

## Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

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

Continuous pagination.

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

THE  
CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

EDITOR:

A. H. WRIGHT, B.A., M.D. Tor., M.R.C.S. England.

Business Management, - - - THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.

TORONTO, NOVEMBER 17, 1890.

Original Communications.

THE FAILURE OF THE REMOVAL OF  
THE TUBES AND OVARIES TO  
RELIEVE SYMPTOMS.\*

BY JAMES F. W. ROSS,

Lecturer on Diseases of Women, Woman's Medical College, Tor.;  
Lecturer on Abdominal Surgery, Toronto University;  
Gynaecologist to Toronto General Hospital;  
and Surgeon to the Woman's  
Hospital, Toronto.

In selecting this subject as my ground for a paper, I determined to throw together, roughly, some facts that have come under my own observation in the last four years. It is a well-accepted fact among sportsmen that a spayed bitch is stupid, listless, and lazy; that she loses interest in her work and becomes almost useless to the gunner. I believe that removal of the ovaries of women, in some cases, interferes with their intellectual capabilities and diminishes their intellectual calibre, even if it does not remove or diminish their sexual desire. It is not such a very important matter that a woman should be endowed with sexual longings, but it is very important that her companionship should be unimpaired by any loss of mental vigor. We hear a great deal about the marital grievances based on this absence of sexual feeling, but I believe that fully one-half of the married women are almost devoid of sexual passion. Let us hope that in a civilized community this is not the chief exact-

\*Read before the Canada Medical Association, at Toronto, September, 1890.

ment of man, but that he looks to woman to be a bright and cheerful companion, a ready counsellor, and a help in the hour of suffering and trouble. Our object, as physicians and surgeons, is to relieve suffering. When suffering and semi-invalidism are due to pelvic inflammation that can be relieved by operation, then we should undoubtedly operate, even though the woman be unsexed. But to operate on organs not diseased for the relief of indefinite pain symptoms, hysterical symptoms, cataleptic symptoms, epileptic symptoms, is to my mind unjustifiable. A craze seems to have taken hold of the profession. The axiom seems to have become: "If a woman has indefinite pains or pelvic symptoms that you cannot account for, take out her ovaries." This axiom requires a radical change. Every case that complains of indefinite pelvic troubles should be taken into a hospital, or watched resting quietly at home, attended by an experienced nurse for a month or six weeks. Valuable information as to the actual amount of pain suffered will be in this way obtained. Examination should be made by an experienced finger under an anæsthetic. It is thus impossible that a dilated tube or an enlarged ovary can escape the finger, or that adhesions be present without being discovered. If no definite enlargement or "boggy" matting together of the parts be felt, then I hold that the ovaries and tubes should be left alone. Ovaries with little fibroid nodules, broad ligaments with little cysts hanging from the tubules of Kobelt, or the

little enlarged hydatid of Morgagni, do not give rise to symptoms and are to be found, in my belief, in the pelvis of most women, and have been made the scapegoats for many of these operations when the nervous system has been really at fault. I believe that a simple catarrh of the tube takes place periodically once a month in the tube on the side on which the Graafian follicle is about to burst. I have opened a large number of these tubes at the operations of others, and have found on two occasions in the tube on one side, corresponding to the ovary developed for the next menstrual period, a collection of clear tenacious mucus. In these cases the ovaries have been non-adherent, have never been surrounded by any inflammation, and to my mind were perfectly healthy. I have seen these unjustifiable operations done both in Europe and America. Fortunately, as after every new procedure, we are now able to glean what is good and throw away what is bad. It is my intention, by the aid of the

specimens I show you and the cases related, to draw, to my own satisfaction at least, a dividing line between these two sets of cases.

I can prove by this specimen (*Plate I.*) of a fibroid ovary that much change may go on in any ovary and produce no symptoms. The patient came to me for the relief of a hernia and asked me if I could tell her why she was sterile. She had been five years married. It was alone on

that account that I examined her, found this mass, diagnosed a fibroid ovary, and removed it a week ago. We all know that ovarian tumors develop with and without pregnancy without giving rise to any particular train of symptoms. Small ovarian tumors may be painful or give rise to no pain. They may give rise to pelvic inflammation or to no pelvic inflammation. My friend, Dr. McFarlane, had a lady under his care for years, both prior to and subsequently to her marriage. She was about to be confined of her fourth child, and as usual, sent for him. Her health had always been good and her married life happy. After he arrived at the house she suddenly developed symptoms of rupture of the uterus, and was dead in twenty minutes. On *post mortem* examination he found the uterus ruptured. He also found a cystic ovary as large as a goose egg. It was non-adherent. She never had any symptoms to point to its presence.

I will now quote one case from my own experience to prove that a small

ovarian cyst may give rise to very curious symptoms and without having contracted any adhesions. A lady, five years married, had two natural labors; she consulted me about an uncomfortable feeling in the pelvis; she had been treated for flexions, prolapse, etc., since girlhood, at the hands of various physicians; I do not doubt that the tumor was gradually but slowly increasing in size at this

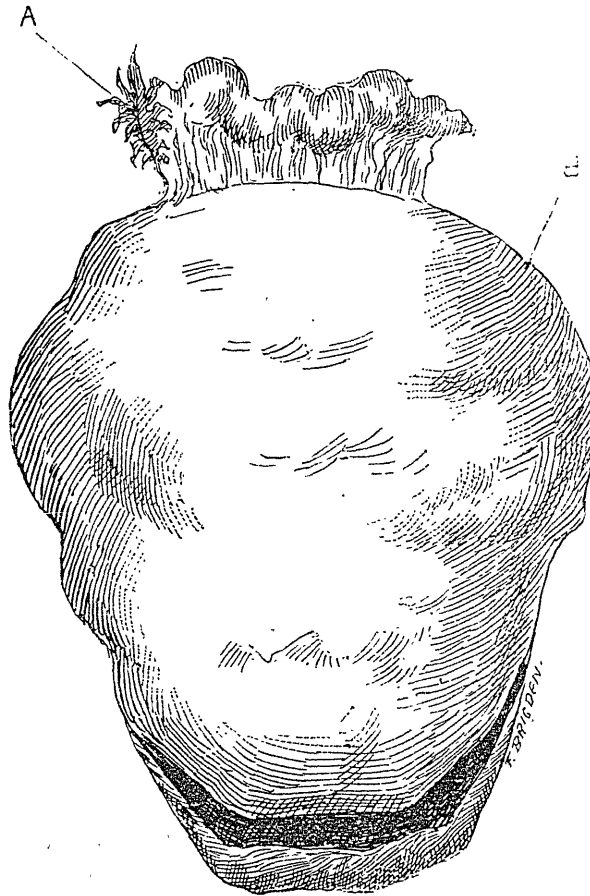


PLATE No. I.

A. Healthy Fallopian tube. B. Fibroid ovary, size of a goose egg.

time, but was perhaps not large enough to be detected; after marriage she bore two healthy children without difficulty; before I saw her she had been put to torture by the insertion of a Hodge pessary to hold up a supposed retroflexed uterus; when she first menstruated at from sixteen to seventeen she had no pain; was never very regular; three weeks before marriage had "inflammation of the bowels," brought on, she was told, by sudden falling of the womb; she was sick at the time of marriage with pains in her back and legs, and felt as if she was losing the power of her legs; she weaned her last child in March and was unwell on May 4th; it lasted six days; menses came on again June 20th, and she continued unwell until I saw her; clots passed, and something like a "little bladder" came away; she believed she had a miscarriage; she subsequently had pains across lower abdomen; pain on sitting down more about rectum; coition very painful. On examination I found a tense mass in right parametrium, dropping in towards curve of sacrum, probably ovary; uterus enlarged; erosion of os. On exploring I found the right ovary enlarged to size of an orange, and removed it; there were no adhesions; she has been in robust health since, and is as cheerful and bright as ever. In this case I removed but one ovary. In another case of ruptured ectopic gestation, I removed but one ovary and tube; the patient then bore another child; and five months ago, three years after the first operation, I removed the other side for tube disease. In other cases I have removed but one ovary, and I may here state that in all cases, unless there is marked evidence of disease of the opposite side, I intend to leave the apparently healthy structures behind. In the case of fibroid ovary just related, it would have been absurd to have removed the other ovary and thus spoil all chance of a subsequent pregnancy. If this holds good with one form of ovarian tumor, it equally applies to another. There is a very marked difference in the mental condition of patients from whom only one ovary has been removed and of those from whom both have been taken. The experience of savage nations does not tally with that of civilized people. It is said that women castrated among aboriginal tribes of the South Pacific become thin, strong,

active, and wiry, and are better able to stand fatigue. My limited experience has been the reverse of this.

There can be no doubt that removal of both ovaries produces a profound nerve change, while removal of one does not seem to produce any such change. It would be interesting to ascertain whether this change occurs equally in those in whom menstruation is and is not entirely stopped by castration.

That neither ovaries, nor tubes, nor the large plexus of nerves in the broad ligament so beautifully demonstrated by Frankenhauser some years ago, exert the sole or whole influence that produces menstruation, is proved by the case reported by Tait. In that case a supra-vaginal utero-ovario-tubal amputation was performed, and though but a small stump of cervix was left, the woman still continued to menstruate from the stump.

I wrote sometime since to my friend Prof. Gaule, Professor of Physiology, at Zurich, for some explanation of this phenomenon. We had often talked the matter over together. In reply, he says that his belief, as set forth some years ago, is that the cells of all organs retain a certain intimate connection with one another, a connection first occurring during embryo life. That is, that certain cells of the blood, of the nerves, of the glands, of the connective tissue, etc., correspond with one another because formed at the same period of time and bound together through certain prevailing structural laws. Take, for instance, the spinal cord as to its fibres. He concluded from a long series of observations that in the frog one fibre of a nerve root corresponds with eleven fibres in the spinal cord, and that these are necessary to carry on the many functions, and to provide against contingencies that may arise. In the ovaries and uterus every cell corresponds to a certain number of cells in the blood, in the nervous system, etc., that belong to the same "litter," that is, were developed at the same period of embryo life. When the ovaries and tubes are removed, these corresponding cells remain behind and give rise to certain sensations and phenomena that existed before the ovaries and tubes were removed, somewhat as neuralgic pains occur in limbs that have been amputated. Hence many cases in which ovaries and tubes are removed to

relieve certain nervous symptoms remain unrelieved. Many suffer from the old pains, others continue to menstruate, and in some menstruation ceases at once and an early menopause is induced. I have one case suffering as intensely as before the removal of the ovaries and tubes from dysmenorrhœa. She had what is called an infantile uterus, with an extremely long neck; the fundus turned over into the *cul de sac* of Douglas. Her pains were unbearable and she was beginning to take too much opium. I removed her ovaries. She has become violently hysterical since, and is more incapacitated for work than ever. She menstruates regularly. Many cases I hear of as cures are not cures. The surgeon loses sight of them. Even if he does ask them about their health, it is doubtful if he always receives a truthful answer. I have known a woman, hardly

ovaries play but a part in their causation; and I believe that we might as well hope for relief of these diseases by enucleation of both eyes as by removal of both ovaries, or both tubes, or both tubes and ovaries, or even both tubes, ovaries, and uterus. I know one husband who would give all he possesses to have his wife's ovaries and tubes replaced. She has her pains, she has her nervous symptoms, but has lost her

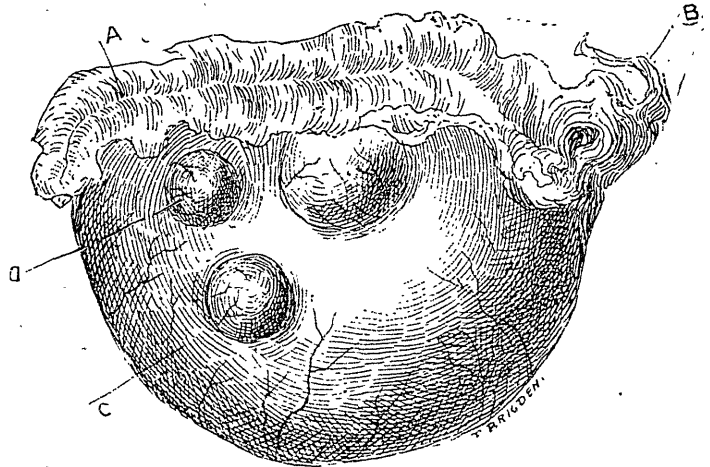


PLATE No. II.

