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CANADA

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REPORT OF THE UNIVERSITY LYING-IN HOSPITAL, MONTREAL, FROM OCTOBER 1ST, 1875, TO OCTOBER 1ST, 1883.

By D. C. MacCallum, M.D., M.R.C.S., Eng.,
Emeritus Professor of Midwifery and the Diseases of Women and Children, Mc Gill University, Consulting Physician Montreal General Hospital, University Maternity, &c., &c.

I have already published a report of the first eight years of the sixteen during which the University Lying-in Hospital was under my supervision, and the present report embraces the statistics of the hospital for the remaining eight years, with a summary of the results for the entire sixteen years.

From October 1st, 1875, to October 1st, 1883, there were 725 women delivered in the hospital. Of these, 716 made good recoveries and 9 died; the mortality being in the proportion of 1 in 80½ cases, or 1.24 per cent. Of 728 children born, 694 presented the vertex, 18 the breech, 13 the feet, 1 the shoulder, 1 the face, and 1 the funis. There were 3 twin births. 688 children were born living—367 males and 321 females. The still births were 40, 24 males and 16 females; the proportion of still births to living children being 1 to 17. The average length of the children was—males, 21 inches; females, 19½ inches. The average weight—males, 7 lbs. 9½ ozs; females, 7 lbs. 7 oz; 54 males and 43 females weighed 9 lbs. and upwards. The heaviest male child weighed 11 lbs. 7 oz.; the heaviest female, 11 lbs. 14 oz. The average duration of labor in 714 cases was 9 hours and 13 minutes. The average weight of the

placenta was 1 lb. 7 oz., and the average length of the cord was 20¼ inches. There were eight placentæ born with single children each weighing over 3 lbs. The two heaviest weighed 4 lbs. each. There was also a single placenta accompanying a twin birth which weighed 4 lbs. 6 oz. The shortest cord measured 9 inches; the longest 41 inches.

The *forceps* was applied to complete the delivery in 17 cases, or in the proportion of 1 in 43 cases. Fifteen of these cases were primiparæ and two multiparæ. All the mothers recovered with one exception, and ten of the children were lost. Tarnier's axis-traction forceps was applied in two cases where the head of the child was arrested in the brim of the pelvis from narrowing of the conjugate diameter, and was found to work well.

Version of the child was performed twice; once in a case of presentation of the shoulder and once after failure to extract with the forceps.

Post-partum hemorrhage occurred in seven cases, or in the proportion of 1 in 103 cases. There were also two cases of accidental hemorrhage.

There were four cases of labor complicated with *convulsions*. Three were primiparæ and one a multipara. In all the mothers recovered. Three children were born living and one was still-born. In one case the convulsions preceded labor. The patient, aged 30, admitted into the hospital on the 15th of March, 1877, was seized with convulsions on the 18th March, at 8 P.M., before any symptom of labor had occurred. On examination, the urine was found to be highly albuminous. A large dose of calomel and jalap was at once administered, which had a powerful action on the bowels. Half a drachm of the bromide of potassium every second hour, and twenty grains of the hydrate of chloral every fourth hour, were prescribed. The convulsions ceased about 2 P.M. on the 19th March, up to which time she had had twenty-three paroxysms. Labor came on at 5 P.M. of the same day, and she was delivered at 8.20 P.M. Albumen rapidly disappeared from the urine after delivery, and she made a speedy and satisfactory recovery.

There was one case of *epilepsy*, which was interesting from

the absence of convulsions during labor. M. T., aged 27 years, confined January 13, 1876, has suffered from epilepsy for the last six years. Has had four seizures since she became pregnant: one occurring in June last and three since her admission into the hospital in November. The last attack occurred eight days before labor. There were no convulsions during labor, nor had she a return of her epileptic seizures up to the time of her discharge from the hospital. This patient had a sanguineous discharge, resembling in every respect her usual menstrual discharge, for three consecutive months after having become pregnant.

A very interesting case of complete occlusion of the os uteri, giving rise to difficulty in diagnosis, has also been reported:

E. D., 37 years of age, a strong, healthy-looking woman, was admitted into the hospital on the 5th April pregnant with her first child. She has been married, and has lived continuously with her husband, for a period of twenty years, but has never before conceived; and there are no appearances to indicate that she has ever passed through a previous labor. On the 12th April, six days after admission, she complained of pains resembling those of commencing labor, and a vaginal examination having been made, no dilatation of the os uteri could be detected. These pains passed off in a few hours, and she was quite free from them until the morning of the 23rd of April. At this time they returned with considerable severity, and an examination *per vaginam* revealed what was supposed to be a nearly fully dilated os uteri, very high up, with the bag of membranes protruding into the vagina; and in the intervals between the pains a hard, resisting substance could be felt. After the pains had continued for a period of twenty hours, recurring at long intervals, the os was supposed to be fully dilated, and the child's head could be distinctly felt above what was considered to be the anterior lip of the os uteri. Attempts were made to rupture the bag of membranes with the finger, but these not being successful, a puncture was made with a stylet and a considerable quantity of liquor amnii escaped. The head after this descended lower and the pains increased in frequency and severity. The

patient at this time began to exhibit signs of fatigue, and I was sent for to decide what further steps were to be taken. Having been informed of the diagnosis and progress of the case, I had the patient placed under the influence of chloroform, certain that I would have to complete the delivery with the forceps. I then proceeded to make a thorough examination with the hand, and found the head of the child occupying the brim of the pelvis, and covered with a smooth structure that felt very much like thickened membranes. This had a uniform surface, there not being the slightest projection to indicate the situation of a cervix. There was a smooth, rounded fold of the anterior wall of the vagina in close connection with it, which had led to the belief that this fold was the anterior lip of the os. On making a careful exploration of the surface projecting into the vagina, a slight depression was felt by the finger at its upper and posterior part. This point, moreover, was softer and more yielding than the parts surrounding it. Convinced that this was the occluded os uteri, I pressed forcibly on it, when the obstruction yielded and my finger passed through the os into the womb. The patient, having recovered completely from the effects of the chloroform, was ordered 15 grains of the hydrate of chloral every twenty minutes until four doses had been taken. This secured her several hours of sound sleep, from which she awoke greatly refreshed. The pains gradually became stronger and recurred at shorter intervals until about three o'clock the next morning, when the os uteri being fully dilated, the forceps was applied to the head of the child at the brim of the pelvis, and after careful traction for thirty-five minutes the child was delivered. There was no laceration of the cervix uteri nor of the perineum. The patient made a good recovery and left the hospital on the eighth day after her confinement.

Summary of Statistics of Hospital for Sixteen Years, from October 1st, 1867, to October 1st, 1883.

Number of women delivered		1720
" deaths		17
Mortality		0.99 p.c.

CAUSES OF DEATH—

Puerperal Fever (epidemic)		7
Chronic Bright's Disease—Uræmic Coma	2	
Apoplexy	1	
	—	3
Rupture of Uterus		1
Septicæmia		6
		17

Number of children born	1726
Number of still births	87
Proportion of still births to living children	5 p.c.

Number of children presenting the vertex	1653
" " " " breech	29
" " " " feet	20
" " " " knee	1
" " " " shoulder	3
" " " " face	3
" " " " funis	3
No presentation given	14
	1726

Average length of male children	20¼ inch.
" " female "	19 "
" weight—Male "	7 lbs. 11¼ oz.
Female "	7 " 9 "
Males weighing 9 lbs. and upwards	159
Females " " "	104
Heaviest male child weighed	11 lbs. 12 oz.
" female " "	11 lbs. 14 oz.

Average duration of labor	9 hours.
" weight of placenta	1 lb. 9 oz.
" length of funis	21½ inch.

Forceps employed in 36 cases	1 in 48
Perforator " in 1 case	
Version of the child, 4 cases	1 in 430
Post-partum hemorrhage, 13 cases	1 in 132
Accidental hemorrhage, 2 "	1 in 860
Puerperal eclampsia, 11 "	1 in 156
Puerperal insanity, 3 "	1 in 513

REMARKS.

Although the death rate of the University Lying-in Hospital for sixteen years compares favorably with that of similar institutions in Europe and America, the mortality for the first twelve was markedly lower than that for the last four years. Thus from October 1st, 1867, to May 28th, 1879, there were 1,392 women delivered, with ten deaths, a mortality of only 1 in 139, or 0.73 per cent.; and the causes of death were epidemic puerperal fever in seven cases and chronic Bright's disease in the remaining three. Whilst from May 28th, 1879, to October 1st, 1883, there were 328 women delivered, with seven deaths, a mortality of 1 in 47 or 2.14 per cent.; the causes of death being rupture of the uterus in one case and sepsis in six cases.

This remarkable variation in the death-rate of the same institution at different consecutive periods is startling, and demands consideration and explanation. From careful enquiry there does not appear to have been any material difference in the class of patients admitted into the hospital during the two periods. The domestic hygiene, the diet and the nursing of the patients were as carefully attended to in one period as the other. There was no epidemic of puerperal fever in the second period as in the first to account for the mortality, and the deaths from sepsis did not follow each other at short intervals, having occurred at the following dates: May 1879, April 1880, April 1881, December 1881, March 1882, and May 1882.

The only reasonable explanation of the increased mortality during the latter term of four years is, I conceive, the following: The University Lying-in Hospital was partly established, and has always been utilized, for educational purposes, the students of medicine in McGill University having access to its wards, and the Professor of Midwifery in the University holding the position of Physician-Accoucheur to the Hospital. For a long period the resident midwife superintended the ordinary labors, and the students (two in number) who had the charge of each case, although invariably several others were in attendance, were restricted to the number of times they examined the patient *per vaginam*: their hands having been previously cleansed by

careful washing with strong carbolic soap and the examining fingers being then anointed with carbolized oil. The patient was carefully syringed twice daily with a solution of the permanganate of potash of the strength of two teaspoonsful of Condy's fluid to a pint of water; and if there were elevation of temperature, or if the lochia became offensive, the vagina was syringed every fourth hour.

Some years ago it was deemed advisable, with the view of giving the student of medicine a more thorough training in practical midwifery, to appoint an "instructor in midwifery" to the hospital, whose duty it would be to attend each case of labor, demonstrate the progress of parturition, and deliver clinical remarks to the attendant students. The first appointment to this position was made in the year 1878, just at the commencement of that period of four years in which six deaths from sepsis occurred, and during which the death-rate of the hospital was raised from .73 to 2.14 per cent. The more frequent manipulations and greater interference with the patient which such instruction demanded were, in my opinion, the causes of this increased mortality. Indeed, a more striking illustration of the danger to be apprehended in making the parturient woman too thoroughly the subject of practical instruction could not possibly be adduced than that which the statistics of the hospital during these four years has afforded.

The proportion of still-births to living children, as given in the above table, is five per cent.; but this does not represent exactly the proportion of mature children who were living at the commencement of labor, but who, from various causes, lost their lives during the act of parturition. If from the total number recorded (87) there be deducted 18, some of whom were born prematurely between the 140th and 190th day of gestation, and others with marks of intra-uterine maceration, the proportion would be only four per cent.

During the sixteen years, the cases (41 in number) in which operative interference was demanded recovered; and there was not a death from hemorrhage, puerperal eclampsia, nor puerperal mania, although the last two occurred in as many as fourteen cases, eclampsia in eleven, and mania in three.

Although there was no strictly routine treatment adopted in the cases of eclampsia, much dependance was placed on the alternate administration of large doses of the hydrate of chloral and the bromide of potassium, particularly after a thorough evacuation of the bowels had been secured. Chloroform was employed when the convulsions occurred during labor, being administered on the approach of each paroxysm, but was suspended on the completion of the delivery. In one case only did the chloral and bromide appear to act injuriously on the patient, and in this case the hypodermic injections of morphia were attended with markedly beneficial effects. Bleeding from the arm was resorted to in two cases. The success which has attended the treatment of cases of eclampsia occurring in the hospital is greatly due to the thoroughness with which the treatment has been carried out by able and intelligent assistants. As soon as a patient was seized with convulsions, a selection was made of four or more advanced students, and to their care the carrying out of the treatment was confided. They relieved each other in relays of two, and kept an accurate record of the progress of the case and the effects of the treatment adopted. Not infrequently the reports of the students in charge led to the adoption of important modifications in the treatment.

LACERATION OF THE CERVIX UTERI.*

By Kenneth N. Fenwick, M.D.,
Professor of Obstetrics and Gynæcology, Royal College of Physicians and Surgeons, Kingston, Ont.

I have been greatly impressed, in studying the subjects of obstetrics and gynæcology, with the fact that so many contributions have come from this side of the Atlantic.

McDowell did the first ovariotomy; Battey the first oöphorectomy; Hodge has immortalized his name in connection with uterine displacements; the invention of the duck-bill speculum by Sims, which by a new principle exposed to view and allowed a more complete examination of the uterus. So great were Sims' contributions to practical gynæcology that it has been said if all he had done were suppressed we should have retrograded

* Abstract of paper read before the Ontario Medical Association, June, 1887.

a quarter of a century. And, lastly, Emmet has discovered a pathological factor and invented a means of relief which is one of the many gynæcological advances of the last twenty years. Dr. Thomas says the "diagnosis and treatment of lacerated cervix is a pathological contribution which, even if this eminent author had done nothing else to lay his profession under obligation, would indelibly write his name upon the records of gynæcology. No one contribution to this department which has been made in the period mentioned has exerted a more marked influence upon uterine pathology than this is now doing and will do in the future. None will have more influence in abolishing useless and hurtful therapeutical resources."

Although lacerated cervix was described by Dr. Bennett forty years ago, its importance as a pathological factor was only recognized by Dr. Emmet in 1862, and with his usual ingenuity at once set about a means of operative cure. He first published an account of his operation in 1869, but it was not until 1874 that general attention was drawn to the subject.

