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CANADA
MEDICAL & SURGICAL JOURNAL
JANUARY, 1881.

Original Communications.

TYPHOID FEVER AT LENNOXVILLE.

By E. D. WORTHINGTON, M.D., F.R.C.S., EDIN.

Governor College of Physicians and Surgeons, Province of Quebec.

The editorial in the December number of the JOURNAL, on "Typhoid Fever at Lennoxville," is my apology for regarding the subject as one legitimately open for public discussion. As you properly state "this is a matter of great public interest and importance. I will, therefore, venture to give you what I know of typhoid fever at Lennoxville, or rather at the Grammar School at Lennoxville, for it is a significant fact, that the two outbreaks of typhoid fever to which you refer, and to which I will confine myself, were limited to, or originated in, that institution.

The village of Lennoxville, and Bishop's College University and Grammar School, are within four miles of Sherbrooke; the College and School being contiguous, and only a short distance out of the village proper.

Typhoid fever, scarlet fever, diphtheria, or any other so-called zymotic disease, occurring in an epidemic form, would, according to all known laws, be expected to show themselves in both places, and in the surrounding country, at a period, or periods, sufficiently close to form a connecting link. At the times, however, to which you refer, neither in the village of Lennoxville, nor in Sherbrooke, nor in their immediate neighborhoods, were there any cases of a distinctly typhoid character. On looking over my memoranda of cases, I find that, since the first outbreak

of fever at Lennoxville, I have had only one case of typhoid fever, and that was in August last. In the same family, I had a case in July, 1879. Both were clearly due to local causes, independent of any epidemic or contagious influence, and in a locality removed five miles from both Lennoxville and Sherbrooke. Dr. Robertson, who is the only resident physician in Lennoxville, assures me that, in the time stated, he has not had one case of typhoid fever, and I know of no other medical gentleman in the vicinity who has had. I may add, that since the last outbreak, we have had a good deal of measles and scarlet fever in Sherbrooke, and none of them, to my knowledge, were attended by fever with even a suspicion of a typhoid type. I am aware that a son of the Chancellor of the University—a Lennoxville boy—has been ill in Sherbrooke, but I have only heard of his case as one of gastric fever (!). And on the Lennoxville road two cases occurred, the first of which, if it was typhoid fever, may somewhat weaken the strength of my statement; but as I never heard it spoken of as other than low fever, and as a brother, a student at Lennoxville, has since had typhoid fever, it will not weaken it very materially.

If I am correct in my statements, and I am open to correction, it will appear that the two last outbreaks of typhoid fever at Lennoxville grammar school, arose from a *purely local cause*.

For many years, that school has had a most unenviable, as well as a most painful reputation, as the centre of a panic, in some form or other. It is the only school in Canada, that I know of, that has struggled through such a wretched experience. There must have been some counter-balancing good in it, to have enabled it to retain its vitality. It is unquestionably a magnificent school, both for the development of mind and muscle; but it is a reproach to those in charge of it, that an implacable enemy, living on its grounds, or within its walls or wells, should not have been wiped out of existence years ago. I mean that "contagium vivum," that much abused, and now much talked of typhoid fever *germ*.

Unfortunately, for the school, when there has been a threatening of typhoid, or scarlet fever, those in charge, either from

ignorance, or obstinacy, or misdirected zeal, have rather aided in the concealment of the fact, until concealment was no longer possible, and then came a panic, and a rush for home, to the extreme peril of those at home, and to the great injury of the school. I am quite aware that this statement may be regarded as "none of his business," or be met by the remark, "We are quite capable of managing the school without any local interference," but, "Fiat justitia ruat cælum," the whole country side is interested in this affair, and there is nothing in the charter of the University that grants it the privilege of fostering, year after year, a hotbed of disease, that, fortunately, hitherto endemic, may, unfortunately, be changed in character, and become epidemic!

Last summer, just before the first outbreak of fever, when the accumulated filth of a drain, that was not a drain, and extended only a short distance beyond the foundations of the school, rendered the air offensive, by backing up its horrid stench into the building, and it became necessary to do *something*, what was done? The most dangerous thing that could have been done! The lid of the trap was raised, and the enemy let out! An enemy that had been a source of dread for years! And these *germs* were not even exorcised before getting their liberty! Incredible as it may seem, this *horrid thing* was actually opened *in term*, in the heat of summer, under the windows of school and college, and close to the public highway, *just before the close of the term*. When this hotbed of disease was opened, it was found for the first time, that this particular drain had no outlet, and that it terminated almost under the dining-room, and in common by both grammar school and college. We all know what followed. Whether what followed was the result of the opening of that drain, at that time, God knows. But, it was an indiscreet act, one involving an utter disregard of the first principles of public health, and common decency, on the part of men in charge of a large public school. Either that drain should have remained untouched for another week, *or*, the boys should have been sent home.

In proof of the statement that the presence of typhoid fever

in the school has, at least once, been kept *sub rosa* for a longer time than was quite proper, I will mention what happened one Saturday night not long ago. It is customary for the boys to have a dance in the school every Saturday evening during the winter, to which "old boys" have a standing invitation. On the Saturday evening before the last outbreak of fever was publicly known, the boys met for their dance. A number of Lennoxville ladies attended, and some people from Sherbrooke. *When they were all assembled in the school hall*, they were told that Booth "had such a headache, and was so sensitive to noise," that it would be better not to have a dance that evening. It is true it was known that Booth and his brother, and Tiffin, and Ogilvie, and Stewart, had been on the sick list for two or three weeks, and two of them had been in bed for more than a week, but the other boys in the school knew only of it as a "bad cold"! All this was, of course, very considerate for Booth, but not quite so considerate for the other boys and the guests. The poor boy who died was taken home only that evening, or the day before, so dangerously ill with typhoid fever, that it was considered extremely perilous to move him. Now, either the school authorities knew, or they did not know, of the existence of this typhoid fever. If they *did not know* what the disease was, they are perhaps not deserving of much censure; but any illness at that time, and in that place, was to be looked upon with suspicion, and none with more suspicion than a bad cold. If they *did know*, the boys should have been sent home, or out of the school, at once, and their parents informed of the situation; or, the sick boys should have been sent home, or out of the school; and, most assuredly, it was hardly a proper place to allow guests to assemble in—*for a dance!* But it would appear as if everything must give way to the school. It would never do—for the reputation of the school—after all the expense just incurred in drainage, in chemical analysis of water, and in the search for that unseen mystery "which smoked with bloody execution"—a typhoid fever "GERM"! No! had not the result of a chemical analysis of the water in common use been flaunted in the

the analysis, without doubt, was qualitatively and quantitatively—and every other way—correct, yet, as affecting the vital question, namely, *whether the water was, or was not, the source of the typhoid fever, it was not worth the paper on which it was written.* With all the refreshing innocence of childhood, men who had crossed the *pons asinorum*, and could discuss with ease the “differential calculus,” proclaimed triumphantly that Dr. Baker Edwards, of Montreal, who had had a whole gallon of the water sent to him, had not found one single “germ” in the whole gallon! Of course Dr. Baker Edwards did not put it in that way; but inasmuch as the result of the analysis was recorded with great minuteness; each product represented in fractions of figures, looking down the long list, and seeing no mention of “germs” or “typhoid poison,” they jubilantly concluded that the water in the school well was of the “first water”—in fact, everything that Lennoxville water ought to be! Had not Dr. Baker Edwards said so? It was highly amusing, just after the trial of this water, and the verdict of “not guilty” in its favor, to hear the ingenuity with which learned professors and divines—whom, I am certain, know more about theology than they do of hygiene—so satisfactorily accounted for the fever in the school. “It was not the water—they knew all along that it was not the water”—and if not the water, it must be the “*grub*”! Those basketsful of affectionate remembrances from innocent and loving mothers—those vile concoctions of plum-cake and other indigestible allurements, acting upon overworked brains, was the cause of this “*grub-fever*,” which it had been attempted hitherto to honor by the name of typhoid! Ignorant were they of the fact, that this “germ,” this “contagium vivum,” this “cesspool poison,” though it has a local habitation and a name, is known only in its habitation, while the exact form of its existence is, as yet, unhappily a matter of theory. But, no matter what its form, thousands of the first medical men in the world know, by experience and observation, that water, apparently the purest in the world, may contain this instrument of death, though the microscope and the severest analysis have failed to prove its presence. Whatever its origin may be, it is quite certain that

in looking for the cause of an outburst of fever, the weight of authority conclusively suggests, as the first thing to be done, an inquiry into the water supply, and whether that supply is exposed to percolation from privies or cesspools.

Dr. Alonzo Clark, of New York, in his very able "Lecture on Typhoid Fever," quotes from the "Transactions of the Medical Society for the State of New York," a report by Dr. Stoddard, of Rochester, which is peculiarly appropriate, as follows:—

"A certain limited portion of the city was invaded with the typhoid fever, while other parts of the city were exempt from the disease. Examination limited this area to about five acres. In the centre of this district was situated a well, the surroundings of which were very filthy. About 30 feet from the well was a privy, and the drainage from this was towards the well. On opening the well, the water was found free and clear from odor or taste. On microscopical examination, nothing unusual was found, and chemical examination disclosed little else of importance, beside a considerable amount of sodium chloride. The presence of the sodium chloride pointed to sewage pollution, as proved to be the case. To test the influence of the water upon those using it, a thorough census of all the families in this district was taken, the number of persons using the water ascertained; also the number using water from any other source, and the cases, character of illness, and deaths, which had occurred during the previous six months, with this result:— 87 families, consisting of 492 persons, occupy the district. 40 families, comprising 249 persons, *use water from this well.* Among these occurred 23 cases of typhoid fever, and one of diphtheria, during the period taken. 47 families, of 279 persons, *did not use the water.* Among these occurred two cases of fever during the same period! Among those using the water, the ratio of sickness was 1 in every 9.12. Among those not using the water, 1 in 139.5. It was ascertained that the *first case of typhoid in the district occurred in the family occupying the premises on which the well was located.* The well was im-

mediately closed, and *not another case of typhoid had appeared* after two months, in this section.”

The above may be taken as a fair sample of the experience of the profession generally, as evidenced by recent articles in the medical journals of the day, not only in this country, but in Europe ; and it is so eminently suggestive to those in charge of public schools that I quote it.

Some seven or eight years ago, from causes similar to those at present existing, Drs. Robertson, Johnstone and myself were requested to examine and report upon the then state of things. After going over the College and school buildings, we found everything in the most admirable order—everything done that could possibly be done to secure the health and comfort of both students and school-boys ; that is, everything inside the buildings proper. Going over the grounds, however, we found a huge privy, used in common ; and I have no hesitation in stating that that privy was the filthiest thing I ever saw, utterly disgraceful. So sickening was it that one of the medical commission retired in haste, with a result that may be guessed at.

That privy was unanimously condemned, and it was suggested that as the water supply was obtained from a well within a suspicious distance from the privy, the water should be sought for from some other source, and that the water of that well should not be used under any circumstances for cooking or drinking. The privy was immediately closed. The well has continued to be used *hinc illæ lachrymæ!* How this privy was closed up—whether the latrine was first emptied and the hole filled up, or the whole covered over with earth—I do not know ; nor do I know the exact distance of the old latrine from the well, but, at a rough guess, I should say that the south angle of the rear of the present school building, the well and the site of the old latrine would form an angle whose sides would be about 60 feet. The latrine was a large hole, without outlet, and the well being a deep one, both being in a light sandy or gravelly soil, nothing could be more favorable for percolation from the latrine to the well. The water in that well still has its friends, and it cannot be denied that its appearance is rather prepossessing ; but at

times I have known that water to *stink*,—but with a wonderful fertility of resource, whenever it did so stink, it was found that some harmless frog was “at the bottom of it,” and then there were congratulations and renewed confidence in the water.

I doubt very much if that well should be regarded as a “spring,” or other than a deep hole for the collection of surface drainage. Now, as this privy had been in use for many years before by a large public school, it is quite fair to infer that the soil in its neighborhood was fully saturated with a source of every-day danger, and no spot in the neighborhood more than this well, which, from its depth, rather courted contributions, and thus became, in my opinion, a very magazine of disease and death.

So satisfied was I that the well was always the dangerous thing, having two boys at the school, as day scholars, I emphatically ordered them never to drink of that water. Of course, I may be mistaken, all the medical experts may have been mistaken, even Drs. Osler, Cameron and Simpson—whose report I have not yet seen—but if only one respectable medical man had ever said “Boo” against the well, that “Boo” ought to have been considered, particularly as it would have been an easy matter to shut up the well for one term, as an experiment, but even that was never done.

At last, the well is to be closed, and I will venture the prediction that this incubus upon the fair fame of Lennoxville Grammar School will never be heard of more.

There is one thing, however, that I will suggest, besides closing the well. It is this, inasmuch as the cellar of the Grammar School is not further removed from the old latrine, than is the well, it is only fair to infer that it is within poison reach; would it not, therefore, be wise, simply as a precautionary measure, to cause the whole surface of that cellar, and its walls, to be covered in cement?

I have written plainly in this article, rather in a public than in a medical point of view, and I think I have written in the best interests of the School.

It has been most unfortunate for the School that it has had

men at the head of it, who have thought that they knew everything in the world, and out of it, better than anybody else; who built a splendid School-house, and years afterwards discovered to their amazement that its main drain had no outlet; and who, on one occasion, ridiculous as it may seem, permitted (at any rate the thing was done) a broken pipe from a water-closet in the building to be mended with a piece of old stove-pipe.

REMARKS ON CLUB-FOOT.

HAVING SPECIAL REFERENCE TO THE EMPLOYMENT OF THE
GYPSUM BANDAGE.

By T. G. RODDICK, M.D.,

Prof. of Clinical Surgery, McGill University; Attending Surgeon Montreal
General Hospital.

