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**ACCIDENTAL CONCEALED PUERPERAL HEMORRHAGE.\***

BY ALBERT A. MACDONALD, M.D.

Medical men, by the nature of their calling, require to be always ready not only to respond to the urgent call, but they must be trained to act with promptitude and judgment. We cannot, like our brother practitioners of law, hear the case, and reserve our opinion until we have searched the authorities for precedents and opinions. We must carry our working library in our brains, and have there an active index for ready reference. It is true that in some surgical cases we have the opportunity of deliberately going into the history of the case, and of preparing our patient and ourselves for the moment of trial. We can study the subject, plan out our operation, and provide for what we deem to be every emergency, and, even then, we may find that perturbed nature has not followed her regular habit, but has led off in an entirely unexpected direction.

The demands made upon the strength and nerves of the surgeon when battling, perhaps, with deep adhesions, or the dreaded oozing which, in some instances, follows their separation, or when endeavoring to remove some morbid growth from a region closely surrounded by vital parts, are great; but I do not think they are to be compared to those made upon the

resources of the obstetrician when he is brought, perhaps at the dead hour of the night, unaided, face to face with a desperate case where the life-blood seems to be flowing away before his eyes, and in spite of his best efforts.

It is of such cases that I would briefly speak to-night. I cannot take up all the ante-partum hemorrhages, but will make a commencement by alluding to "accidental" and "unavoidable" hemorrhages occurring during the last three months of pregnancy. These are so different in character and results from those happening at an earlier date that they would not bear discussion together.

It is now over a hundred years since Rigby made this artificial division of the hemorrhages of the last three months of pregnancy into "accidental" and "unavoidable," and though the terms have been assailed as unscientific, undesirable, and too absolute, we are not yet in possession of terms more suitable. It is my intention, first, to mention accidental concealed hemorrhage occurring during the last three months of gestation. By giving this clear definition, I exclude that form of hemorrhage which happens when the placental attachment is in the lower polar circle. In such cases, though the bleeding may at first be concealed, it soon finds its way out in much the same way that it does in placenta prævia lateralis. Fortunately for both patients and practitioners, this distressing accident is by no means common. Blundell, Churchill, Burns, Cazean, Meigs, Hodge, and Bedford are all authors of considerable note

\*Read at a meeting of the Toronto Medical Society, Nov. 3, 1892.

who have acknowledged to having had no clinical experience in such cases. They mention and dismiss them with slight consideration. In the Dublin Lying-in Hospital but one such case is mentioned in an experience of 156,000 deliveries. At Guy's Hospital, in London, 22,498 consecutive labors happened with only three of this form of hemorrhage. Madame Boivin and Madame Lachapelle, who could unitedly lay claim to 42,000 labors, and who were acknowledged to be close observers, denied the possibility of this complication. Velpeau more recently expressed his strong scepticism. He said: "How, indeed, can we consider that the blood which escapes from the uterine vessels in somewhat considerable quantities is capable of dilating beyond measure, and almost instantly, the cavity of the wound, instead of running between the gestative organ and its contents, so as to escape outwards, or of rupturing the membranes and becoming effused within their cavity?" I can conceive it possible, and know too well that it takes place.

Prior to 1860, according to the researches of Dr. Goodell (whom I may thank for a good deal of my information on this subject), there were only twenty-two published cases of this form of hemorrhage. In 1869, however, he reports one hundred and six cases. Doubtless, just as many cases happened in former years, but they were either unrecognized or unreported. On looking up the literature of the subject, I find authentic reports of innumerable cases, many of them being of extreme interest, as we know not the moment when such may fall to our lot.

During the later months of pregnancy hemorrhages depend upon detachment of the placenta. The blood flows from the ruptured utero-placental vessels, the weakest part of the vascular system. In giving the predisposing causes, I find that at the outset Robert Barnes affirms that "premature separation of the placenta rarely occurs in the young and the robust. It is most common in women about forty years of age who have borne many children, whose constitutions are worn by sickness and poverty, and whose tissues are therefore badly nourished, wanting in tone, tending to atrophy or degeneration." This statement, which, I have no doubt, is true, contrasts strangely with what I

saw in my limited experience, for in my cases the patients were young, strong, and apparently in robust health; the placenta, however, presented a diseased condition. Certain impoverished conditions of the blood lend their indirect aid in the production of the hemorrhage, and such diseases as scarlet fever, variola, typhoid fever, albuminuria, acute atrophy of the liver, and leucocythæmia are potent factors. An exception is mentioned by Osler in the case described by J. C. Cameron, of Montreal, where a leukæmic patient went through three pregnancies without accident, and the children were all non-leukæmic. In this case both mother and grandmother suffered from symptoms strongly suggestive of leukæmia.