The early recognition of this condition is often determined by the presence after the confinement of an elevated temperature, indications of slight septicæmia, the absence of milk, and a general impression that the patient is not doing well. These symptoms are due to cellulitis, which often occurs with a laceration of the cervix, without which it would otherwise have healed, but which causes obstruction of the circulation, and so arrests involution and the repair of the injury.

It would be well, therefore, when such a condition occurs after labor, to examine the case, not immediately after parturition, when the parts are so soft that the tear could not be recognized, but six or eight weeks afterwards, and then by appropriate means prevent a life of suffering.

Now, while on the one hand I believe some have laid more stress upon this condition than it deserves, and perhaps operated when it was not necessary, Emmet going so far as to say that "at least one-half of the ailments among those who have borne children are to be attributed to lacerations of the cervix," on the other hand there is little doubt that this condition is often

overlooked by the general practitioner, or else it is mistaken for erosions of the os (so-called ulceration) or cancer, and either neglected or impropely treated.

Perhaps in this condition the safest course is the middle one, and the truth may be stated thus:—

1. A certain degree of laceration of the cervix is the rule in all first labors.

2. A certain number of these are entirely recovered from, or else they exist without producing any symptoms.

3. A certain proportion form important factors of disease.

It is this last class of cases, when correctly diagnosed, that alone require Emmet's operation, and in which relief of the symptoms may be expected.

The tendency, then, of laceration of the cervix is to heal unless either septic poisoning takes place or the tear extends beyond the crown of the cervix into the connective tissue, the accompanying cellulitis obstructs the circulation, interferes with involution, and prevents repair of the injury.

It is most commonly met with on the left side, probably because the vertex occupies usually the right oblique diameter.

When a laceration exists there is a tendency, especially on standing, for the tissues to roll out, while the obstructed circulation, the irritation of the vagina, and the resulting subinvolution increases the laceration, and as the vaginal outlet is usually patulous, owing, perhaps, to use of forceps or traction, or the accompaniment of a ruptured perineum, there is usually prolapse and retroversion.

The reticulated mucous membrane containing numerous Nabothian glands undergoes cystic hyperplasia and granular degeneration.

Then we have inability to walk or stand comfortably, backache, pains in the abdomen, irritability of the bladder, profuse menstruation, uterine leucorrhœa, headache, insomnia and other nervous derangements, or if pregnancy occurs, it often results in abortion.

If these symptoms which are so pronounced can be relieved by trachelorrhaphy, surely a great advance has been made by

this discovery, for there is little doubt that if neglected they sometimes lead tc cancer. In my own experience, every case which I have operated upon has been completely cured, and in two of them pregnancy followed, one of these having been delivered without a return of the laceration, nor followed by any of the previous symptoms. I mark out the intended incision with a scalpel, then remove the angle with Skeene's hawk-bill scissors, trim the edges with long-handled scissors, and use chromic catgut sutures. On the fourteenth day the parts are examined, when I nearly always find complete union.

PROSTATOTOMY.*

By A. Groves, M.D., Fergus, Ont.

Having lately practised this operation in a few cases of enlarged prostate, and finding the results in every way encouraging, I have thought it worth while to bring the subject before the profession, more especially as the operation is one rarely practised and the cases in which it is indicated are comparatively so numerous in men beyond middle life. To the practitioner with a patient who has enlarged prostate, requiring the use of the catheter several times daily, particularly when the passage of this instrument is painful and difficult, or when the bladder contains ropy mucus or pus, I can strongly recommend the operation; but even before this stage is reached, I am of opinion the operation is often indicated. The operation itself is similar to an ordinary median lithotomy, the patient being placed in the lithotomy position and a staff grooved on its convex surface passed into the bladder. The membranous portion of the urethra is opened as close to the prostate as possible, and a lithotomy knife is passed along the groove of the staff into the bladder. A tube is passed through the wound into the bladder, and, as Harrison advises, it is better to use an outer and an inner tube, the latter being of soft rubber is less irritating to the bladder than a rigid tube, and it can be cleaned and replaced without pain or worry to the patient. Little bleeding, as a rule, takes place, and after

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the first few days the patient sits up and goes about, the urine being caught in a rubber urinal, or in some cases a stop-cock may be attached which can be opened as occasion requires. Under this treatment the patient's condition rapidly improves. As a result of the perfect drainage the mucous membrane takes on healthy action, pus and glairy mucus disappear, and the more or less paralyzed bladder recovers its tone. The tube should be left in from one to three months. The results are not only permanent, but progressive, for the obstructing portion of the prostate having been incised, cicatricial tissue is formed, which by its contraction causes gradual diminution of that portion of the prostate which caused the trouble in the first place. It is difficult to lay down an exact rule as to when the operation should be undertaken, but long delay not only subjects the patient to a great deal of avoidable suffering, but also diminishes his chances of ultimate recovery, and at the same time tends to bring the operation into undeserved disrepute. It is, of course, unjustifiable to operate upon a dying man, but it is much more unjustifiable to defer an operation until hope has fled.

CASE OF ARSENICAL NEURITIS.*

By J. Ferguson, M.D., Toronto, Ont.

The patient had used liquor arsenicalis in twenty to thirty minim doses. She began to complain of severe pain in the legs; the hyperæsthesia was very great on some parts of the feet and legs. She had diarrhœa, headache with giddiness, and the sight was weakened. The skin over the greater part of the body was covered with purpuraceous scales. On the brow and face the integument was brownish and mottled. The hyperæsthesia began to change into anæsthesia, and finally tactile sensation was almost lost. The perception of heat remained longer than mere touch. The reflexes, both tendinous and muscular, were greatly weakened. The responses to faradic and galvanic currents were very imperfect. The gait was not that of true ataxy; it was rather a paretic one. The muscular sense of weight and resistance was

* Abstract of paper read before the Ontario Medical Association, June, 1887.

markedly reduced. The voice became a mere whisper, due to paresis of the vocal cords. She had several attacks of pain in the stomach, with nausea and vomiting. She had a few attacks like girdle pains. The sudoriferous glands were thickened in some parts of the integument, and a proliferated epithelium in the lumen of the sweat ducts was abundant. The Pacinian corpuscles contained accumulations of epithelioid cells between the tunics. This caused pressure on the core. The central core of these corpuscles in many instances was homogeneous, having lost all trace of nuclei. The nerves of the integument in some parts showed changes similar to those met with around bed-sores. Many sections of the muscles yielded good specimens of degeneration, showing the muscle fibre was giving place to connective tissue. The sheaths of some of the larger nerves were reddened and thickened, while the nerve substance was softened. The myelin was often broken up and appeared in granular masses. In some places the nerves were infiltrated with leucocytes. In the cord some parts were found full of disorganized cells; in other parts there was increase in the connective tissue. In the neuroglia there was a good deal of cellular and granular matter. It was concluded, from the clinical history and microscopic examination, that the patient had suffered from a multiple neuritis.

PHOSPHATURIA.*

By H. Arnott, M.B., London, Ont.

Our knowledge of many portions of urinary pathology is in a very confused state. By the term phosphaturia, or the so-called phosphatic diathesis, many author's refer merely to a neutral or alkaline condition of urine in which the phosphates are precipitated. This may occur on being passed, or when a sample is heated in a test-tube, and has no other significance than depressed acidity. It is well known that if urine contains an excess of base or a deficiency of acid it will be alkaline, and the phosphates, under such circumstances being triple compounds, will be precipitated. Under such circumstances there may be

* Abstract of paper read before the Ontario Medical Association, June, 1887.

a deficiency of phosphates rather than an excess, and, consequently, this phenomenon is indefinite and unreliable as a symptom.

On the other hand, many of the later writers on the subject, by the term phosphaturia, mean any marked and continued deviation from the normal amount of phosphates excreted in the urine. This seems to me to be the definite and therefore proper basis for a study of the subject, and it is chiefly from this aspect that it will be found of service in differential diagnosis. The important point is the amount of phosphoric acid excreted, and this is approximately arrived at by estimating the total amount of phosphates. For this purpose a sample can be put in a long, graduated test-tube and saturated with the ordinary magnesia mixture or Liessier's fluid, and set aside for twenty-four hours, when the phosphates having settled to the bottom, the relative amount can be read off.

It seems to be settled that the total phosphates are increased in acute disease of the nerve centres and after any prolonged nervous excitement. They are diminished in chronic nervous disorders, excepting epilepsy, hysteria and chronic renal disorders. Beyond this all is contradiction and what looks like guess-work, which, it is hoped, time will clear up. In the differentiation of obscure nervous disorders this symptom will be found of very great value, and in many other diseases will also be found useful.

The cause of any notable excess of phosphates is always some nervous disturbance. If true, this is an important fact and worthy of careful study. At times it may seem to be due to indigestion, but in reality this will be found to be one of the symptoms of neurasthenia.

The treatment of any disease involving this symptom must include rest as the main feature. Many cases are œdematous from the deposit of phosphatic crystals in the urinary tubules. A lowering of the diet will increase the acidity of the urine and remove the difficulty. Medicines are useful only so far as they improve general nutrition or quiet nervous agitation.

THE RELATIONSHIP OF INSANITY TO MASTURBATION.*

By Stephen Lett, M.D.,
Medical Superintendent of the Homewood Retreat, Guelph, Ont.

In endeavoring to estimate and arrive at conclusions as to the relationship that exists between the unnatural gratification of the sexual appetite by masturbation and the psychological effects consequent thereon, we are met at the threshold of the enquiry by a lack of reliable data upon which to base opinions or demonstrate facts. The very secret nature of the vice prevents us from knowing by whom and to what extent it is practised. If we turn to hospital and asylum statistics, unreliable as they are in other matters pertaining to the causes of insanity, they are absolutely worthless in this particular. The admission papers filled out by the family physician do not, in a very large majority of cases, throw any light on the subject, and in the few instances where masturbation is set down as the cause of insanity, it is but a factor or single link in the long chain of combined causes which led up to, and finally culminated in, an attack of pronounced mental alienation, whilst in many cases it is not a cause, but the result of disease or irritation in the nerve centres.

Some people will no doubt contend that masturbation *per se* is quite sufficient to produce insanity, and many authors accurately describe a class of so-called "masturbational insanity"; but if all those who masturbated to excess became insane, it would be beyond the powers of any government to provide asylum accommodation for this class alone. It is chiefly those of a neurotic organization, with an insane diathesis (as some have aptly called it), who come under its baneful influence to such an alarming extent and with such disastrous results. In those thus predisposed to mental trouble, masturbation may be set down as an exciting cause of insanity.

Although, in the sense in which I have pointed out, masturbation may be an exciting cause of insanity, it would be a grave error to conclude that all insane persons who practise self-abuse have thus caused their mental estrangement. In many cases

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masturbation is but a symptom of mental disease. The intellectual part of our nature being disabled, the animal passions burst forth, and self-indulgence in all its unrestrained gratification reigns supreme. Irritation or disease in the cortical centre for the sexual appetite would produce similar results, as instances of masturbation being the consequence and not the cause; witness the general paralytic, puerperal insanity, climacteric insanity, senile insanity, also certain traumatisms of the brain and spinal cord.

Eckhard and others have shown that irritation of the medulla oblongata, the pons varolii, and the crura cerebri, cause vascular turgescence of the generative organs and priapism. This, however, may be solely due to the relaxation of the local blood-vessels in the sexual organs, which would be a natural consequence of irritation or injury in these centres. Whilst the centre for the sexual appetite is not definitely settled, it is pretty generally held by scientists of the present day that it is in close relation with the centres of emotion and the sense of smell. Thus Ferrier states: "From certain facts of experiment, we have reason to conclude that the centres of sexual feelings are probably localizable in the regions connecting the occipital lobes with the lower and inner part of the temporo-sphenoidal lobes;" and he further adds, "As the reproductive organs in women form such a preponderant element in their bodily constitution, they must be more largely represented in their cerebral hemispheres, a fact which is in accordance with the greater emotional excitability in women and a relatively *larger development* of the posterior lobes of the brain."

Whilst a certain number of cases of masturbational insanity recover, a large proportion of them are incurable; they are apt to lapse into a chronic condition, frequently degenerating into dementia.

In early life, the child who thus pollutes himself retards and arrests the healthy development of his nervous system, and the practise in such an one tends to idiotcy and imbecility rather than to insanity.

That masturbation is a most debasing, debilitating and depress-

ing vice, which has a deleterious influence upon the physical, mental and moral nature is beyond controversy. It is equally true that its baneful effects are *cæteras paribus* in direct ratio to the early age at which it is practised, the extent to which it is carried on, and the nervous instability of its unfortunate victim.

Masturbation occurs in both sexes, and is equally harmful to the mental vigor of either. It is practised by the youth not yet in his teens, indulged in by the adolescent, and carried on by the octogenarian.

Masturbation, with an adequate predisposition, is an exciting cause of insanity. It is, perhaps, more frequently a symptom of that disease, but when present it hampers treatment, retards recovery, and in many instances precludes the possibility of a cure.

INJURIES RELATING TO THE ELBOW-JOINT.*

By J. P. Brown, M.D., L.R.C.P., Galt, Ont.