(Read before the Medico-Chirurgical Society of Montreal.)

MR. PRESIDENT AND GENTLEMEN,—There is, perhaps, no congenital deformity of such frequent occurrence as that usually described under the term “Club-foot,” and yet it would be difficult to find a surgical condition, the treatment of which is so commonly shirked by the general practitioner, and is, withal, usually so unsatisfactory. This is doubtless explained in that the methods of treatment ordinarily recommended exact a greater amount of attention from the busy practitioner than he can usually afford to devote to any one class of cases; and, moreover, the cost of apparatus often constitutes an item of considerable magnitude in the case of persons whose means are limited. It has always, I think, been one of the great aims of the profession of our day to simplify its *armamentarium*, where, of course, that simplicity is not obtained at the expense of strength and usefulness. Simplicity also begets economy, so that our knowledge and skill will be found now-a-days to benefit a much greater number of our suffering humanity than was the case with our predecessors. Thus, to give one illustration, the amount of suffering and the number of untimely deaths which Sayre has been instrumental in alleviating and lessening, through his energetic advocacy of the “plaster jacket” in spinal caries, can

never be told. There are, perhaps, without any exaggeration, thousands of children on this continent and in Europe to-day, the subjects of Potts' disease, wearing this simple and inexpensive apparatus, and moving about with comparative ease and comfort, who otherwise, by reason of their poverty, would have been doomed to a miserable existence and an early death. So in the treatment of other surgical diseases there is a constant and growing desire on the part of our profession to simplify plans and economize material. I have treated to a successful issue more than one case of hip-joint disease in the house of the poor laborer, and I am convinced that the total cost of the apparatus employed throughout a long illness would be covered by one dollar; and in this experience I know I am not singular.

In the treatment of club-foot also, there has of late been a disposition on the part of surgeons to disregard the complicated and expensive shoes hitherto in vogue, and to substitute a simpler and often more common-sense form of dressing. Thus in the out-patient departments of the great London Hospitals, these deformities are treated by tin, or pasteboard, or felt splints, which are so easily moulded, and later, perhaps, by a gutta percha boot. I had an opportunity, when in London, of watching a number of cases treated in the Children's Hospital, by the tin splint, adapted, in the case of varus, or equino-varus, to the outer surface of the leg and foot. I saw children in whom this treatment had been followed by very admirable results. I noticed, however, that the ordinary bandages employed were constantly becoming loose and ineffective, and the treatment was on that account often most unsatisfactory. In the winter of 1877, I happened to have under my care in the General Hospital some five club-feet of the equino-varus variety, which gave me an opportunity of testing several modes of dressing. I found that I obtained the best results from a combination of *strapping*, such as that recommended by Bryant, and the *gypsum bandage*, having performed tenotomy when and where required. My original method I have since modified in a slight degree. I will proceed, with your permission, to describe in detail the plan which I now almost universally adopt.

In the first place, I would state that over ninety per cent. of all the cases of congenital club-foot which I have had an opportunity of examining belong to that compound variety termed *talipes equino-varus*. This fact may not be borne out by the experience of others present, but such is my experience. A pure *varus* is rather a curiosity to me, and a congenital *talipes equinus* I have never yet seen. A pure congenital *valgus* is rarely met with excepting in connection with knock-knee, and will be usually soonest relieved by treating the latter. In any case, the treatment of *valgus* is most unsatisfactory, and in children very little can be done. I have a case at present under my care in which I believe I am correcting the deformity, and certainly relieving the symptoms, by means of an air pad which I have had adapted to the sole of the boot, the ankle being at the same time supported by steel bars. I doubt whether division of the perineal tendons can be of any material benefit in the deformity. The other varieties of *talipes* described are comparatively very rare, are usually paralytic in their origin, and are benefited often more by general treatment than by any special surgical appliance.

Talipes equino-varus is then undoubtedly the most common variety of "Club-foot," and to the treatment of it I intend, on the present occasion, solely to refer. It is due, as you are all aware, to a contracted condition mainly of the muscles, inserted into the *tendo Achillis*, and the *tibialis anticus* and *posticus* muscles. The sole of the foot is also usually shortened through contraction of the plantar fascia. In treating the new-born infant, I trust for a time to manipulation, instructing the nurse or mother to handle the foot frequently, and I give it my personal attention occasionally. At the end of one month, or two at the latest, depending on the vigor of the child, I proceed to perform tenotomy under chloroform. Contrary to the instructions usually given, I first divide the *tendo Achillis*, as I have found, on more than one occasion, that the tibial tendons may not require division, but that the deformity can be quite corrected by the single tenotomy. The *tendo Achillis* seems in many of these cases to be inserted chiefly into the inner and

posterior border of the os calcis and not into its lower central portion, so that it tends, while drawing the heel upwards, to invert the foot at the same time. The plantar fascia, however, almost invariably requires division. Having tenotomised, I bring the foot at once into position, and seal up the wound with absorbent cotton, retained in place by ordinary adhesive plaster. I then take a strip of that excellent rubber plaster, recently introduced into the market, of the width of an inch, and apply it, beginning about the centre of the dorsum of the foot, carrying it round the sole, over the most prominent part of the outer border, and up the outer side of the leg to the lower third of the thigh. This will be found to throw the foot out, and at the same time to flex it on the leg. Another plaster, less than an inch in width, is made to encircle the limb opposite the ankle, and this will be found not only to do service in keeping the first strip in position, but also to increase the eversion of the foot. A flannel bandage is now applied, and then one or more of cotton, or gauze, and the whole well starched. Care is taken that the dressings are not too firmly applied, as the circulation is apt to be seriously interfered with in this altered position of the foot. The child necessarily suffers for the first few hours, and I usually prescribe some anodyne to be given if required. The anæsthetic is invariably continued until the dressings are all applied.

At the expiration of five days everything is removed; the foot and leg are well bathed, and if the tenotomy wounds are closed, and not likely to give further trouble, I again apply the strapping, and then a *plaster of paris* bandage *directly* to the skin. I encase the foot in plaster, leaving the toes only exposed. In about a fortnight this is removed by dividing it carefully down the centre either in front or behind; passive motion for a few moments is practised; fresh strapping readjusted, and the same case (if in good order) again applied and held together by another plaster bandage. This process is repeated every ten days or a fortnight for a couple of months or longer, depending on the severity of the case.

I have brought here, for your inspection, a child on

whom I operated a little over a year ago. It was a very well marked case of equino-varus. I found it necessary to divide both the tendo Achillis and the tibialis posticus tendon. The child was under treatment for three months, since which time nothing but an ordinary shoe (such as this) has been worn. The little thing is now fifteen months old. I had hoped to show you two other cases, in both of which both feet were clubbed, but one of them died in August last of some infantile disorder, and the present address of the other I could not obtain in time to have him at this meeting. The results in both cases were admirable. I may say that now and then, in very restless children, I secure the movements of the knee-joint by a back splint of leather or pasteboard.

I am aware that some of the English surgeons have, within the last year or so, recommended the employment of gypsum dressings in the treatment of club-foot, but their method of application will be found to differ from that just described in many important particulars, notably in the adaptation of the retaining straps, and the application of the plaster directly to the skin. The latter device is especially worthy of note, for when cotton wool is employed, as in ordinary cases, beneath the bandage the foot is much more likely to become displaced. The difficulties attending this method, doubtless, increase rapidly with age, but my experience hitherto has been confined to cases under one year.

CASE OF RHEUMATIC PURPURA.

By W. A. MOLSON, M.D., M.R.C.S., Eng.,

Attending Physician Out-Door Department Montreal General Hospital.

[Read before the Medico-Chirurgical Society of Montreal.]

On Nov. 1st, 1880, was called to see M. M., æt. 19, and found her suffering from an attack of acute tonsillitis, this being her third attack within five weeks. There had been a distinct rigor two days before.

Nov. 2nd.—Throat symptoms much relieved this morning, the tonsil having discharged a good deal of pus during the night. Patient complains of severe pain in her ankles, which are swollen, red, and very tender on pressure. Temperature, 102°; pulse,

112; headache, and nausea. Ordered joints to be wrapped in cotton wool, and salicylate of soda gr. xv. to be given every three hours. 5 p.m.—A purpuric papular rash has appeared on the feet, ankles, legs and thighs, equally distributed on both the upper and lower surfaces. The spots are distinctly raised, and of a bright red color: they do not fade on pressure, and vary in size from a hemp seed to a half dollar, many of them being distinctly crescentic in outline. No spots on any other part of body.

Nov. 3rd.—Pulse 100; temp. 102 $\frac{1}{2}$ °. No sweating; no new joints affected. Patches are much darker to-day, and have a mottled look; no new ones.

Nov. 4th, 10.30 A.M.—Pulse 120. The right wrist and hand are much swollen, and on the back of the right hand there is a large, very dark discoloration, the edges being much brighter in color. There is much pain in wrist. 4.30 p.m.—Saw patient with Dr. Osler, when the following condition was found: Both elbows, ankles and wrist joints swollen and painful; pulse 128; no sweating. There is an extensive purpuric rash on the lower extremities, equally distributed on both legs and thighs, and most abundant on the posterior surfaces. It is made up of large irregular purplish areas, which are not affected by pressure. Most of the patches are in contact with each other at certain points, leaving irregular tracts of unaffected skin, which are not injected. The greater part of the skin on the dependent parts of the thighs and legs is involved; the patches on the anterior parts are much smaller and more discrete. No spots on the body or arms except the back of hand on right side. On the face, which is not swollen, are three peculiar spots on left side; they are arranged in line, about a quarter of an inch apart from the malar prominence downwards, and are about the size of a ten cent piece; the centre one has an extravasation, but the other two are anæmic and elevated. There is a slight swelling, but no injection about them. On the right cheek are two small, slightly elevated spots, which are purpuric in the centre. There is a sanguineous discharge from the vagina—second time in four weeks.

Nov. 5th.—No change in the condition of joints, but the erup-

tion has developed in a remarkable manner on the face, which presents the following appearance: The chin and lower lip are greatly swollen; the skin glazed-looking and pale at the peripheral parts, deeply ecchymotic at the centre. The swelling is so tense that it scarcely pits on pressure. It is painful, and movement of the lower lip is impossible. The eyelids are swollen, almost closing the eyes, and at the outer parts are becoming purpuric. On the right cheek, just below the malar prominence, is a patch the size of a cent, elevated, anæmic at the margins, ecchymotic at the centre, and looking not unlike a spot of erythema nodosum. On the same side, just above the zygoma, is a similar patch, and on the left side of the face there are four, one just above the zygoma, the other three on the cheek being those described in yesterday's note, increased in size and more œdematous, but the skin interspersed with hæmorrhages. Altogether the appearance was most remarkable, almost like what one might expect in infarction, if it took place in the skin. The rash is fading on the extremities. A fresh spot, size of a penny, has appeared on the sternum. Heart sounds normal; sweating profusely, particularly on the head. Passed only a small quantity of urine, which was not kept.

Nov. 6th.—Condition remains much the same, but many new patches on the body. The eyelids are now so swollen that they cannot be opened. The gums are swollen and spongy, and bleed on pressure.

Nov. 7th.—Pulse 104; temp. $101\frac{2}{3}^{\circ}$. Passed about 3 ozs. of urine during last 24 hours; no albumen; urine dark-colored. Swelling of face decreasing.

Nov. 8th.—Joints not so painful, though still much swollen. Pulse 90. Condition of eruption as follows: Face looks as if she were recovering from a severe beating, the greater part being "black and blue." The lower half of the ocular conjunctiva of right side is ecchymotic, having come on during the night. The eyelids of left eye, and the surrounding skin for a distance of about an inch from the lashes, is of a livid red color, not disappearing on pressure, and only slightly swollen. Lids of right eye in same condition, but staining does not extend so

far on lower lid. No conjunctival effusion on left side. Swelling of lip and chin much diminished, leaving the skin of a purple red color, with spots interspersed of a darker color. The mucous surface of lip covered with a dark scab. There are a few small, flat spots on the left ear. An extensive new crop of petechiæ has appeared on thorax and belly; no spots more than a few millimetres across, most of them being punctiform. The left arm is much swollen at the elbow, in the flexure of which there is a purpuric patch 6+5 cm., and also a few small bullæ. The flexor surface of the forearm near the spot has a bluish-green bruised look, and is much swollen. There are also about a dozen spots scattered over the arm, varying in size. On the right arm, on the outer side, there is a patch the size of the palm just above the elbow. There are also several fresh spots about the wrist. The old rash on the legs is fading rapidly, ten or fifteen new spots having appeared during the night.

Nov. 9th.—Continues to improve. The tongue, which was coated with a white fur, is cleaning; swelling of joints decreasing. Fresh crops of spots on right wrist, right hip, and back of thigh.

Nov. 12th.—Is convalescing rapidly. Swelling and pain of joints entirely disappeared. Slight staining of the face where the extravasations were situated. A fresh crop of spots appeared to-night on the legs. An irregular pale-brown discoloration can be seen in the localities from which the original eruption has faded. From this date the patient went on rapidly to complete convalescence, a few new patches appearing occasionally.

Remarks.—Rheumatic Purpura, says Living, in the *Lancet* for Sept., 1877, is a disease with fairly defined symptoms. Thus far most observers are agreed, though they hold different views as to its nature and affinities. By some it is regarded as a form of rheumatism, by others as a kind of purpura, and by a third set as a scorbutic affection; but he considers it a kind of erythema, in which cutaneous hæmorrhages and joint affections are prominent symptoms. Two cases of erythema with purpura are reported in Vol. III. London Hospital Reports. In 1829, Prof. Von Schonlein described, under the name of Peliosis

Rheumatica, what he thought was a new disease, characterized by purpuric spots and acute articular pain. Later on, Hebra and others recognized this as a distinct disease, and his description of it closely resembles Von Schonlein. He says the disease begins with dragging pains in the joints and feverish symptoms, and that when dark red, livid, or almost black spots appear on the skin the rheumatic pain subsides. He also mentions that the disease is most frequent between 20 and 30, and in males. Fuchs and some other German writers regard the disease as allied to rheumatism, but yet sufficiently distinct as to be regarded as an independent disease, and distinct from both purpura and erythema, while Dr. Bohn, of Konigsburg, regards it as identical to erythema nodosum, and conjectures that in both cases the eruption is due to embolism of the cutaneous capillaries. The French writers are almost unanimous as regarding it as a variety of erythema nodosum.