Right and Left. Removed from a woman ill four years with attacks of so-called pelvic cellulitis.

RIGHT SIDE.—A. Tube opened, not much thickened. B. Fimbriated end. C. Cystic ovary; held about two ounces bloody fluid, a blood cyst. D. Smaller cysts.

energy, and is in a worse condition than before operation.

Now to look at the other side of the question, where operation and operation alone is imperatively and urgently called for. I firmly believe that the tubes have more to do in the causation of pelvic inflammation of the recurrent and most distressing type than the ovaries, and there is no reason why we should not, in suitable cases, remove the tube and leave the ovary.

(Plate II.) Here are two ovaries and tubes removed, ten days ago, from a patient who had been allowed to suffer for six years. Many thought she was simply hysterical. But she had good cause to be hysterical. Her trouble originated in the ovaries. She had a small ovarian cyst on each side, each had given rise to inflammation, and tubes and ovaries became matted together, so that at the operation it was with great difficulty that I could get beyond the brim of the pelvis.

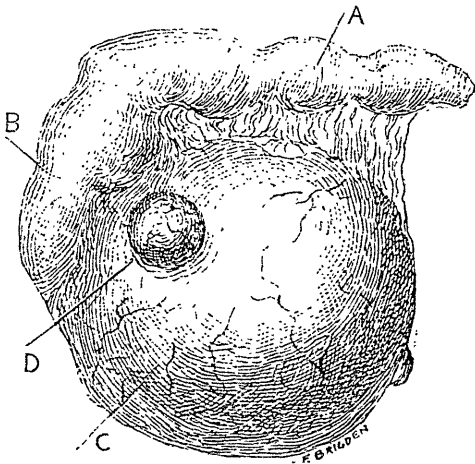


PLATE No. II.

LEFT SIDE.—A. Tube slightly enlarged. B. Fimbriated end, ending in a tubo-ovarian cyst. C. Cystic ovary, containing serous fluid. D. Small cavity filled with pus.

ever well after the removal of her tubes and ovaries, state that she was much better. The friends who see these cases every day ought to know something about their condition, and their statement is more to be believed than the reply given by the patient herself. From our many failures to remove nervous diseases as hysteria and epilepsy by castration, we can see that the

I show in Plate III. ovaries and tubes matted together. The disease in this case was, as can be seen at a glance, primarily and chiefly tubal. I could relate many other such cases—cases allowed to suffer on owing to a prejudice in the mind of the physician to such operations. Many cases go the rounds, as these did, with a “matting” of their pelvic organs diagnosed as that indefinite misnomer “pelvic cellulitis,” deluged with hot water, charged and recharged with electricity, curetted and cauterized, until at last they come into the hands of some one whose experience of the pelvis is *from within* and *not without*, and such tubes and ovaries are removed and the patients permanently cured. There is too much tinkering in gynæcology. These are the cases that should be referred to the specialist without going the rounds of iodine applications and glycerine tampons. With such a condition of tubes and ovaries as I

result might have been brought about many years before. I am well aware that the skeptical and theoretically informed say: “I know such and such a case cured after operation had been advised”; and they bring such a flimsy apology for an argument to weigh down the general weight of experience of the abdominal



PLATE No. III.

Right and Left. Disease of Fallopian tubes, from patient ill six years with so-called pelvic cellulitis. RIGHT.—A. Ovary with old corpora lutea. B. Fallopian tube, much thickened and diseased, laid open. Three or four times thicker than normal. C. Fimbriae not to be discerned, but tube ending in clubbed extremity.

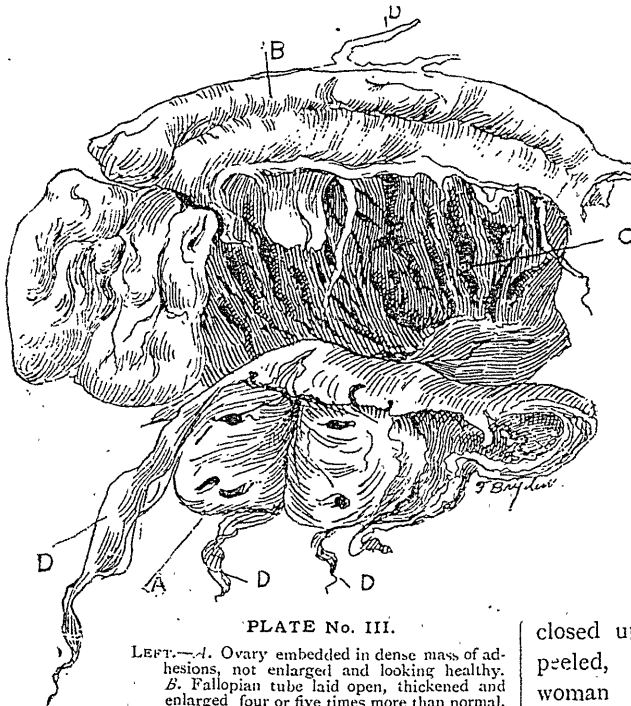


PLATE No. III.

LEFT.—A. Ovary embedded in dense mass of adhesions, not enlarged and looking healthy. B. Fallopian tube laid open, thickened and enlarged four or five times more than normal. C. Thickened meso-salpinx with D. Immense shreds and bands of adhesions torn during enucleation.

show here, nothing but an operation will cure the patient. To be sure they may go round in a wretched, broken-down condition, a worry to their husbands and families, peevish, fretful, irritable, until at last the menopause sets in, when their health improves; but this happy

surgeon—the worker from within. Accurate diagnosis in many cases is impossible until the abdomen has been opened but in each case in which this matting of the organs is to be felt per vaginam under an anæsthetic, the experienced finger inside the abdomen will soon recognize the nature of the condition present. In many cases it is only the experienced finger that is of any use; the inexperienced would at once determine that parts were so matted together that nothing could be done; the woman would be closed up, or the parts would be pulled and peeled, important structures damaged, the woman would die and our art suffer. In my second case of abdominal operation my inexperienced fingers tore the ureter, the pus tubes I then thought could not be removed, were not removed, and the patient died in forty-eight hours. I then learnt a valuable lesson. With each operation I feel more at home in the pelvis. Patients with hardly any pelvic peritoneum left (as seen in Plate

III., left) recover without a bad symptom as long as the parts are kept aseptic; as long as no important structure is injured, the bleeding controlled, and pelvis cleared out. I record these facts to show you that I am in favor of operation in certain cases. Now to look at another feature of the question—a rare case, in which no matting or marked enlargement of the pelvic organs was present and yet serious disease existed, found upon exploring the cavity of the abdomen, forming an exception to the rule I have laid down. I will now relate the same and show the ovaries removed (*Plate IV.*)

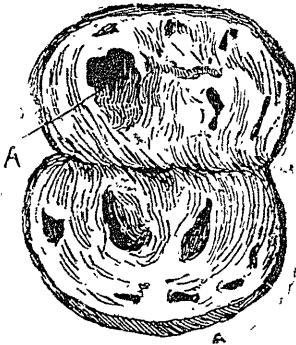


PLATE No. IV.

One of two ovaries removed from patient. Case recorded. Ovary riddled with pus cavities. A. One of the abscess cavities.

This is the only case in which I have found abscess of both or one ovary unaccompanied by pelvic inflammation. Such cases may therefore occur. The patient was a great sufferer and the result of operation has been satisfactory. The ovaries were but slightly enlarged and non-adherent. I show them here. They were extremely tender. I believe that occasionally in some cases the abdomen may be justifiably opened, the ovaries examined, and if found apparently healthy, left alone. Because an operator opens the abdomen, it is not necessary for him to remove the ovaries so as to make one error bolster up another. Let him be courageous enough to leave them alone when to the eye they appear healthy, and look elsewhere for a cause for the symptoms. This patient then was a lady twenty-eight years of age. She was first seen by me in August, 1885. Married eleven years, and had borne four children, giving birth on the last occasion to twins; recovery on the last occasion had been protracted; appetite was poor; occasional nausea; dysuria; menstruation every two weeks;

suffers pain in left groin; when walking has a bearing down pain; pain in back; aching in limbs; "cramps in the stomach," which are very severe; painful defecation. On examination I found (these cases are extracted from my case book, and are given as written at the time) vagina normal; perineum lacerated, not complete; uterus in first stage of prolapse; sound enters three inches; not tender; urethra, anus, and rectum, normal; cervix thickened; both ovaries somewhat enlarged and to be distinctly felt; left larger than the right. On April 8th, 1886, nearly a year later, I find the same pain; headaches; uterus tender and more fixed, and can be readily seen by dilating vagina with fingers without a speculum; utero-sacral ligaments tense and tender; intense pain on coition; if she remains in bed, feels great relief from pain. On August 2nd, 1886, I find: pain all over "stomach"; when she turns on her right side, the pain shoots down to the anus; a piercing pain; dystocia; scalding on urinating; last unwell, July 10th; three days before it came on had pain, and a little dark spot appeared on the napkin; it then came on at the end of the three days profusely; clots; fine doughy nodular masses behind uterus, one probably larger than the other, very tender; feel like prolapsed ovaries, but too numerous; has had chills; sallow in color.

I removed the ovaries. Both were enlarged and riddled with cavities, many of which were filled with pus. The ovaries were non-adherent and there were no evidences of pelvic inflammation. Tubes were not enlarged. Recovery was perfect.