Towards the end of the period of gestation there is a great change in the relations which exist between the uterus and placenta; the adhesion becomes much less firm, and slight cause may give rise to detachment. If the placenta is situated in either the fundal or equatorial zone, the bleeding lies concealed, and we have only the general symptoms to guide our diagnosis.

We must not forget the changes in the muscular structure of the uterus itself. In the later months there is a great and rapid increase in muscular fibre, as well as in susceptibility for contraction. If such contraction be sudden or severe, we have a sufficient cause for partial detachment of the placenta—a small extravasation between uterus and placenta will cause further contraction. The placenta is loosened, hemorrhage takes place, and in this way the child is usually killed; and it, in turn, excites contraction and precipitates labor, and, by disturbing the balance between the external and internal layers of the muscular structure of the uterus, so upsets their relations with the vascular layer as to cause hemorrhage, for when contractions take place pressure is brought to bear on the intra-uterine vascular plexus; the blood must find somewhere to escape, and it is forced to some part of the placental disc. The utero-placental vessels, being the weakest part of the vascular system, are the first to yield, and so the bleeding may start.

This is in striking contrast to what may happen during the first half of pregnancy, when it is harder to produce the bleeding in this way;

and if it should happen, it may not be followed by such disastrous consequences.

Emotion may not only cause uterine contraction, but may strongly determine a flow of blood to the uterus, producing a sudden tension of vessels. This tension may find relief by bursting through the extremely delicate uteroplacental vessels, causing an extravasation of blood between the uterus and placenta. Or extravasations may take place into the substance of the placenta, producing placental apoplexy, which will probably lead to detachment and hemorrhage. Direct violence, which is assigned as one of the most common causes, acts in a most obvious manner. Though the blow may not be directly over the placental site, it may act by *contre-coup*, throwing the uterine walls into active vibration, or causing violent contraction, and so separating the placenta. Pressure of the abdominal muscles may be a cause. Lifting, vomiting, straining at stool, coitus, coughing, standing at hard work, and many other causes have been assigned; but when we notice the many accidents which pregnant women may come through in safety, we are apt to think that perhaps the potency of violence as a cause may be exaggerated. At best, the causes are obscure.

In both of my cases, which have already been presented at meetings of this society, the patients complained, during the greater part of the pregnancy, of a continuous severe pain over a portion of the uterus which I afterwards learned corresponded with the placental site; and in both there were numerous foci of placental apoplexy, as well as portions which had undergone premature retrograde changes, which in my last case I have requested Dr. J. Caven to investigate and report fully to you to-night.

The symptoms of puerperal accidental concealed hemorrhage are acute pain over a portion only of the uterus. It is important to bear in mind both the circumscribed situation of the pain and its continuous cramp-like character, which conveys to the patient the idea of extreme tension. It is an early symptom, agonizing in character; it is soon associated with that group of symptoms which indicate collapse. The state of collapse arises partly from blood loss, and partly from shock to the nervous system. Shock is indicated by quickened,

feeble pulse, pallor, and pinched expression, coldness of surface of the body, shallow respiration, restlessness, sighing, and retching. Labor pains are absent. If the abdominal walls are thin, local bulging of uterine surface may be noticed.

With these symptoms there is an absence of any appearance of blood from the genital tract, or, if the condition has lasted some time, oozing of blood serum may take place, the crassamentum being retained in its original situation. "Rupture of the membranes near the seat of the effusion, and a consequent appearance of blood in the liquor amnii, holds, as a symptom, the lowest rank in the order of frequency (Goodell); because should the os uteri be closed the membranes, however delicate, cannot, other things being equal, rupture any sooner than the uterine walls. For the sum of the resistance of the inclosed liquor amnii being equally distributed, exactly counterbalances the sum of the pressure exerted by the effusion."

The diagnosis is embarrassing at the outset. Intestinal colic may be suggested by the symptoms, but by careful examination we soon see that the symptoms are much too urgent—indeed, so urgent that the condition might readily be mistaken for rupture of the uterus; but uterine rupture is attended by retrocession of the presenting part and diminution in the size of the uterus when the foetus has wholly or in part escaped from the organ, and the membranes are relaxed, or, more commonly, ruptured; whilst in concealed hemorrhage we have increased size of the uterus, and the membranes are entire. When the child is born, the placenta and black, hard clots usually come away with a rush. Prognosis in these cases—which often happens under conditions of debility or of disease, where there is little inherent power of resistance or of recuperation, and where the blood itself may have little tendency to clot—must always be extremely grave. "Death may occur in a few hours, even before delivery (Barnes); and sometimes the additional shock of delivery induces fatal prostration." Again, in spite of our best endeavors, a further continuance of hemorrhage after delivery of the child may extinguish what little hope remained. The child usually dies at an early stage. In 106 cases collected by Goodell, 54 mothers died,