In Ziemssen's Cyclopædia, Vol. XVI., Senator appears to disbelieve in true purpura rheumatica as a separate disease. He says that in anæmic persons you sometimes get articular pains unattended by any change or swelling in the joints, but present in a slight degree; that the two diseases should be kept separate, as you never get sweating, which is so constant a symptom of rheumathritis purpura.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women, &c.

The Treatment of Rupture of the Uterus.—Two important papers on this subject have recently appeared. One of these, by Dr. R. P. Harris, in the *American Quarterly Journal of Obstetrics*, is entitled: "If a woman has ruptured her uterus during labor, what should be done to save her life?" Dr. Harris refers to the valuable papers of Dr. Trask, of Astoria, New York, on "Rupture of the

Uterus," based upon a collection of 417 cases, and published in 1848 and 1856. In these articles Dr. Trask shows the dangers of rupture under the ordinary methods of treatment, as contrasted with the results of delivery by abdominal section, and proves the great superiority of the latter in saving life. These figures were, however, made up from reports of published cases, a small proportion of the whole, because they are generally confined to those of special interest from recovery or peculiarity otherwise. Dr. Harris has, after nine years labor, collected in the United States 39 cases of laparotomy for rupture of the uterus, with 21 recoveries, a percentage of 53 $\frac{1}{2}$. The author then alludes to the treatment advocated by the newest text-books. Playfair's rules are as follows:—1. If the head or presenting part be above the brim, and the foetus still in utero, the forceps, turning, or cephalotripsy, according to circumstances. 2. If the head lie in the pelvic cavity, forceps or cephalotripsy. 3. If the foetus have wholly, or in great part, escaped into the abdominal cavity, gastrotomy. Leishman's teaching is essentially the same as Playfair's. The cases in which the child still remains in utero are not common; usually it is found to have escaped with much extravasated blood into the abdominal cavity. The usual plan of treatment recommended is to pass the hand through the fissure, seize the feet, and drag the child back through the torn uterus, and then to reintroduce the hand and search for and remove the placenta. In condemnation of this practice Playfair justly says: "It is surely hardly a matter of surprise that there is scarcely a single case on record of recovery after this procedure."

Dr. Harris designs in his paper to take a step in advance of Drs. Trask, Playfair and Leishman, and advocates, in all cases of rupture, whether the child remains in utero or not, the opening and careful cleansing, (the toilet of the peritoneum) of the abdominal cavity. He bases his arguments on the facts and considerations already stated, and adduces in support the remarkably small fatality of laparotomy in ovarian tumors. Ludwig Winckel asserts that liquor amnii is not injurious if it simply escapes into the peritoneal cavity and is then removed. Blood,

with the same precautions, is also innocuous, but both may light up peritonitis and septicæmia. The marvellous success of Keith of Edinburgh in ovariectomy is believed to be due to his great care in securing every tiny blood-vessel that may possibly bleed into the peritoneal cavity, and cleansing out every particle of escaped blood. By such methods he has saved 97 out of his third hundred of cases. The experience of all modern operators in abdominal surgery goes to show that we may with considerable impunity, by antiseptic precautions, open and cleanse the abdominal cavity. Dr. Harris has undoubtedly a good case, and his paper is well worthy of perusal.

The second paper is by Dr. Frommel, assistant physician to the Gynæcological Clinique in Berlin, and appears in the *Centralblatt für Gynæcologie*, No. 18, 1880. Its subject is the report of two most interesting cases of rupture of the uterus. The first case is that of a patient aged 40, who had previously borne 12 children, and had slight pelvic contraction—the diagonal conjugate diameter being 4 inches. The labor had been tedious and prolonged, when it became suddenly arrested, and Dr. Hoffmeier was sent for. Without much difficulty by version he removed a dead full-grown child. Then he discovered an almost complete transverse rupture of the uterus between the lower segment and the cervix, only a bridge of tissue about $2\frac{1}{2}$ inches broad to the left and anteriorly remaining to connect the two. The peritoneal investment of the uterus was quite entire; but as the child had passed out through the uterine tissue, it was almost completely separated from the uterus, so that now a large cavity, shut off from the peritoneal cavity, existed. The patient was placed under chloroform and this cavity thoroughly irrigated with a warm two per cent. solution of carbolic acid, and a thick drainage tube introduced and made secure. An ice-bag was laid over the abdomen. The patient was now in a very satisfactory condition. Pulse 84, strong and regular. No vomiting. The highest temperature, 100° Fah., was noted on the evening of the sixth day. This was the only time that an antiseptic injection was made through the drainage tube. For the first few days patient was restricted to fluid nourishment; after the

eighth solid food was allowed. The discharge from the drainage-tube was at first a tolerably copious bloody fluid, which gradually became pure pus. On the twenty-sixth day, the discharge having ceased, the drainage-tube was removed. On the twenty-eighth day she was allowed to leave her bed, and on the thirtieth discharged from hospital. At this time, on internal examination, an opening several centimetres deep was found to exist anteriorly, through which the finger could penetrate to the peritoneum. On the right was a considerable amount of exudation, the uterus dislocated to the left and retroflected. General condition good.

The second case was that of a woman of 30, who had suffered from rickets in early life, and was the mother of three children born naturally. In her fourth labor she was in charge of a midwife, who, because it was tedious, gave her patient four powders of ergot. A medical man was sent for, and he prescribed morphia. By the assistance of another, rupture of the uterus was diagnosed, and laparotomy decided on. This it was impossible to carry out on account of the drunken husband of the patient; so she was taken to hospital. An examination under chloroform discovered the parts of the child directly under the abdominal walls. Internally the child lay with the head presenting, quite moveable, at the pelvic brim; the whole child and placenta in the abdominal cavity. The body of the uterus was almost entirely torn from the lower segment and cervix, except for a small connecting part on the posterior wall, and lay powerfully contracted, pushed upwards and backwards. Professor Schroeder at once delivered by version and extraction a recently dead full-grown female child. The abdominal cavity was now thoroughly irrigated with a two per cent. solution of carbolic acid, and a large-sized drainage-tube introduced as high as possible. A bandage was then applied over the abdomen in such a way as to compress the uterus downwards and backwards, and prevent any great accumulation of blood in the abdominal cavity. An ice-bag was applied over the abdomen. The condition of the patient thereafter was wonderfully good. No elevation of temperature. Pulse somewhat frequent and irregular, but of good

quality. The course of the case was favorable. During the first few days, the discharge from the tube was copious and bloody; after six or seven days it was purulent. On one occasion only did the temperature rise to 101° Fah. As often as it rose to 100° , which it did on several evenings, a two per cent. solution of carbolic acid was injected through the drainage-tube into the cavity. This readily flowed out past the tube. For the first few days opium was given to control the peristaltic action of the intestines and permit of the formation of adhesions around the torn part. On the seventeenth day after delivery the drainage-tube was removed, and the opening found large enough to hold the tube only. A small quantity of healthy pus was secreted. On the nineteenth day the patient got up, felt well, and complained of nothing. Two days afterwards she was discharged.

Obstructed Labor, the result of Emmet's operation.—Dr. J. E. Janvrin reported the following important case to the New York Obstetrical Society on the 2nd March, 1880. The patient was a multipara, aged 36; had been in labor 24 hours, with tremendous pains. She had been operated upon two years previously at the Woman's Hospital for lacerated cervix. On examination, there was no dilatation whatever of the cervix; the opening was no larger than a pin-hole. The hot-water douche did no good, even after three or four hours' trial. Chloroform was then given and the cervix incised on both sides; afterwards dilatation with the fingers was practised. In half-an-hour the forceps was applied and the patient delivered of a dead child.

The Treatment of Adherent Retroflexion.—A paper by Dr. Erich of Baltimore, describing the treatment of seven cases of this troublesome affection by a new method, appears in the *American Quarterly Journal of Obstetrics* for last October. As the author remarks, "under the current teaching of nearly all gynæcological authorities, such cases would have been doomed to more or less hopeless palliative treatment." In the light of our experience of the treatment of adhesions in the operation of ovariectomy, in which, with certain precautions, they are separated with comparative harmlessness, Dr. E. thinks that the separation of a few square inches of peritoneum in the retro-uterine space,

with complete exclusion of air, and with consequently no danger of septicæmia, is not so serious an operation as it has been hitherto considered. The only precedent for the undertaking Dr. E. has been able to find is a procedure advocated in a clinical lecture by Prof. Schultze of Jena, in which he asserts that if there be adhesions which prevent replacement, he divides them carefully, but firmly, and then puts the patient to bed for a few days and applies an ice-bladder over the womb. He has never seen peritonitis result from this method of treatment. He warns, however, against mechanical interference if the fixation of the womb is due to parametritis, or if there be peritoneal adhesions between the uterus and ovaries or Fallopian tubes. We think that such refinement of diagnosis as to make out accurately certain of these latter conditions is rarely possible.

Dr. Erich's method of procedure in these cases was to dilate with sponge or tupelo tents, then introduce up to the fundus a slightly-curved steel sound, with thick blunt end measuring 36 millimetres in circumference, and with this to draw or raise the uterus to its normal position. An intra-uterine stem and Hodge vaginal pessary were then introduced, and the patients put to bed for a week. There were no evidences of peritonitis in any of the seven cases. The ice-bag was never necessary. As to the results, a strong tendency to return of the displacement occurred in some of the cases, but while the others have been under observation no such return has occurred. All have been relieved, and some quite cured, of the symptoms.

Correspondence.

LONDON LETTER.—SURGICAL NOTES.

To the Editor of THE CANADA MEDICAL AND SURGICAL JOURNAL.

SIR,—Perhaps your readers may not begrudge the time spent in perusing these fragmentary and imperfect notes, which, in some feeble manner, may indicate what is going on in the largest of the metropolitan hospitals—the great London Hospital, with its 800 beds.

In the department of surgery I very naturally elected to follow

the illustrious Jonathan Hutchinson, whose kindly, gentle manner charmed me quite as much as his classical but unostentatious clinics, sometimes given in a few important sentences by the actual bedside of the patient, sometimes at more length in the operating theatre. His views upon Chloroform administration are so important that I shall give them briefly: He holds that it being a matter of fact that many children over a certain age die under Chloroform, and that many persons, of all ages, frequently barely escape death, it can be no longer questioned that this drug is not innocuous. He thinks Ether almost without danger, and lays down the following rules for the administration of Anæsthetics:—

(1.) Chloroform may be safely administered to children under six months of age.

(2.) Between the ages of 6 and 30 years, Ether should be substituted for Chloroform.

(3.) To give Ether first, and then maintain the anæsthesia by Chloroform, is comparatively safe.

As a matter of practice, Ether is always, or almost always, given in this Hospital to adults, and a special apparatus is employed by which the patient can be anæsthetized almost, if not quite as quickly, as by Chloroform, and kept so without the slightest difficulty. The lower jaw is held well forward, but I have never yet seen the tongue drawn out—indeed, there seemed to be no ground for the slightest anxiety. Mr. Hutchinson used the *Thermo-Cautère de Paquelin* a good deal in operations on the face—as for Lupus, &c. In one instance it was applied when I happened to be present to the hard palate for Lupus. Mr. Couper, however, tied piles, and did not use the Cautery. He strongly advocates snipping off a *portion* of the external hæmorrhoids, when the internal are ligatured; otherwise they will, in all probability, require another operation. Mr. Couper, instead of injecting Tr. Iodin., or any other irritant, into the sac of a Hydrocele, simply places a drainage tube in an opening into the sac, and retains it in position; this simple foreign body exciting the required inflammation without the severe pain caused by the process of injection. It has always

appeared to me that there was a good deal in the directions of the books relating to Hernia, and the operations for their relief, that was mere book ; in other words, not followed in practice. I have within a few days seen Mr. Hutchinson operate for the relief of an oblique inguinal triangulated hernia, and Mr. Couper for a femoral. They both seemed to observe all caution after the skin was cut through, but neither used a director during any stage of the operation, and seemed to follow the dictates of common sense, enlightened by a sufficient knowledge of practical anatomy, rather than any fixed rules.

Mr. Hutchinson's remarks on "the Taxis" do not accord with Bryant's views, though the former seems to base them on the success of this manipulative proceeding. The success which has followed it, he believes, has been due largely to the perseverance displayed, and as much to the strength of the fingers as to the skill of the manipulator. These remarks apply, of course, only to recent hernia, when no gangrene of bowel complicates the case. In the instance that resulted in operation, four different surgeons tried before the cutting operation was resorted to ; but as soon as it was ascertained that reduction was impossible, the patient was immediately relieved by the knife, for, of course, he had been under the influence of an anæsthetic all the time the taxis was being tried. The antiseptic spray was employed.

Mr. Couper also operated antiseptically, and applied Lister's dressings after the wound was closed. After the constriction (femoral hernia) was reached by the index finger, and grasped by it, a blunt-pointed bistoury was passed along the finger—it being first ascertained that no loop of intestine protruded in the way—and the blade very lightly *turned* a little, when the constriction at once yielded, and the reduction was completed ; a drainage tube was placed so as to protrude from the lower part of the wound, the latter being closed by sutures.