Aug. 24, 1888. In splendid health ever since operation. No erethism and never experienced any more than she does now, even with ovaries.

I saw this patient in January, 1890. She has gained flesh; begins to look gross. Puffy face. Suffers from headache, but otherwise feels very well. Her mental condition is not what it was before. She seems lazy, indolent and fat, and is not the bright little woman that she was before the operation, even when she had her aches and pains. Sexual intercourse is only indulged in as a marital duty. It gives neither pain nor pleasure. The operation was a necessary one and it relieved the pains; but whether the pains were due to the condition of the ovaries alone,

or to the prolapsed condition of a tender uterus drawing down tender ovaries, I am not prepared to say, but I think the sequel shows that the disease of the ovaries caused the pain. In this case the pains were relieved.

(Plate V.) I now show a specimen of simple single abscess of the ovary. Nothing but operation would have relieved such a case. She has been completely relieved since the operation done by my colleague, at the Woman's Hospital, Dr. A. Davidson.

I have but once removed the ovaries for the relief of a certain set of symptoms supposed to be due to ovarian irritation, ovarian adhesions, or to slight pathological changes in the ovaries, but symptoms that are undoubtedly due to other changes, changes that I firmly believe take place in the delicate structure of the spinal cord, and,

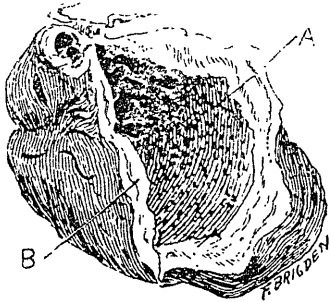


PLATE No. V.

Single abscess of ovary, from patient whose tube is shown in plate viii. Ill several years with so-called "pelvic cellulitis." A. Roughened inner surface of abscess cavity. B. Edge of wall cut out to show cavity.

as do all nerve changes, require a long period of time for their removal. Many deaths from these operations have been recorded. Many failures to relieve symptoms have not been recorded. I sincerely hope that this short paper may evoke such a discussion in this prosperous association as to give forth no uncertain sound, and that its opinions may be voiced abroad to add its small quota to our already extensive knowledge of this subject.

I will now relate my own isolated case, referred to above, and will then relate cases occurring in the practice of others and made use of with their consent.

A young woman, aged 22 years, was referred to me by my friend Dr. T. A. McKenzie. Her occupation was that of a night nurse, one that must try any young woman of her age and temperament. Her appearance was not robust.

She was pale and evidently anæmic. Tonics had been given with but little success. Menstruation first came on at fourteen. She lost a large quantity, the discharge usually lasting seven or eight days. She complained of pain on motion, especially when going up or down stairs, or when she turned over in bed. Pain in the back and on the right side, in the neighborhood of the groin. There was very little pain on the left side. On examination, the uterus was found to be normal in size and density and freely movable. The parametrium was free. The ovaries were enlarged and tender. They were mobile and the right was prolapsed into the *cul de sac* of Douglas. The usual treatment recommended for such cases was adopted and faithfully carried out by Dr. McKenzie. After failing to give relief, I decided to remove the prolapsed

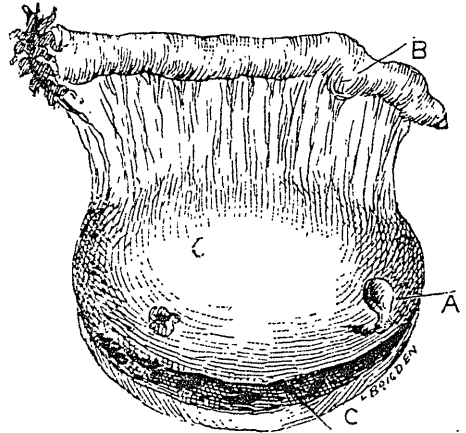


PLATE No. VI.

One of two ovaries removed for pain. A. Peculiar fibroid nodule, probably only a freak of nature and of no pathological significance. There were two such teats on the other ovary and one or two pendulous cysts from broad ligament. B. Fallopian tube quite normal. C. Ovary cut open. Patient not relieved by operation.

ovary, believing that the pain must be due to the abnormal position of the organ. There is no doubt that in man one testicle hangs lower than the other, and I have met with many cases in which the right ovary lies much lower than the left without giving rise to symptoms. This is a normal condition, owing no doubt to the absence of the rectum on the right side. The operation was performed two years ago. I showed the ovaries to this association, and asked Dr. Johnston, of Danville, Kentucky, present by invitation at the operation, to point out to us the nerve that he supposed held such a close relationship to the occurrence of menstruation. At



the operation the right ovary was drawn up, and though somewhat enlarged and with two minute growths, like little teats, protruding from its surface, it did not look much amiss. (*Plate VI.*) It was the general belief of those present that the organ was undoubtedly the cause of the pain and it was accordingly removed. The other was drawn up, and as it had also one of these little teats, it was also pronounced diseased and removed. On one side was one of those little cystic formations derived from the tubules of Kobelt, and this was said to be found in many similar cases. These little harmless pendulous vesicles seem to have incurred the enmity of some pathologists and have been branded with an anathema. I myself firmly believe that these vesicles will be found in fully half the number of healthy women. I also believe that such little teat-like excrescences have no pathological significance whatever; that they do not produce severe pain any more than do small uterine myomata, or small myomata developing in the layers of the broad ligament. The testicles undergo a great amount of change without producing pain, and so do the ovaries. The patient recovered perfectly from the operation.

On the 8th February, 1890, the patient was sent to me by Dr. McKenzie, suffering from pains in the left breast, nausea, pain in the right inguinal region as bad as before operation. She has only menstruated twice since the operation, in the first two months. She had an enlarged and painful gland under one arm; suffers from headache and flushes—these, of course, are expected to be present during the first two or three years. A herpes occurred over the left breast, evidently due to neuritis. She had severe pain before the eruption came on. On examination I found the uterus smaller and quite normal, but the left parametrium was as tender as before operation. There was no rise of temperature. She is mentally changed; has become melancholy and depressed; suffers from lassitude and feels always tired; rest does not refresh her. She tried a complete rest from work in the country for six weeks, without deriving any benefit from it. Appetite is very fair. Nothing seems to do her good. Her case never presented either hysterical or epileptic symptoms. Distinct symptoms of ulceration of some portion of the colon have developed. She has irregular

diarrhœa; blood and mucus is passed, with symptoms resembling chronic dysentery.

I know of another such case in which oophorectomy was performed to relieve symptoms supposed to be ovarian, but where ulceration of the colon has since shown itself.\*

I lately diagnosed a case on first examination as one of tender dilated tube curled behind the uterus, but on closer examination subsequently, under an anæsthetic, concluded that it was a tender empty lower portion of the omega flexure of the colon (erroneously called sigmoid flexure), and that it was ulcerated. Her symptoms have for some time simulated those supposed to be due to ovarian neuralgia. She has, however, been pregnant about as often as she well could be.

There is at present in a Canadian Home for Incurables a case with the following history: *Æt.* 35 years. Menses first appeared at 13 or 14 years of age; always excessive in flow and accompanied with pain; otherwise she was strong and healthy. At 16 an abundant leucorrhœal discharge began, and she suffered from ovarian neuralgia. Her disposition seemed to have changed at this time; she became nervous and hysterical. Eight years ago she entered an American medical institution for treatment. Both ovaries and tubes were removed. She does not know whether they were diseased or not; she fancies that they were not. Her pain and discharge ceased after the operation. For a year she was stronger mentally and physically. In October, 1885, she entered a Home for Incurables, and has been there ever since. She suffers no pain and has no discharge, either menstrual or leucorrhœal. She remains in bed all the time, merely getting up to wash. She cannot be induced to do more. Appetite abnormally large and she complains of being always hungry. Her chief complaint is that she suffers from "attacks of exhaustion," even while in bed. She starts upon hearing the slightest noise; readily becomes hysterical. Conversation is rational, but she cries a great deal. Suffers from headache. For this history I am indebted to my friend Dr. Ardagh, one of the house sur-

\* NOTE.—During the discussion Dr. Imrie, of Detroit, mentioned a case of his operated on in Philadelphia (removal of appendages), that had developed exactly the same evidences of colon disease since the operation. Operation did not benefit her.

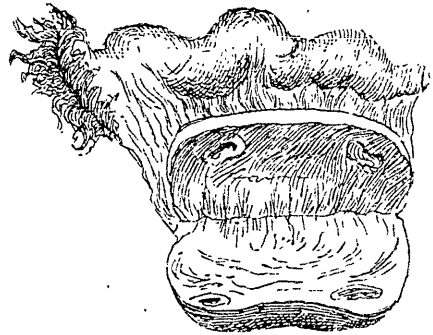
geons. Operation in such a case I consider unwise. A girl's prospect of marriage, maternity, and a happy life, are blasted for ever by such a procedure. The symptoms were not more severe than those met with in delicate, developing, anæmic young women, met with so frequently in practice, women who marry, bear children, and become most useful members of society, if but carefully looked after, properly fed and clothed, and guided by the good wholesome advice of the old-time type of family physician.

Two months ago I opened the abdomen of another case, but refused to remove ovaries or tubes. They were perfectly movable and healthy. The woman had borne six children in six years and the last one within fifteen months. Her symptoms were pain in back, in head, and in left groin; some pain in right groin; worse when she walks; cannot turn in bed; worse when turning to the right than to the left; pain severe when she lies on her back; when she stands up she cannot stand up straight; leucorrhœa. These pains have been present for two or three years. Has been under many doctors and obtained no relief. On opening the abdomen, for purposes of exploration, I thought I detected some feeling of thickening in front of the sacrum, but the uterus and ovaries and tubes were perfectly normal. No doubt the case is one of some organic or functional nerve lesion affecting the lumbar enlargement of the spinal cord, due either to actual disease of the spine or perhaps to an over-indulgence in sexual intercourse.

The nervous system of a woman seems to be more complex than that of a man. We have all met with curious cases. I have seen the menopause brought on suddenly and permanently by marriage. I have seen menstruation cease suddenly during lactation from grief, and amenorrhœa continue for three years and the breasts remain filled with milk during all this time. We have many severe nerve symptoms in women that we cannot as yet explain; we have endeavored to relieve them by removing the ovaries and tubes and have failed. In cases of atrophy of the ovaries the symptoms are—in the opinion of Dr. Annie Clark, so long associated with Lawson Tait—due to other causes, and no relief is afforded by oophorectomy. In cases of infantile

uterus with good sized ovaries, I have tried galvanism, dilatation, and other methods, but with little if any benefit. In one case I have removed the ovaries and the patient has been worse ever since. (*Plate VII.*) I know that many cases operated on by abdominal surgeons come back several times after the operation complaining of their old pains. Obtaining no further relief and becoming uninteresting to the surgeon, they drift into other hands, after their cases have gone to swell the list of so called "cures."

I know of one woman who was delivered of a child after having both ovaries removed. Early pregnancy often gives rise to excessive pelvic tenderness, and is liable to mislead any of us into the opinion that serious pelvic mischief exists.



