might seem to be one of minor import, for the same original epithelium is implicated in both cases, the only question being as to the stage of development reached by that epithelium at the moment when the tumour begins to form. Nevertheless, it is one that has been much discussed, and a series of examples, such as those brought before the Society, might serve to start and illustrate a discussion on the subject.

Dr. ALLOWAY, commenting on "Case I" of the series just discussed by Dr. Adami, said that since her last childbirth, 11 years ago, when she had puerperal fever, she suffered from pelvic pain, so severe as to almost incapacitate her for work; and that this history led him to suspect that she had wholly inflamed and adherent ovaries and tubes, and that there was also pus, possibly in an inspissated condition, in the tubes. He was pleased to find such was the case. In the operation he found great difficulty in separating the adhesions, which, from their density, must have been there for years. He ligated the tubes close to the uterus, where they were not inflamed. Good recovery.

Case II was a subperitoneal fibro-myoma, which is much

more common in the negress than in the white woman. The uterus was in ante-version; somewhat enlarged (9 centimetres in depth), but not sufficiently so to produce much hemorrhage. The fact of the tumour being entirely separated from the uterus simplified the operation; it was only connected to the uterus by a ligamentous band, which was covered with peritoneum; in fact, by a sort of meso-metrium. To cause the complete disappearance of all the symptoms, he thought it better to bring on the menopause, and, to do this, adopted Tait's operation—the removal of the appendages. This, where the uterus is not very much enlarged, is adequate, safer, and, therefore, a better operation than total extirpation. The tubes were found, on pathological examination, to be chronically inflamed.

Abdominal Section after Confinement.—Dr. ARMSTRONG read a paper on this subject, which appeared in the July number.

Dr. ENGLAND, referring to Case No. 3 of the series just reported, had nothing more to add to what Dr. Armstrong had so well expressed. The woman had a very satisfactory puerperal period. The giving of the enema was, or seemed to be, the beginning of her pain, which persisted till death. He saw her the same night as the enema had been given, and even a hypodermic of morphia could not relieve pain.

Dr. LAPHORN SMITH dwelt upon the necessity of greater care being exercised by the accoucheur in cleansing the hands, and for this purpose he knew of nothing better than permanganate of potash and oxalic acid.

Relative to Case No. 3, he did not agree with Dr. Armstrong in thinking that a volvulus or obstruction was the cause of the trouble. Two pints of pus in the peritoneal cavity is more than could be manufactured in such a short time, and in his opinion it must have been locked up somewhere in the form of an abscess, and during the administration of the enema it suddenly burst and flooded the cavity.

Dr. J. C. CAMERON said that Dr. Armstrong's series of cases seem to confirm the belief that abdominal section is sometimes useful in local peritonitis, and that it is always hopeless in general septic peritonitis.

With reference to curetting, he said that this should be

done before the peritonitis was set up. Where there is a suspicion of any portion of the placental tissue being left in the uterus, we should not treat a rise of temperature with douching. Douching is not sufficient to remove any adherent membranes or placenta; nothing but the curette is sufficient in such cases. Here in Case 2, if the curette had been early used, the necessity for an abdominal section would have been spared. Interfere early and interfere thoroughly was his advice in all such cases.

He was not in accord with Dr. Smith in his absolute faith in permanganate of potash and oxalic acid as disinfectants. He thought it a dangerous doctrine to set forth that the thorough use of those agents on the hands does away with the necessity of any or all other precautions. In the abstract it may be correct to say that thorough disinfection makes previous occupation of no importance; but, in practice, it will be found unjust and unwise to counsel men that they may leave the post-mortem room and confine a woman with impunity, provided they wash their hands in permanganate and oxalic acid. It will be found that disinfection comprises much more than the cleansing of the fingers.

Dr. JAMES BELL thoroughly agreed with Dr. Cameron's remarks regarding the insufficiency of manual disinfection. The truth of this is well seen in the hospital, where students, ever apt to seize upon the most prominent part of the technique, often confine their disinfection to washing the hands, etc., and neglecting other and very essential precautions.

Dr. ARMSTRONG, in reply, said that relative to the Dr. Smith belief that the hands are the only source of infection in midwifery, it has lately fallen to his lot to see three cases, two of them fatal, occurring in the practice of accomplished, faithful, truthful men, who asserted that the children were born before they reached the house; that they never touched the vulva, never made a vaginal examination. Granting that the hands are the most important part, if you have a dirty field of operation, a dirty vulva; if you have fecal matter coming down, no matter how clean your hands are, you carry over the germs that are on that surface; you must have everything clean.