Mr. Hutchinson's remarks on "Fracture of the Femur" were decided. After having tried fairly the double-inclined plane, he has arrived at the following practical conclusion, which I give you in his own words : " I put up all fractures of the femur

with a straight splint, with *vigorous extension*, using a strong perinæal band. It is a good plan to put up the limb with an anæsthetic." So that there may be no doubt about a matter of such actual concern to patient and surgeon, I have been careful to write in my note-book the exact words this distinguished surgeon used.

Upon measuring a patient's legs that had just had a splint removed from a united fractured femur, it was ascertained that the injured limb was really the longer; upon closer examination the difference was found to be explained by the fact that the tibia of the sound limb was the shorter of the two. A difference in the length of the two legs, experience proves, is not uncommon, and doubtless, when slight, explains certain peculiarities in gait which are scarcely of sufficient moment to be called a limp.

Mr. Hutchinson is very felicitous in expressing his opinions on the matter to which he has given so much thought and investigation—that of Syphilis. To say, as he did at the bed-side, "Syphilitic eruptions often come in waves," seemed to me to express briefly and perfectly that condition we are all acquainted with—of one rash following before its predecessor has quite faded; the poor patient being an afflicted Job, without, however, that ancient worthy's sense of rectitude to console him. Attention was called in the ward to a case of syphilis that was remarkable enough. The patient had on his hand a suspicious sore, for which he could not account. It was manifestly a hard chancre (I do not hear the term "chancreoid" used here, "soft chancre" being substituted.) He had had no sore of any kind on the generative organs; but the nature of the sore on the hand was confirmed by the presence of an unmistakable specific rash on the body, especially about the flexures of the limbs, where Mr. H. says it may appear *when seen nowhere else*. A further point of interest in this case was the presence of enlarged and *suppurating* glands in the neck, Mr. H. stating, as we all know, that suppuration is rare. It does now and then occur, however. Reference was made to the case of a policeman who had chancres on every part of the body where he had been

bitten by a syphilitic patient he was attempting to arrest. Truly "a policeman's lot is not a happy one."

Scraping for certain forms of Cancer seems to be a common practice now. To illustrate, Mr. H. was brought in consultation to a case of extensive Superficial Epithelioma of the Buttocks, extending upwards from the Perinaeum. It presented a raw looking surface, with a glazed appearance added, as though it had been varnished over roughly. Mr. H. suggested either the Cautery or Scraping, giving the latter the preference.

Mr. Waren Tay exhibited a pathological specimen, taken from a fatal case of Intussusception of the Ileum that he had had. Mr. Hutchinson was called in consultation. There had been a tumour in the R. Hypochondrium, but it disappeared. This disappearance rendered the diagnosis somewhat uncertain, notwithstanding the other symptoms. Also the child had passed three hard motions. It had passed blood, but no bloody mucus. I mention the case among the Surgical Notes, because Mr. H. proposed to cut down upon the tumor and relieve the Intussusception, which could easily have been accomplished, as the condition of the specimen showed; but the diagnosis was not quite clear, and it is only when such certainty as to diagnosis exists that the operation is considered justifiable. I think I am correct in stating that Mr. H. has successfully performed this operation more than once.

I must not omit to mention an interesting case under Mr. Couper. An Aneurism appeared in a young man in delicate health, after a protracted fever. It was in the line of the femoral artery, just below Poupart's ligament, and was at first mistaken for Aneurium of the main vessel, but later it was thought to be of the profunda. It was cured in *six hours* by digital compression. Mr. Couper thinks a better result is obtained if a little blood is allowed to pass under the finger, than when total stoppage of the blood stream is effected. It may be mentioned that this delicate patient has since (two weeks after) not been in very good health; the temperature has been elevated, and there have been some symptoms of Emboli in the vessels of the leg. But I must not weary you, Mr. Editor, so close the first letter by signing myself,

Yours faithfully,
T. W. M.

Reviews and Notices of Books.

Diseases of the Pharynx, Larynx, and Trachea.—By MORELL MACKENZIE, M. D., Lond., Senior Physician to the Hospital for diseases of the Throat and Chest, Lecturer on Diseases of the Throat at the London Hospital Medical College, &c. New York: Wm. Wood & Co. Montreal: Dawson Bros.

A part of the matter contained in this treatise had already been published in the pages of the *Lancet*, *British Medical*, and *Medical Times*, but “by far the larger portion is now published for the first time.” The first section contains a very complete account of all the affections of the soft palate, tonsils and neighboring parts, including malignant and specific growths and ulcerations, diphtheria, the peculiar appearances observed in scarlatina, and other exanthems, and in certain of the specific fevers. The second is a condensation of Dr. Mackenzie’s well-known monograph on the larynx, the laryngoscope, and the diagnosis and treatment of laryngeal disease. This has long been one of the principal standard works on laryngology. The third section deals specially, and at some length upon the troubles which may occur in connection with disease in, or disturbance of the trachea, inflammatory conditions, strictures, tumours, and wounds of this part are particularly detailed. Also, foreign bodies in the trachea. The important subjects of laryngotomy and tracheotomy are also considered, the best method of operating, the dangers, the after treatment, &c. The whole is concluded by a useful Appendix of Formulæ. Amongst these are recipes for steam inhalations, sprays, gargles, insufflations, &c.

From this resumé of the contents it will readily be seen what a large field is covered by the treatise. It need only be added that it seems to be very complete in all its parts, the views held with reference both to diagnosis and treatment, carrying with them the weighty authority of one of the most able and experienced specialists of Great Britain. The book is illustrated with a large number of wood-cuts, and is gotten up in very good

style. It is one of the "Library" series, and will no doubt be welcomed by the subscribers.

A Practical Treatise on Fractures and Dislocations.—By FRANK HASTINGS HAMILTON, A.M., M.D., LL. D., Surgeon to Bellevue Hospital and New York; Consulting Surgeon to Hospital for Ruptured and Cripples, to St. Elizabeth Hospital, &c. Sixth American Edition, revised and improved. Illustrated with three hundred and fifty-two wood cuts. Philadelphia: Henry C. Lea's, Son & Co. Montreal: Dawson Bros.

This new edition of the above well-known standard work is welcome. Strange as it may appear, Prof. Hamilton's "still remains the only complete treatise on fractures and dislocations, in any language, except that of Malgaigne, which latter has undergone no revision or re-publication since the date of its first edition." Every chapter of it deals with most important cases, many having value, both from the standpoint of diagnosis and treatment, and not unfrequently from a medico-legal aspect as well. The author is well-known as an excellent writer, whose explanations and descriptions are always clear and particularly felicitous. These are aided by the introduction of a large number of excellent wood-cuts, which greatly enhance the value of the book to the reader. It is twenty years since the first edition, and during the whole of that period the special subjects treated of have received the constant study of the energetic writer, whose experience, owing to an extended reputation in this particular department, has been enormous. For the information of those acquainted with the earlier editions, we quote the following from the preface to show the chief additions made in the present re-publication:—"A chapter has been added on general prognosis; the chapter on fractures of the patella has been entirely re-written, in order that the results of a recent exhaustive study of this subject might be given; and most of the chapters have undergone thorough revision. Several illustrations have been omitted to make place for new ones,

and a few additions have been made from the German edition, published in 1877, at Göttingen."

Of the publishers' work we cannot speak too highly. The book is very handsomely printed on excellent paper, and the binding in half Russian leather makes of it an elegant addition to the library.

Treatise on Therapeutics.—Translated by D. F. Lincoln, M.D., from French of A. Trousseau, Professor of Medicine in the Faculty of Medicine, Paris, Physician to the Hotel Dieu, &c.; and H. Pidoux, Member of the Academy of Medicine, Honorary Physician to the Hospitals, &c. Ninth Edition, revised and enlarged, with the assistance of Constantine Paul, Prof. Agrégé in the Faculty of Medicine of Paris, &c. Vol. iii. New York: Wm. Wood & Co. Montreal: Dawson Bros.

We have already noticed the appearance of the first two volumes of this work. This, the third, makes it complete. It contains some of the most interesting and important of the chapters. They are as follows:—Anæsthetics, anti-spasmodics, neurosthenic tonics, excitants, sedatives and contra-stimulants, and anthelmintics. We have nothing to add to what has been already said concerning the great value of this treatise with reference to the earlier volumes.

A Manual of Minor Surgery and Bandaging.—By Christopher Heath, F. R. C. S., Surgeon to University College Hospital, and Home Professor of Clinical Surgery in University College, London, Honorary Fellow of King's College. Sixth Edition, revised and enlarged, with one hundred and fifteen illustrations. Philadelphia: Lindsay & Blakiston. Montreal: Dawson Bros.

This is one of the best of the manuals for surgical dressers, and has long enjoyed great popularity. It is chiefly addressed to house surgeons, and students working in hospitals, but it contains a great deal that is of much importance to every one practising surgery, with reference to the minor details of the

arrangement of surgical appliances. This revised edition contains all the more recent methods of using plaster bandages, antiseptic dressings, &c., and many other comparatively modern innovations. A great number of wood-cuts are introduced to facilitate the comprehension of the detailed instructions given. For the purpose intended it has few equals, being very concise and clear, whilst every matter of importance to the subject in hand is fully treated of.

Diet for the Sick.—By J. W. Holland, M.D., Professor of Materia Medica, Therapeutics, &c., in the University of Louisville. Louisville: John P. Morton & Co.

We have received a small pamphlet of 57 pages, bearing this title. It consists of a series of lectures on the above subject, published originally in the *Louisville Medical News*. The writer's object is to give in plain words an idea of the various kinds of food entering into an ordinary diet, and how these can best be modified to suit the requirements of sickness. The teaching appears quite orthodox, and its publication will, no doubt, assist in the diffusion of useful knowledge. It seems the intention of the publisher to issue others of a similar character, as it is marked "Morton's Pocket Series, vol. i."

The Physicians Visiting List for 1881.—Lindsay & Blakiston.

This useful annual comes to hand in its usual convenient form. It may be had of various sizes. It contains, besides the regular pages for visits, obstetric and vaccination engagements, &c., the following useful information to be kept at hand, Marshall Hall's ready method for asphyxia, poisons, and antidotes, the metric, or French decimal system of weights and measures, posological table, and table for calculating the period of utero-gestation. We have used it for many years, and still prefer it to any other.

Medical Record Visiting List for 1881.—Wm. Wood & Co.

This visiting list is one of the most complete and handsomely gotten-up lists for physicians which we have seen. It contains

all that is necessary in a concise form, and is well and strongly bound. J. M. O'Loughlin, medical bookseller, St. James street, is agent for Montreal.

The Popular Science Monthly.—D. Appleton & Co., for December, is to hand, with the following contents :

The development of political institutions, by Herbert Spencer ; science and culture, by Huxley ; experiments with the "Jumpers" of Maine ; the August meteors ; the early practice of medicine by women ; methods in industrial education ; the migration of fishes ; domestic motors ; indigestion as a cause of nervous depression ; oriental music ; the Sabbath, by Prof. John Dumas ; with the usual literary notices, notes and miscellany.

Books and Pamphlets Received.

Diagnosis and Treatment of Ear Diseases. By Albert H. Buck, M.D., New York city, Aural Surgeon to the New York Eye and Ear Infirmary, &c. New York : Wm. Wood & Co. Montreal, Dawson Bros.

Food for the Invalid, the Convalescent and the Gouty. By J. Milner Fothergill, M.D., and Horatio C. Wood, M.D. New York : MacMillan & Co. Montreal : Dawson Bros.

How to use the Forceps, with an Introductory Account of the Female Pelvis. By Henry G. Landis, A. M., M. D., illustrated. New York : E. B. Treat. Montreal : Dawson Bros.

Photographic Illustrations of Cutaneous Syphilis. By Geo. Henry Fox, A.M., M.D. Forty-eight plates from life, colored by hand. Complete in twelve parts, Parts I., II. and III. New York : E. B. Treat.

Proceedings of Societies.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

A regular meeting of the Society was held November 12th, 1880, the President in the chair.

Dr. Osler showed a case of myeloid disease. Last March the patient was admitted with some affection of the tibia, which was found to be a myeloid tumour, and the leg was amputated. He had an attack of scarlet fever (surgical), amputation done, and then had an apparent attack of pneumonia of the lower part of one lung. He was then transferred to the medical

ward, and then it was found that he had extensive dullness over the left lung. The history pointed to a secondary growth in the chest. He had persistent dyspnoea and orthopnoea, œdema of the fauces, and enlargement of the veins of the chest; some of them being as large as the fourth finger. He was in great distress, and in this condition died.

Dr. R. P. Howard said Dr. MacDonell removed a myeloid of the wrist 28 years ago, in Montreal. Saw a patient in the Eastern Townships, 20 years ago, whose leg was amputated, and the patient was still living. Dr. Scott or Dr. Fenwick amputated a thigh for disease in the lower end of the femur. Dr. Howard had placed myeloid among semi-malignant growths. This is the first instance of a recurring myeloid he had seen.

Dr. Ross said another case was seen in its early stage, and diagnosed by Dr. Shepherd as myeloid. The patient was sent to the Montreal General Hospital, and the arm was amputated. The disease recurred in the stumps, and a second amputation was made.

Dr. Hingston said he met one case last summer, from the United States. It was in the abdomen. A *post mortem* examination was held some months after admission, and proved to be an enormous tumor of probably 18 to 20 lbs.

Dr. Osler showed—2nd, A large gall stone in the gall bladder, and a fistulous opening. There had been no symptoms of gall stones. The man died of emphysema. There was complete obliteration of the cystic duct, and the gall bladder remained and embraced the stone. 3rd, An overgrowth and fatty extension of tissue about the auricle of the heart, the musculi pectinati are changed into fibrous tissue. It occurred in a patient who died of pneumonia, following fracture of the leg. 4th, A myoma of the uterus, which occurred in this same case.