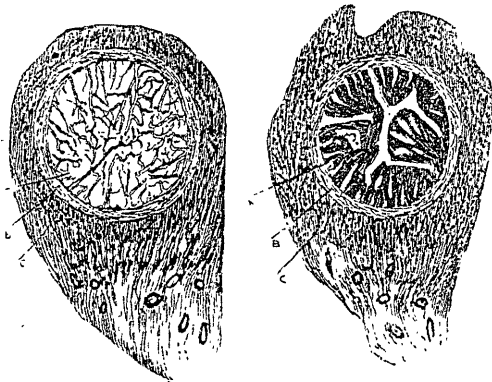
PLA. E No. VII.

One of two ovaries removed for dysmenorrhœa in patient with infantile uterus, fundus in *cul de sac* of Douglas. Ovary and tube normal. Patient worse since operation.

Neuralgic conditions often exist in the pelvic organs of young women who are anæmic. If once they have been examined by the finger of the physician per vaginam, and have heard from his lips the words, "congestion of the ovaries," they have ovaries "on the brain," instead of in the pelvis, and a very injurious mental effect is produced. Examination through the rectum, and a silent tongue, when nothing distinct and definite has been discovered, does them no harm. Women indulging in sexual intercourse too freely, I believe, suffer from these neuralgic pains. Women who, to prevent pregnancy, do not allow completion of the sexual act, also suffer in this way. Young married women, with some irritability of the external genitals, preventing completed coition, also suffer from neuralgia of the ovaries. Women suffering from painful erosion of the cervix, sensitive as a boil to the touch, also suffer from ovarian pains. These causes of

ovarian pains and tenderness must not be overlooked. Leopold believes, and it is undoubtedly true, that pains in the pelvis are often caused by myomata so small as to be overlooked, and so situated as to give rise to no excessive hemorrhage; but I do not believe that these pains, as a rule, are very severe. The castration of men for the relief of neuralgic pain, and for other nervous diseases, has not been successful; such cases are better dealt with by the neurologist than by the surgeon. It is better for surgery that we should never do a surgical operation than that we should perform operations without benefitting our patients. While lunching some time ago with a celebrated surgeon, I met a young lady whose mother had been operated on by another surgeon. Her ovaries and tubes had been removed. My friend said the operation had been done contrary to his advice, and that now, when the patient was worse than she had been before operation, she had again returned to him for advice. It is only a few months since I read in a medical journal an account—to me a melancholy one—of the castration of twenty women in one year, in a small place, by one surgeon. Surely this kind of thing will soon cease. Many of us have erred in this particular; we have all made mistakes. Let me ask you now, in conclusion, to leave the ovaries and tubes where the Creator put them in all cases in which no enlargement or matting together of the pelvic organs is to be felt per vaginam under an anæsthetic after repeated careful examinations; to leave so-called prolapsed ovaries alone if they are not enlarged; let me, above all, urge you to send your cases to some one in the habit of doing abdominal surgery, if they have any enlargement, ovarian or tubal, or if they have this peculiar matting of the pelvic organs, the old time “cellulitis”; let me urge you to send, also, any doubtful cases before you blister them and paint them, curette them and cauterize them, deluge them with hot water and go twice a week to insert a glycerine tampon, before the husband’s pocket has been emptied by continuous and unavailing treatment, so that he is forced to partake of charity when the final and only curative treatment—operation and removal of the diseased organs—is carried out. I could show you three histories to-day, and you would say after reading each of them: “Oh! pelvic hæma-

tocele.” So I thought until I opened the abdomen of each case. One was pelvic hæmatocle, rupture of a hæmato-salpinx into a broad ligament; one was double pyo-salpinx, with rupture of a pus tube into a broad ligament, so that the communicating opening could be readily made out; one was double ovarian disease, with what I thought was rupture of one cyst into the broad ligament, either that or a broad ligament cyst intimately connected with the enlarged cystic ovary. These ruptures gave rise to the sudden symptoms. Surely such cases should open our eyes. To my mind “chronic pelvic cellulitis” means diseased ovaries or diseased tubes, with periodical attacks of peri-ovarian or peri-salpingeal inflammation. This is no vain imagining, but is the outcome of a practical acquaintance with the inside of the female pelvis

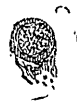


*Healthy tube enlarged.*  
A. Villi not agglutinated but perfectly normal.  
B. Circular muscular fibres.  
C. Longitudinal musc. fibres.

*Diseased tube enlarged.*  
A. Villi agglutinated.  
B and C. Same as before.

PLATE No. VIII.

Transverse section of tube, from case given in Plate V, and beside it that of a healthy tube. Life size.



*Healthy tube, actual size.*



*Diseased tube, actual size.*

Here we have transverse sections of the tubes from such cases, and beside them, for the purpose of comparison, sections of a normal tube. No one can look at such tubes side by side and fail to see the marked difference between the condition of health and disease. If it is difficult to cure a chronic catarrh of the nasal passages, and to prevent its recurrence, with the parts before us, easy of access, allowing the ready use of all

kinds of applications, including electricity, how much more difficult must it be, if not impossible, to cure a similar condition in the Fallopian tubes, organs placed beyond the reach of topical applications, opening into a large and readily infected serous cavity, fastened to organs undergoing great changes every month, and irritated by the discharge of marital duties? Such tubes as I

I show also a plate pointing out the microscopical appearances of the interior of the diseased and healthy tube. The plates were drawn from preparations made by myself. Two different points in the interior of the diseased tube have been chosen, one to show the partial loss of epithelium and the presence of only ill-developed epithelium without cilia, and the other to show the total

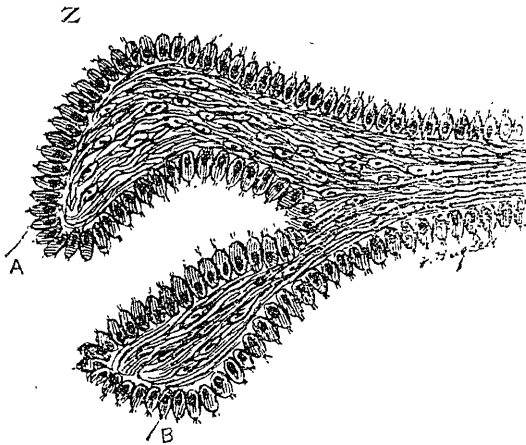
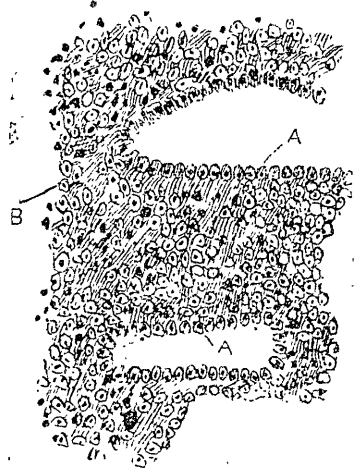


PLATE No. IX.

Z. A. Epithelium, in part destroyed; cilia gone. B. Inflammatory, new formation cells. Y. A. Epithelium left in spaces by agglutination of villi. B. Free surface covered with inflammatory cells. L. Villi from healthy tube.

show here must come out, if the patients are to be permanently cured. Because occasionally a mistake in diagnosis is made, or because occasionally a case may go on in apparent health, with a sealed pus tube that permits no escape of its contents, are we, therefore, to let the great majority of the cases drift into chronic invalidism? They do not die early in a great many cases, but they are not cured, though they try all kinds of medicines and all kinds of practitioners. Operation, urged so forcibly on the profession for years by Tait, a profession still imbued with the old vague ideas of a peculiar inflammation of pelvic cellular tissue, and with equally vague ideas of its origin and the cause of its recurrence at irregular and frequently long intervals, will cure these cases.

loss of epithelium on the free surface of the villi, *i.e.*, toward the lumen of the tube and the agglutination of the villi, leaving small spaces lined with epithelium. Then we have a careful drawing of a beautiful preparation showing the normal condition.

As to the removal of ovaries and tubes to relieve hemorrhage produced by the presence of myoma, I will

say nothing now. Whether the operation will fulfil all that is expected of it by its supporters, will be determined in time. For the present I intend to continue to perform the operation.

As to the use of electricity in the cases in which I am convinced nothing but the knife will suffice, I may say I regard it as a veritable "will-o'-the-wisp," and an expensive one to the patient's husband. This opinion is gaining

ground daily. If electricity could stop menstruation in these cases of recurrent pelvic inflammation, it could possibly cure them. I have used it in cases of salpingitis, with pelvic inflammation, to satisfy the patient's friends that nothing but the knife would eventually avail. I will not do so any more. If they require such treatment for a disease upon which its vaunted potency is, in my experience, lost, they must go elsewhere.

I wish here incidentally to state, and I hope you will pardon the digression, that I have been interested to notice the peculiar relationship existing between tubercle and chronic inflammatory pelvic disorders. In at least every other case in my case book I find that the patient has lost either father or mother, or both, from phthisis, or has a strong tendency to tubercle from her collateral family history. When the organs become more than usually active, owing to marriage, they seem unable to undergo the great changes required without becoming diseased. I hope at some future time to collate my cases and bring this subject before you. Such a relationship has been noticed by many others.

Some of you may think I have been too aggressive and conservative; my remarks have been made in a spirit of friendly criticism, and in the hope that they may be, in a humble way, the means of assisting in the cure of suffering, by operation, that is too often but alleviated, and of impressing, to some slight degree, upon you the necessity of searching for other means than the knife for curing diseases as yet left uncured by either the gynecologist or the neurologist.

Thanking you for your kind attention, I will now close.

---

## Selections.

---

### COMPLICATIONS OF DIABETES.

I will speak to-day of the complications of diabetes and the various forms which this malady may assume.

Most authors have attributed these complications to a formation of acetone in the blood, and have described them under the name of acetonæmia. The question is not settled. I

think the word acetonæmia can be retained, without inconvenience, for the condition which we understand by it.

By it we ought to designate the collection of phenomena, occurring in the course of diabetes, and acknowledged to be caused by the retention in the economy of poisonous products, whatever they may be.

Just so, uræmia means a poisoning, not by urea, but by all the excrementitious material which the kidneys no longer eliminate.

These facts being granted, we must admit five principal forms of acetonæmia, which may remain separate, but which ordinarily co-exist, and give rise to a picture of symptoms peculiarly complex. I will designate them as follows, according to the functional disorder predominating: Muscular form, gastro-enteric form, dyspnœic form, cardiac form, cerebral or comatose form.

*Muscular Form.*—This form is characterized by extreme languor, painful points in the muscular masses, and a sensation of suffering occasioned by motion. These patients have a presentiment of approaching death. The face is discolored, although there is no notable change in the expression of the physiognomy. There is no febrile reaction, but rather a lowering of the temperature by half a degree, coincident in general with a diminution of the quantity of urine.