Among the most common and at the same time most troublesome afflictions to which young boys are prone are those relating to injuries of the elbow-joint. Curious, too, is the fact that fractures and dislocations in this region are almost exclusively confined to children of the male sex. In my own experience, while I have had a large number of boys suffering therefrom, yet I never had the misfortune or satisfaction, whatever way you like to make it, of seeing a girl suffering from the like injury. In speaking to my medical confrères on this matter, I have found that my own experience agrees pretty generally with theirs. This seems to be a curious circumstance, as our Canadian girls are almost as fond of out-door pastimes as are boys. Witness, as we may, our ice-ponds, skating-rinks and toboggan-slides in winter, and our croquet and tennis lawns in summer. I presume, however, that the girls, while fond of out-door exercise, display more prudence and general forethought in their amusements than the rough-and-tumble lads, who, in their harum-skarum fashion, lay the foundation for the future yeomen of our country.

At this early age fractures of the elbow are more common than

* Abstract of paper read before the Ontario Medical Association, June, 1887.

dislocations. The difficulties of diagnosis are often very considerable. The injuries, which are often of a severe nature, produce so much general contusion with rapid swelling of the soft parts in the vicinity of the joint that it is often impossible to tell the exact nature of the injury. Sometimes the surgeon, summoned several hours after the accident, finds so much tenderness and swelling, that although he can discover deformity and produce soft crepitus between the segments of the severed cartilage, yet fails to discover with absolute certainty whether the head of the radius is *in situ* or not; also whether one or both condyles have separated from each other or the shaft of the humerus. He is forced to take cases of this nature on general principles. And the question that has often presented itself forcibly to my mind, whether the treatment as recommended and laid down by our works on surgery is altogether to be relied on. For all the multitudinous injuries in the vicinity of the elbow, flexing the arm to the right angle and the application of angular splints, the arm being kept in a position midway between pronation and supination and supported by a sling, appears to be the *sine qua non*. Embron makes some exception in the case of the head of the radius being displaced forwards, when he recommends the straight splint padded and applied to the palm-surface of the arm. Even in this he leaves the matter open.

My own opinion is that our text-books are too lax in dealing with cases of this nature. We have general principles instead of fixed data to work upon, and the result has often been detrimental to the best interests of the sufferer. During the course of my lifetime I have often seen more surgery about a diseased arm, the result of permanent deformity, resulting from personal injury, which with timely and judicious treatment might have been avoided.

During early years the tissues about the elbow are exceedingly soft and yielding, the bony sutures themselves are only in a process of formation, the child is restless, nervous and excitable, and owing to the swelling at the seat of injury it is difficult to so bandage the arm while in a flexed position that the various

segments constituting the joint may retain the position in which they were placed when the splints were applied.

Of late years I have pursued a different line of treatment. The chief difficulty in many of these cases is to ensure the position of the head of the radius. We are told that full extension will reduce a dislocated head, and if that is the case, then continued extension will incur continued reduction. And a week in that position would in a great measure restore the articular ligament to its original attachment. The ulna dislocated backwards, when reduced, would find no tendency to slip out of position upon full extension, save when the coronoid process was fractured, and even then the position would be a good one, as it would limit the action of the triceps muscle. In separation of the epiphysis, the straight position would be equally good for the latter reason, which, with anterior and posterior splints judiciously applied, would retain the fragments from slipping past each other. I think, from my own personal experience, as well as from reason, that these same injuries to the elbow-joint in juvenile life, in which, for the first dressing, the long, well-padded splints are infinitely preferable to the ordinary angular splint. If retained for one or two weeks, according to tho nature of the case, then the time will arrive for flexion and the application of angular splints to suit the character of injury with which we are called upon to deal.

I do not think I should conclude my short paper without briefly recounting my own experience in this matter for the past four years. Previous to this I had used the ordinary methods with varying result:—

Case I.—On May 9th, 1881, D. B., a boy aged 13, fell off a branch of a tree, a distance of ten feet, lighting on his elbow, producing a compound fracture of the olecranon process. The wound was ragged, oblique, and nearly two inches long. The olecranon was completely severed and retracted slightly by the triceps muscle. The forearm was flexed and the joint laid open. There was profuse hemorrhage. The clothing being removed, I flexed the arm still more so as to open the joint more fully, and douched it freely with slightly tepid water

until hemorrhage ceased, thus cleansing the parts thoroughly from extraneous matter. The arm was then fully extended parallel with the body. This brought the segments of bone in almost juxtaposition. A long, well-padded splint was applied to part of arm from shoulder to wrist, the bandages so arranged as to draw down somewhat on the upper fragment. The elbow was left open for dressing. The wound was saturated with carbolic oil, one to eight, on lint. Oil silk protection and light bandages applied, and patient put to bed. The bowels were operated on by a laxative, and Dover's powder administered at night. Dressing was removed forty hours afterwards. Bones were separated about the eighth of an inch, the interstices being filled with blood and serum. No pus had formed. There was no great rise of temperature, and thermometer under tongue indicated 100.° From this time the dressing was repeated every day until the 19th. The wound was filling by granulation, the surface being bathed by a few drops of laudable pus. I saw the case once a day, and the temperature varied from 99° to 100°. After this date it abated. The dressing was changed every second or third day, and by the 10th January wound had completely healed. There was bony union, but the olecranon process seemed slightly elongated. From this time passive motion was commenced. At first very gently, efforts at flexion being increased as time advanced. Still the improvement was very slow. I did not see patient from Jan. 30 to July 25. The adhesions at the joint had become partly firm, for he could only bring the arm to an angle of about 140 degrees. On the 30th, Dr. Radford kindly administered chloroform and we broke up the adhesions by forcible flexion, bringing the arm to a little less than a right angle. We could not do more with safety. From that time passive motion was employed. The result was that the boy had a very useful arm, flexing to a right angle with full pronation and supination, but owing probably to the elongation of the olecranon he could never extend the arm fully after the forcible flexion under chloroform.

CASE II.—On the 4th Jan., 1885, Mrs. R. S's little boy, aged 21 months, fell off a table. Owing to my absence from

home I did not see him until the 7th. By this time the joint was very much swollen. The child was feverish and crying with pain. It was very difficult to tell the exact nature of the injury. Still there was crepitus, and I thought the head of the radius was thrown forward. The limb was extended fully and with coaptation pasteboard splints applied the full length of the arm. These were padded and kept in position by starch bandage. The child was placed on his side, and the arm extended on a pillow. All pain subsided. It was, however, difficult to keep the little fellow contented with his position for the ensuing week. At the end of that time I removed the splint. The swelling had subsided, and bringing the arm to the right angle, I put on a starch bandage for another fortnight. The child trotted about quite contentedly, and by that time had fully recovered.

Case III.—On August 10, 1885, Mr. C.'s son, a stout little fellow, aged about five years, fell some distance, injuring his elbow. I saw him in less than half an hour. There was fracture of the epiphysis of the humerus. This was marked very distinctly, the whole elbow projecting backwards, and being upwards on extension, slipped back again when the arm was liberated. The head of the radius was also thrown out. The boy had a full, soft, fleshy arm, and it seemed to me almost impossible to ensure the retention of the head of the radius, together with the fractured humerus, by means of the angular splint. Coaptation, together with extension, reduced the head of the radius as well as replacement of the fractured humerus; but it slipped forward again when extension ceased. I dressed the arm with long, stiff, well-padded pasteboard splints, keeping extension up till the starch bandage was applied, and binding with moderate tightness to keep the fractured humerus from slipping upwards. A few hours later I loosened the bandages somewhat by snipping the upper and lower ones for half an inch. There was no discoloration of the hand, and very little pain. The bandages were not removed for two weeks. When examined, the head of the radius was in position and the humerus had united at the epiphysis. The arm

was bent to a right angle. An appropriate splint applied for another two weeks leaves the limb as useful as ever and without deformity.

CASE IV.—On January 18, 1886, a medical friend sent for me in consultation. Mrs. G.'s son, aged about 10 years, had slipped on the ice on New-Year's Day, falling upon his elbow. There was a good deal of swelling about the joint when the doctor saw him, as well as deformity and some crepitation. He diagnosed separation of the epiphysis and displaced radius (forward). He reduced the arm and put on the angular splint. The patient apparently did well. On examining him, however, in his office that morning, he found the head of the radius dislocated forwards. The forearm could not be extended fully. We administered chloroform and then put on full extension. The head of the radius was pressed without much difficulty to its natural place; and one of us holding it in position, the other bent the forearm to an acute angle, thus effectually preventing the head of the radius from again slipping forward. The arm was bound in position and kept there for a week or two, resulting in perfect recovery.

CASE V.—On Sept. 24, 1886, the son of Mr. H., aged nine, fell from a grocery waggon, lighting on his elbow and resulting in separation of the shaft of the humerus at the epiphysis. The radius was in situ. Believing, from my past experience, that the long splint was the best and safest for injuries to the elbow joint, I applied my ordinary pasteboard and starch bandage, thus insuring against displacement. After the first day or two the boy was allowed to walk about, hanging his arm by his side. In two weeks I dressed it again with the angular splint, and in due course the boy made a perfect recovery.

CASE VI.—On Oct. 23, 1886, Mr. F.'s son, aged between nine and ten, was thrown from a waggon with great force, falling with all his weight upon his extended left hand. I found the arm pronated and flexed, and shortened fully two inches. The forearm was dislocated directly backwards. The olecranon process could be felt beneath the skin, while the projection of the

condyles forward increased the antero-posterior diameter of the joint very materially.

Counteraction was performed by an assistant, but it took all the strength I had to reduce the dislocation over the knee, the coronoid process being locked in the trochlea of the humerus. Steady extension, however, had the desired effect, and in time it slipped into its place. The middle of the joint was not reduced, the internal condyle being moveable and very prominent. There was evidently separation of the internal condyle from the shaft. The radius apparently had not been displaced. Thinking that the fragment of the humerus could be kept in better position by full extension than flexion, I again applied the long splints. This time, however, only for a week. On removing the splints I found the whole arm in a state of ecchymosis from the internal hemorrhage produced by the severity of the injury. The olecranon and head of the radius was in position, but the internal condyle was as before, unusually prominent, though firm. The joint was half an inch wider than the one on the right arm. I put on the angular pasteboard splint. Patient wore it for several weeks, when passive motion was commenced. The arm is strong, but somewhat limited in motion. Pronation and supination are intact, and the hand can be brought to the mouth, but cannot be extended or flexed to full extent by several degrees. The projection of the internal condyle is sharp, and the breadth of joint before referred to still continues. Still the boy has a very useful arm, with prospect of still further improvement.

I trust my short paper has not proved wearisome. I cannot claim perfect accuracy in my views, but such as they are they are the result of experience; and if they serve as a medium of food for thought, if not for discussion, I shall be more than satisfied.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

CONDENSED REPORTS OF CASES IN DR. MACDONNELL'S WARDS.

CASE I.—AORTIC ANEURISM.

Aneurism has always been a common disease in the practice of the General Hospital, mainly by reason of the large number of old soldiers who have taken up their residence in the town. The case of Good, aged 54, a Crimean veteran, who left the hospital in April after a four months stay, is instructive, as illustrating the good effect of iodide of potassium in relieving symptoms and influencing the growth of the tumor.

On entry, the patient was suffering severely from cough and dyspnœa, and was unable to walk unaided from one part of the building to another. During sleep the respiration was markedly noisy. There was severe pain extending up the back of the neck. The physical signs pointed to the existence of an aneurism either of the arch or more probably of the origin of the innominate artery. At the time of his leaving all urgent symptoms had disappeared. He had gained weight, lost the cough, pain and dyspnœa, and on the day of his discharge was able to walk a distance of nearly a mile without any difficulty. The condition of the aneurismal tumor remained stationary. He had been taking all along ten grains of iodide of potassium three times a day, with full diet and no restriction as to his movements.

Very many other cases, showing the great good done by this mode of treatment have occurred lately, both in my own practice as well as in those of my colleagues. There was no history of syphilis in this case.

CASE. II.—MEDIASTINAL TUMOR (?).

A young butcher, aged 19, came into No. 11 Ward in March last, complaining of a swelling of the abdomen. He had been in good health up to within a few weeks of admission, when he noticed this very gradual enlargement. The feet were slightly

œdematous, but had been much larger before entry. His habits had been temperate, and there were no previous illnesses whatever. When the patient is standing, there is nothing noticeable in his appearance beyond that the complexion is rather florid and the abdomen large and prominent. On lying a few moments on the back, the face becomes darker and cyanotic, and the ears particularly blue; the pulse is rapid, generally over 100, small and irregular; temperature normal. Suffers from headache occasionally, but does not feel at all ill. The chest is well formed and the pectoral muscles well developed. On the upper part of the left chest there are some enlarged veins, one larger than the rest, the size of a slate pencil, crosses the clavicle, the blood current in which is downwards. The heart's area of dulness is normal. The sounds are weak and irregular, but there is no murmur generally present, though occasionally a systolic basic murmur has been heard in the vicinity of the left second costal cartilage. Examination of the lungs yields a negative result. Has never suffered from cough or hæmoptysis. The digestive functions are properly performed; never suffered from vomiting, hæmatemesis or melæna. The abdomen is uniformly enlarged and contains fluid, measuring 36 in circumference. Hepatic dulness measures 5½ from the fifth interspace. The liver margin is plainly felt, the surface uniform in outline and not painful to pressure. The urine contains lithates, but is otherwise normal.

During the four weeks that he was in hospital the condition remained in the main unchanged. The recumbent posture did not cause the same degree of lividity, and the ascites was not quite so prominent when he left.

This was a puzzling case, and the question arises, was the evident obstruction to the circulation due to cardiac causes or to the presence of a tumor? In favor of the cardiac view is the fact that the obstruction is general, affecting both the head and neck as well as the abdomen and extremities. Moreover, there is a probability that the obstructive symptoms have been present from childhood, or even from birth, for he tells us that the enlarged thoracic veins were always present. On close questioning he admits that the œdema of the feet preceded the

ascites. The irregular action of the heart and the feeble pulse add to the likelihood of the obstruction being situated in the heart itself. The nature of the obstruction, if any, must become a matter of guess-work, so many cardiac anomalies being capable of producing symptoms and physical signs of a similar kind to those observed. The fact of the occurrence of cyanosis on lying down would point rather to the presence of a tumor, which in that posture rolled upon the heart or great vessels. The patient left hospital with his case not diagnosed.