Dr. Osler then read a paper on "Delayed Resolution in Pneumonia," in which, after speaking of the morbid anatomy and terminations of the disease, he reported the following cases:

CASE I.—*Apex Pneumonia; Resolution in the fourth week.*
—A plumber, aged 33, was admitted to Hospital on April 15th.

Initial chill had followed exposure on the 5th, and from that date he had suffered from shortness of breath, fever, and cough. On examination, signs of hepatization in upper part of right lung; temperature 103° . The fever kept up, and the physical signs persisted, with but little change, until the 18th day, when the dullness became less marked. It was not until the 26th day that the temperature became normal, and resolution fully established.

CASE II.—*Pneumonia of right lung; Resolution in eighth week.*—Discharged soldier, aged 42, well developed, and not a hard drinker, admitted to Hospital May 10th with a history of illness of a week's duration, there having been a single initial chill on the 3rd. Dullness over whole of right lung, except in the lower mammary region; blowing breathing and râles. Temperature 103° ; pulse 120; respirations 35. On evening of 13th was much worse, becoming cyanotic; pulse 130, small in volume; respirations 66. Was bled to 18 ozs., with great relief. Respirations 15 minutes after were 52, and pulse 106, of better volume. Throughout the third and fourth weeks the patient's condition kept about the same. Temperature range from 101° to 103° . From the 31st the temperature kept below 100° , and the general condition improved, but the physical signs of consolidation continued; respirations 20 to 25; pulse about 80. It was not until the 16th of June, 45th day of the illness, that signs of commencing resolution were noticed in front, and from this time went on slowly, and by the 54th day there was not much difference in the percussion note behind, and only a few râles were heard. He was discharged on the 28th of June feeling quite well, and with only a slight shade of dullness at right base. Ten days after he presented himself for examination; had gained 17 lbs. in weight within a month.

Dr. Osler remarked that it was difficult to understand how a solid exudation could remain for weeks in the air cells without permanently damaging them, but that it may do so is evident from these and other cases. The lung appears to alter but little, maintaining the features of hepatization. Grisolle gives a case in which death occurred on the 60th day, and yet the affected

part looked not unlike the acute stage of the disease. It is not easy to see the reasons for retardation of resolution in these two cases. The situation of the consolidation in case I. may have had some influence. Of 150 cases of simple pneumonia reported by Beuler, in 7 resolution was delayed beyond the 20th day, and in three of these the right upper lobe was affected. Huss, and several other writers, have noticed the same thing in apex pneumonia. In case II., the fact of the man having been a soldier for 21 years is rather against soundness of constitution; though there were no evident signs of degeneration, and he denied excessive use of alcohol. Chomel calls attention to excessive bleeding as a cause of protracted resolution; but the amount abstracted in this instance was scarcely sufficient to have had any such effect. The reader remarked that we could learn from these cases not to be over-anxious about delayed resolution in ordinary pneumonia, so long as the patient's condition keeps up and the constitutional disturbance is slight.

Dr. R. P. Howard said arrested resolution is one of the most uncommon facts in his experience. He did not remember a single case of simple sthenic pneumonia, that did not end in either death or immediate resolution. He had notes of 180 cases, and possibly if these were turned over, he might find two or three; but arrested resolution is exceedingly rare, and when it does occur, may be from latent tubercle, or pleurisy. He had never seen a case of acute sthenic pneumonia become chronic, and the ablest pathologists deny that it ever occurs. He had had doubtful cases, but in these there was tubercle or some other special cause. He drew the attention of the Society to a remarkable fact that exudation should remain in the air cells, without causing caseation, why did not the lymph bring about some ulterior serious change, even if it be a genuine pneumonia delayed. There is no reason to fear that resolution may not occur. A great majority of the cases of pneumonia are well at the end of two weeks; then look out for some disturbing element. One element that has produced delay is inflammatory rheumatism. He has noticed that this disease prolongs pneumonia, and interferes with its resolution.

Dr. Jno. Reddy said he remembered 14 years ago being sent to see a case of sthenic pneumonia on the 8th day. Blue finger nails and lips, and put her on aconite and liquor ammoniæ acetatis. Resolved also to bleed her, and took sixteen ounces of blood, and she made a perfect recovery. After thirty-five days, normal breathing was restored. It was a pneumonia of the apex of the right lung.

Dr. Kennedy said that some years ago he had a patient, in whom resolution should have begun, and then disease came to a stand still. He suspected that he had had syphilis. The whole left lung was dull, and remained so for three weeks. He administered large doses of iodide of potash and quinine, and this condition remained for 10 or 14 days, without any change. He finally recovered.

Dr. F. W. Campbell said that during the last 14 years he had only seen one case of delayed resolution.

Dr. Trenholme said, in regard to treatment, he thought that medicine had a controlling influence. In *veratrum viride*, we have a medicine to mitigate the disease and hasten resolution; also, antimony will materially assist in that form where there is imperfect aeration of the blood.

The meeting then adjourned.

Extracts from British and Foreign Journals.

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

Examination of Children.—For the proper examination of sick children both time and tact are necessary. The work cannot be forwarded by haste and impatience. It is important, at the outset, to win the confidence and good-will of the little-one. This is easy to those who love children; difficult often to those who dislike them. But love grows by the using, and he who will cultivate their society and interest himself in their affairs, will come to have a genuine interest in them. If the patient is a stranger and old enough to be observing, be careful how you approach it. "First impressions are lasting." Avoid brusqueness. Better, at first, talk about the child than

to it. Get the history of the sickness from the mother, and while receiving that, you may notice the child without seeming to. A trained observer can see a good deal in a short time. The first glance will show whether the child is very ill, and may even indicate the probable character of the ailment. Notice the physiognomy first. The features of a child under three or four months have little expression, but beyond this period they may be taken as an honest declaration of its feelings. It has not yet learned the art of hiding trouble under a tranquil mien. In acute diseases attended with fever the cheeks, and perhaps other parts of the face, are flushed from congestion. If the redness is circumscribed and transient, appearing on one or both cheeks, the forehead or the ears soon fading into paleness, to reappear after an uncertain time, we have in this a reliable sign of serious brain trouble. Drooping of the upper lids, squinting, rolling of the eye-balls, fluctuating or unequal pupils, or a steady gaze on vacancy, associated with fever, are symptoms that point in the same direction. A small, pinched face, overtopped by an enormously enlarged head, characterizes hydrocephalus. Rapid out and in movements of the *alæ nasi*, with flushed and anxious countenance, attend severe inflammations of the respiratory organs. I know of no disease that will change the physiognomy of a little child so quickly as a diarrhœa, with copious watery dejections. I suppose that full three-fourths of the weight of a child's body is water; and its rapid abstraction by an intestinal flux may, in a few hours, work such changes in a plump and ruddy face that it is scarcely recognizable.

Notice also the voice. You know the clear, ringing, exuberant tones of healthy childhood. In sickness they are changed. Diseases that produce great debility render the voice weak and plaintive. In pneumonitis and peritonitis it is restrained, because its exercise causes pain. Fits of loud crying are evidence of the absence of these diseases. In croup, and other affections of the larynx, the voice is apt to be hoarse and brassy. Hoarseness is also an early sign of congenital syphilis. Some cases of cerebral inflammation are attended by an occasional solitary,

piercing cry—a cry so peculiarly expressive of agony that it is not easily forgotten. This is the “hydrocephalic cry” of the old authors. Sighing is a symptom frequently seen in like cases.

Cough is very frequent in children, and its character varies with the cause. After taking cold, the most frequent cause, the cough is dry at first from diminution, but becomes moist at length, from an increase of bronchial secretion. The cough of pneumonitis and pleuritis is apt to be restrained. That of whooping-cough is always paroxysmal after the first stage, though the whoop is not always present. The cough that accompanies some forms of heart disease is dry, stuffy and frequent. A laryngeal cough is peculiarly loud and resonant—clarion-like. Stomach and intestinal irritations, as from worms or undigested food, also cerebral and spinal irritations, often give rise to a persistent, dry cough, from reflex nervous influence. Lastly, continued fevers in children are often attended throughout their course by a hacking cough, difficult to subdue, and more annoying than dangerous.

Notice, again, the position and movements of the patient. If very weak, it lies upon its back without much movement of its limbs. If the head is retracted and cannot be brought forward without pain, if the body is rigid, and there are muscular spasms and twitchings, this condition points strongly towards cerebro-spinal irritation or inflammation. If any of the abdominal viscera are inflamed, the child prefers to lie on its back with the limbs drawn up. In colic the prone position is chosen because pressure gives relief. Children often carry the hand to the seat of pain—to the forehead in head-ache, to the ear in ear-ache, to the gums when teeth are coming. Rubbing the nose and upper lip is popularly regarded as a sign of worms. It may be due to these, or to any other irritant in alimentary track, to a cold, or a dose of Dover's powders or other opiate. In spinal and hip diseases, children instinctively assume positions so characteristic that they are of great diagnostic value. In all conditions of the respiratory organs, in which the need of air is urgently felt, there is apt to be extreme restlessness.

Inspection of the surface of the body will frequently lead to

a correct diagnosis without other examination. All the exanthemata may be known in this way. Congenital syphilis is wont to betray itself by coppery discolorations of the surface and eruptions around the anus. In infants the first stage of intermittent fever is seldom attended with shaking, as in older people, but by lividity and paleness of the skin and a characteristic goose-flesh appearance. Jaundice, a frequent ailment in the newly born, imparts a yellowish tinge to the surface.

In grown people we make much of the pulse; not so with children. It is usually absent at the wrist for a week or ten days after birth, and throughout infancy it is feeble and very rapid. Its average during the first year is about one hundred and thirty (130.) It is considerably slower during sleep, and much faster during active movement. Gradually it becomes less rapid, and at the fifth year it is about ninety. During the whole of child life it remains somewhat faster than in the mature. At puberty it is about eighty. The infant pulse is liable to great acceleration from slight causes. A cold, the coming of a tooth, or any transient emotion of joy or grief, may affect its rate as much as a serious illness. You will naturally infer that a rapid pulse is of little significance in very early life. A preternaturally slow pulse is of more importance, being one of the ordinary accompaniments of serious brain disease. The difficulty of counting the pulse, owing to the incessant movement of children, still farther detracts from its value.

The thermometer, an instrument of the greatest value in our work among grown people, is comparatively of little worth when we are dealing with young children. Often the child is refractory and must be held down in order to keep the instrument in the axilla long enough to take the temperature. This is of the less consequence, since its revelations are of much less value than in adults. For, in children, the temperature, like the pulse, is liable to sudden increase from slight and transient causes. A fit of indigestion, or even an outburst of anger with hard crying, will cause the temperature to mount to 103° or 104°, and the case might seem to wear a serious aspect; but an emetic or a dose of oil for the indigestion, and such wholesome

correction in the other case as shall restore the calmness of an obedient spirit, will soon bring the body heat down to the normal standard. When the thermometer is used, it should be remembered that the temperature of the young child is a little higher than that of mature age. In the very young infant, the breathing is frequently intermittent and irregular. There may even be pauses of such considerable length between the inspirations that the mother fears the cessation of the function. From an average of about forty respirations per minute, during infancy, the rate decreases as the child grows older. At the tenth year the average is about twenty-two. Like the pulse, the breathing is liable to great disturbance from slightest causes. Exercise, emotional excitement, or a transient fever, may increase it as much as more serious ailments. In capillary bronchitis and pneumonitis, the respiration is quickened. In acute pleurisy, and in peritonitis, it is short and difficult from the increase of pain to which the movement gives rise. In all acute febrile affections in the young child respiration is apt to be rapid and panting. This, with the cough to which I have before alluded, often renders parents apprehensive of lung disease. In acute encephalic inflammations the respiration as well as the pulse may be abnormally slow and intermittent. In obstructive disease of the larynx and trachea, as croup, inspiration is prolonged, and, if the obstruction is considerable, is accompanied by a peculiar wheezing sound.

In affections of the chest in infants, you will have frequent occasion to resort to auscultation and percussion; and you will be more fortunate than I have been, if, owing to the uneasiness of the child, to the small size of the chest and to the faintness of the respiratory murmur, you do not fail of that diagnostic precision which is so easy of attainment in the adult. Some things, however, may be learned by these means from the youngest and most refractory patient. We may always know by auscultation whether the lungs are freely and equally pervious to air, and by percussion whether there is any considerable dullness in any part of the chest. If a stethoscope can be used without frightening the child, it is preferable to immediate aus-

cultation, because with it the sounds are collected from a restricted area, while adventitious noises from the nares, the larynx and the stomach are included. It is my habit to begin this examination at the back to avoid frightening the child. The young auscultator should have a care not to mistake the naturally harsh breathing of youth for a condition of disease.