and in 107 cases only six children survived. Treatment must be judicious. We may wait, watching our case to see what nature can do. Bearing in mind the great shock produced by dilatation and delivery, if we think our patient can stand it, we may allow more time for natural dilatation of the os. It has been stated (Tyhrsmith) "that owing to loss of blood there is no rigidity of the os uteri." I have not found it so. We must give close attention, with a view of assisting delivery before alarming symptoms set in. We know how little likelihood there is of saving the child; we must, therefore, bend our energies towards rescuing the mother from her perilous condition. There is no safety for the mother until after delivery; it must, therefore, be brought about speedily, whilst every effort is made at diminishing the bleeding. Dilatation of the os must be brought about by artificial means.

Rupture of the membranes is advised in a most dogmatic manner by a number of authors. Does such rupture meet the indications in any way? I think it does not! And when we consider how slight the experience of any one man can be, we may not be considered egotistical if we express our views against such men as Playfair, Barnes, Leishman, and many others of equal eminence. Rupture of the membranes cannot offer in itself any probability of checking and bleeding; in fact, it seems to me that it would offer increased facility for blood loss, whilst version, which is often demanded in the subsequent treatment, must be rendered more difficult by the evacuation of the liquor amnii.

How could rupture of the membranes tend to check hemorrhage? They answer, by reducing the bulk of the uterus, allowing it to contract, and so close the uterine sinuses. There is probably not a man in this room who has not seen a considerable amount of post-partum bleeding where the amount of contraction of the uterus, though not sufficient, was much more than we could expect to produce by rupture of the membranes, for we must bear in mind that, as a rule, the uterine contractions are not firm in these cases, but there is a striking absence of expulsive effort.

In my cases there was no diminution of the bleeding after rupture of membranes. I strongly

advise that the membranes be not disturbed until we are ready to proceed further. Produce dilatation either by manual effort or by Barnes' dilators. The latter method has the advantage of acting as a tampon whilst the dilatation is proceeding. After dilatation, it must be decided whether to use forceps or to turn. If the amount of liquor amnii is large and the child small, turning may be rapidly effected, and is the best plan. We must be ready with the forceps in case of delay in delivery of the after-coming head. If the amount of the liquor amnii is not great, and if the child is large, I prefer to apply the forceps as soon as dilatation has advanced sufficiently. During the entire time stimulants must be administered—ergot may have some effect, given either by the mouth or by hypodermic.

An anæsthetic is necessary in order to quiet the patient, and to reduce the shock of the sudden delivery.

The danger may not terminate with delivery. In a patient already exsanguined, what at another time would be a trifling blood loss would now add greatly to the gravity of the case. Copious intra-uterine injections of hot water, after having removed the placenta, may suffice. Equal parts of whiskey and water, or pure whiskey, injected freely into the uterine cavity usually control the bleeding; but the treatment after the delivery of the child resembles that of any other form of post-partum hemorrhage.

At the outset, it was my intention to take up unavoidable hemorrhage to-night also; but I feel that the time at my disposal has only enabled me to do scant justice to concealed puerperal accidental hemorrhage. I hope that our experience in such cases may be slight. Though it is an accident of extreme rarity, we require to be prepared for it in every way. Let me hope that the discussion may impress ready and efficient measures upon us.

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#### A WORD FROM MR. MIKE ROBE.

Some call me a bacillus,  
 A germ I'm known to some;  
 I'm also dubbed spirillus,  
 And eke cacterium.  
 But I was a good Irishman—  
 Till Patrick banished snakes;  
 And since that time I've been Mike Robe,  
 The Prince of Stomach Aches!

—N. Y. Recorder.

## Selections.

### AMPUTATION OF RIGHT THIGH — LOWER THIRD—FOR TUBER- CULOSIS OF ANKLE AND KNEE JOINTS.\*

BY NICHOLAS SENN, M.D., PH.D.

GENTLEMEN.—I am very sorry indeed that the conditions presented in this, our new patient, although he is younger in years, render it necessary this morning to make a mutilating operation, for the same pathological conditions, but affecting two great joints instead of one. The case is an exceedingly interesting one from an etiological standpoint, illustrating the infectiousness of tuberculosis, the disease commencing in this instance in the same insidious manner as in the one which has just left the arena. A simple sprain of the ankle joint has been followed by an insidious tubercular affection which has destroyed the soft parts of the joint, and the probe demonstrated that it has invaded the articular ends of the bones forming the joint.