These symptoms persist for a certain time, then disappear; sometimes, if they are not controlled, they suddenly increase, or become complicated with symptoms of one or the other of the forms which follow; in this case they may be regarded as a prodrome of these latter.

*Gastro-enteric Form.*—Preceded in certain cases by extreme languor and general weariness; this form is characterized by a sensation of malaise, and by nausea, followed by abundant vomiting.

The vomit consists of mucus and bile. The vomiting returns at intervals during many days. An obstinate constipation occurs in some cases. But at other times, there exists a liquid diarrhœa, extremely abundant, and preceded or accompanied by violent colic and a notable diminution in the secretion of urine. This flux appears to me to be the result of natural causes, and to be destined to eliminate the organic

waste products which intoxicate the patient. That is why some of our patients in whom the diarrhoea has ceased for a little while, are attacked by headache, intense dyspnoea, and a coma which carries them off rapidly. The diarrhoeas of this nature are, therefore, beneficial, and elimination should be encouraged by the administration of purgatives and diuretics.

*Dyspnoic Form.*—This is especially characterized by a painful sensation of oppression with difficulty of respiratory movements. It may come on suddenly, or it may follow some of the other symptoms which we have described. Respiration is accelerated, but regular, differing in this respect from that of uræmia. There is a shortness of breath comparable to that which a fast walk or long run produces. The face is not purple, but pale and livid; the patient is in bed in a half-upright posture, or he has complete orthopnoea; he is worn out by a dry, but not paroxysmal cough; agitated and anxious, he experiences a feeling of anguish which gives the idea of approaching death; his breath has an odor which may be compared to that of alcohol, ether, or certain kinds of fruits, as the apple or melon for example.

This state cannot be explained by any pulmonary or cardiac disorder, and if sometimes auscultation shows the presence of a slight murmur over the cardiac orifices, it has no significance; there is here a dyspnoea of toxic origin, either simply nervous, or perhaps connected with anoxæmia.

Differing from Cheyne-Stokes respiration, which has no intermittence, diabetic dyspnoea is, nevertheless, most painful, for the respiratory act is very frequent and extremely labored. This dyspnoea has a variable duration; it may persist many days, then disappear, unless there occur in addition phenomena of cardiac paralysis or diabetic coma.

*Cardiac Form.*—The cardiac disorders manifest themselves, so to speak, constantly, by rapidity and smallness of the pulse, which increases rapidly to 120, 140, or even more beats a minute. It is small, regular, and more or less feeble. The extremities are cold, the weakness is excessive, the fatigue extreme, the temperature lowered. Some patients who apparently do well during the night, excepting slight shortness of breath, are suddenly taken with general

uncasiness, with inability to maintain the upright posture, or to execute the least movement without getting pale and falling down exhausted. I have recently observed this grave form in a patient of mine. An old lady, rheumatic and diabetic, was, after some exertion and motion, affected with excessive weariness; she grew lean, nevertheless she continued her jaunts, and seemed always to enjoy good health, when one morning in getting out of bed, she fell down unconsciously.

"I am going to die," she exclaimed. She was put to bed and made to inhale ether. She finally recovered, but said she was very ill and that her life was in danger. She complained of a pain in the front part of the chest, and between the shoulders. On auscultation, I heard a slight murmur at the base of the heart. I asked myself whether this patient was not suffering from angina pectoris, and whether the accidents observed were not dependent on a lesion of the aorta or coronaries. Next day, wishing again to rise, the patient again broke down. Struck by the peculiarity of these accidents, I now thought of diabetes. Examining the urine, I found it to be of a high specific gravity, and to contain fifty grammes of sugar to the litre. I now made the diagnosis of heart phenomena dependent on diabetic intoxication.

I prescribed a purgative enema and a draught of ether and bromide of soda. During this time the pallor and oppression increased, the anguish grew more excessive, the heart beats reached 140 per minute, and five days later death took place as the result of a slight effort, consciousness being preserved to the last.

It is no doubt difficult to explain this kind of death. Still we know it was not from syncope. For in syncope death is instantaneous, and results from spasm of the heart; on *post mortem* the heart is found either empty or containing a small quantity of fluid blood. In the cardiac form of diabetes, the pulse accelerates itself at first, then the heart grows feeble and ceases to beat, as it gradually loses its power; the cavities are filled with blood clots. It remains to be determined what is the cause of this paralysis. Is it the result of an abolition of the red blood-corpuscles, of an anoxæmia, as the discoloration of the skin would indicate, or does it result from failure of action of pneumogastriacs, which

no longer exercise their moderating influence on the sympathetics?

*Cerebral Form.*—This form, which is by far the best known, comes on suddenly, or follows one or the other of those forms which we have studied. In most cases it is announced by prodromic phenomena, such as lassitude and extreme weariness.

The symptoms which characterize it are variable. Sometimes there is a headache of medium intensity with vertigo at the moment of waking or during the day; sometimes there is a coma, more or less profound. There is a delirium which urges the patient to get out of bed and to run away.

These diverse varieties of the cerebral form are more rare than diabetic coma; they may exist alone, then disappear; but often they are accompanied by somnolence and coma.

The coma, which is the most common expression of cerebral acetonæmia, has under some circumstances a beginning no less sudden. Frequently, after a sudden effort, the patient falls, stricken by a kind of apoplectic stroke which reminds one of that produced by cerebral hæmorrhage. The collapse is complete, the muscles relaxed, the integument insensible, the eyelids closed, the pupils dilated, the extremities cold, the face pale, the mouth sometimes half open. The breath is sour and very penetrating. Its odor is midway between that of alcohol and vinegar. Deglutition is difficult or impossible; respiration short and abrupt, sometimes slowed. The temperature is normal or lowered. The dejections are involuntary, and the torpor profound. This state may last from a few hours to many days, and always terminates fatally. Nevertheless, I think appropriate medication should be able to render itself master of it, as is to-day the case in uræmic coma.

Such are the grave symptoms of diabetes. In order to draw attention to them in a more special manner, it appeared to me proper to consider them separately, in spite of the fusion which they present in certain cases.

The symptoms, when of a certain intensity, with difficulty escape notice; but, coma excepted, they frequently do not sufficiently arouse the attention of the physician. Exhaustion, accompanied by acceleration of the pulse, great dyspnœa, excessive fatigue and a presentiment

of death, are easily recognized. It is otherwise with the dyspnœa which it is possible to confound with uræmic dyspnœa (especially when albuminuria co-exists) in spite of the differential characteristics of which we have spoken.

As to delirium and the coma, they are so similar in uræmia and acetonæmia that without the odor of the breath and the analysis of the urine it would be difficult to distinguish them. What renders error more easy, is that frequently the phenomena of the acetonæmia may be explained by an important disease of some organ. Thus the exhaustion following movements which render the upright posture impossible may be attributed to an affection of the heart, to angina pectoris, etc. The presence of pre-sternal pains, and of oppression and of cardiac murmur render error more easy. A cardiac murmur is indeed the rule in many diabetics who are at the same time subject to chronic rheumatism and arterio-sclerosis.

In other cases, the stomach might be considered as the origin of the oppression, pallor and despondency, but the troubles arising from a disorder of this organ do not appear as suddenly as those of acetonæmia.

Acetonæmia, like uræmia, is almost always occasioned by a disorder of the organism. It manifests itself, sometimes as a result of a purely physiological cause, as a vivid emotion, fatigue, a chill, and, according to some authorities, a too highly animal regimen; sometimes it is occasioned by an intercurrent disease (no matter how mild), as for example, gastric disturbances, bronchitis, or pneumonia. As the danger in diabetics is from acetonæmic complications, we recommend a careful hygiene.

Since we are ignorant of the pathogenetic conditions of acetonæmia, no precise therapeutic indications can be drawn from them. Nevertheless, it is certain that the accidents which we have described under this heading are the result of auto-intoxication, which, as a rule, is accompanied by diminution of the quantity of urine. Hence the indication of favoring, like in uræmia, the elimination of poisonous substances both by the gastro-enteric and the renal channels.

To these general indications, others may be sometimes added. Thus, when there is general pallor, and oppression seemingly due to faulty absorption on the part of the red blood-corpus-

cles, inhalations of oxygen find a natural indication. When the pulse is very rapid, and the least movement induces faintness, and there are signs of cardiac paralysis, then the employment of caffeine and ether, as also the use of lotions and cutaneous frictions impose themselves. In such cases, the physician ought to appreciate the gravity of the situation, and should act with promptness and energy. The grave phenomena which are observed should be immediately combated.—*Dr. Lanceriaux in le Bull. Med.*

THE *Annals of Surgery*, a journal devoted exclusively to surgery, is undoubtedly a publication of value. From the numerous important papers which have already appeared during 1890, we have made the following extracts :

*On the Removal of Enormous Vesical Calculi by the Supra-pubic Route, with Report of a Successful Case.* By J. William White, M.D. The author records a case of a patient, æt. 55, from whom he removed a calculus which weighed  $9\frac{1}{2}$  ounces, its greatest circumference was  $8\frac{1}{2}$  in., and its transverse circumference  $7\frac{1}{2}$  inches. The bladder was nearly filled with the enormous stone, it was covered, over at least three-fourths of its extent, with folds of mucous membrane, and was held tightly in place by strong bands of lymph. It was only with great difficulty, and by the exercise of considerable force, that the operator was able to extract the stone from its bed. Two large drainage tubes were inserted through the wound into the bladder. The bladder was washed out every three hours with a saturated solution of boric acid, with 1:5000 perchloride of mercury. The bichloride caused an erythema around the wound, and phenol sodique, 1 to 10 of water, was substituted. The patient sat up on the 25th day, and the wound was entirely closed at the end of  $4\frac{1}{2}$  weeks.

The author commented upon the incarceration of the stone by means of such firmly organized lymph, and by such a projection of the mucous membrane around about it; the stone practically lay in a cavity of its own, communicating with the bladder by means of the aperture through which a portion of its convex surface protruded. The mode of formation of these cysts is variable. In the majority of patients of the age of this one, it has seemed probable that the condition was brought about

primarily by enlargement of the prostate, causing vesical hypertrophy with distention, and with the protrusion of the mucous membrane between the fibres of the detrusor, which gives rise to the well-known sacculated bladder of old people. Gross mentions a case in a man, æt. 84, where such a sacculus held a gallon. These cysts have no muscular fibres and, of course, no power of completely evacuating their contents, although they may do so partially by aid of the abdominal muscles. A certain amount of "residual urine," therefore, always remains in them, throwing down a sediment, and setting up a catarrh, the mucus of which binds together the crystals and sedimentary deposit, forming the nucleus for the stone. In this instance, however, the symptoms date so far back into middle life (the man had suffered from vesical irritation for 26 years), that this explanation hardly seems entirely satisfactory, and it appears more probable that the cyst was formed by the gradual sinking of the stone, as it grew, into a pocket made by its own weight, the hypertrophied and thickened mucous membrane rising above its borders and becoming fastened to it by lymph bands.