CASE III.—EFFECTS OF ASPIRATION IN CIRRHOSIS OF THE LIVER.

R. B., aged 55, a baker, was admitted into hospital March 8th, 1877. He was a large, stout man, and had always enjoyed good health until about a year or a year and a half ago, when he began to suffer from flatulence, uncomfortable sensations after food, with a constantly present sense of lassitude and wearinesss. The bowels had been irregular, and there has been an habitual condition of constipation, alternating with attacks of diarrhœa. Five months before admission he had a severe attack of erysipelas, during which jaundice and œdema of the feet were present. Nine months before admission he had been told that his face was getting yellow. Recovery from this illness was but partial, the acute symptoms subsided, but he still remained in an indifferent condition of health. During the first week of March he again began to become jaundiced, and was attacked with violent hæmatemèsis, which was present from time to time for thirty-six hours, and on account of which he was brought to the hospital. He has never had hæmorrhoids, nor has he been aware of the passage of any blood per rectum.

Patient has for many years past been in the habit of taking stimulants, gin and beer, very freely.

State on admission.—Conjunctiva and whole surface of the body deeply jaundiced. Venous stigmata on side of nose. The abdomen moderately distended (40 inches) from fluid in the peritoneum, and the superficial abdominal veins are unusually distinct. Considerable œdema of legs. The abdomen is nowhere tender. The liver is uniformly large and smooth, and measures

nine inches in right mammary line. There was considerable exhaustion from loss of blood, and the hæmatemesis continued at intervals for a day and a half after admission, ceasing under the influence of rest.

For several days dark-colored blood was passed by the rectum and the bowels acted very frequently. The urine contained a large amount of bile, but no albumen; as far as could be ascertained, the total quantity passed did not exceed twenty ounces. None of the other organs of the body were enlarged. At the bases of both lungs there were fine, moist râles, but no dulness on percussion.

After a few weeks residence in hospital the jaundice almost disappeared, but the ascites increased, and the feet, legs and scrotum soon became very œdematous, the last attaining the size of a cocoanut. The total quantity of urine passed per day was very small, averaging but about twenty ounces. Aspiration of the belly to the small extent of 46 ounces was practised. On the following day the tension of the skin of the legs was much relieved, the scrotum resumed its ordinary size, and the quantity of the urine increased to 40 ounces. During the following week the size of the abdomen became much less, the legs much more reduced in size. The diuretic mixture (Infus. Digitalis with Acetate of Potash) seemed to become active, and 50 to 60 ozs. of urine were passed daily. Finally the general condition of the patient improved to such an extent that he left the hospital and now reports himself every week. There is still a moderate degree of ascites and the feet are still swollen, but the patient can attend to his business and walk some distance to the hospital for advice.

CASE IV.—GRAVES' DISEASE.

Within the last three months two cases of this somewhat rare disease have found their way to our medical wards. At the latter end of Dr. Ross' term of duty and at the beginning of mine a man aged 27, a plumber, was admitted with cough, headache and gastric disturbances, pain in stomach, and vomiting. It was noticed that the eyes were lustrous and projecting. The thyroid was enlarged moderately. Has been obliged lately to

wear a No. 16 collar instead of a No. 14½, as formerly. The heart is enlarged, the apex beat extends one and a half inches beyond the nipple line. At the apex there is a systolic murmur which is transmitted to the mid-axillary line; a second murmur is heard at the aortic cartilage, systolic, short and rough. Pulse 112 to 120, soft and compressible. Græfe's eye symptom is present. The man remained in hospital some three months, without any very marked change in his condition.

The second case is that of a woman aged 28, who has been married eight years and is the subject of constitutional syphilis, there being a history of a primary sore, followed by sore throat, falling off of the hair, and periosteal inflammation of the tibia. Besides superficial scars which are found upon the legs, she has a large liver, with albuminuria and enlarged spleen. The exophthalmos is not very prominent, but a stranger entering the ward could not fail to notice her staring expression. The lids are retracted, and Græfe's symptom is present to a small extent. Thyroid enlargement is slight, but the pulse is continuously frequent; I have never found it less than 100, and it is usually at 116. There are no special heart complications. Digestion is much disturbed, diarrhœa frequent, and pain about the abdomen complained of. The intense anæmia present may account for the occurrence of Graves' disease.

Reviews and Notices of Books.

The Science and Art of Obstetrics.—By THEOPHILUS PARVIN, M.D., Professor of Obstetrics and Diseases of Women in Jefferson Medical College. Philadelphia: Lea Brothers & Co.

This scholarly and readable book, the work of an able and accomplished teacher, is in many respects a welcome addition to American obstetrical literature. As Lusk's Midwifery is largely an epitome of German views and methods, Parvin's book shews similarly the influence of the French school. While, as a rule, the teaching is sound, it is somewhat conservative in tone and frequently less decided and outspoken than might have been

expected from a man of such ripe experience. A stronger infusion of the personal element would enhance the value of the book. The chapters on Rupture of the Uterus and Puerperal Fever are somewhat disappointing, but those on Pelvic Deformity and Obstetric Operations, especially the forceps operation, are particularly good. On the whole, the work is a creditable production, and in subsequent editions the author will no doubt make such changes as will bring it fully up to the high standard expected of him.

A Manual of Obstetrics.—Ay A. F. A. KING, A.M., M.D. Third edition. Philadelphia: Lea Brothers & Co.

Dr. King's manual, originally prepared for his students in the Columbian University and the University of Vermont, has now reached its third edition. It is probably the best of the small obstetric manuals, and is popular among students. In judicious hands it may be of some value, but as a general rule the use of such manuals as text-books cannot be too severely condemned. The average student is apt to fancy that everything worth knowing in obstetrics has been "boiled down" into three or four hundred pages; he accordingly sets to work to cram down the condensed mass, hoping to digest it at his leisure. As he rarely manages to assimilate it, superficiality of attainment and crudeness of thought are the inevitable result.

Drug Eruptions: A Clinical Study of the Irritant Effects of Drugs upon the Skin.—By PRINCE A. MORROW, A.M., M.D., Clinical Professor of Venereal Diseases; Consulting Surgeon to the Bellevue Out-door Department, &c. With one lithographed plate. New York: William Wood & Co.

The untoward effects of drugs is a subject which has received but scant attention until recently. It is, however, a subject that will well repay the practitioner's earnest study. How frequently we are compelled to give up the appropriate treatment of a case owing to the appearance of some untoward effect? Among the most frequent and annoying of these effects are those that result

either from the direct or remote irritation of the skin. It frequently happens that our most valuable agents, when ordered in pressing cases, are attended by such disagreeable effects on the skin that their discontinuance becomes a necessity. As instances, we might mention the intolerable itching that at times attends the administration of morphine; the disfiguring acne that so commonly results from the use of bromides and iodides; the painful and distressing dermatitis that sets in both from the local and remote effects of mercurial preparations. By judicious administration these effects can often be prevented. Dr. Morrow has rendered an important service in collecting from the mass of literature what is known on this subject. His work must have been one of great labor. He has, however, performed it well.

Practical Pathology.—By JOHN LINSAY STEPHEN, M.D., Assistant Physician to the Western Infirmary. Glasgow: MacMillan & Co. Toronto: Williamson & Co.

This little book, like sundry other little books recently published on the same subject, shews a decided tendency to give undue prominence to the description of microscopical methods and appliances at the expense of equally important coarser changes and methods, which are very briefly disposed of. Otherwise it is an excellent small handbook, the style is easy, yet clear and concise, and the author evidently a thoroughly practical man. It has no illustrations; the descriptions being intended to be read while actually studying specimens of the diseases to which they refer.

Handbook of Practical Medicine.—By DR. HERMANN EICHHORST, Professor of Special Pathology and Therapeutics and Director of the University Medical Clinic in Zurich. Vol. II—Diseases of the Digestive, Urinary and Sexual Apparatus. Vol. IV—Diseases of the Blood and Nutrition and Infectious Diseases. New York: Wm. Wood & Co.

This work, which has been issued in several numbers of Wood's library of standard authors, furnishes an admirable exposition of

practical medicine as taught in Germany. Its author is one of the well-known teachers and writers of that country. It is necessarily much condensed, but it is surprising what an amount of ground has been gone over, expressing the author's views on most of the important points concerned in the subject treated of. The present numbers contain especially interesting chapters upon tuberculosis, syphilis, rickets, blood disorders, and the diseases of the stomach, with the modern methods of their diagnosis and treatment. Many illustrations are introduced, a large proportion of which are taken from original observations.

Bright's Disease and Allied Affections of the Kidneys.—By CHARLES W. PURDY, M.D., Queen's University, Professor of Genito-Urinary and Renal Diseases in the Chicago Polyclinic, etc. With eighteen illustrations. Philadelphia: Lea Brothers & Co.

This volume contains a systematic, practical and concise description of the pathology and treatment of Bright's disease and the affections of the kidney allied to it and sometimes included under the same term. The writer has evidently made prolonged observations upon these diseases, and furnishes very clearly the results he has arrived at. Although, as we should expect, these are mainly corroborative of the accepted doctrines, yet on many points it will be found that the author will not blindly follow high authority, but thinks and argues for himself. The classification adopted is a very simple one, and yet includes practically all the essential divisions of the subject. Having cleared the road by introductory chapters upon albuminuria and uræmia, thus avoiding much subsequent repetition, the following are treated of in separate chapters: Acute and Chronic Nephritis, Scarlatinal and Puerperal Nephritis, Cirrhosis, Lardaceous Degeneration, and Cyanotic Induration. On the subject of uræmia, much importance is claimed for persistent observation of the average daily amount of urine, the contention being that a greater or less degree of oliguria always prevails when uræmia is being induced, apparent exception to this rule being otherwise explained. In regard to the treatment of uræmia, the usual

eliminative system is followed, but the special directions given appear to us very sensible and well-founded. No mention is made, in acute uræmia, of the employment of morphia subcutaneously, except for the arrest of actually-present convulsions. We have long been of opinion that this drug (or chloral) is most valuable when administered as a prophylactic in that stage of headache and active vomiting which so commonly precedes convulsions by some hours. The very important subjects of scarlatinal and puerperal nephritis receive all the prominence which is their due, and are ably treated. The book is a good guide to a general understanding of the phases of Bright's disease, and will serve well the practitioner who comes to it for assistance in the management and treatment of those formidable and common diseases.

Society Proceedings.

ONTARIO MEDICAL ASSOCIATION.

The seventh annual meeting of the Ontario Medical Association was held in Toronto, on June 8th and 9th, under the Presidency of Dr. Richardson of Toronto.

The forenoon of the first day was occupied with routine business.

The first business of the afternoon session was the President's Address. Dr. Richardson dealt for the most part with the recent advances in bacteriological investigations, especially dealing with the labors of Pasteur and Koch.

The first paper read was by Dr. Fenwick of Kingston, on *Lacerations of the Cervix Uteri*, an abstract of which appears on page 712.

Dr. Groves of Fergus then read a paper on *Prostatotomy*, (see page 715).

Dr. Ferguson of Toronto gave an account of a case of neuritis, supposed to be due to the medicinal administration of Fowler's solution of arsenic.

Dr. Arnott opened the discussion on medicine by reading a paper on *Phosphaturia*, for an abstract of which the reader is referred to page 717.

Drs. Bruce Smith of Seaforth, McDonell of Orillia, and Thorburn of Toronto, followed in the discussion of this subject.

Dr. George Henry Fox of New York read a much appreciated paper on *The Surgical Treatment of certain Skin Diseases.* This was illustrated by cases and large photographs. He discussed the use of the lancet in indurated acne and hypertrophic rosacea, the use of the electrolytic needle in destroying various forms of naevus and in removing superfluous hairs, and the use of the scarifying knife in lupus and of the curette in epithelioma.

He presented two interesting cases from Dr. Graham, of Toronto practice, which were only amenable to treatment by surgical procedure. One was an extensive naevus of the cheek and eyelid, the deeply pigmented skin being covered with hair and numerous warty excrescences. The other was a lupus of the cheek, on which Dr. Fox had operated the same day at the Toronto hospital, by the method of linear scarification, the knife used being of kidney shape, and peculiarly adapted to this purpose.

Dr. S. S. Murray (Thorndale) related a case of *Laceration of the Femoral Artery.* On Feb. 18, 1885, J. Mc. was gored by a bull (a short-horn); the upper wound was eight or nine inches long, extending into the femur at its deepest part and an inch and a half outside the femoral artery. The tip of the horn must have passed between the artery and anterior crural nerve, tearing open the sheath and stretching and lacerating the femoral artery; the femoral vein was not injured. There was no hemorrhage from the main artery, but just at the lower edge of Poupart's ligament there was a spot on the artery about a quarter of an inch in size, like a hard, black scab. Below the apex of Scarpa's triangle the horn had passed through the thigh nearly parallel with the upper wound, and the tissues between these wounds sloughed away. The artery could easily be lifted up with the finger. The upper wound was above the profunda; the pus at one time burrowed up under Poupart's ligament. The usual antiseptic treatment was followed, and the wound healed by granulation; the blue line gradually c ept down until

the artery was covered. Of late the patient at times complained of a sensation of numbness and as if the place had torn open again, after sitting a length of time.