In regard to Case 3, and Dr. Smith's remarks about the two pints of pus, he said that he had no knowledge of any kind of peritonitis that could be present for nine days and give no symptoms; that, at the operation, puzzled with the obscurity of the case, the incision was enlarged and a most thorough examination of the cavity and its contents made, with a view to find an abscess or some such explanation for the quantity of the pus, but without success. In the face of these facts, unlikely as it appeared, the conclusion expressed was the only one left them.

In regard to operating in peritonitis, he agreed with Dr. Cameron; still there is no other hope for these patients, and while there is even the shadow of a chance by operating, he felt it is hard to refuse to undertake such a step.

THE CANADIAN MEDICAL ASSOCIATION.

(Reported by Dr. J. N. E. Brown, Official Stenographer of the Association.)

THURSDAY, Sept. 21st, 1893.

AFTERNOON SESSION—*Continued.*

Dr. HODGE presented three cases of Friedreich's ataxia in one family, two sisters and a brother. Father had eczema of legs so badly that he was obliged to use crutches; also had leucoderma of hands. A paternal uncle suffered from hemeralopia. These were the only neurotic points in the family history. The first, M. W., aged 41, had a history of falling down stairs, having since then a weakness in the legs; got worse since she was ten years of age, now patient could not walk without support. Staggered while standing with eyes open; left alone falls forward; gait like one drunk. Leg muscles suffer only atrophy of disuse; legs sensible to pain, touch and temperature variation. Has pain now and then in right hip. Plantar reflexes normal; patellar increased. Feet in condition of talipes varus. Marked curvature of spine; upper extremity normal; pupils act normally. When she looks to either side there is marked horizontal nystagmus. Face not symmetrical, mouth drawn to left side; tongue on protrusion

turned to right and exhibits fibrillar twitching. All senses normal. The second, Sarah, aged 37, has suffered since she was 13, but nothing wrong with gait till six years ago, at which time she received a hurt in the knee; now she cannot walk without a cane; she would fall forwards if unsupported. In most respects she resembles her sister. Her speech is slow and not very plain.

The brother, aged 36, deformity of feet began at 15. When eyes were closed he would fall backwards. Gait wide-legged and zig zag and somewhat stamping. Lying down he can do all the ordinary movements of the legs. In prominent symptoms much like sisters'. Right hand is claw-shaped. Atrophy of muscles of hands. Left hand somewhat affected too. Curvature of spine. Suffers with excessive sweating.

Drs. Meyers, Macallum, Mills, Arnott and Moorhouse took part in the discussion, Dr. Hodge replying.

Dr. McKEOUGH then followed by reading a paper on "Puerperal Eclampsia." In all cases the urine should be examined, more especially in primiparæ, who make up seven-eighths of the cases. Albuminuria, however, was not always followed by eclampsia. The prophylactic treatment should be directed to diet and the use of eliminatives. Fluid diet (milk being the best) should be recommended. Salines should be given to keep the bowels free, while for the skin nothing was so good as the daily hot bath for 20 minutes, the temperature on immersion 99° and gradually raised to 112°. Ice might be applied to the head and large quantities of water should be given the patient. If after this treatment the albuminuria is still present, labour should be induced. The process the reader of the paper then described. If any nervous symptoms showed themselves chloroform should be administered. One should always keep in mind in treating such cases three points in the etiology—heightened vascular and nervous tension; the presence of some poison, probably from the kidneys, in the system, and the presence of the foetus in utero. If eclampsia comes on in spite of all previous treatment the steps should be, (1) sedative; (2) eliminative, and (3) induction of labour. The doctor referred

to venesection. In certain plethoric cases it might prove useful; but in trying it as a last resort in two of his own cases it did not save them. In 50 cases in Guy's in which it was performed 20 per cent. died. Immediately after in 34 cases where it was not used 20½ per cent. died.

THURSDAY EVENING.