When an encysted stone is partially within the bladder and partly encysted, the neck of the cyst being the obstacle to removal, if the stone be of moderate size, and if the condition be discovered during a perineal lithotomy, after the projecting part into the bladder has been removed, or before, in some cases, the operator endeavors with the finger nail, or a director, a searcher, a scoop, or other elevator, to dilate, or slightly tear the neck of the cyst and work out the calculus. In this manœuvre, pressure upon the hypogastrium or through the rectum may be of great assistance. If moderate manipulation fail to dislodge the stone, a curved probe-pointed, long bistoury, may be used with great caution upon the finger as a guide, to cut moderately the constricted edge of the neck of the cyst in one or more places. Such use of the knife involves risk, and it rests with the operator to decide, according to the circumstances of each case, whether to assume the risk or to resort to supra-pubic section. In the case of a large pouch connected with the bladder, and containing a small stone, the neck of the pouch may be dilated with the finger or



small forceps, and the stone reached. When the stone is practically outside the bladder, or in a dilated ureter, some operators prefer to leave it untouched. Thomson acted in this way in the presence of a stone in the ureter. It is plainly the surgeon's duty to cut scantily in such cases.

As to the choice of operation, Dr. White adds, that there can scarcely be two opinions, supra-pubic cystotomy being so evidently the only available method. He states his opinion as to the duty of the surgeon who, having opened the perineum by either the median or lateral section, finds that he is dealing with an encysted calculus of large dimensions. Under these circumstances the abandonment of the perineal route being imperative, the high operation should be performed, either at once, if the patient is in good condition and well-fitted to bear shock, or, if that is thought inadvisable, as soon as the perineal wound is fairly well granulated, the patient then having the benefit of the drainage by that route without the danger of septic absorption.

*On the Symptoms of Chronic Obstruction of the Common Bile Duct by Gall-stones.* By William Osler, M.D.

Since the bile passages have been brought within the sphere of surgery, a renewed interest has been taken in all symptoms which give us more accurate knowledge of the character and situation of lesions in these parts; and in this paper Dr. Osler deals particularly with a form of fever met with chiefly in chronic obstruction of the common bile duct by gall-stones, as it possesses features of the greatest importance for diagnostic purposes. The fever is intermittent in character, and the cases present the following group of symptoms:

1st. Jaundice of varying intensity, deepening after each paroxysm, and which may persist for months and even years.

2nd. Ague-like paroxysms characterised by chill, fever, and sweating, after which the jaundice usually becomes more intense.

3rd. At the same time as the paroxysms, pains in the region of the liver, with gastric disturbance.

In the majority of cases this combination of symptoms is characteristic of the existence

of gall-stones in the common duct. We meet with rigor, fever, and sweats, in three conditions of the bile passages: as an acute and transitory process in ordinary hepatic colic, associated with the passage of a stone through the duct; in chronic obstruction of the duct, usually by stone, without lesion of the bile passages other than dilatation and catarrhal cholangitis; and in suppurative cholangitis produced by gall-stones or other causes. Dr. Osler proceeds to speak of intermittent hepatic fever with its associated symptoms as characteristic of chronic obstruction of the duct by gall-stones and without suppuration.

The clinical histories of eight cases are recorded, presenting the conditions referred to. Of these eight cases, six were women; two died from the effects of the long-continued jaundice; three recovered after the persistence of the condition for from eight months to three years, and one passed from observation.

In analyzing the symptoms associated with these paroxysms we have:—

First: *Jaundice*.—This was present in every instance, and may be said to have been constant, though varying very greatly in intensity. In every one of the cases the statement occurs that after the paroxysm, the jaundice invariably deepened. With this the amount of bile pigment increased in the urine, and the stools became more clay-colored. After persisting for a week or ten days, the tint would become lighter. The urine, too, would become lighter in color and the stools contain bile.

Second: *Fever*.—This in well-developed paroxysms begins with a sharp rigor. In one case in particular, a large, stout woman would, during the rigor, shake the entire room, and cause the small wooden house in which she lived to vibrate. It may be represented, however, only by a sensation of cold, a creeping chill, in contra-distinction to a shaking one. The fever rises suddenly, and may reach from 103° to 105°. At first dry and pungent, the skin gradually becomes moist, and usually within from two to five hours of the commencement of the rigor the patient is bathed in perspiration. The entire duration of the fever is from six to twelve hours; rarely does it persist for an entire day. Defervescence takes place rapidly when the sweating begins. Although the rule

is for the paroxysms to present the usual stages, as here described, there were in each of the cases lesser attacks, often of fever alone or of fever with sweating. Slight rises of temperature without chills also occurred. Sweating was occasionally seen without the fever. The paroxysms occur at irregular intervals, but they have recurred daily for a week or ten days. They may present a tertian or a quartan type, and in such cases the diagnosis of ordinary ague may be made. In one case the paroxysms recurred for weeks on Friday.

Third: *Pain* of some sort is, as a rule, present. It may, but certainly does not always, precede the rigor. In some cases it is not at all a striking feature, and the most intense paroxysms may be quite painless, or only accompanied by a sense of gastric distress. It may have all the symptoms of genuine hepatic colic, agonizing, gripping pain in the liver region, with the associated symptoms, feeble pulse and clammy skin. In several of the cases the pain was not at all a distressing symptom.

Fourth: *Gastric disturbances*.—Vomiting often precedes or accompanies the attack, and frequently before its onset the patient complains of loss of appetite or nausea; the tongue becomes furred, and it seemed very often as if a gastric catarrh really initiated the paroxysm.

The condition of the patients in the intervals between the attacks is a point of considerable importance. They are often able to resume their work, or in the case of women, to do light household duties. There is not progressive deterioration of health and strength such as we meet with in malignant disease.

*Diagnosis*.—The significance of hepatic intermittent fever cannot be appreciated without taking into account the associated group of symptoms, and when these are present it points clearly to obstruction of the common duct by calculus. The condition of the bile passages in these cases is one of catarrhal, not suppurative, cholangitis.

Chronic obstruction of the bile duct, either by stenosis or by gall-stones, may persist for months without inducing this intermittent pyrexia as illustrated by two cases which Dr. Osler narrates.

It is, therefore, not the obstruction alone which induces the intermittent fever; there

must be something superadded, probably the ferment-producing agents, the micro organisms which have been found in two cases.

From a practical stand point suppurative cholangitis is the only affection from which gall-stones with hepatic intermittent fever is to be differentiated. The *post-mortem* examination in two cases, and numerous observations which Dr. Osler has found in the literature, show conclusively that the intermittent pyrexia in these long-standing cases is not necessarily associated with suppuration in the ducts. But, unfortunately, suppurative cholangitis is most frequently caused by blocking of the common duct with a stone; and it is important to determine in a given case the onset of suppuration. In deciding this, stress may be laid on the following points:—1st, increased tenderness in the hepatic region with possible enlargement of the gall-bladder, as this is a more common event in suppurative cholangitis than in simple obstruction of the duct; 2nd, the more frequent return of the paroxysms; and in some instances the irregularly remittent character of the fever; 3rd, the jaundice is not so intense in suppurative cholangitis, and we do not see the remarkable deepening in color after the paroxysms; and 4th, the general condition of the patient in the interval is very different in the two conditions. When suppuration exists there are rarely the prolonged periods of apyrexia, the freedom from distress; and the general betterment which we see in cases of simple gall-stone obstruction.

There may be, however, the greatest difficulty in deciding, and, after all, in the question of treatment it does not make much difference.

In the chronic obstruction which results from the compression of a cancerous mass either in the head of the pancreas, or secondary, in the lymph glands, there are occasional rigors, due to catarrhal or suppurative cholangitis, but the sequence of the symptoms would, I think, enable one to decide between this condition and gall-stones.

A confusion of these cases with malaria is not likely to occur; the negative condition of the blood is very suggestive; the absence of Laveran's organisms led to a revision of the diagnosis in two cases.

*Pathology*.—Two views have been advanced. Charcot believes that hepatic intermittent fever

is due to the production of a ferment in the bile passages, the absorption of which into the blood excites the febrile paroxysms. A certain measure of support is lent to this view by the discovery in the ducts of a case of cholangitis, by Netter and Martha, of a bacillus similar to one of the intestinal organisms.

On the other hand Murchison inclines to the belief that the febrile paroxysms are due to the simple irritation of the stone, not to a septi-cæmia.

*Prognosis.*—Recovery is the exception; the majority of cases result in death from exhaustion and cholæmia.

*Treatment.*—The remarkable success which has already been obtained by surgeons indicates clearly the line of treatment which should be followed, and although the results of opening the common duct have not been so favorable as in cholecystotomy, yet they are sufficiently hopeful to warrant the attempt, in every case, either to push the stone into the duodenum, to crush, or to extract it.

Of medicinal agents, Dr. Osler has not found any of the slightest value; quinine is quite ineffectual either to prevent or to control the paroxysms.

#### CONCLUSIONS.

1. Chronic obstruction of the common bile duct is often accompanied by an intermittent pyrexia, associated with a symptom-group of the greatest diagnostic importance.

2. This pyrexia is not usually the result of suppuration, as has been supposed, but occurs with a catarrhal cholangitis.

3. That it arises from the absorption of a ferment, produced in the ducts, is rendered highly probable by the discovery of micro-organisms, both in the catarrhal and in the suppurative cholangitis.

4. While recovery may follow, even after months or even years, a fatal event is only too common.

5. A recognition of the importance of this intermittent pyrexia and its associated symptom-group, as diagnostic of obstruction of the common duct by gall-stones, should, in the present condition of hepatic surgery, lead to more frequent operative interference in these cases.

#### *A Method of Operating for Complete Prolapse of the Rectum.* By John B. Roberts, M.D.

The patient was a young woman, suffering from prolapse of the rectum, of several years duration. The anal aperture was so dilated that the ends of five fingers of the hand could be readily inserted into the rectum. When the bowel was prolapsed it protruded from the anus as a sausage-shaped mass, about four inches in length.

The steps of the operation were as follows: Making a small incision in the middle line near the point of the coccyx, the finger was introduced and the cellular connections behind the rectum were broken up, as is done in preparing to excise its lower portion for carcinoma. The sphincter muscle was then divided in two places by incisions, situated each about a-half inch away from the posterior median line. By carrying these incisions obliquely backward through the skin until they met at the original incision, near the tip of the coccyx, including between them a triangular portion of tissue, which had, as its base, about one inch of the anal sphincter, with scissors was then cut from the posterior wall of the rectum a long, triangular piece, consisting of the entire thickness of the wall. The apex of this V-shaped section was situated about three inches up the gut, while its base corresponded with the space between the incisions, by which one inch of the sphincter muscle was removed. After the hæmorrhage had been controlled by catgut ligatures, chromatised catgut sutures were used to bring the divided wall of the incised rectum together. The first suture was introduced at the apex of the wound, that is, three inches above the anus, and was tied with the knot *within* the bowel. Successive sutures were introduced with intervals of about one-third of an inch between them, until the lower margin of the rectal wound was reached. The last intra-rectal suture was placed just within the margin of the anus. They were all tied upon the mucous surface of the bowel, so that the knots were within the lumen of the intestine. In this manner the lower portion of the rectum was greatly reduced in diameter. The divided ends of the anal sphincter muscle were then brought together by two catgut sutures and one wire shotted suture. The anal aperture was thus reduced so that it was barely possible

to introduce the tip of one finger, whereas originally five fingers could readily be thrust into it. A drainage tube of rubber was then introduced into the cavity between the rectum and the sacrum, and the wound leading backward from the anus to the coccyx was closed by numerous shotted wire sutures, carried deeply by means of a strong and curved cervix uteri needle.