DR. GERSTER, of New York, read a paper on *The Antiseptic principle as applied to the treatment of the primary induration and the initial sore of syphilis.* An animated discussion followed, in which Drs. Porter of New York, Canniff, Teskey and McFarlane of Toronto, took part. We hope to be able to present our readers with an abstract of this paper in our next number.

DR. HOLMES (Chatham) read a paper on *Puerperal Fever.* After referring to the various generally recognized causes, he read reports of six cases which were shown to have been due to the presence of damp, stagnant air in the lying-in room. The cases were all marked by frequent, irregular chills and fever, and in all respects resembled cases of true puerperal septicæmia. The six women were confined in houses having no sewer connections, but having the space between the ground and the sills boarded up tightly so that there was little or no circulation of air beneath the houses. The land on which the houses were built was level, low and undrained, and the soil under them was found moist even in dry weather. Four of the cases occurred in the same block, three in adjacent houses, within a year, and two of the four proved fatal in spite of every effort of the writer and of other physicians who saw them. Antiseptic intra-uterine injections faithfully tried did no good, but, on the other hand, were so frequently followed immediately by chills that some of the patients became afraid of their use. All measures proving unavailing in the last two cases, Dr. Holmes had them removed to houses with good sanitary arrangements, when immediate improvement began and went on to complete recovery. The convalescence was so prompt and unchecked in the cases removed as to leave no doubt that it was due entirely to the change of air.

DR. PACKARD of Philadelphia read a very elaborate paper on *Our views of the Surgeons of the Past Century.*

DR. YEOMANS narrated the following case of *Acute Intestinal Obstruction:*—The patient, a strong, healthy farmer, engaged

in active, physical labor and exposed to wet, cold weather for some days, was suddenly taken sick with a violent chill and symptoms of enteritis. I saw him on the 22nd of April last, and noted the following symptoms: Pulse 98; temperature 100°; severe pain in the umbilical region; no tympanitis; a "sausage-shaped" tumor extending from the right iliac fossa upwards to the right hypochondrium; extreme tenderness on the right side, especially about the cæcum. Enemata of castor oil and soap-suds brought away no fæces.

April 25.—Pain, tenderness and high temperature still continued; somewhat relieved with powders of opium, bismuth, etc., and hypodermic injections of atropia and morphia. An enema of olive oil, injected through a long rectal tube, was administered, with no beneficial effect. The hips were elevated and about two pints of warm water injected through the rectal tube. This large quantity was retained for a few minutes and then came away without any appearance of fæces.

April 26.—Pain, tenderness and tympanitis had all increased. Patient was becoming exhausted; hands and arms cold; pulse rapid and small. Following the suggestion of Dr. Ashurst, as contained in his chapter of "International Encyclopædia of Surgery," I tried venesection, taking from the arm one and a half pints of blood. About noon next day a spontaneous, free evacuation of the bowels occurred, with evident relief and mitigation of the symptoms. The patient complained of no discomfort from the loss of blood. Hardened fæces, which had apparently been impacted in the bowels, continued to come away for two or three days, at intervals of a few hours.

May 1.—The tympanitis which had commenced in the right iliac region now extended across the abdomen to the left side, causing shortness and difficulty of breathing.

May 4.—Tympanitis and distressed breathing increased. Upon careful examination and palpation there appeared to be a circumscribed accumulation of pus immediately over the cæcum. I introduced the aspirating needle and drew off about four ounces of pus, with some bubbles of gas having a fæcal odor. This seemed to relieve the distressing pain and tympanitis. Convalescence was followed by complete recovery.

Second Day.

Dr. Lett of Guelph read a paper on *The Relations of Masturbation to Insanity*, an abstract of which appears on page 719.

Drs. Roseburgh, Oldwright, Powell and McDonell joined in the discussion which followed the reading of this paper.

The discussion on Surgery was opened by Dr. Strange, of Toronto, who dealt with the surgical treatment of whitlow, erysipelas and carbuncle. Drs. Gerster of New York, Richardson and Ferguson of Toronto, took part in the discussion.

At the conclusion of this discussion, the Hon. G. W. Ross, Provincial Minister of Education, entered the room, and was invited by the President to a seat on the platform.

Dr. J. E. Graham of Toronto read a very carefully prepared report of a fatal case of *Herpes Zoster* that lately came under his observation. Full details were given of the changes found in the affected nerve areas.

During the afternoon session, Drs. Porter and Satterthwaite of New York read papers; the former *On the Etiology and Pathology of increased body heat, in relation to disease, and the use of antipyretics;* and the latter on the so-called *Uric Acid Diathesis.* We hope in our next number to be able to give abstracts of these two valuable papers.

Removal of the Uterine Appendages.—Dr. Adam Wright treated this subject in three aspects: 1. Operation for the relief of nervous diseases. He thought that generally it was unjustifiable; but exceptional cases might occur where life or reason became endangered, when such interference might be considered advisable after careful deliberation and consultation. 2. Operation for bleeding uterine fibroids. He thought it the best and safest procedure when dangerous hemorrhages could not be controlled by medicines. In the great majority of such cases it stopped the hemorrhages and frequently reduced the size of the tumors. 3. Operation for diseased conditions of the appendages, including, especially, hydro-salpinx, pyo-salpinx and hæmato-salpinx. He advised the operation when a persistent attempt to relieve the symptoms, according to methods such as those advised by Emmet, had failed.

DR. POWELL (Ottawa) read a short paper on *Pelvic Hæmatocele of the Extra-Peritoneal variety*, often termed *Hæmatoma*, recording an unusual case which recently came under his observation following immediately upon delivery at full term, and making some observations upon it. Dr. Powell could not quite believe his case unique, as similar ones in most respects have undoubtedly been recorded, but his researches failed to discover one with similar details, especially as regards its interesting, rare and fortunate termination.

March 2, 1887—Was hastily summoned to Mrs. P. in labor, aged 25, healthy; fourth pregnancy. First normal and terminated at full term in September 1884; next two pregnancies ended in abortion. Enjoyed good health throughout gestation. Labor began about noon and terminated by a strong expulsive effort unexpectedly. It was precipitate, and child was born before Dr. P. arrived; no bleeding. Uterus contracted, and after delivering placenta, which was quite normal, Dr. P. left the house, leaving her comfortable in all respects; bowels had moved in the morning, and she had passed water. She began to suffer great pain within an hour, and a morphine powder was sent to her. At 5 P.M. Dr. P. was summoned. The morphine had not relieved her. She seemed to be suffering acutely—face blanched, features pinched, and appearance suggested a shock rather than an anæmia. Pain complained of entirely in lower rectal region and a desire to strain. Bandage had been unpinned, belly was prominent, and uterus could be felt high up over pubes. On vaginal examination, the whole pelvis was felt filled with a firm, tense, resisting, elastic tumor, which flattened vagina forwards against pubes. Os uteri could not be felt. Per rectum, same tumor felt, but rectum was flattened forwards and to one side, not on to sacrum. A hæmatocele was diagnosed, and the hemorrhage had no doubt been checked by the pelvic tissues and viscera, as is usual. A hypodermic of morphia and atropia was given in coccygeal region, which gave complete relief to the pain.

March 3—Seen in consultation with Dr. McDougall, and later on with Dr. H. P. Wright. They agreed with diagnosis, and to await events was decided upon; meanwhile pain was to

be relieved by hypodermics morning and night. Local condition just the same ; lochia natural. She was catheterized night and morning and a guarded prognosis given.

March 5—Patient said she felt relief early in the morning, and was not in nearly so much pain. On examination, to our surprise it was found that the blood had forced its way down by the rectum to the perineal fascia, and so on, spreading itself between the layers of cellular tissue under the skin of the inside of left thigh and over the buttock to near the hip joint, and no doubt between the layers of glutei muscles, as the left buttock felt full and boggy. Per vaginam, the remains of the hæmatoma could still be felt, but soft and yielding. From this time forwards she made a good recovery, and was up in about a fortnight, the remains of the blood tumor gradually absorbing; and when examined by Dr. Powell on May 2nd, no trace of the former mischief could be felt, and she was about her ordinary household duties.

Dr. Powell concluded his paper with some general remarks about the condition known as hæmatocele, and discussed it as bearing on his own case, quoting leading writers and observers.

A spirited discussion followed by the members, Dr. Moore of Brockville quoting a similar case occurring in his own practice, in which he aspirated through the vagina, emptying the tumor, and the patient recovered completely. Dr. Powell replied to the various speakers, and took issue with Dr. Moore on his treatment on the ground that unless there were some special indications for interference such collections should be let alone, and he thought it especially hazardous to operate immediately following a labor.

Dr. McDonagh of Toronto read a paper on *Tuberculosis of the Larynx*, dealing with the subject chiefly in its relation to pulmonary phthisis from a diagnostic point of view. After a reference to the frequency of laryngeal tuberculosis, shewing that it existed in fully 33 per cent. of phthisical patients, the history of a case in practice was related, in which there had been hoarseness and ulceration of the vocal cords for nine months before any disease could be detected in the lungs by physical examination. The purulent matter from the ulcerated surfaces

was removed by passing a dry brush into the larynx, and on examining the same with the microscope tubercle bacilli were found in abundance. Other cases of the same nature were referred to. It was contended that these cases afforded fair proof of the possible existence of primary laryngeal tuberculosis, but in order to advance positive evidence, the report of an autopsy made in the Toronto General Hospital was given, in which case tuberculous deposits were found in the larynx and not in the lung. The writer expressed the opinion that a case of phthisis may often be diagnosed by the laryngoscope earlier than by the stethoscope, and urged an examination of the larynx in all suspicious cases, and that, if necessary, a microscopical examination be made of the secretions.

The session was closed by an interesting discussion on Ophthalmology, which was opened by Dr Roseburgh of Toronto, and shared in by Drs. Ryerson, Palmer, Burnham, Reeve and others.

TORONTO MEDICAL SOCIETY.

Stated Meeting, May 19, 1887.

THE PRESIDENT, DR. NEVITT, IN THE CHAIR.

Adjourned discussion on Dr. Powell's paper.—DR. OLDRIGHT, in the course of the discussion, presented a patient on whom he had performed paracentesis thoracis in 1871. The syphon was inserted each day and the chest cavity washed out antiseptically until a cure was effected. The patient is now in good health, the expansion on the affected side being perfect. He regards syphon drainage as most effective, since if the free end of the tube be kept under water the bellows action of the chest is maintained.

DR. MCPHEDRAN congratulated Dr. Powell on the excellent results in all his cases. His method of drainage is ingenious, but there is probably nothing to be gained by it. If the suppurating cavity can be well drained a free opening is preferable, and to obtain such, a portion of a rib should, if necessary, be removed. The entrance of air under such circumstances can do no harm, and washing out of the cavity will not be required. He thought the cases were few in which much could be effected from

aspiration, unless under exceptional circumstances it would seem advisable to resort to free drainage at once, not only as the most certain means of effecting a cure, but also on account of the importance of relieving the lung from compression, and thus prevent, as far as possible, its being bound down by adhesions. The parabolic curve of the upper margin of the area of dulness that obtains in many cases of moderate effusion is doubtless due to the elasticity of the lung, as explained by Broadbent, Ellis and others. As the fluid is effused the lung contracts by virtue of its own elasticity, as it does when the chest is opened to the admission of air. This contraction is greatest upward, inwards and backwards, and thus tends to leave most space between the lung and chest wall in the axillary region, and in this the fluid collects chiefly. With this limited amount of effusion there is no compression of the lung, only a contraction of it, due to its own elasticity. This disposition of the fluid would indicate that the lower parts of the axillary region should be selected for making drainage; if the patient were confined to bed, the opening should be made back near the apex of the scapula, as the fluid would gravitate backwards more or less. In cases of old thoracic fistula, exsection of the ribs (Estlander's operation) should be resorted to. It had been done lately with very good results by Drs. Park of Buffalo and Gerster of New York. It has been successfully resorted to in some cases of pyopneumothorax, and offers the only ground of hope in this disease.

Dr. Atherton said—In looking over my notes on cases of empyema, I find that I have treated since 1874 eight patients suffering from this disease. Their ages, taken in regular order, were 24, 19, 40, 21, 10, 8, 2 years and 11 months, and 16. Out of these the one aged 40 died, about ten weeks after operating on the chest, from an atack of purulent diarrhœa, set up by eating a lot of green things contrary to my strict orders. The empyema in her case followed a few days after the opening of a pelvic abscess; and previous to her indulgence she had very much improved in her general condition, being able to get down stairs for the first time subsequent to the attack of pelvic inflammation. The side was still discharging somewhat at the time of seizure with bowel trouble, and she succumbed after twelve

days of diarrhœa, which was uninfluenced by any treatment. My first and fourth cases were still living at last accounts, with fistulous openings in side, it being more than ten years since I operated on them. Both of them had symptoms of pleuritic effusion lasting more than a year before coming under my care. One of them I tapped five times in the course of two years, the intervals between the tappings being, on two occasions, as long as nine months, and the increase of weight was as much as 15 lbs. Finally, however, after the last tapping symptoms of severe inflammation arose, and I was forced to make a permanent opening. My other five remaining cases all fully recovered in from six weeks to three months after opening the chest. The last one of them was a boy aged 16, who had about ten weeks before got a bit of nutshell in right bronchus, where it set up ulceration and suppuration of right pleural cavity. The piece of shell was expectorated eleven days before the chest was opened, but he continued to spit up most horribly offensive pus, and at the time of operation he seemed nearly moribund, there being general anasarca, and his respiration being fifty per minute. About two quarts of fœtid matter were removed, and I was informed that in a few weeks he was able to be out and at light field work. As to prognosis in cases of empyema, there can be no doubt the two chief factors to be taken into account are the age of the patient and the length of time during which the chest has been distended previous to operation. If the pleural cavity has been full of fluid for a year or more, and the patient is eighteen years of age or upwards, the best results attainable, without a resort to Estlander's operation, is recovery with a permanent fistula. Even patients younger than the above would likely be a long time subject to some discharge. In younger persons, however, where the disease has been going on less than six months, my experience would lead me to expect a perfect recovery in from six weeks to three or four months. In only the first one of my cases did I wash out the chest cavity; and as I found this procedure was somewhat annoying in the patient's weak state I omitted it after the first week, and have never resorted to it since. I consider that the free ingress and egress of a volatile antiseptic as applied on the dressing produces much the same

effect as the use of antiseptic washings. Besides, the latter are known more than once to have been attended by sudden death; and they are now, I think, very generally condemned during the first few weeks of treatment. When, however, fistulæ remains for a long time they are permissible with a view of drying up any small cavity which may be left. During a recent discussion upon the subject of empyema in the London Medico-Chirurgical Society, a large proportion of the speakers expressed themselves as opposed to washing out the pleural cavity after operation, and none of those present spoke in its favor. I am strongly of the opinion that all of these cases should be treated with the strictest Listerian precaution, including the spray.