While you have been bringing the examination to this point, some chance opportunity of inspecting the tongue and inner side of the mouth has probably presented itself. If not, this part of the investigation had better be made last, since it is pretty likely to provoke crying and a lusty resistance, which occurring earlier would interfere with and retard your work. To examine these organs the patient should be brought in front of a good light. While the nurse holds it and controls its hands, the mouth may be opened by pressing the chin downward. The tongue being in view, notice the condition of its upper surface. If coated, observe the color and depth of the fur, and whether there is any undue prominence of the lingual papillæ. In infants, examine the inner side of the mouth for aphthous sores; also, if at an age when teeth may be coming, pass the index finger backwards over the gums and ascertain their state as to heat and turgescence. If there is ground for the least suspicion of throat trouble, do not neglect to make an examination. This is easily accomplished by steadying the head and passing the handle of a teaspoon over the dorsum of the tongue nearly as far backwards as the circumvallate papillæ and making downward pressure.—*W. T. Plant, M.D., in Obstetric Gazette.*

The Treatment of Empyema.—Antiseptic treatment of this disease is at present fashionable, but more has been claimed for the method than we think it deserves. We give the following contribution to the subject from the *Medical Times and Gazette* :—

Antiseptic surgery has done much to render success more certain, but the antiseptic dressing of an empyema and the insertion of a drainage-tube give trouble, and a simpler plan has been long a desideratum. The siphon trocar, as used by

Dr. Douglas Powell and others, is sufficiently simple, but is open to the objection that if the chest is washed out after drawing off the pus, the same tube being used for both operations, septic matter is liable to enter and infect the pleural cavity. Most of Dr. Goltdammer's cases were treated by incision under the spray and antiseptic dressing, resection of part of a rib being performed in several. The last case, however, to which he refers in his lecture was treated by a new method, recommended by Dr. Kashimura, assistant to Professor Baelz, of Tokio, Japan (*Berliner klin. Wochenschrift*, No. 3, 1880), and which is the simplest imaginable, consisting in puncturing and evacuating the pleural cavity, washing it out freely with an antiseptic liquid, and *then allowing the opening to close*. The instrument (figured by Dr. Kashimura) consists of a canula provided with a stopcock, which closes its outer end after the withdrawal of the trocar, and with two lateral openings to which india-rubber tubes are attached with spring clamps, so that either can be closed or opened at pleasure. Before tapping, these tubes are filled with thymol-water and clamped. When the instrument has been introduced, the stopcock is closed, and one of the tubes, which dips into a vessel of thymol-water, is opened, and the pus allowed to escape. The first tube is then clamped, and the second, which communicates with an irrigator containing warm thymol-water, is opened, and the antiseptic allowed to enter the pleural cavity. It is then evacuated by the first tube, and the process is repeated until the wash-water returns uncolored. The canula is then withdrawn, and the opening closed. Of course the whole of the instrument is assumed to be thoroughly disinfected before use. The cases hitherto treated by this plan, though not numerous, are eminently satisfactory; all have recovered. Dr. Goltdammer tapped a woman aged forty-one, in a state of great prostration, with an empyema of a month's standing, and removed seven hundred to eight hundred cubic centimetres of pus. About two litres of thymol-water were used to wash out the cavity. She was operated on on February 19, 1880; *eight* days afterwards all traces of the effusion had disappeared, and there was no return of it

later on. The patient, who had entered the hospital with extreme cyanosis, and with orthopnoea, ascites, extensive anasarca, and slight albuminuria, as well as an unresolved pneumonia of the right base, to which the empyema was secondary, had entirely recovered, even to the restoration of clear percussion and vesicular breathing over the whole right side, on April 10th. It is needless to enlarge on such a result. A few years ago, however, we may remark in passing, it would have been considered miraculous. Now, thanks to the antiseptic method, whose beneficent effects are making themselves felt in every part of the field of surgery, we scarcely wonder at it. We recommend the special mode of its application above described to the attention and imitation of our readers.—*Boston Medical and Surgical Journal*.

Cynæcology Viewed by a General Practitioner.—Although gynæcology is acknowledged as a true specialty, it must be admitted that it occupies towards general practice a very different position from that of ophthalmology. It is allied so closely to obstetrics, which of necessity, till the very constitution of things is altered, must form a prominent part of the family physician's work, that it is hard to draw the line and say how far the general practitioner should intrude himself upon the gynæcologist's field, or, more properly, how far the gynæcologist should be allowed to usurp the field already occupied from time immemorial by the family practitioner. At what shall the latter stop? Certainly he must know enough to perceive the necessity for recommending his cases to the specialist; and between the knowledge requisite to diagnose a uterine displacement and that required to rectify it by a properly adjusted pessary is but a small step; and in local congestions, erosion of the cervix, menorrhagia, leucorrhœa, the use of curette, and application to the cervical canal, and even to the fundus uteri—at what point is he to pause?

Perhaps the greater operations—the removal of the tumors, polypi, fibroids, and ovarian cysts, the cure of fistulæ and lacerations—would about cover the field of the gynæcologist and

indicate the point where the family doctor could leave his patient, having seen her safely there, in the hands of the great man. But the specialist is not by any means disposed to limit his practice in this manner. He claims the right to be considered an expert in obstetrics on occasion, and considers himself as the only proper custodian of all cases of uterine disease; nor do his large fees leave the usual attendant any chance, for where the circumstances of the patient are too limited to admit of such payment he offers the facilities of his free clinic or dispensary, with the ægis of his great name.

In rural practice, of course, the specialist is not so accessible, but it is a mean city to-day which cannot boast at least one skilful gynæcologist, and the already narrowed field of practice on which, it seems, we general practitioners have been squatting since the time of Hippocrates is being rapidly claimed and enclosed by these lords of the soil, till at last it may happen that the whole class of general practitioners will be evicted to make room for still more enterprising claimants, who will divide and subdivide till, by retributive justice, the holdings will become too small to support their occupants. Then the specialist who removes ovarian tumors will sullenly glare at him of the uterine fibroids, and the wielder of the tenaculum come to blows with him of the curette.

But to avert that dreadful day it behooves each practitioner to fit himself as much as possible for advanced gynæcological work, that the patient, if she by evil chance break forth from his hand uncured, may at least have paid him tithe before she goes. to acquire this knowledge requires both courage and industry. Only those specially favored by circumstances and location can enter again upon a student's career, and books must therefore afford them the information which the graduate of to-day has almost unconsciously imbibed.

The books that are to supply the stone for these defensive fortifications are not far to seek; they are furnished by the enemy himself. They should be, not the work of a novice, who teaches himself as he writes, nor the product of the book-maker, who sees in publication a rapid step to reputation, nor even the

labored compilation or the elaborate treatise of the scholar, but books which are the mirror of the daily work, the daily and hourly experience and expedients, of a practical master. The new edition, so fresh that the treatise by Professor Thomas, of New York, might well furnish the material for the first line of intrenchments, whilst to the inner citadel might be assigned the "Lessons in Gynæcology," by our fellow-townsmen, Dr. Goodell.

Lay deep, then, O brother-practitioners, the foundations of that knowledge which shall be our sure defence against that spectre, whose name is Gynæcology, which now confronts us in the doorways of our choicest patients,—

"A formidable shape;
The one seemed woman to the waist, and fair,
But ended foul in many a scaly fold,
Voluminous and vast, a serpent armed
With mortal sting."

—*Philadelphia Medical Times.*

What Constitutes the Black Head of the Comedone.—Under this heading Unna, of Hamburg, disposes of a long cherished dogma, advocated by Wilson, Hebra, Bacrensprung, Rindfleisch and Virchow, that the black so-called head of the comedone is due to the accumulation of and staining by dirt at the uppermost part of that body. He found that the black head existed in comedones that were so deeply seated in the skin that the overlying layers of epithelium rendered these invisible, so that he was compelled to suppose that if dirt were the real cause of this coloration, it must have got there while the follicles were open, and then the epidermiss have grown over the opening of the follicle. But he finds that this is not the case, and argues, that if dirt were the cause, black-headed comedones should be found with greatest frequency in coal miners and others engaged in dusty occupations, and also more frequently in the face than in other parts of the body. This is not the case, however. The crucial test was now applied by Unna, of examining the substance microscopically, and no dirt or indications of dirt were found. The few colored parti-

cles which he discovered showed the action of ultramarine, and the dark color resulting from their presence, disappearing on applying acids. On this the author bases a treatment of the skin with dilute acids, as these in the first place act directly cosmetically, and in the second, stimulate the skin to normal activity. A comedone is a very little matter, it is true, but it is just as well for physicians to have a basis for knowing that want of cleanliness can be no cause of *acne punctata*.—*Chicago Medical Review*.

Chlorate of Potash in the Night Terrors of Children.—Dr. Harkin writes, in the *Dublin Medical Journal*, November, 1880:—

Young children from the first to the sixth year, particularly those sleeping in over-crowded rooms, are subject to frequent attacks of screaming at night, with insensibility, and semi-convulsions, and somnambulism if not watched, and something approaching to the *petit mal*, due to the protracted inhalation of air deficient in oxygen and laden with carbonic acid and other morbid products—a persistence in this habit often leading to tubercle of the brain or lungs. For this condition I have always found the chlorate of potassium a sovereign remedy; and for the true convulsion and epileptic attacks of children it has proved not only curative, but, more important still, a true preventive. For the adult epileptic, although not so useful as the bromide. I have prescribed with great advantage this salt alone and in combination with the bromide.

Paralysis Agitans.—M. Luys has presented to the Société de Biologie, Paris, plates of microscopic preparations of the pons in this disease, that exhibit remarkable variations from the state of health. The cell-elements were found hypertrophied to nearly twice their usual normal diameter. He concludes that this fact, which is a new one, furnishes a rational physiological explanation of the symptoms of the disorder. We have in it, he says, a function, hyperexcitation of the excitomotor tracts of the spinal axis, that has passed beyond the stage

of volitional control. This discovery of the concomitant hypertrophy of the generating mechanism of this influence in the pons, seems to indicate the natural relations between them, the hypertrophy being the semiological index of the phase of motor excitation to which the nerve element has been subjected. The fact, however, though good as far as it goes, does not seem thus to afford a complete explanation of the pathology of paralysis agitans.—*Chicago Medical Review*.

Tight Rings.—Treatises on operative surgery are absolutely silent on the constriction, by rings, of fingers swollen from one cause or another, and on the method of removing them. The accident is, nevertheless, of common occurrence, causes great pain, sometimes gives rise to great uneasiness, and may even threaten the safety of the finger itself. As a rule, in these cases of constriction, the ring is cut unnecessarily, for want of a simple method of removing it, notwithstanding the popular plan, which comes to us by tradition, and is thus described by Oribasius, vol. iv., p. 251, Daremberg's edition. He writes: "Sometimes the finger is constricted by a ring; and it is necessary to remove the ring without delay, by giving it a rotatory motion; bathing at the same time the finger with warm water, and greasing it with some kind of fatty matter. If the ring does not yield to these efforts, the following operation is recommended. A thick and twisted thread is sharpened at one end in the same way as cobblers sharpen their threads, and passed between the finger and the ring, whilst the rest of the thread is rolled round the finger. When this thread is unrolled, the ring moves towards the tip of the finger, whence it can be removed. If the ring resist this treatment, it is then necessary to cut it." Aetius, who lived at the end of the fifth and the beginning of the sixth centuries, repeats the recommendations of Oribasius. A writer in the *Concours Médical* suggests some improvements on the plan, so as to reduce the volume of the ring by ischæmiatising it, in the same way as ischæmia is produced with Esmarch's bandage. In the first place, the finger is coated with fatty matter; then a thin thread, about a yard

and a quarter long, is taken ; one end is placed under the ring, and passed above it with a pair of pincers to the length of about three inches. The end of the thread being thus fixed by the ring, the rest of the thread is taken to the top of the finger, round which it is rolled in close overlapping lines, not leaving any space between them. This done, the second end of the thread is also passed under, and brought up above the ring. Then, this end being taken between the fingers, the rest of the thread is unrolled resting on the ring, which is thus gradually brought up to the point, where it is easily removed. If a first trial does not always succeed, it is rare for the ring not to yield to efforts twice or thrice repeated. Should this be the case, the ring, of course, must be cut on a canulated sound with a file or divider.—*British Medical Journal*.

Treatment of Scarlet Fever by Warm Baths.—The following communication from Dr. W. V. Lush, physician to the Dorset County Hospital, appeared in *The Lancet* of August 14th, 1880 :—

In December, 1869, while we were experiencing a very severe epidemic of scarlet fever, there appeared in *The Lancet* a reprint of a letter by Dr. Charles T. Thompson, strongly advocating the use of warm baths in this disease, and stating that he had pursued the practice for fifteen years, and had never lost a patient. In consequence of this communication I commenced this practice ten years ago, and have followed it from that time to the present. At first I order the patient to have three warm baths daily, to be kept in from three to five minutes, rapidly dried, wrapped in a blanket, and returned to bed. As the disease subsides, I reduce the baths to two or only one daily. I find that—1st, it brings out the rash ; 2nd, reduces the temperature ; 3rd, soothes the patient ; and when this treatment has been adopted at the onset, I have as yet not lost a single patient. In one case the warm bath was objected to till the child had been ill some days, and this case, and this alone, proved fatal. My friend, Dr. Alfred Hollis of Freshwater, has told me of the great comfort he himself experienced from warm bathing when suffering

from the disease ; and, of course, in the treatment, neither medicine proper nor good nursing is precluded.

Some of my readers may recollect a case of small-pox published by the late Dr. Stokes of Dublin, where the warm bath proved singularly beneficial, and who doubted not that the mortality in small-pox hospitals would be greatly diminished by the use of the bath. The case I refer to was that of a medical student, in which "the pustulation was almost universally confluent ; the purulent matter highly putrescent ; the hæmorrhagic state developed, the body one universal ulcerous sore, and the blackness of the worst purpura developed ; the odor of an intensely pungent and offensive character, which seemed to pass through the bystander like a sword. Stimulants alone, freely and constantly employed, seemed to preserve the patient alive. The pulse was rapid, weak, and intermittent, and for several days life was despaired of. At this juncture Dr. Stokes happened to describe the case to his colleague, Mr. Smyly, who suggested the trial of the warm bath. Pillows were adjusted in one, the patient placed in it, and the effect was instantaneous and marvellous. The delirium immediately ceased. The patient exclaimed, 'I am in heaven ! I am in heaven ! Why didn't you do this before ?' He was kept at least seven hours in the bath, brandy being freely administered, and removed to bed. The bath was repeated the next day, after which he fell, for the first time, into a tranquil slumber. From this time recovery was progressive." This may seem a digression, but the treatment of another of the exanthemata by similar means is not inapposite. My ten years added to Dr. Thompson's fifteen make twenty-five years' experience of a treatment which I can confidently and heartily recommend.