---

THE  
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

---

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

*When a change of address occurs please promptly notify the Publishers, THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.*

---

TORONTO, NOVEMBER 17, 1890.

---

THE MEDICAL HEALTH OFFICER FOR  
TORONTO.

The interest manifested by the citizens of Toronto in the appointment of a medical health officer is, in some respects, very satisfactory. It is unfortunate, however, that many of the discussions and comments on the various phases of the question have been very acrimonious. Although we hear of many candidates, the contest appears to lie at present between two whose names have been brought forward by their friends during the last few weeks. There was a strong feeling that the medical profession of the city should have something to say about the choice. The Council have shown their willingness to act in accordance with such wishes, and have appointed a committee of physicians to consider the capabilities of the various candidates.

As far as we understand the matter, it was expected that this committee would carefully conduct a competitive examination, and report the result of such examination to the Council. There is a fear in the minds of some that such examination will degenerate into a mere farce, and bring a certain amount of ridicule upon the whole profession. The criticisms respecting the fitness of the board appointed for such work by the daily press of the city have been harsh in the extreme. We may say with reference to this committee that it is scarcely one which can be

considered representative from a sanitarian point of view; but, after all, it is one which, in spite of its weak spots, is likely to command considerable respect. There are many who think that a certain amount of variety in such a committee is a very good thing, in consideration of the fact that a certain proportion of sanitarians invariably become cranks. We have enough confidence in the ability and judgment of the members of the committee to believe that they will be able to reach certain conclusions, which will materially assist the Council in filling the position. To hold simply a competitive examination, and to report the results in marks or percentages, would be rather a school boy way of doing business, and, from a professional point of view, an exceedingly undignified method. From what we can learn of the feeling of the profession in Toronto, we think there is a general desire that this committee shall view the question in all its aspects. In the first place, is the salary offered (\$2500) sufficient? We are told that the health officer will be required to give all his time to the city's work. In looking for official officers from other professions, such as law and engineering, sums of four or five thousand dollars per annum are offered. Why such a difference? Is the health of the citizens only half as important as the construction of by-laws or roadways, or can the men best qualified for the position be obtained from the medical profession at half price?

Will the new health officer be endowed with authority, or will he be merely an acting foreman and statistical book-keeper for some all-wise aldermanic committee? Should the new health officer be purely a laboratory bacteriologist and analyst, or should he combine the practical with the scientific, and possess a spinal column as stiff as that of Engineer Jennings?

What the committee may accomplish, we know not. It ought to be in a position to bring in a report which will materially aid the Council. We believe its members, individually and collectively, are working conscientiously in that direction. Under the circumstances, we believe they are fairly entitled to the sympathy and assistance of the profession as a whole. Any suggestions made in a kindly spirit are likely to receive respectful and careful consideration. Adverse criticisms and cynical sneers cannot possibly do any good.

## NOTES.

**DIRECTORY FOR NURSES.**—The Directory for Nurses has its office in the rooms of the Ontario Medical Library Association; telephone 1718. It is under the general control of the Board of Trustees of the Library Association, and more particularly under the direction of Dr. W. H. Pepler. A small fee is charged for information regarding the qualifications, engagements, and addresses of the nurses asked for. The list of nurses is fairly large, and is carefully classified into male and female, and medical, surgical, and obstetrical. Great care is exercised in obtaining the correct addresses, and in keeping a correct list of the engagements of each nurse, so that no difficulty may arise in not finding a nurse when sent for, nor in finding her at another engagement. The Directory subserves a very useful purpose, but, to attain its maximum of usefulness, requires the cordial support of the profession, who might easily refer all applications for nurses to the Directory, with the full assurance that satisfactory attention will be given to the applications, and that the nurses will be of the best in the city.

**CHLORAL FOR RIGID CERVIX.**—It is about sixteen years since Dr. W. S. Playfair first recommended chloral for rigidity of the cervix in labor. At the recent meeting of the British Medical Association, Dr. Playfair referred to his experience of such treatment, which had been uniformly satisfactory. He said: "Under the use of this agent, the pains become longer, steadier, and more efficient, and the patient falls into a somnolent condition, dozing quietly between the pains, which are not lessened or annulled, as is so often the case when chloroform is used. More important than all, the wild stage of excitement which is so frequent in cases of rigid cervix is calmed, to the relief, not only of the patient, but of the practitioner. It is not necessary to administer large doses; fifteen grains, repeated in twenty minutes, by either the mouth or the rectum, produce an effect that usually lasts for several hours. Possibly a third dose may be required, but never more. Another good effect of this drug is that when the exclusive stage is reached, the patient being already in a state of partial anæsthesia, much smaller

quantities of an anæsthetic are required than would otherwise be the case." The writer has used this drug, as recommended by Dr. Playfair, for the last fifteen years, with the most satisfactory results.

---

**Meeting of Medical Societies.**


---

**NEW YORK ACADEMY OF MEDICINE.**

## SECTION ON ORTHOPÆDIC SURGERY.

Stated meeting, Oct. 17, 1890. V. P. Gibney, M.D., Chairman.

## NON-UNION OF FRACTURED RADIUS.

Dr. C. A. Powers exhibited a patient in whom this condition had existed for many years, and also showed an extension apparatus which had given relief. The first fracture occurred twenty-nine years ago, at the junction of the middle and lower thirds. A refracture took place eighteen years later, and united with deformity and disability. The radial nerve had become involved in the callus, and this gave rise to such intense pain that, five years later, she underwent an operation for its relief, in which the bone was again fractured. All attempts to cause this fracture to unite failed. When she came under the care of the speaker, in May of the present year, it was found that the carpus had slipped upwards, with the lower fragment of the radius, and had caused the ulna to project very forcibly against the soft parts, giving rise to much pain in the region supplied by the ulnar nerve. As further operative measures were not deemed advisable, a simple extension apparatus was applied and had answered admirably.

Dr. A. M. Phelps said that he thought it had been wisely decided not to subject the patient to further operation, as fractures of the radius, and of the lower third of the tibia, were peculiarly prone to non-union. Out of about 300 osteotomies, he had had only one case of non-union, and that was after an operation for the correction of an anterior tibial curve. Operations by himself and others had failed to bring about union. Thomas, of Liverpool, claimed that such fractures could be made to unite by pounding the parts with a mallet, but, in his experience, this method had not proved successful, and he thought that where there was muscle

between the ends of the bone, and the peculiar ivory-like condition of the ends of the bone, which was not uncommonly present, none of the methods heretofore proposed were likely to prove successful. He had very recently proposed and performed a new operation, which he thought might prove successful. It consisted in cutting down upon the ununited fracture, freshening the ends of the bone, and grafting in between them a part of the forearm of a dog—both patient and dog being secured in plaster of Paris. When the graft had united firmly, the dog's leg would be amputated, and the skin flaps of the dog united to those of the patient.

#### HIP JOINT DISEASE, AFTER TYPHOID FEVER.

Dr. J. McG. Woodbury presented a girl of eleven years, who, six months after a severe attack of typhoid fever, was found to have some limitation of motion, and pain at the right hip, with distension of the capsule. Flexion caused lordosis, and some pain. She was treated by counter-irritation over the joint, and a plaster of Paris spica bandage, and was allowed to walk around upon a high patten, with crutches. Now, after a period of eight months, there was no pain.

#### A CASE OF OSTEO-MALACIA.

Dr. Woodbury also presented a case of this nature. The patient had lived in Switzerland until twenty-six years of age, and had suffered considerably from exposure during the late war. On October 26, 1886, when forty-three years of age, he sustained a fracture of the surgical neck of the left humerus, and between that date and May 26, 1890, he received five other fractures, viz, two of the left humerus, two of the right humerus, and one of the left clavicle. Most of these fractures were caused by very slight falls. During the last three months, but more particularly since the first of last August, a tumor has been rapidly growing between the sites of the two fractures of the shaft of the right humerus. Two small tumors may be observed upon the clavicle, one at the point of the fracture, and the other to the inside of it. A specimen, removed from the large tumor with a harpoon, was sent to Dr. J. S. Ely for microscopical examination, and he reported that it contained "polyhedral cells, and occasional large spindle and giant cells." He adds, that this "speaks very strongly for sarcoma." A loud murmur, similar

to that heard in aortic aneurism, is audible over the large tumor. Dr. Woodbury said that as in cases of tumor of the middle of the spinal cord, osteo-malacia, due to trophic disturbances, is one of the early symptoms, concurrent with disturbances of sensation; he had referred the case to Dr. M. A. Starr, with the hope of learning more about the etiology of this interesting condition. Dr. Starr examined the patient on two or three occasions—the last time only a few days ago—and had reported that there was no central lesion of the cord. The patient had had no pain with the fractures, or upon resetting these bones, and this, together with the fact that there had been no fractures of the lower extremity, seemed to favor the view that the condition was due to a syringo-myelia or tumors of the cord.

Dr. Powers said that Dr. Woodbury's case of multiple fracture with tumors, was very similar to a case of sarcoma which he had recently presented to the surgical section.

Dr. V. P. Gibney thought the pulsation in the tumor might be due to the condition of the tumor itself—in other words, it might be a pulsating sarcoma.

#### ANKLE JOINT DISEASE.

Dr. A. B. Judson presented a case of this disease, which he said was interesting because the child had suffered from this condition almost all her life. The disease began at the age of one year, and she is now about seven years old. Notwithstanding that she had been under mechanical treatment only two years, she had recovered, with but little disability and deformity. There was considerable lateral motion at the ankle joint; extension was almost normal; flexion was arrested at about ninety degrees. Scars on both sides of the ankle showed where abscesses had opened spontaneously. There was a difference of one inch between the two calves, and the shortening amounted to only a small fraction of an inch. This result had been obtained by the use of a simple brace, and without resorting to any operation.

Dr. John Ridlon presented an astragalus, which had been removed from a child by Dr. B. Farquhar Curtis, which had been brought to the speaker when only six weeks old. He had faithfully tried stretching, and the various retentive appliances, during a period of one and a half

years. Dr. G. S. Huntington had then operated by Dr. A. M. Phelps' open method, but without improving the condition. The specimen which he presented was interesting on account of two bony prominences which it showed, and which apparently had been the obstacle to flexion of the foot.