The report of the Committee *re* Inter-provincial Registration was presented by Dr. Praeger, in the absence of Dr. J. E. White, Chairman of the Committee. It proposed that a Dominion Medical Council be formed "to take general surveillance of the medical curriculum, and of all matters affecting the general public and profession of the whole Dominion," formed either by representatives (one each) from the members of the various Provincial Medical Councils, or elected by the medical population of Canada, irrespective of provincial lines; or on the "line of the British Medical Council." Its duties should be the equalization of the medical curriculum to a just and high standard; to secure inter-provincial reciprocity; to have the power to withhold or take away a Dominion license from a provincial graduate for a just cause; to approve all provincial examination papers before they were presented to candidates. There should be only one examination for the provincial and Dominion licenses, an extra fee for the latter. If it followed the British Medical Council in its formation, the British Medical Council regulations should be operative as applicable to the Dominion. All men now on provincial registers to be entitled to Dominion registration within one year of the formation of the first Dominion Medical Council, on payment of \$10. All practitioners outside of Canada and Great Britain would be allowed a Dominion license upon passing the prescribed examination. All those on the British register would be entitled to registration upon payment of \$25 as soon as Great Britain extended the same privilege to Canada. The Committee further recommended that the Association, through a committee, should present these views to the Provincial Councils, and by concerted action with them to apply at the next session of Legislature for

such permissive legislation as would be required to establish the powers and duties of the Dominion Medical Council. If any Provincial Council refuses to accede to the demands of the general profession for these objects, that this Association should instruct their delegates to go to the Legislature of such Province and secure the required concession.

Dr. PRAEGER moved its reception.

Dr. A. B. MACALLUM thought there were a great many difficulties in the way of bringing about the result desired in the report. The formation of a Dominion Council as recommended in the report would have to conflict with the various Provincial Legislatures which had under their control the subject of medical education. Such a council would be inert. One of the difficulties was that the graduates of universities in Quebec were granted licenses to practice, while this was not the case in Ontario. If such outside universities were granted such extended privileges, the Ontario, Manitoba and institutions of the other Provinces would be clamouring for their rights. Then, too, the courses of study in medicine in the various universities were much different. In Quebec, for instance, subjects were taken up which were regarded as foreign to medical education. Some of their universities demanded of the students a knowledge of Catholic history, metaphysics, etc., much to the dissatisfaction of the English minority. Dr. Macallum would strongly support a Dominion Council, but one with powers considerably different from those outlined in the presented report. A British Medical Council would answer our conditions far better than such a Dominion Council as proposed. He suggested that representatives of all the various councils and universities of the Dominion and Britain form a Council and that they, after debate, recommend after proper legislation, that the standard shall be raised in this or that subject of every Province. Then it would be easy to have the desired reciprocity. The report presented was a most ill-digested one.

It was moved by Dr. CAMERON and seconded by Dr. MACALLUM that the report be tabled. This carried.

Dr. WESLEY MILLS, of Montreal, then took up the subject,

“Peculiar Forms of Sleep or Allied Conditions.” He gave a report of his observations of the arctomysmonas (wood-chick) during a period of five years, and more particularly during its season of hibernation. With the phenomena presented he compared strikingly similar phenomena in two or three cases in human individuals. Some of the points were the periodicity of the attacks of stupor, abstinence of food and consequent emaciation, great slowing of respiration and circulation, the partial cessation of stupor to attend to urination and defecation, the tendency to increased reflex action. The professor’s account of the lethargic condition in man was listened to with exceeding interest, the cases, some of them being authentic, having come under his own observation. The professor, as an evolutionist, contended that these tendencies were analogous to those in the lower animals, and inherited, so to speak, from them. Although Dr. Mills takes this advanced view, he says he is inclined less than ever to pooh-pooh what is said regarding trances and other similar popular notions.

Dr. A. B. McCALLUM, of Toronto, while admiring Dr. Mills’ able paper very greatly, took some exception to his views. He contended that pathological conditions in the subjects whose cases were cited caused the lethargy; no such change in the brains of the lower animal, so far as he knew, took place. The subject, however, was one of extreme interest in connection with medical psychology—a question of the relationship of periods of lengthened sleep to mental disease. Dr. Mills would be prepared, he said, to believe in the Rip Van Winkle legend. (Laughter.)