Complete and universal Alopecia following Fright.—Total baldness coming on rapidly is usually the result of severe fevers, and is followed by entire restoration to the normal condition (*ibid.*) A case of Frédet is cited, however, which may perhaps be regarded as a unique one. A healthy Italian blonde, aged 17, lymphatic, with exceptionally

profuse hair, was sewing at her window. Suddenly the floor fell in, leaving her only time to catch hold of the window-frame, where she hung till taken down by means of a ladder. No subsequent loss of consciousness nor nervous excitement through the day. At night, headache, chills, and bad dreams. In the morning nervous excitement, weakness at the knees, spasms in the fingers, and great itching of the scalp. The following day she felt better, only the itching of the scalp remaining. But on arranging her hair great tufts came out at the roots, adhering to her comb. In three days not a single hair was left on the scalp. Eyebrows, eyelids, axillæ, and genitals began to lose their hair the day after the falling began from the scalp, and in five days those regions were devoid of hair. General health good and no functional disturbance of any kind. A month after the fall of hair began Frédet was consulted. The fallen hair, destined for a wig, was fine, silky, very rich, and long. Not a hair on the body, though a lens was used in the search. Head smooth as a billiard-ball; no more itching, and sensation normal. Physical condition otherwise perfect. Mentally the patient has become despondent, fearing non-recovery of her hair. Two years later, after constant treatment, no return of the hair.—*Dr. Wigglesworth in Boston Med. & Surg. Journal.*

Renal Albuminuria as a Symptom.—

Perhaps there is no one question relating to pathology which is at present attracting more universal attention than the nosological significance of renal albuminuria. It is a subject which has induced recent elaborate experimentation, that in its turn has led to numerous important contributions to current medical literature. Once more it has become a prominent object of discussion by professional societies; and it even looms up in the mind of the practitioner as a practical question involving or determining therapeutic action. It is easy to understand why this should be so. The importance which the physician attaches to this symptom, and the views he entertains concerning its origin and meaning, directly affect the conduct of his treatment in a given case. Moreover, the presence in the urine of this abnormal ingredient

(for such it must be considered despite the contrary statements of some authors) is readily detected, and often as readily interpreted as a palpable manifestation of existing disease. Any obscure case, which at first sight may have appeared hopelessly intricate to the puzzled diagnostician, with the detection in the urine of an albuminoid substance suddenly, as if by charm, loses its questionable character and ceases to bewilder. Albuminuria did it. Albuminuria is responsible. But, if the routine practitioner is thus easily satisfied, the rational physician and man of science is not. Here, as elsewhere, the latter strives to ascertain the why and the wherefore. And it is the results of inquiry in this spirit which have modified, and are still modifying, our views respecting the significance of albuminuria.

For a long time the primitive simplicity of Bright's views swayed the professional mind, and, according to the then dominant ideas, albuminuria meant renal disease. Even at the present day, by some, the two terms are believed to denote one and the same thing. When, however, the rapid advances of pathological histology revealed some of the complexities of the subject, other factors came prominently to the front. Soon sharply defined distinctions were created separating diffuse from parenchymatous, and both from renal cirrhosis. Albuminuria was now only one in a train of symptoms indicative of kidney disease. To-day the pathogeny of albuminuria, although by no means in a completely satisfactory condition, is still better understood. We know now that various affections are associated with the appearance of albumen in the urine. Thus, Dr. Ellis has contributed much valuable information on this topic by compiling a table of the manifold conditions under which it occurs, and the list, though avowedly incomplete, furnishes 150 such conditions—and all exclusive of renal disease. Of course one should not look upon attendant phenomena in the light of causes, unless there is some satisfactory reason for so connecting them. Though the number of etiological factors is large, we have no ground for presuming that it reaches the figures just indicated, nor do we believe that Dr. E. wishes it so understood.

Transient albuminuria may be observed in a great variety of

disturbances, and even the prolonged presence of albumen in the kidney secretion does not *per se* argue permanent histological change in those organs. Protracted muscular exertion may lead to albuminuria. Certain articles of diet, notably eggs, produce it—a change in the condition of life may lead to it. The effects of climate may also act as exciting causes. And all this in persons of apparently excellent health. On the other hand, slight ailments may be found in connection with albuminuria, and *vice versa*. Indigestion appears to be frequently accompanied with the renal excretion of albumen. Stimulation of the spinal cord below the medulla, irritation of the renal nerves, and other neurotic influences give rise to it. Furbringer (*Zeitschr. für klin. Med.*, vol. i., sec. 2) records, among other cases, the interesting instance of an otherwise healthy physician subject to albuminuria, in whom nervous depression was always followed by an increase in the amount of albumen voided.

Da Costa and Longstreth, as the result of recent important investigations (*Am. Jour. Med. Sc.*, July, 1880), even claim that “in Bright’s disease, especially in the contracting kidney, there exists a constant lesion of the renal plexus.” Moreover, that this is the true cause of the renal malady.

The albuminuria of fevers may also be the result of vasomotor disturbances. In anæmic persons albumen may appear in the urine (Edlefsen, *Mit. d. Ver. Schles.-Holst. Aerzte*, 1879, No. 2), especially after exertion. Cardiac failure, or at any rate a relative weakening of the heart’s power, has been pointed out as the probable cause of the symptom in such persons. This appears to be a plausible explanation enough in the light of recent investigations by Runeberg (*Deut. Arch. f. klin. Med.*, vol. xxiii., p. 41, and vol. xxiv., p. 248), for the permeability of animal membranes becomes greater under low than high pressure. Thus, Runeberg explains the transient albuminuria of healthy persons in the following way: he asserts that the transudation of serum-albumen takes place in the glomeruli on account of the increased permeability of the walls of the blood-vessels composing the tufts. The epithelial investment of the latter participate in this abnormal permeability. As the cause

of this augmented permeability there may act any factor resulting in the diminution of the difference between the blood-pressure inside the glomeruli and the external counter-pressure of the renal tubules. In this connection it is well to note that Dr. Munn, of this city (*Medical Record*, March 29, 1879), reported that among a number of applicants for life insurance, he found albuminuria in eleven per cent., where the individuals appeared, after careful examination, to be otherwise in perfect health.

Persistent albuminuria is also explained by Runeberg as the result of structural alterations of the vascular tufts. It seems that Leube (*Virch. Arch.*, vol. lxxii., p. 145) and others have taken exception to the unavoidably theoretical deductions of Runeberg, but they certainly appear to deserve attentive consideration.

Taken altogether, it must be confessed that there exists just now a rather unsettled state of professional opinion on this important subject. Certainly, we lack the desirable basis of assured knowledge, and though some new points of interest have been elicited, the physiological laws governing the passage of albumen into the urine are still in part unknown. The practical importance of a complete comprehension of these matters should prompt untiring efforts and new researches in this direction. Meanwhile we should solace ourselves with the comforting thought that albumen may often be made to disappear by proper attention to the exciting cause, which may frequently be found if diligently sought for. Albumen, though occasionally an ingredient in the urine of healthy individuals, indicates an abnormal state at the time it is voided, and no rational physician can be otherwise than extremely watchful whenever it makes its appearance.—*N. Y. Medical Record*.

“Castration for Hysteria.”—Under the above title a French journal gives an account of a case which was presented to the Berlin Medical Society some months ago, and which has scarcely attracted the attention in this country which its significance deserves. Dr. Israel presented to the Society a young woman twenty-three years old, cured of severe hysteria

by "Battey's operation," of which she bore the cicatrix. The patient had suffered for some years from obstinate vomiting, accompanied by severe ovarian pains. She became extremely weak and anæmic. Many surgeons advised the operation, and she gradually arrived at the conviction that castration was the only remedy for her sad state. The operation was performed under chloroform "with all antiseptic precautions." During the first three days after the operation there was extreme tenderness in the lower part of the abdomen, and ice was obliged to be constantly applied. At the same time there was retention of urine, which only passed off at the end of twelve days. A week after the operation the vomiting had ceased, and the pain in the ovarian region had disappeared. The patient's cure remained permanent. One detail, however, of this beautiful illustration of the value of "oöphorectomy" remains to be mentioned, and it is not unimportant. The operation was a pretended one. A superficial wound only was made! The result certainly justified the means.—*London Lancet.*

The Treatment of Whooping-Cough in Gas-Works.—A series of recommendations on the treatment of whooping-cough in gas-works has been made to the Académie de Médecine. A commission was appointed some time ago consisting of three members, of whom M. H. Roger, the President of the Académie, is the sole survivor. He has presented a report to the Académie which is of some interest. Before considering the communication, he described the arrangement of the chambers for the purification of gas, and the chemical products which patients would breathe in them. The purifying chamber is a large room, with doors and windows freely open. Each contains twenty-four vessels, holding five cubic metres of depurating substance—lime and sulphate of iron, mixed with sawdust—through which the gas has to pass. When the workmen are emptying and re-filling one of these vessels the children with whooping-cough are placed around it, and inhale the vapors which escape. They are in an atmosphere containing ammonium sulphide, carbolic acid, and tarry products. The statements made regarding the efficacy of this

treatment are the following. M. Commenge records 169 cases in which the treatment was persevered with. In 20 the treatment failed completely, in 48 improvement was obtained, and 101 were cured. M. Bertholle merely states that, of 341 cases, 122 were improved and 219 were cured. Failures or deaths are not mentioned. M. Rogers points out that these figures are too good to be quite satisfactory. A method of treatment which gives, of 510 cases, 490 ameliorations, and no death, would be indeed an admirable result. But besides the 490 cases improved there were, it appears, 671 cases not included because the treatment was not persevered in, and these probably include a large number of total failures. Moreover, the cases alleged to be cured were not carefully followed up. Evidently also slight and uncomplicated cases only can be treated in this manner. The remote situation of most gas-works, and the exposure involved in the treatment in winter, limit the application of this method. M. Roger thinks that it acts only upon one element of whooping-cough—the catarrh—and that it is contra-indicated in febrile attacks of the disease, and would be positively dangerous in complicated cases. The method is, however, easy of use in some localities and in summer, and seems worthy of further trial in suitable cases, but it is desirable that its effects should be more exactly noted.—*London Lancet*.

Mudfog Association.—In the section on anatomy and medicine, Dr. Kutankumagen (of Moscow) read a report of a case which had occurred within his own practice, strikingly illustrative of the power of medicine, as exemplified in his successful treatment of a virulent disorder. “He had been called in to visit the patient on the 1st of April, 1837. He was then laboring under symptoms peculiarly alarming to any medical man. His frame was stout and muscular, his step firm and elastic, his cheeks plump and red, his voice loud, his appetite good, his pulse full and round. He was in the constant habit of eating three meals *per diem*, and of drinking at least one bottle of wine, and one glass of spirituous liquor diluted with water, in the course of the four and twenty hours. He laughed

constantly, and in so hearty a manner that it was terrible to hear him. By dint of powerful medicine, low diet, and bleeding, the symptoms in the course of three days perceptibly decreased. A rigid perseverance in the same course of treatment for only one week, accompanied with small doses of water-gruel, weak broth, and barley-water led to their entire disappearance. In the course of a month he was sufficiently recovered to be carried down stairs by two nurses, and to enjoy an airing in a close carriage, supported by soft pillows. At the present moment he was restored so far as to walk about, with the slight assistance of a crutch and boy. It would perhaps be gratifying to the section to learn that he ate little, drank little, and was never heard to laugh by any accident whatever."—*Mudfog Papers.*

Epithelioma of the Rectum Removed

AFTER A NEW PLAN WITHOUT INJURING THE SPHINCTER ANI; RECOVERY.—The following case was under the care of Mr. Rowse :—

I. C—, aged sixty-four, married, was admitted into St. George's Hospital, in May last, with an epithelioma of the rectum, of about six months' growth, situated on the left side of the bowel, about one inch above the anus. The growth was flat, sessile, of about the area of half a crown, and limited to the mucous membrane and the sub-mucous tissue. The deeper parts felt apparently uninvolved.

On June 17th Mr. Rowse removed the growth in the following manner. A curved incision, an inch and a half in length, was made, just outside to the external sphincter, and parallel to the outline of that muscle. The skin was then dissected up outwards for a short distance, so that the outer circular fibres of the sphincter were exposed. The muscle was then drawn over towards the middle line. By introducing the finger into the rectum, the growth was pressed into the external wound, and it was then cut out, together with that part of the wall of the rectum to which it was attached. In this way an opening, about the size of a half-crown, was made through the bowel. After the closure of the skin wound but a small cavity

could be felt, corresponding to the former situation of the growth. The hæmorrhage was very slight.

Opium was given in order to keep the bowels confined for some days. The recovery was almost uninterrupted. For some few days slight feculent discharge took place from the wound, but after about three weeks this had completely ceased, and the patient then had entire control over the contents of the rectum. As a matter of fact, scarcely any fæces escaped, but the suppuration resulting during the granulation and closure of the cavity possessed a faecal odor. When the patient left the hospital, about a month after the operation, the power of the sphincter was perfectly normal. The general symptoms were much relieved.

Remarks.—The advantages of this method of operating, in suitable cases, are obvious. In the instance described above, it is true, the growth was of small extent, and limited to one side of the bowel. There seems no reason, however, why this operation should not be equally applicable to growths of much larger size. The advantage of preserving the sphincter intact is patent; no doubt, in some cases an operation of this nature might advantageously be substituted for complete removal of the lower end of the rectum. Certainly, numerous cases have been recorded where no incontinence of fæces followed the latter proceeding; but still this method of operation gives the patient additional security against a highly unpleasant condition, without any additional concomitant risk.—*London Lancet.*

Tabes Dorsalis Cured by Nerve Stretching.—Dr. Langenbeck reports, in the *Berlin Wochenschrift*, a case of tabes dorsalis, in which nerve-stretching, conducted under antiseptic precautions, resulted in a complete cure. The left sciatic was first operated upon; the motor and sensory paralysis following disappeared in a few days. Twelve days subsequently the right sciatic and both crural nerves were stretched, and with the same results. The feebleness which marked the first efforts at locomotion soon passed off, and the ataxic symptoms disappeared.—*Philadelphia Medical and Surgical Reporter.*

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1881.