DR. MACHELL related several successful cases of pleurotomy for empyema.

In closing the discussion, DR. POWELL urged the more frequent use of the hypodermic syringe for diagnostic puncture in cases of doubt as to the presence of fluid in the chest. It is by the very early detection of empyema that we are placed in a position to treat it most successfully. No hard and fast rules for operating can be laid down. The indications are clear, and that method is best which most fully meets them. Free incision, with drainage into antiseptic absorbents, will most frequently be called for.

Acute Recurring Endocarditis.—DR. W. H. B. AIKINS presented a *Heart* with greatly dilated right auricle, hypertrophied left ventricle, and a considerable stenosis of the aortic orifice due to thickening, partial calcification, and adhesions of the aortic valves with one another. There were numerous small, recently-formed vegetations on the free margins of the valves and one or two spots of erosion. Years ago the patient had organic heart trouble, with intermissions of tolerable good health. When seen for last illness she was suffering from a facial erysipelas, the temperature not rising higher than 103°; as the fever was subsiding the cardiac symptoms became marked and distressing, with, for a short time, pain in and swelling of the left arm. The action of the heart was irregular, apex beat diffused and displaced outwards, an aortic systolic murmur was distinctly heard. It was supposed that the erysipelas caused a general sepsis,

which resulted in the *materies morbi* being deposited on the valves and giving rise to a fresh endocardial infection, although, on examining the valves for micro-organisms, the *streptococcus erysipelatis* was not observed.

Cystic Tumor.—DR. R. B. NEVITT then showed a tumor removed from the upper and inner aspect of the thigh of a man aged 40. The tumor had appeared as a hard, round, moveable nodule, and had gradually assumed its present dimensions—about six inches in length and the same in circumference—containing three or four cysts. The lower portions were ulcerated and sloughing, and an inflammatory zone surround the lower third of the tumor. Thirty minims of a four per cent. solution of cocaine were injected in the line of the proposed incision and the tumor removed. The blood supply was large, one vessel the size of the internal pudic requiring ligature, and two other smaller being twisted. The pedicle peeled clearly from the connective tissue of the sheath of the adductor. There were several other tumors on the body—one on the opposite side, one on the same thigh, one on the back, and one on the face.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 11th, 1887.

DR. WILKINS, 1ST VICE-PRESIDENT, IN THE CHAIR.

DR. GEO. H. FOX of New York, DR. PHELPS of Chateauguay, and DR. JACKSON of Brockville were present at the meeting.

Common Errors in the Treatment of Skin Diseases.—DR. FOX read a paper on the common errors in the treatment of skin diseases. He said that the great error made by practitioners in treating skin diseases was failure to treat the patient; the disease is treated, not the patient. It is most important that the patient have fresh air, wholesome food—in short, everything that tends to improve the general health. Special treatment of the disease is of no avail without improving the condition of the patient. He regarded attention to the diet as most important, and said there should be a radical change both in the quantity and quality of the food; a strict course of diet should be given the patient; the majority of patients improve on starvation diet.

He advised his patients to increase the quantity of fluids taken and decrease the solids; to eat less and exercise more. A change of diet almost invariably proves of value, the more radical the better; he gets the best therapeutical effects from a vegetable diet in the treatment of inflammatory skin affections. A meat diet congests the skin; a vegetable diet relieves the congestion. He is in the habit of restricting the meat in winter and forbidding it in summer. In giving directions to a patient it is better to tell them what to eat than what to avoid. Water should be taken sparingly at meals, but in quantity between meals. In speaking of local applications, he said that very few are needed. If the disease be acute, soothing applications should be given; if chronic, stimulating ones. Infantile eczema is, as a rule, too much stimulated, and chronic eczema with infiltration too little stimulated. In treating psoriasis, chrysophanic acid is the best remedy, but even this agent should not be used in every case, as it does positive injury where there are congestion and inflammation, but later, when the eruption becomes dry, it does good. In acne a tonic treatment is best. In speaking of local applications, the reader of the paper stated that when the substance is needed to be absorbed by the skin, then the animal fats should be used; when mere protection is wanted, then vegetable fats do very well. Vaseline has but little power of penetrating the skin. He then went on to speak of arsenic, which, he said, is used too much by the general practitioner in the treatment of skin diseases, and which, as regards skin diseases, would not be missed if abolished from the pharmacopœia; he now rarely uses it. It is at best a much over-rated remedy, and its indiscriminate use in skin diseases is fraught with evil.

Discussion.—Dr. Shepherd said he was not prepared to go the length Dr. Fox did in attributing such a vast influence to diet in the treatment of skin diseases. No doubt it is often of importance, but he thought that Dr. Fox, like many others, was riding his special hobby too hard. Did not think that individuals among the poorer classes with eczematous diathesis or when the disease was due to their occupation could be cured by dieting. No doubt people eat too much, and this is especially true in the higher ranks of society. In such patients diet is of the utmost

importance. In this country people eat too much meat, and he is in the habit of limiting it to one meal a day. In regard to local applications, he was thoroughly in accord with Dr. Fox. Most physicians in inflammatory diseases stimulate too much. It is a common thing for physicians to prescribe zinc ointment in every case, and give no directions about the use of soap and water. He found many skins in the acute stage of eczema unable to bear ointments at all, and to be much relieved by mild lead lotions. He also agreed partially with Dr. Fox concerning the misuse of arsenic; it, like zinc ointment, is prescribed in routine practice by many practitioners. Though of little value in eczema, he thought he had given it with good effect in psoriasis and bullous eruptions. He had no hesitation, however, in stating that it was a most valuable tonic, and he would be sorry to do without it.

Dr. Howard said that the paper presented but few novelties in the present state of the science of medicine. Skin diseases are but local manifestations of a general condition, and it is but natural that the most successful treatment would be an alterative one, aimed at the cause of the unhealthy condition of the skin. He was not prepared, however, to hear that so much attention is given to diet, but it seems only rational. Chronic diseases generally require dietetic treatment, so one should not be surprised to find it efficient in chronic forms of skin diseases. Formerly arsenic was given for all forms of skin disease. He agreed with the last speaker in thinking that arsenic was valuable as a tonic, and he had obtained good results from its use in psoriasis and bullous affections.

Dr. Hingston said that for the last ten or fifteen years he had practically abandoned local treatment in skin affections and used only constitutional, and had always regarded a carefully regulated diet of the first importance. He could not agree with Dr. Fox in what he said about a meat diet. The French Canadians are great meat eaters, yet they were remarkably free from skin affections. Some, however, visit the United States, work in factories, and live in boarding-houses where the diet is largely composed of hot biscuits, doughnuts, pies and pastry, and live in small rooms; then come back with skin diseases which cannot

be due to a meat diet. The speaker attributed most of the skin affections he had met with to want of fresh air and use of highly-spiced and other forms of irritating food, while not a few cases could be traced to the excessive use of green tea. Bread and meat he considered a good diet in skin diseases; he also believed in taking large quantities of water between meals.

DR. PHELPS said that as a general practitioner in the country he could endorse every word Dr. Fox had said. He believed most thoroughly in a complete change of diet in skin affections. He had even found a change from a good diet to an apparently bad one beneficial. He mentioned some severe cases of infantile eczema which were completely cured by changing the diet from fresh cow's milk to condensed milk. Acne in females is very generally caused by uterine disease, and until this is cured the acne cannot be relieved.

DR. LAPTHORN SMITH said he had long held that all skin diseases not parasitic or specific were due to errors in diet. He had little faith in local treatment, but considered that it is most important to attend to the condition of the stomach. He thought that the good old mixture of rhubarb and soda is too much neglected in the treatment of skin diseases.

DR. MILLS believed Dr. Fox's paper to be of great importance to the medical public. He regarded Dr. Fox as a type of a specialist, who, though a specialist, treats his patients from a broad knowledge of general medicine and dietetics. To this in no small degree he believed Dr. Fox's successful career to be due.

DR. WILKINS asked if Dr. Fox believed in an exclusive milk diet in eczema; also if in penitentiaries, where the diet was regulated, was there less skin disease. He also asked if in Germany, where little meat is eaten, there is a less amount of skin disease.

DR. FOX, in reply, stated that he did not so much object to meat as an article of diet as to its excessive use. He had found the most obstinate cases of eczema yield to a complete change of diet that was only temporary. With regard to milk diet in eczema, he formerly believed in it, but found many patients could not take it. He had tried it on himself, and found he was

unable to stand it for more than a few days. The excessive amount of skin disease in Germany could be accounted for by the habitual use of cabbage and beer as articles of diet. He found beer very injurious in inflammatory skin affections, much more so, indeed, than whiskey. Rhubarb and soda he regarded of great use, but are prescribed too much in a routine manner in dispensaries and hospitals. One must always treat each particular case, remembering that what is suitable treatment in one case may be positively injurious in another patient with the same disease.

DR. HOWARD, in proposing a vote of thanks to Dr. Fox, referred to the great privilege the Society had enjoyed in so being brought in contact with a man of such extensive experience. In Dr. Fox's paper there was nothing new, and in saying this he paid him the highest possible compliment, for the whole tendency of his paper was to illustrate the great scientific truth that in medicine we cannot treat the disease. We must treat the individual, the constitution. He was struck by the effect of change of diet, as shown by the numerous examples quoted by the previous speakers in breaking up the sequence ol disease ; one speaker even advising the use of peaches as an article of diet.

DR. HINGSTON seconded the motion. In the course of a few happy remarks he referred to the effect that the present fishery dispute might have in lessening the supply of a wholesome article of food in the American market.

It was then moved by DR. TRENHOLME, seconded by DR. LAPTHORN SMITH, that Dr. Fox be made an honorary member of the Society. This was carried unanimously.

BRITISH COLUMBIA MEDICAL COUNCIL.

A meeting of the British Columbia Medical Council was held in Victoria, B.C., on Tuesday and Wednesday, the 7th and 8th of June. There were present—Dr. Trew (New Westminster), President ; Dr. Milne (Victoria), Registrar ; Drs. Harrington (Victoria), Powell (Victoria), McGuigan (Vancouver), Davie (Victoria), and Tunstall (Kamloops).

It was decided that hereafter the meetings of the Council should be held semi-annually, and alternately at Victoria and on

the mainland. The meetings on the mainland will be held alternately at New Westminster and Vancouver.

It was also decided to have printed the proceedings of the Council from the time of its incorporation, together with the British Columbia Medical Act and amendments thereto.

After examination, the following gentlemen were admitted upon the register: Dr. J. A. Duncan (Comox), Dr. Ebberts (Wellington Mines), and Dr. A. M. Robertson (Vancouver), while Dr. Farrar (Kamloops) was registered without examination on a British diploma.

Extracts from British and Foreign Journals.

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

An Anomaly of the Cord.—On the evening of April 22nd, 1887, I was called to attend Mrs. S. S. in her sixth confinement. The labor was in all respects normal, child healthy and well developed. On delivering the placenta I found a condition of things I think sufficiently rare to warrant publication. The placenta was normal in size and general appearance, attached at the fundus uteri, and rather easily expelled. The umbilical cord was normal in appearance, twenty-six inches in length, and bifurcated. The bifurcation, in two distinct branches, began fourteen inches above the insertion of the navel, one branch being inserted at the right side of the placenta and the other at the left, with no intermediate ramifications to the placental structure. On close examination we found the umbilical vessels at the bifurcation very nicely branched, each "limb" of the cord containing its vein and accompanying arteries. The mode of formation of such an anomaly is readily comprehended when we remember that all modifications of the cord "depend on the way in which the allantois contracts its adhesions with the point of the ovum in contact with the womb. The placenta is always developed somewhere on the interior surface of the uterus, "and if the allantois happens to strike the chorion at a point somewhat removed from that which is in apposition with the internal uterine surface, the umbilical vessels must evidently have a tendency towards the latter, just as the roots of a plant always

stretch towards the spot which will afford them the most nourishment." Cases similar to the one reported above, although somewhat rare, have been recorded, and several obstetric authors have made a quite extensive study of the subject. Benckiser, in his thesis delivered before the French Academy, gave a very learned view of numerous cases of this anomaly that had been brought to his notice. M. Jules Colquet of Brussels has also written extensively on this subject.—*Dr. Wessinger in Medical Age.*

The Cause of Urethral Fever,—Mr. Reginald Harrison contributes a short paper on this subject to the July issue of the Liverpool *Medico-Chirurgical Journal*, in which he takes the ground that almost all cases of fever occurring after internal urethrotomy are due to poisoning from alkaloidal substances contained in the urine. His attention was first called to the urine as a possible cause when studying his notes of operations upon the urethra. He was struck, he says, by the fact that neither rigors nor fever showed themselves until after micturition had been naturally practised, or there was evidence that urine had found its way into the wounded urethra and was lodging there. This view was afterwards strengthened by the results of Bouchard's studies concerning the toxic elements of normal urine. This observer found that the urine contains a certain amount of the alkaloids formed in the intestines (ptomaines), which are absorbed by the intestinal mucous membrane and excreted by the kidneys. To the objection urged against this theory that rigors and pyrexia are not produced when extensive subcutaneous extravasations of urine occur, Mr. Harrison replies that the conditions are very different in the two cases. A mixture of blood and urine, such as is found after internal urethrotomy, he thinks, is capable of producing very different compounds from those that extravasated urine alone is likely to yield. Again, when urine is extravasated into the tissue, its action is that of a virulent local poison, under the influence of which the contiguous tissues are killed outright, probably before they can exercise any power of absorption. Another objection which might be raised is, that cases have proved rapidly fatal from urinary fever where there was no evidence that the urethra had sustained any appreciable lesion. The writer believes, however, that any statement that the urethra is free from injury should be received with

caution. Though the operator is not conscious of having inflicted a lesion on the urinary passage with an instrument which he has been using, nor the patient show evidence of it immediately, this by no means implies that a structural lesion on the urethra has not been inflicted. As a rule, he says, it is not the most difficult cases of catheterism which are most liable to urinary fever. In those in which structural damage is inflicted, or false passages made, the injury is usually on the distal side of the stricture, and consequently well protected from urine infiltration or contact. In such cases the amount of shock must be greater than that caused by the slight wound of a urethrotomy knife, which, Mr. Harrison asserts, is almost invariably followed by rigors and fever.