#### THE TREATMENT OF ANKLE JOINT AND TARSAL DISEASE.

The paper of the evening, with the above title, was read by Dr. T. Halsted Myers, who also presented a patient illustrative of this subject.

Dr. Myers said that tubercular inflammation might attack, first, the synovial membrane, later, the cartilage, and lastly, the bone; or the primary local focus might be in the bone.

While it was still confined to the synovial membrane, a number of surgeons recommended excision. If it had attacked the bone, many more urged operative methods, irrespective of the general health of the patient. The author considered only the latter condition.

Simple incision was of no advantage, for we had no element of tension, as in acute processes, and we only opened new channels of infection, leaving the original disease unchanged.

The usual method of treatment, curetting the abscess walls and the sinuses, could not be expected to remove all disease, and would greatly increase the risk of absorption. The success which had been secured in some of these cases, seemed to be due to the power of the antiseptic agent to render inert the bacilli which remained.

The rational method was to remove all the disease at once; but apparently healthy bones contained tuberculous foci, and hence, it was a most difficult problem to know when to stop, and in fact, this could not be determined at the time of operation. If all the disease were successfully removed, the duration of treatment was less than under conservative methods. The ultimate results were, however, less satisfactory. He had seen a considerable number of misshapen and atrophied feet after operative treatment which were weak and painful, and required support to render them able to bear the weight of the body. He had not observed such results from conservative treatment. It was confessedly difficult to ascertain the ultimate results; and, although Dr. Shaffer had kindly placed the

records of the New York Orthopædic Dispensary at his service, he had not been able in the short time at his disposal to do more, in most of the cases, than quote the histories.

The number of cases treated before July, 1888, was fifty-five, and of these, he knew personally that at least twenty-one were cured. Five were cases of synovitis, and sixteen of osteitis. The average duration of treatment in the latter was twenty-one and a half months, the longest case being under treatment fifty-five months. The results in all were extremely good; yet under careful private treatment still better results should be expected.

From our knowledge of the various ways in which the bacilli of tuberculosis may be spread in the body, it would seem that a primary tubercular process in a joint must be extremely rare. Drs. Prudden, Northrup, Biggs, and Thacher, to whom he had written for information on this subject, all considered that these affections were generally secondary, but agreed that primary joint lesions did occur. The practical importance of this was that the danger of general infection from a joint lesion, which was not interfered with surgically, was an entirely unknown, and probably extremely small, quantity.

Of the whole number treated (fifty-five), but three had died—one of diphtheria, one while tarsal disease was active, and the other, six months after a note of "nearly cured" had been recorded. In neither of the latter was the cause of death stated. However, in Dr. Scudder's report of eighteen cases of excision, six deaths occurred; three were due to the operation, or to its direct effects; another might have been; and the other two were from tuberculosis, but occurred one and two years after the operations.

The treatment of synovitis consisted in absolute protection of the joint from traumatism. In children, he considered a perineal crutch absolutely necessary while walking. Ordinary crutches were invariably laid aside at times, and the joint left unprotected. In addition to this crutch, the foot should be protected by a splint to avoid local injuries, and to maintain a good position. There being no involuntary muscular spasm while the disease was confined to the synovial membrane, traction was not necessary.

In cases of osteitis, the same protection of the joint was imperative, and if there were pain and

spasm, indicating the necessity for traction, this could be applied at the ankle by means of a Dow's brace, or the apparatus of Dr. Sayre or Dr. Foster.

The application of adhesive plaster to a painful ankle required more care than a dispensary case was willing to give, especially when abscess was present. For this reason, he had found it most serviceable to employ a leg brace, or plaster splint, worn constantly, and a perineal crutch for walking, which could be laid aside at night; or the Dow's brace, as modified by Dr. Shaffer, might be used.

Abscesses should be left entirely alone, and the sinuses simply kept aseptic. After the joint was considered cured, it was well to wear an ankle brace for some months to prevent twists. The malpositions found in the acute stages were almost entirely due to muscular spasm, and did not require tenotomy or other operative treatment.

In the later stages, there might be bony changes, and these, if not painful or progressive, did not require treatment. However, if these conditions did exist, and yet there was no evidence of active disease, an attempt should be made to restore and preserve the normal relations of the parts.

The value of hygienic surroundings during the treatment of these cases could not be over-estimated. His observations had been made on children only, and, for contrast, an extended series of cases in the adult would be very valuable. Without exception, every one of his cases of ankle-joint, or tarsal osteitis, in children, had done well under conservative treatment, and he had yet to see the case which he would condemn to erosion or excision.

Dr. N. M. Shaffer said that his own experience led him to think that one point in Dr. Myers' paper should be particularly emphasized, *i.e.*, the necessity of absolute protection of the articulation. He had accomplished this in practice, whenever possible, by the use of a modification of Dow's brace, and had found that adhesive plaster was rarely required, as a well-fitting shoe made efficient counter traction. He thought that the further removed the tuberculous joint was from the centre of the body the more benign was the disease, and the less the danger of general infection; and he was inclined to speak

more strongly of the conservative treatment of ankle-joint disease than of any other articulation in the body.

Dr. Ridlon thought these cases did well with the Dow instrument; but with this, as with some others, we could not secure immobilization, but only protect the joint from the jar of walking. He had seen such excellent results in cases of suppurative ankle-joint disease without any treatment whatever, that he often doubted how much of a good result could be attributed to the treatment received.

Dr. H. W. Berg said that he had had such good results in the treatment of phthisis by the administration of the bichloride of mercury in doses of one-twenty-fourth of a grain, three times a day, that he was inclined to believe the old theory, that tuberculosis was really a change in the syphilitic virus, due to passing through several generations. He considered that splints like Dr. Judson's were imperfect, for, by taking their bearing from the outside of the foot, intra-articular pressure was increased. To diminish this pressure, the foot must be adducted and rotated inwards.

Dr. Phelps was of the opinion that the vast majority of these cases were cured by immobilization and relief of intra-articular pressure; but in suppurative cases, he believed that the soundest and most scientific surgery demanded operative measures. If we could protect the hip joint as well as the ankle joint, we ought to get equally good results in hip disease. He believed that these cases were inoculations of pathogenic germs on a diseased surface, and that they were purely local.

Dr. R. H. Sayre exhibited a splint which his father had devised for an adult with ankle-joint disease. He agreed with Dr. Ridlon, that it was difficult to apply traction at this joint, but he thought this splint solved the problem. His views regarding the prognosis and treatment of this disease were in accordance with those just expressed by Dr. Phelps.

Dr. Samuel Lloyd said that fifteen cases of adult ankle-joint disease had been treated in the New York Post-Graduate School by the so-called conservative method, but the relapses had been very frequent, and he thought this method was less likely to yield good results in adults than in children. In answer to questions from the



chairman, he said that several of the cases were due to injury, and a number of them were suppurative, while four were recorded as synovitis. Two of the cases had been discharged as cured before 1888, and were known to be well in 1889.

Dr. Judson protested against the statement that cases of disease in the ankle should do equally well without treatment, although neglected cases of ankle-joint disease would have nothing like so bad a deformity as those at the hip.

Dr. H. L. Taylor also spoke about the different mechanical conditions present at the various joints. The weight of the limb exerted great leverage upon the joint, especially in a spasmodic condition of the muscles. It is more marked at the hip than at the knee, and very much more noticeable than at the ankle. He referred to a case of ankle-joint disease occurring in a distinctly phthisical subject, where the sinuses were treated by injections of a saturated solution of iodoform in ether. The beneficial effect upon the healing process was almost magical.

Dr. Gibney said that, about ten years ago, the surgical section of the "Therapeutic Society" of this city spent about two years collecting data relative to the comparative results obtained by the operative and non-operative treatment of this condition; and the conclusion was, that the conservative method yielded the greatest number of useful ankles, even in cases where the foot was seamed with cicatrices. There were two or three operative cases having a high degree of equinus, and a stiffened and shortened joint, and one or two flail joints were also shown. In his experience, cases of adult ankle-joint disease relapsed again and again on the slightest provocation; later on, abscesses would appear; still later, pulmonary signs would develop, and then amputation would follow. As regards the mercurial treatment of tuberculous disease of the joint, he need only call attention to the fact that many years ago the routine treatment for these cases at the Hospital for Ruptured and Crippled was one-twenty-fourth of a grain of the bichloride of mercury in tincture of bark, three times a day; and the results attained by this treatment were certainly far from striking.

DR. GILPIN, of Brechin, had a severe attack of typhoid fever, but is slowly recovering.

## Personal.

DR. E. MEEK (Tor., '89) has settled in Port Rowan.

DR. OSLER, of Baltimore, paid a flying visit to Toronto a few days ago.

DR. G. A. PETERS, of Toronto, expects to return to Canada about the first of December.

DR. JAMES M. MACCALLUM has been appointed Lecturer on Therapeutics in the Medical Faculty of the University of Toronto.

**Mr. THOMAS J. R. COOK,**  
**Certificated Masseur**  
 AND  
**MEDICAL ELECTRICIAN,**  
 204 King Street West, TORONTO.  
 — TELEPHONE 1286. —

## FOR SALE.

A Physician's OFFICE, RESIDENCE, and PRACTICE, in a Thriving Town in Ontario, of 3,500 Inhabitants.

**PRACTICE OVER \$3,000.00.**

Good introduction given. Retiring on account of failing health.

Address—

**BOX C, CANADIAN PRACTITIONER,**  
 58 Bay Street, Toronto.

## Practical Text Book of the Diseases of Women,

BY ARTHUR H. N. LEWERS, M.D. LOND.,  
 M.R.C.P. LOND.

Second Edition (1890). 146 Illustrations

Price \$2.50, post paid to any address.

**VANNEVAR & CO.,**

Medical and Educational Booksellers,  
 410 Yonge Street, Toronto, Ont.

N.B. A large stock of Medical Books always on hand.

## Bellevue Hospital Medical College

CITY OF NEW YORK

SESSIONS OF 1890-91

The REGULAR SESSION begins on Wednesday, September 24, 1890, and ends about the middle of March, 1891. During this session, in addition to the regular didactic lectures, two or three hours are daily allotted to clinical instruction. Attendance upon at least two regular courses of lectures is required for graduation.

The SPRING SESSION consists of recitations, clinical lectures and exercises, and didactic lectures on special subjects. This session begins about the middle of March and continues until the middle of June. During this Session, daily recitations in all the departments are held by a corps of Examiners appointed by the Faculty.

The CARNEGIE LABORATORY is open during the collegiate year, for instruction in microscopical examinations of urine, practical demonstrations in medical and surgical pathology, and lessons in normal histology and in pathology, including bacteriology.

For the annual Circular and Catalogue, giving requirements for graduation and other information, address Prof. AUSTIN FLINT, Secretary, Bellevue Hospital Medical College, foot of East 26th Street, New York City.