Dr. CAMERON regretted that Dr. Mills had been obliged to omit the latter part of his paper, which dealt with the real nature of the hibernating and allied conditions. It would have been interesting to have heard a comparison between such various conditions as sleep, ordinary coma, the somnolent form of status epilepticus, etc. Regarding the pigmentary and fatty changes Dr. Mills spoke of, all were familiar. As to pathology, Dr. Cameron was inclined to think it was more a question of pathological chemistry than a gross pathological change.

Dr. H. A. McCALLUM gave Dr. Bucke’s tide theory, that

sleep was influenced by or in the same manner as the tides. The child's sleep corresponded to the two periods of rest between the tides.

In replying, Dr. MILLS said that changes had been observed on examination of the brain cells of hibernating animals. He believed the object of the condition was for preservation of life. In winter, when it was difficult to get food, the wood-chick did with little or none. On account of his peculiar condition, inherited, no doubt, from his sluggish ancestors of ages ago, "Sleepy Joe" (one of the cases reported) found it agreeable to his constitution and economical to spend that portion of time when sustenance was difficult to obtain and weather inclement in the lethargic state. Regarding the Rip Van Winkle story, he (Dr. Mills) thought it was, like Shakespeare, a case in which the genius anticipated the science.

Dr. J. C. MEYERS, of Toronto, then read a paper on "Multiple Neuritis." He gave a brief history. Family history negative. Had for eleven years a suppurating knee; began from an injury. Always used to work. Two years ago had an attack of paralysis, from exposure to cold; recovery in ten weeks. Present illness began in July last. Noticed first stiffness in right foot, which soon attacked the left, then went to the hand. The stiffness changed to paralysis, legs and forearms becoming involved. Took to bed. No pain or abnormal sensations. Complete paralysis of the flexors of the ankles and extensors of the toes. Posterior tibial muscles weak. All forearm muscles affected, extensors most. Slight wasting of the affected muscles, particularly those of the thenar eminences of the hand. Marked hyperalgesia over the body. Tactile and temperature sense were exaggerated. Knee and elbow jerks lost, also skin reflexes. No paralysis of the ocular muscles. Discs normal. Health in other particulars good. Galvanic current shows A.C.C. is equal to K.C.C. From August 15th patient began to improve, and is continuing to do so. Power gradually returned, muscular nutrition increasing, and ability to walk returning, the walk being that of a "stepper." Myelitis was suggested as the diagnosis; this Dr. Meyers negated by the distribution of the paralysis, integrity of the muscles, and

absence of bladder and rectum symptoms. He diagnosed it multiple neuritis, with a favourable prognosis. Treatment:—Salicylate of soda and warm baths; after a few days, strychnine and other tonics, with massage and electricity, were given.

The reader of the paper then gave a minute description of the pathological changes which take place in this disease,—the parenchyma being almost alone affected. The nerves most often affected were the anterior tibial and musculo-spiral. It was caused, it seemed, from a morbid state of the blood. This poison had a special affinity for nerve tissue. Modern pathology had enabled us to see that this was a separate disease from those with which it used often to be confounded, in which the lesions occurred in the central nervous system. Dr. Meyers pointed out the various differences between such diseases and multiple neuritis, both as regards pathology and symptomatology.

“Ophthalmic Memoranda” was the subject of Dr. A. REEVES’ paper. He referred to the progress that had been made in ophthalmology since the introduction of such instruments as the ophthalmoscope; also in the treatment of such affections as trachoma, astigmatism, stricture of the lachrymal duct, etc. The speaker outlined the present treatment for such affections, and methods of employing surgical therapeutics where necessary. He discussed at some length the subject of sympathetic ophthalmia.

Dr. OSBORNE, in discussing the paper, spoke of the necessity of treating the nasal catarrh which was found in many cases of lachrymal duct affections. He also spoke of the great value of the ophthalmometer in astigmatism.

Dr. REEVES replied.

Dr. Harrison, the President elect, was then voted into the chair.

Votes of thanks were heartily given to the retiring President, the medical profession of London and the railroads.

Dr. ANGLIN moved that the usual honorarium be given to the Secretary.—Carried.

Mr. J. H. Chapman, of Montreal, had an extensive and beautiful array of all kinds of surgical instruments on the platform, which were much admired between sessions by the members of the Association.

THE
Montreal Medical Journal.

VOL. XXII.

DECEMBER, 1893.

No. 6.

THE PROPOSED HOSPITALS FOR INFECTIOUS
DISEASES.