That there are other forms of pyrexia, such as the so-called irritative and the malarial, following occasionally the mere passage of a catheter or a sound, the author does not deny; but these have nothing in common with the severe urinary fever which is usually referred to nerve-shock, but which the author regards as caused by the absorption of poisonous matters contained in the urine.

The practical point of these views is the bearing which they have upon the prophylaxis of urinary fever. This can be prevented, Mr. Harrison maintains, by providing for free drainage of the bladder and removal of the urine as rapidly as it is excreted. This drainage is to be secured by means of a perineal section performed simultaneously with the internal urethrotomy. The author says that he has never seen rigors and fever after combined internal and external urethrotomy, so long as the bladder drainage of urine through the external perineal wound was free and uninterrupted. Fresh urine flowing freely over the glazed surface of a wound is innocuous, but when it is pent up, as in a urethral wound, it is apt to be speedily converted into a most destructive and poisonous agent. It is not improbable that Mr. Harrison's views of the causation of urethral fever are in the main correct; but the necessity of resorting in every instance to a perineal section is not so evident. The author's experience as to the frequency of this complication is certainly not that of most surgeons. He met with it so constantly that he was even led to practically abandon the operation of internal urethrotomy for a number of years, and resumed it only when he adopted the method of combined internal and external operation.—*N. Y. Med. Record.*

CANADA

Medical and Surgical Journal.

MONTREAL, JULY, 1887.

THE DEGENERATION OF NERVES AFTER SECTION.

In a paper by Dr. Shepherd in the January number of this JOURNAL, the results of secondary suture of nerves in several cases are reported. The subject is both instructive and suggestive. In one case the operation was attended with partial success after the lapse of nine years since the original division. Dr. Shepherd himself united the ulnar nerve in a case that presented itself in the Montreal General Hospital ten weeks after its division by an axe cut. The day after the operation there was "tingling feeling in the little and ring fingers and general and tactile sensibility was good." In 1884 Dr. Roddick sutured the sciatic nerve seventeen months after division. "The immediate result of the operation was the healing of two troublesome ulcers on the foot."

The above results, indicating an almost immediate restoration of the functional activity of nerves, the ends of which had been long sundered, are not easy of explanation. They seem inconsistent with the Wallerian law of degeneration. New and much-needed light has very recently been thrown on this subject. Dr. Prause, at a meeting of the Berlin Physiological Society, reported the results of his examinations in the human subject after operation, and in animals after experimental section of nerves. In a case of amputation just below the knee for gangrene of the foot, the nerve had degenerated, it was found, up to, if not beyond, the point of amputation; but some normal fibres were found. In the case of experimental section of nerves in animals, when both sensory and mixed nerves had been divided, it was found that in the peripheral part, while the ma-

jority of the fibres degenerated, a considerable number did not. The same applies to the central end of the nerve ; but the relative number of each kind is in inverse proportion to that in which they are found in the peripheral part. It therefore appears that one set of fibres degenerates towards the periphery and the other towards the centre. The assumption seems to Dr. Prause justifiable that those fibres which degenerate towards the periphery have their trophic centre in the spinal cord or brain, while those which degenerate centripetally have their trophic centre in the periphery, perhaps in the tactile corpuscles of Meissner.

At all events, while there is much still to learn on this subject, the results of the surgical cases referred to above, and of similar ones, find a much readier physiological explanation in the light of Prause's facts. It appears that there is not such complete degeneration of all the fibres of the nerve as was once supposed. Dr. Roddick's case illustrates the great influence of nerves over nutrition, and lends a certain degree of support to the doctrine of the existence of separate trophic fibres. A microscopic examination of some of these nerves after union following secondary suture might prove very valuable, if it could be secured.

COUNTRY RESORTS.

The opinion commonly prevails in the mind of the laity that the country is the place for health, and that a residence amidst the green fields or by the river-side for two months in the year will go far to increase the general health of the family and restore the bodily and mental wear and tear induced by the long winter —and truly it will. But, like many of the good things of this world, care and caution must be exercised in indulgence in it. Pater and mater-familias, before they decide upon a country-house, must bear in mind that other considerations are necessary in selection beyond the prettiness of the scenery, the boating advantages, or the time of starting of the trains. Most medical practitioners have found that when their patients return from these annual migrations many bring unpleasant reminiscences of their journeying in the shape of fevers and sore throats, and

often the town doctor has to visit outlying villages to find his child-patients stricken with one of the preventable diseases.

Our object is to point out to parents the wisdom of devoting their attention to the sanitary condition of our watering-places. Many of these villages are filled to repletion by an annual influx of thousands of new comers. Drainage does not exist in any of them. Water is drawn from that prolific source of disease, the shallow well, which drains a surface on which the universally prevalent privy pit is situated, and which in so many instances has been found to provide a water highly charged with organic matters. Privies in the country are notoriously dirty. In many of our country places dirty farm-yard, undrained stables and offensive cattle-shed are found to exist. The intending visitor should take the precaution to see that in addition to pure air, pure water is supplied to the family. The character of the milk supply should be looked into. Scarlet fever has been shown to come directly from the unhealthy cow, and greater care should therefore be taken in seeing that the dairy department is conducted upon true hygienic principles. The village to which the townsman and his family are going may itself contain cases of zymotic disease. We all know that diphtheria is rife in country parts, and typhoid disguised under various names is never entirely absent. A judicious exhibition of care in selection would not only benefit the townsman, but would exert a most salutary influence in enlivening the energies of the village folk, teaching them the wholesome lesson that an unsanitary state of their municipality and the existence of preventable disease will tend to diminish the revenue from summer visitors. Considerations such as these might with propriety be suggested to the heads of families by their confidential medical advisers, and if carried out would tend to prevent much of the unhappiness and misery which falls to the lot of the medical man to witness.

FUNERALS.

That we must all die cannot be denied; it is a necessity of our fallen nature, and we shall never be able to avoid it, but can avoid making our death a cause of danger to others. The

mode in vogue of conducting funerals in this city we must heartily denounce, as being not only in many cases a source of unnecessarily cruel expense to the afflicted family, but a most prolific cause of disease and death to those whom custom compels to join the melancholy procession to the grave.

There is an old superstition of Highland origin—indeed we believe it is mentioned in one of Sir Walter Scott's novels—to the effect that he who falls at a funeral will be the next to die. Now such a superstition is doubtless founded on fact, the man who falls being probably the weak man of the party, the one on whom the fatigue of the walking tells most. In Montreal it has been a matter of observation to us that after the death of an elderly and highly respectable citizen one or more of his contemporaries soon follow, and in many instances this is the effect of attendance at the funeral of the first. When an old man dies, the majority of those who follow the hearse are his old friends, and likely therefore to be of or about the same age—the pall-bearers certainly are. There is hurried preparation on their part to get to the house of the deceased, and clothing often quite unsuitable to the surroundings is donned. In summer the attendant exposes himself to the burning sun in his black, hot Sunday clothes and heavy tall hat, and in winter he can scarcely be too warmly dressed. In wet weather he will most certainly be damp from one end of the ceremony to the other. A fatiguing half-hour is commonly spent in standing about, in or near the afflicted house. If he stand inside, he breathes air vitiated by the presence of the corpse and the exhalations of often some hundred of his fellow-mourners. Standing outside is no less dangerous. A man of advanced years, with fatty heart or thickened arteries, is then compelled to take a long walk in muddy or slushy roads, perhaps in winter exposed to a very low temperature and to traverse a space longer than he has travelled over for years. The pace is slow, the surrounding circumstances of a depressing kind, and there is risk of chilling in winter and of sunstroke in summer. Churches, when used for burial services, are commonly most ineffectually heated. We have been in some where no attempt whatever was made to raise the frigid

air to a comfortable temperature. The church service is often very long, but long as it is, an end comes, and then the dangerous march is resumed. Those who drive to the cemetery incur fresh dangers. The way is long, the wind is cold, and, as we remarked, the mourner may be both infirm and old. The danger of chilling is again incurred on the homeward drive, and fortunate is Senex if he escapes entirely from the ordeal that custom has imposed upon him.

Cremation, as a general practice, is a long way off, and such a reform, desirable as it is, is not likely to be attained in our generation. We therefore advocate a modification of existing fashions, and venture to hope that before long this tedious and mischievous pomp and ceremony will be dispensed with, and that the weary may be laid at rest attended by a few loving friends and not by the long train of acquaintances we see at the present time, drearily trudging along our streets.

ARREST OF LABOR BY GASTRO-INTESTINAL FLATUS, NECESSITATING THE APPLICATION OF FORCEPS.

Prof. Bouchacourt of Lyons reports a rare and interesting case of accidental dystocia in the *Nouvelles Archives d' Obstetrique et de Gynécologie* (May 25th, 1887). The patient, a young woman of 23, married fourteen months, after once aborting came to her full time about 20th December, 1886. About the age of puberty she had suffered from dyspepsia and chloro-anæmia, but was in good health at the time of her marriage. During the course of her pregnancy she was troubled with nausea, vomiting, and a tendency to flatulence, which yielded readily to appropriate treatment. Labor began in the morning, the liquor amnii drained away about 9 A.M., and the head was found to be presenting in the first position of the vertex. About 5.30 P.M. slight vomiting occurred as the head cleared the cervix. The pains being very strong, the head well flexed came down rapidly upon the perineum and began to distend the vulva. All at once the pains ceased, the patient had neither the will nor the power to press down, and felt as if the child had receded into

the upper part of her abdomen. At the same time the abdomen suddenly distended with such a loud noise as to alarm those around the bed. She lay as if dead, and the fœtal heart sounds became rapid and feeble. Forceps were applied without delay, and a living female child delivered. In a short time she began to rouse up, and for nearly an hour kept noisily expelling from mouth and anus a quantity of intestinal gas. Convalescence was normal, except that about the fourth day as lactation began, the dyspeptic symptoms with flatulent distension returned. She ceased nursing and the symptoms disappeared. The urine examined a few days before confinement was free from albumen, but contained a little sugar, which had disappeared by the twelfth day when a second examination was made.

Prof. Bonchacourt considers the case unique, and is unable to find or to give a satisfactory explanation of the phenomena. He read the case before the Lyons Medical Society, and in the discussion which followed several explanations were suggested. The rapid diminution of abdominal pressure as the head suddenly cleared the cervix, hysteria, the effect of the previous chloro-anæmia, and a sort of flatulent idiosycrasy were variously suggested; while others thought a more probable cause to be the mechanical action of the head in compressing the rectum and preventing the exit of intestinal gas. The author is inclined to think that the mechanical element was only one factor in the case since the dyspeptic symptoms recurred when nursing began and disappeared when it was discontinued.

SIR JAMES ALEXANDER GRANT.

It is with great pleasure we record the fact that Dr. J. A. Grant, Ottawa, has been created Knight Commander of the Most Distinguished Order of St. Michael and St. George. This is the first instance of a Canadian physician being honored with the title of K.C.M.G. Dr. Grant was born in Inverness-shire, Scotland, on the 11th of August, 1830. He received his arts education in Queen's College, Kingston, and graduated in Medicine in McGill University, in 1854. He is a member of the Royal College of Physicians, London, and Fellow of the

Royal College of Surgeons, Edinburgh. Shortly after graduating he started to practice his profession in Ottawa, and in a very short time his energy and ability placed him in a distinguished position. He has been a physician to Lord Monck, Lord Lisgar, Lord Dufferin, Lord Lorne, and is now physician to their Excellencies of Lansdowne.