MEDICAL GOVERNORS.

Since the recent troubles at Guy's, attention has been much directed to the constitution of the governing body of that and other Hospitals. As a consequence of this, we find many of the most influential journals pointing out that much of the disagreement there arose from causes which probably would have been obviated if the medical staff had been fully represented upon the managing committee. Thus, the *British Medical Journal* says: "In almost every English Hospital, the honorary medical officers are, by law, *ex officio* governors. In twenty-nine out of thirty instances, the physicians and surgeons are either *ex officio* members of the committees of management, or they are largely represented at such boards." It certainly seems but reasonable to suppose that in an institution like a hospital, medical officers would naturally prove most useful members of a managing committee. A great many questions are frequently coming before the committee which, for their settlement, necessarily presuppose some medical knowledge. Without this, that body must obviously feel itself-sometimes decidedly at a loss in coming to a decision. It is no wonder, therefore, that we find the regulations of the British Hospitals, with hardly an exception, providing for the admission of one or more of the honorary medical staff as representatives to the stated meetings of the Committee of Management. We have been led to these remarks from the fact that in our own Hospital the deficiency observed at Guy's is seen also to exist. There are no medical members on the Managing Committee. Not that we imagine that even the continuance

of the present system would lead to any clashing between the lay governors and the medical staff. On the contrary, working under the constitution, as at present administered, the most complete harmony has always existed between these two branches of the service. But simply, we believe that the interests of the entire institution would be best served by adding some representatives from the Medical Board to the Managing Committee. The idea is not at all a new one. It has been several times mooted by individual governors at their meetings, but it has never been properly and formally brought up and discussed. We hope it soon may be, for we are satisfied that if that is done, the result will be the introduction of the innovation we are advocating. We are satisfied that the benefit of the presence of professional members would soon be acknowledged, and wonder would be felt how or why they should so long have been excluded.

THE ASYLUM AND THE "ABEILLE."

Our French contemporary takes up the cudgels in favor of the judiciousness of the appointment of Dr. Perrault to the Longue Pointe Asylum. We certainly did say that the person alluded to could not be looked upon as one having that special knowledge and experience which would qualify him for the entire management and control of several hundreds of lunatics. It is surprising to find any medical journal capable of gravely arguing that Dr. P. is a specialist on insanity. To support this statement we are favored with an outline of the life of Dr. P. We learn that this gentleman passed the Provincial Examining Board in 1849. No mention is made of any University qualification, which we must therefore conclude to be wanting. He then began practice in the parish of Longue Pointe, and has ever since continued to perform the routine duties of a general practitioner in the same locality. As further claims to public consideration, it is mentioned that he was a member of "the Medical Society" (what Society?), and was even President of the same. He was also elected a member of the Provincial Medical Bureau. To crown all, he was called even by that hostile journal, THE CANADA MEDICAL AND SURGICAL, "a reputable physician of

good standing," (which, however, merely showed that his name was on the Provincial Register). Having, owing to residing in the neighborhood, sometimes assisted Dr. Howard, and even, in emergencies, acted for him, it is thought that this has been sufficient to give him a complete insight into the difficult subject of the management and treatment of the insane! It is amusing also to learn that he has taken special care to avoid several errors which he was able to detect in the treatment ordered by his supposed instructor. Now, it may be that this satisfies *L'Abeille* that Dr. P. is indeed a specialist, and thoroughly deserving of the public confidence in his important charge, but we are equally certain that such a view is not that held by a great many of the most intelligent and observant of our professional men. We know of several cases where the friends have been deterred from sending patients to the Institution owing entirely to the contrary advice received from their ordinary attendants, this advice having been based upon the belief that they would not there receive that skilful management which is frequently necessary for the restoration of a diseased mind. Our opinion on this subject is not a particle altered by the very lame defence attempted by our contemporary: and we think it is a matter for great regret that this want of trustful feeling is (very properly) widely felt throughout the community.

To an uninitiated person, it would almost appear as if the provision made for the medical attendance upon the inmates was more than ample, for we find that no less than five medical men have an official connection therewith—all paid Government officials—viz., Drs. Smith, Demartigny, Howard, Desaulniers, and Perrault; but it requires to be understood that from out of these five, four are inspectors, and that the sole responsible person for the daily work of the Asylum is the last-named gentleman. He carries the entire responsibility of the actual treatment of every lunatic within the Asylum's walls. As far as we know, the experience even of Dr. Howard, is never availed of for consultation or advice in cases of difficulty or of an unusually severe character. We have said before that we do not think this should be, and many communications we have since received upon the

subject make us know that a great many others think like us. We should be glad to see, and hope we may yet see, such arrangements made as will advance this large Provincial Institution into the position which it should occupy. Until such is done, we cannot, in the interests of deranged sufferers, and in the interests of the profession at large, abstain from expressing our convictions.

The following remarkable sentence is from the same article: "We regret to be obliged to differ in opinion from our *confrère* of the CANADA MEDICAL AND SURGICAL JOURNAL, but it is our duty, and we perform our duty in defending our institutions, our nationality, and our rights." Now, that sort of thing might go down if delivered from a political hustings, but in the name of common sense, what has it to do with the medical matters of a lunatic asylum? We are quite sure the nationality of our *confrère* and the rights thereof need not to be defended from us, for we have been entirely guiltless of any attack upon either. We would certainly deprecate at once the imputation that unpleasant but perhaps necessary things said by us concerning a public official should be prompted by aught but a desire for the public good—certainly not from the mere fact that we differed in origin from the person spoken of.

TYPHOID AT LENNOXVILLE.

We had intended making, in this issue, some further remarks on the origin of the outbreaks at the Grammar School, but, unfortunately, there has been some delay in the presentation of their official report by the medical gentlemen who were charged with making the necessary investigations. We therefore prefer waiting until that document is before us. In the meantime, we would draw attention to the important communication on this subject from Dr. Worthington, which appears in another place. His statements, certainly, are most damaging, and we do not know whether any of them can be explained by the authorities. There is nothing like plain speaking in these matters, and it is quite possible that if more of this had been indulged in sooner, the present disastrous troubles might have been averted. There has always been far too much tendency to keep things quiet

through fear of injuring the school. With reference to the delay in notifying parents of the illness of scholars, we know, from communication with the relatives of several of the patients, that the statements of Dr. Worthington are mainly correct. Indeed in one case public indignation has been loudly expressed at the unnecessary suffering inflicted upon friends who could only reach Lennoxville in time to find their sufferer delirious and soon passing into a moribund condition.

Since writing the above, we have received a second letter from Dr. Worthington, dated 9th January, from which we take the following important extract:—

“There is another case of typhoid fever at Lennoxville from the school,—a boy who has been engaged as a servant. It appears that he has been ill for three weeks, and Dr. Robertson, who is attending him, thinks the case rather serious.

“The school is about to be opened again, and here is a fresh case. If the school should assemble, and one other case occurs, it will kill the institution beyond all redemption. Would it not be better, then, in the best interests of the school, to miss a term, so as to give opportunity for all necessary alterations?”

We fully endorse the caution which is here advised, and would recommend the Lennoxville authorities to think well before risking the lives of boys again.

MONTREAL GENERAL HOSPITAL TRAINING SCHOOL FOR NURSES.
—The following circular has been issued by the Committee of Management:—

A Training School for Nurses, in connection with the Montreal General Hospital, will be opened on 1st January, 1881, under charge of a competent Lady Instructor. Special instruction in various departments of technical work will also be given by members of the Medical Staff, who have kindly consented to undertake the duty. Young women desirous of receiving this course of instruction must apply at the Hospital to the Lady Superintendent.

The most desirable age for candidates is from 21 to 35 years. They must be of sound health, and must produce certificates as to their good character.

Upon the recommendation of the Lady Superintendent, applicants will be received for one month on probation, during which period they will be boarded and lodged in the Hospital, but will receive no compensation.

Probationers who have fulfilled the duties of their probationary month

to the satisfaction of the Lady Superintendent of the School will be accepted as pupils, and will be required to sign a written agreement to remain in the School for two years, and to conform to its rules. They may, however, be allowed to withdraw upon grounds to be approved by the Committee of Management, and will be subject to be discharged at any time by the Committee, upon the report of the Lady Superintendent, in case of misconduct, or should she consider them inefficient or negligent of their duties.

The pupils will be employed as assistant nurses, and will receive during the first year of their course \$7.00 per month, and during the second year \$9.00 per month.

It is intended to open the School also to ladies who may be desirous of joining without receiving remuneration, or who may be willing to pay for the instruction afforded. Special terms and conditions will be arranged with such applicants, but no term of service will be accepted for less than one year.

All pupils will be required to wear the Hospital uniform in the wards.

When the full term of two years' instruction is completed, pupils will receive, after passing the final examination, diplomas certifying to their knowledge of nursing, their ability and good character.

COURSE OF INSTRUCTION.

The dressing of blisters, burns, sores and wounds; the application of fomentations, poultices, cups and leeches.

The administration of enemata and use of catheter.

The best method of friction to the body and extremities.

The management of helpless patients, making beds, moving, changing, giving baths in bed, preventing and dressing bed sores, and managing positions.

Bandaging, making bandages and rollers, lining of splints.

They will also be given instruction in the best practical methods of supplying fresh air, warming and ventilating sick rooms in a proper manner, and are taught to take care of rooms and wards; in keeping all utensils perfectly clean and disinfected; to make accurate observations and reports to the physician of the state of secretions, expectoration, pulse, skin, appetite, temperature of the body, intelligence, as delirium or stupor, breathing, sleep, condition of wounds, eruptions, formation of matter, effect of diet, of stimulants, of medicines, and to learn the management of convalescents.

Medical Items.

REMOVAL.—Hon. Dr. Brouse, of Prescott, Ont., has removed to Ottawa to enter upon the practice of his profession in that city.

REMOVED FROM MEMBERSHIP.—The Council of the Royal College of Surgeons, England, has recently removed a medical man—a resident of Ontario—from being a member of the College, for a contravention of the by-laws, in publishing and professing a secret method of cure.

DEATH IN THE TRACHEOTOMY TUBE.—Dr. Sandford B. Hunt, of Gum Point, N. Y., after operating for tracheotomy in a case of diphtheria, found the tube choked up. He placed his mouth to it in order to clear it by blowing. As a consequence, he contracted the disease and died of it. These sad cases are warnings to physicians not to imperil their lives in this way.

A SINGULAR CONCATENATION OF MISFORTUNES.—The death of a Dr. Desire Voulet, of Saillans, is announced under the following circumstances. He was called by a midwife to a woman in childbed; and, whilst assisting in the delivery, had an apoplectic fit. The midwife fainted, and the poor patient died of hemorrhage from want of timely assistance. It may be noted that the unfortunate Dr. Voulet was eighty years of age.—*British Medical Journal*.

—Over six thousand homœopathic physicians are registered in the United States. Of this number nearly one thousand practice in the State of New York; between six and seven hundred in all New England; Boston has less than one hundred; Baltimore less than fifty. It is said that in Great Britain and Ireland there are not two genuine homœopaths altogether.

—The frequency of chloroform deaths in England is leading to a revolution in favor of ether. In one medical journal alone seven deaths have been recorded from chloroform during the last nine weeks, and professional feeling is becoming very strong in demanding that nothing but ether be used. The English surgeons begin to recognize that ether is safer than chloroform, at which our Boston friends rejoice.

—In a recent work entitled *Histoire de la Médecine à Troyes*, Dr. Guichet relates that the College of Physicians of that town brought an action against a certain Nicholas Bailli for adminis-

tering internal remedies to his patients and *putting them to sleep*. In defense Bailli declared that, having observed that in great operations, amputations, incisions, actual and potential cauterizations, many patients slipped through his hands for want of sleep, he had studied the secrets of nature, and had at last found a cordial, or marvellous essence, which put them to sleep softly, and appeased their sensibility to pain.

TEST FOR SUGAR IN THE URINE.—Dr. L. S. Oppenheimer (*Louisville Medical News*) gives the following:—

℞	Cupr. sulph. cryst. - - gr. i.	
	Glycerine purif. - - - ʒ j.	M.

One drachm of this mixture will reduce one grain of grape-sugar in a caustic alkali. Two or three drops of the mixture are put in a test-tube, and ʒss. liq. potas. added; the whole is then boiled, a few drops of urine added, and the whole boiled again. If sugar is present it will be thrown down as the brownish-yellow cuprous oxide. The test is surer than Trommer's; it can be used to determine the quantity of sugar, albumen does not interfere with the reaction, and the mixture will keep indefinitely.

A VENERABLE PHYSICIAN AND HUNTER.—The *Philadelphia Reporter* says that Dr. Graham, an old physician of Louisville, who is in his 97th year, has just started for the mountains on his "last hunt." He is the only living fort-born native of Kentucky. When he came into the world his parents were dodging arrows and tomahawks, and his youth was spent with a rifle in his hand. He says that he cannot die in peace until he shall once more have eaten venison of his own killing and cooking.

—One of the most ludicrous typographical errors lately reported was from the substitution of a "d" for the final "l" in chill. A gentleman, on making a trip east, left his wife in her usual good health, and was surprised in a few days at the receipt of a telegram announcing her serious illness. He telegraphed the family doctor for particulars, and received in reply the following: "Mrs. B. has had a child. If we can prevent her having another to-day she will do well." The husband's mental condition was somewhat perturbed until he ascertained the exact state of affairs.