Through the wisdom and energy of a few members of the managing committees and medical boards of the General and Notre Dame hospitals, Montreal is likely to have two hospitals for infectious disease before long. It is in some senses unfortunate that it is necessary to have two distinct places for the treatment of infectious diseases, but any other arrangement would be impracticable in this dual city.

At a recent joint meeting of the Health Committee and representatives of the different hospitals, the former agreed to recommend that the proposition of the hospitals should be accepted. This proposition is that two distinct hospitals be erected, each to consist of several pavillions, and that the separate organizations be managed by one of the general hospitals. The city is asked to contribute the sum of \$7,000 per annum to each hospital for 20 beds and 75 cents daily for each additional bed occupied; the entire management to be under the lay and medical boards of the Montreal General and the Notre Dame hospitals.

There can be no question of the urgent necessity there is for immediate and complete provision for infectious cases. The only special provision for such cases open to the Protestant population in Montreal is the old brick annex of the General Hospital. Owing to its proximity to the new surgical wings, it has been found necessary to have it removed.

We, therefore, hope that the recommendations of the joint committee will be accepted by the Council. The General and Notre Dame hospitals have in their lay and medical officers men who are thoroughly competent in every respect to undertake the duties and responsibilities of the care and treatment of infectious cases.

The offer of a private society to undertake the management of infectious cases for a definite sum should not be entertained. Surely this province has had proof enough of the disastrous effects of farming out the sick and afflicted.

Equally undesirable would be the establishment of a civic hospital. Anyone who has visited civic hospitals in the neighboring republic will not be anxious to see them instituted in this city.

The formal opening of the Royal Victoria Hospital took place on the 2nd inst., His Excellency the Governor-General and Lady Aberdeen being present. In our next number a full account of the proceedings will be published.

Obituary.

SIR ANDREW CLARK, BART.—Through the death of Sir Andrew Clark the English profession has lost one of its ablest representatives. He rose from humble ranks to occupy a most distinguished position. As a practitioner and clinical teacher he had few equals. He was born in Aberdeen, and received his medical education in the University of Edinburgh. Here he was brought under the influence of the late Hughes Bennett. While in Edinburgh he was also Assistant Demonstrator of Anatomy to Dr. Robert Knox in his final course of lectures. Few men were more highly honoured by their brethren than Sir Andrew Clark. He filled in succession the coveted appointments of the Croonian, Lumleian and Lettsomian lectureships of The Royal College of Physicians, London. He was appointed also to the presidency of the chief medical societies of London. He was Physician and Lecturer on Clinical Medicine at the London Hospital. Since 1888 he has been President of the

Royal College of Physicians. The able way in which he filled this important position is well known.

As a consulting physician he occupied for years the leading position in the great metropolis. His relations with his professional brethren were characterized by unflinching courtesy and kindness. The thoroughness of his investigation into every detail of a case at once gave confidence to the afflicted who sought his aid and counsel. He especially excelled in his knowledge of dietetics.

His published papers refer chiefly to diseases of the chest, those on fibroid phthisis and pleurisy being especially valuable contributions.

JOHN M. KEATING, M.D.—We regret to have to record the death of Dr. John M. Keating, of Philadelphia. Dr. Keating has made a number of valuable contributions to medical literature. His cyclopædia of children's diseases is a standard work.

HUGH McEWEN, M.D.—Through the death of Hugh McEwen, of Carleton Place, on the 26th of October, the profession in Canada loses one of its most promising and rising members. Dr. McEwen graduated in McGill University in 1889, and after spending some time attending the Scotch hospitals, he started practice in Carleton Place, and soon made a reputation for himself.

F. W. SHERRIFF, M.D.—Another of our old practitioners has passed away, after a long and useful career. Dr. F. W. Sherriff died at his home in Huntingdon on Nov. 20th. A few days before he had fallen and broken his leg, and from the shock of this accident he never rallied, but passed over to the silent majority, at the age of 82.

Julius Sommerbrodt, Professor at the University at Breslau, an eminent medical authority and specialist, died at his home, August 14, 1893. Professor Sommerbrodt was the originator of the *intense* creosote treatment for tuberculosis, and he published a highly instructive and valuable report on his method. Deceased was distinguished in scientific circles, and prominent in the social life of the University town, as well as other cities throughout Germany, and he had many followers in America.

Personal.