The distinguished subject of this notice has occupied, at various times, all the responsible and important positions that is in the power of the profession in Canada to confer on one of their own number. He is an ex-President of the Canadian Medical Association, and of the College of Physicians and Surgeons of Ontario. At the meeting of the British Medical Association last year, in Brighton, he had the great honour conferred on him of being made an honorary member of this great body. That Dr. Grant has been an earnest and devoted student of his profession, the following contributions from his pen, at various times during the past few years, abundantly testifies :—

1. Punctured wound, anterior lobe of Brain, 1856.—*Med. Chronicle, Montreal.*
2. Compound comminuted of Femur and Ligature Femoral Artery, 1857.—*Medical Chronicle, Montreal.*
3. Punctural wound of Pleura; Pleuritic effusion; Iodine injection.
4. Carcinoma Medullare, 1859.—*Medical Chronicle, Montreal.*
5. Notes of cases of poisoning, 1859.—*Medical Chronicle,* "
6. Twins with single Placenta, 1859.—*Medical Chronicle,* "

(*British Medical Journal.*)

7. Notes of Surgical cases, 1860.
8. Unique Anchylosis of knee joint, forward at a right angle, 1861.
9. Tetanus and Poisoning by Strychnine contrasted, 1861.
10. Obstruction of the bowels, appendix concretion, 1861.
11. Notes of Surgical cases, 1862.
12. Treatment of Rheumatism by Boletus Laricis Canadensis, 1862.
13. Notes of obstetrical cases, 1862.

(*Canada Medical Journal, Montreal.*)

14. Puerperal Mania, 1865.
15. Protracted uterine gestation, 1865.

(*Medical Times and Gazette, London.*)

16. Treatment of Skin Diseases, 1863.
17. Disease termed "Black Leg," as observed amongst Ottawa Lumbermen, 1864.
18. Excision of the Knee Joint, 1865.

19. Retrospect of the year 1876.—*Canada Lancet.*
20. Addresses delivered before the Bathurst and Rideau Medical Association, 1876, 1877, 1878 and 1879.—*Canada Lancet.*
21. Dermoid Cyst of the Ovary, 1879.—*Medical and Surgical Journal, Montreal.*
22. Cancer of the Breast, in its relation to Paget's Disease of the Breast, 1882.—*Medical and Surgical Journal, Montreal.*
23. Urethral Stricture and Perineal Section.—*Canada Medical and Surgical Journal,* 1886.
24. Aneurism of the Thoracic Aorta.—*Canada Medical and Surgical Journal,* 1885.
25. Address on Medicine. Medico-chirurgical Society, Ottawa, 1885. *Canada Lancet.*
26. Uterine Fibrous Polypus.—*Canada Lancet,* 1881.
27. Aphasia or Alalia.—*Canada Lancet,* 1881.
28. Gymnastics of the Brain.—Canadian Medical Association and *Lancet,* 1880.
29. Epidemic Zymotic Diseases of Animals and how they are communicated to man.—*Canada Lancet,* 1885.

CANADIAN MEDICAL ASSOCIATION.

The twentieth annual meeting of the Canadian Medical Association will be held in the city of Hamilton, on Wednesday, the 31st August, and Thursday, September 1st. The following discussions will be held :—

1. On " Empyema," by Dr. McPhedran of Toronto.

2. Dr. Grasett of Toronto will open a discussion on some surgical subject.

3. " Subinvolution of the Uterus," by Dr. Eccles of London.

4. " The present state of Cardiac Therapeutics," by Dr. Jas. Stewart of Montreal.

The following are the officers of the Association for the present year :—

President—T. K. Holmes, M.D., Chatham.
President elect—J. E. Graham, M.D., Toronto.
General Secretary—James Stewart, M.D., Montreal.
Treasurer—Charles Sheard, M.D., Toronto.

ONTARIO MEDICAL ASSOCIATION.

The seventh annual meeting of the Ontario Medical Association proved one of the most successful gatherings ever held by this body. The attendance was good and the attention keen.

The president, Dr. Richardson of Toronto, occupied his position with credit. We think he was unfortunate in the choice of a subject for his address. Modern bacteriology is not a subject that can be handled easily, even by an expert, to the satisfaction of a general professional audience. One of the most noticeable features of the meeting was the presence of a number of prominent American physicians and surgeons. Their contributions contributed not a little to the scientific success of the meeting.

A UNIQUE WORK ON CANADIAN TOPICS.

Mr. Erastus Wiman, President of the Canadian Club, writes as follows:—

"It is the intention of certain members of the Canadian Club, in New York, to issue, in the form of a beautiful book, the papers which have been delivered before the Club during the past winter by prominent parties, together with those which are to be delivered during the remainder of the season.

"These papers will include a speech on 'Commercial Union,' by the Hon. Benjamin Butterwork, member of Congress, who is said to be one of the most eloquent men of that body. A remarkable production by Prof. Goldwin Smith on 'The Schism in the Anglo-Saxon Race.' A paper by Dr. Grant of the Queen's University on 'Canada First.' One by J. W. Bengough, editor of Toronto *Grip*. By Mr. LeMoine of Quebec, on 'The Heroines of New France.' By J. A. Fraser, 'An Artist's Experience in the Canadian Rockies.' By Edmund Collins, on 'The Future of Canada.' By Professor G. D. Roberts, of King's College. By George Stewart, jr., of Quebec. By the Rev. Dr. Eccleston, on 'The Canadian North-West.' By John McDougall, on 'The Minerals of Canada.' And by the editor, G. M. Fairchild, jr., on 'The History of the Canadian Club.' The work will also include extracts from the speeches and letters of the President.

"The book is to be issued in beautiful style, at $1 per copy.

"A great many Canadians will doubtless desire to possess themselves of this rare compilation, and, by purchasing copies, indicate the interest which is manifested throughout Canada in the attempt of the Canadian Club to lay before Americans the resources, advantages and attractions of their native country.

"Parties desirous of obtaining copies can do so by enclosing the price of the book to JAMES ROSS, Canadian Club, 12 East 29th Street, New York."

NOTES AND COMMENTS.

Is there a true heart-strain? Early on the morning of the 11th ult., I was sent for to see Mr. A., aged 51, an active business man, not obese, but an unusually gross eater. He had always been healthy and in December had placed very large additional insurances on his life. On Monday, the 6th, he was very constipated and had strained violently at stool for over half an hour. His son, a physician, said he was livid and much exhausted after the effort. From this time he presented the following symptoms: Shortness of breath, feeble circulation, cardiac pain, sleeplessness and gastro-intestinal disturbance. On Friday night his physicians noticed Cheyne-Stokes breathing and he was extremely restless. At 7 A.M. when I saw him he was rational; pulse 140, extremely small; hands mottled. After 25, 30 or 40 seconds of rapid and increasing breathing, there followed 25, 30 or 35 seconds of absolute cessation, during which the heart would droop and the pulse become smaller. The heart sounds were extremely feeble and rapid, no murmur, no gallop-rhythm. At aortic cartilage a rat-tat-tat of clear, sharp sounds like the fœtal heart. Dulness not much increased. At 11 A.M., still conscious; Cheyne-Stokes rhythm persists. Apex beat more punctuate at, and a little outside, the nipple. Sounds sharp and clear. The hypodermics of ether and strychnia, with counter-irritation, seemed to have temporarily strengthened the action. The urine was scanty and careful examination showed slight amount of albumen and a few tube casts. In the evening mental condition not so good; wanders. Has no pain, complains of no distress and *looks* remarkably well for a man in his critical state. No change in heart symptoms. Cheyne-Stokes breathing persists. He died in the night.

As an autopsy was not allowed, we have no knowledge of the exact anatomical condition, but I think this may be regarded as an instance of 'over-strain' on a heart, the seat of secondary changes in a latent Bright's disease. The prolonged efforts at stool, doubtless caused an acute dilatation, with strain of the heart muscle, and the development of a condition of cardiac

insufficiency with imperfect and ineffective contractions leading finally to asystole and death. Leyden has recently written upon this subject, and an abstract of his views will be found in our Reports on Progress, in the *American Journal of Medical Sciences* for Oct. 1886.

The term *spurious*, used now in connection with traumatic aneurism, has also been applied to those instances of dilatation and pulsation of larger vessels which not infrequently simulate aneurism so closely that the greatest caution must be exercised to avoid error. The words 'mimic' and 'phantom' define even better, and with less confusion, the same condition. It is met with particularly in the abdominal aorta, and it is not too much to say that for one true aneurism of this vessel there are twenty or more instances of mimic dilatation. In neurotic, hysterical women, the condition is extremely common, and in anæmic, debilitated states, the throbbing may be so extreme, that when a murmur co-exists it is really difficult to decide. In the absence of a positive, *expansile* tumor, which can be grasped, the diagnosis of abdominal aneurism is always doubtful. In the March number I reported a series of cases of duodenal ulcer, one of which (case IX) illustrated this point. There were pulsations even strong enough to shake the bed, a well-marked bruit, and severe pains—but no aneurism. Dr. Samuel West has written on the mimic subclavian aneurisms in Vol. XVI of St. Bartholomew's Hospital Reports. It is less common in the innominate artery. Some months ago a young girl, aged 21 or 22, was sent to my clinic with signs of aortic insufficiency and dilatation and hypertrophy of the heart. The pulsation in the carotid vessels was very strong and above the sterno-clavicular articulation the dilated innominate could be distinctly seen, and felt as a tumor which did not entirely disappear during diastole. There was dulness beneath the articulation and the manubrium, extending also a little to the right. Evidently there was dilatation of the vessel, but was it truly aneurismal? The existence of aortic insufficiency, in which we have such remarkable systolic dilatation of the aorta and its branches, and

the debilitated condition of the patient induced one to give a negative opinion. Some time after I saw a report of the case in a medical journal as one of aneurism; then heard that it had been made the subject of a clinical lecture on aneurism. About six weeks ago I saw the patient again, as it was suspected that an abdominal aneurism had developed, but the existence of the most intense pulsation was not convincing. Finally, by the kindness of her physicians I saw the *post-mortem*. Enormous hypertrophy and dilatation of the heart, extreme curling and insufficiency of the aortic valve; aorta with innominate and other branches absolutely normal—no dilatation, no atheroma. Abdominal aorta also of natural size. The case is instructive as showing the extent to which dilatation may reach without any lesion of the arterial coats. That there was actually increase in volume of the arch and the innominate cannot be doubted. Bramwell, in his work on the Heart, gives an instance of dynamic pulsation of the aortic arch, simulating aneurism.

Dr. F. C. Shattuck has called attention (*Boston Medical and Surgical Journal*, April 28th, 1887) to the value of leeching in conditions of over-distension of the right ventricle, and reports six cases, of which three were materially benefited. A dozen leeches are applied over the liver and the bleeding kept up by means of poultices. When there are objections to venesection, this plan has great value, but, as with bleeding, it may not be used early enough or blood may not be drawn in sufficient quantities. In a case of pneumonia recently, with commencing cyanosis, the leeching did not seem to have any influence, and I regretted—too late—that free bleeding had not been employed.

The choice of a hypnotic in the insomnia of heart disease is often a source of worry to the practitioner. I have been using urethran and paraldehyde in a number of cases, the latter with marked relief. The urethran seems so variable; sometimes 2 or 3 grains will prove effective, at others 20 or 30 grains are

required. In appropriate cases and when the proper dose is reached, it acts promptly. In two instances in which Hoffman's anodyne—with which I always begin—had failed, paraldehyde in 3i doses gave quiet sleep and relieved entirely, during several nights, the distressing paroxysms of dyspnœa. It has an advantage in stimulating the heart's action and increasing the urine.

If statistics prove anything, we should turn without delay to hydrotherapy in the treatment of typhoid fever. Brand of Stettin, the original Brand, who in 1861 revived the Currie method of treating fevers, has presented in eight or ten numbers of the *Deutsche Med. Wochenschrift* an overwhelming array of figures in support of his method. He claims that severe cases are converted into mild ones; that the temperature is kept at or near the normal; complications are prevented, and the morbid processes are suppressed. A bath at 15°R. for fifteen minutes is given every third hour, so long as the fever is above 39°C.; not solely against the fever, but to control the general morbid processes. No other treatment is employed. He claims that when begun early and properly carried out the mortality is 0. per cent., and in general and hospital practice the death rate should not exceed from three to five per cent. He has analysed over 19,000 cases with a mortality of only 7.8 per cent., certainly a much lower percentage than can be shown by any other method. It is not a little curious, however, that in Germany, where Brand's method is best known and has been most thoroughly tried, the treatment has been abandoned at many of the larger clinics and seriously modified at others. For Brand it must be "all in all or not at all," and the combined plans receive his unsparing condemnation.

WILLIAM OSLER.

Medical Items.

—Dr. Roseburgh of Hamilton is the President of the Ontario Medical Association for the coming year.

—After a service of twenty-two years, Dr. Grailly Hewitt has resigned the chair of Obstetrics and Gynæcology in University College, London.

—Dr. Karl Pawlick of Vienna has been appointed Professor of Obstetrics and Gynæcology in the Bohemian University at Prague.

—Prof. Henoch of Berlin has been obliged, on account of ill-health, to resign the Directorship of the University Clinic for Diseases of Children.

—Prof. Senator succeeds Prof. Henoch. The former is especially known by his excellent work on the Nature and Treatment of Albuminuria.

—Dr. Alexander Ecker, Professor of Anatomy in the University of Freiburg, is dead. Prof. Ecker is well known, especially for his work on the Convolutions of the Human Brain. This work has been translated into English by John C. Galton.

—The following have been appointed examiners of the Ontario Medical Council for the year 1888:—*Anatomy*, Dr. Grasett, Toronto; *Practice of Medicine*, Dr. Irwin, Kingston; *Midwifery*, Dr. McArthur, London; *Physiology and Histology*, Dr. H. P. Wright, Ottawa; *Surgery*, Dr. I. H. Cameron, Toronto; *Medical and Surgical Anatomy*, Dr. J. Wishart, London; *Chemistry*, Dr. R. A. Reeve, Toronto; *Materia Medica*, Dr. H. McKay, Ingersoll; *Medical Jurisprudence*, Dr. Elliott, Orillia.