Professor Bergmann has been elected Dean of the Medical Faculty of the University of Berlin for the coming year.

Medical Items.

— The International Medical Congress will meet in Rome from March 29th to April 5th, 1894.

— The number of students enrolled in the classes of the Medical Faculty of McGill University for the present session considerably exceeds that of any previous session.

— Dr. Harold C. Ernst, of Harvard University, has discovered a new bacillus in the fluid removed from a case of pericardial effusion. When cultivated it develops a bluish-green colour, which gradually deepens after some days. It is turned red by acids, and bright green by alkalies. Dr. Ernst has given this bacillus the name of *bacillus pyocyaneus pericarditis*.

— The contributions to the Semmelweis Memorial from England and the colonies amounts to \$400. It is to be hoped that this sum will be greatly increased. The father of antiseptic midwifery, like many another great man, received but little honour during his life. The memorial to him in his native city will prove a stimulus to future investigators.

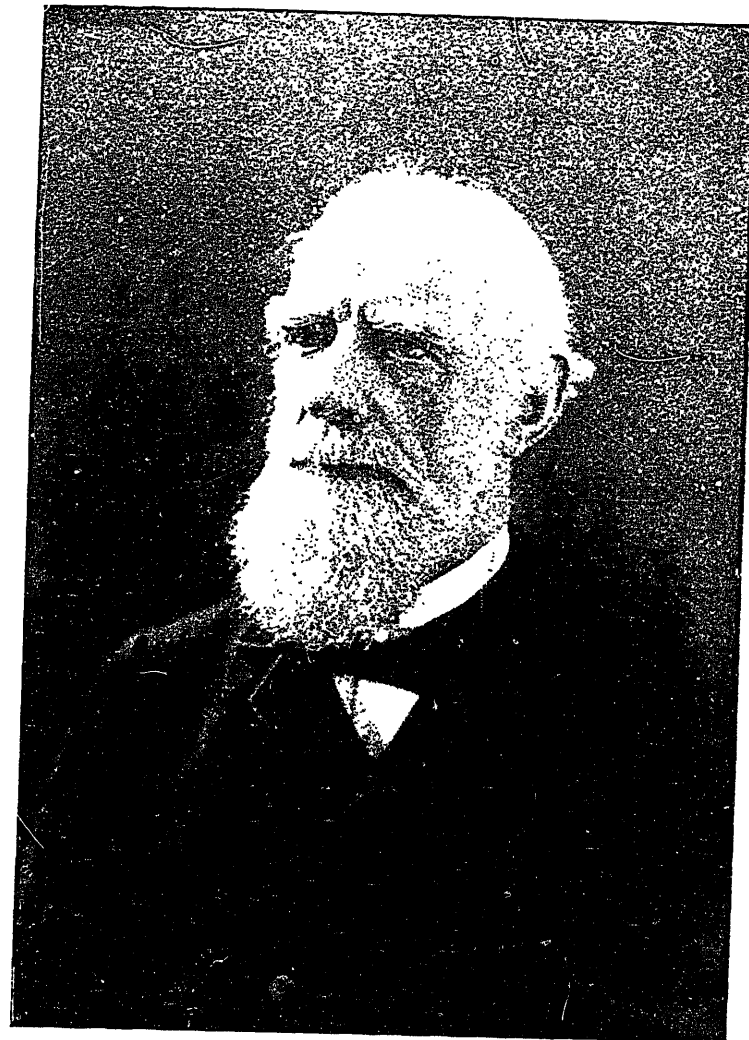
PRESENTATION.—A very pleasant event took place on Friday evening, the 20th October, at the Manse, Dalhousie Mills, when a few of the numerous friends of Dr. Walter C. Cattnach (McGill, '86) met to offer him an address and a handsome gold-headed cane, on his departure for Europe; with their sincere and hearty good wishes for his safe return to his native county, at no very distant date.

— A young doctor, wishing to make a good impression upon a German farmer, mentioned the fact that he had received a double education, as it were. He had studied homeopathy, and was also a graduate of a "regular" medical school. "Oh, dot vas nodding," said the farmer; "I had vonce a calf vot suckd two cows, and he made nodding but a common schteer, after all."

THE FOUNDERS OF THE ROYAL VICTORIA HOSPITAL.



LORD MOUNT-STEPHEN.



SIR DONALD A. SMITH.