In fact, here is a case of so-called caries, which is in reality an effect of disease, not a disease *per se*. Caries of bone is produced by molecular destruction of bone tissue by granulations, and is, in ninety-nine out of a hundred cases, the result of a tubercular inflammation. I had decided to make a typical resection of the ankle joint when my attention was called to the knee joint, where I found destructive changes of a similar origin and character to the affection of the ankle joint. I believe that in this case there is absolutely no direct etiological connection between the ankle and the knee-joint affections, but the infection of both joints can, in all probability, be traced to the same primary focus. There is great danger that in this case, with two tubercular joints, the seat of secondary infection with pus microbes, the patient would soon become the victim of pulmonary tuberculosis, tubercular meningitis, or even of disseminated miliary tuberculosis, if the peripheral lesions were allowed to pursue their own course; hence it becomes necessary for us to sacrifice the lower limb and make the am-

putation through the thigh, eliminating by the same operation the two tubercular joints. There are only a few essential principles that become necessary to memorize and to carry into effect in amputating through any part of the upper or lower extremities. If you will remember to make the incision so as to bring the resulting scar away from pressure in wearing an artificial limb; to preserve the periosteum; and to amputate the principal nerve trunks at least an inch above the level of the incision through the soft parts, in order to prevent a common and very painful affection, neuroma; and under all circumstances to secure complete hæmostasis, you have all the essential rules that should guide you in making an amputation anywhere.

The operation that I am just about to make through the thigh may be regarded as a type for any amputation of the upper or lower extremities. In order to throw the scar away from where it will do harm, it will be necessary to make one long and one short flap; whether you take a long flap from the front, from the side, or from behind, is immaterial; you will take tissue where you can obtain it, and you will make the amputation as far away from the body as possible.

It makes my blood curdle, and my hair stand on end, when in the nineteenth century, during this progressive age, men are held up in courts of justice to answer a malpractice suit for having made a posterior long or a lateral flap; but old text-books are still revered by lawyers, but they are of little use to the surgeon. If called upon, under such circumstances, do not hesitate for a moment in supporting your colleague, whether he has made a long anterior or a long posterior flap. Rest assured that if he is a progressive man he has taken the flap from the region best adapted to serve as a covering for the stump.

Here, fortunately, we are able to make a long anterior flap, which is the ideal flap, of course, and, as you will notice, the flap by its own weight will seek to maintain its proper position, at the same time securing the best conditions for efficient drainage. If the knee joint had formed sinuses, and I had found the tissues over the anterior aspect of the knee joint in a less favorable condition for a flap than on the opposite sides, I

\* An abstract of part of a Clinical Lecture delivered at the second annual meeting of the Association of Military Surgeons of the United States.

would have no hesitation in transgressing public opinion, and would make a long posterior and a short anterior flap. I should then come to the rescue of the flap, and, instead of relying too much on gravitation in keeping the flap in place, I would furnish it with proper mechanical support by suturing, splints, and careful bandaging, and establish drainage by making a buttonhole in the centre of its base.

I have carefully examined the cutaneous covering, and believe I can safely make an anterior flap, reaching down at least to the upper border of the patella, and I will therefore follow the rule that should never be violated, the same as in resection, of not removing, unnecessarily, healthy tissue, even in making a mutilating operation. We will use elastic constriction to control hemorrhage during the operation. Having made a long anterior and short posterior flap, I will divide the remaining soft tissues with a long knife, and make the incision a little conical, the apex of the cone directed upward. To provide a normal envelope for the sawn bone, I now make a circular incision through the periosteum about two inches below the circular incision through the muscles, and carefully reflect the cuff of the periosteum, because, as far as the immediate risks of traumatic infection are concerned, this material is of more importance than the remaining deep structures of the limb. I will now saw the bone through in such a way that the sawn surface will be on a higher level than the section through the soft tissues, in order to prevent undue prominence of the bones in the stump, so that the patient can wear an artificial limb with comfort. I clip away the edges of the bone with bone forceps, in order to protect the periosteal cuff against the harmful effect of linear pressure.

I wish to isolate the arteries separately, and in a second ligature, about one-third of an inch higher up, I shall include the accompanying veins, which will place the vessels in the best condition for closure by cicatrization in the shortest space of time. In ligating a large vessel, it is important always to use ligature material that will be removed by absorption. An absorbable ligature cannot be excelled, and I believe we have overdone the last few years in the way of using silk ligatures, which to me have often become a source of great annoyance,

and more so to my patients. A silk ligature that fails to become encysted in a suppurating wound is always a source of mischief. I have now applied one ligature; the next ligature shall include not only the artery, but also the accompanying veins. I am tying with a double ligature, the second one of which includes also the veins. The bloodless space in the artery, in four to seven days, becomes closed permanently by granulation tissue. We will now seek for additional vessels, and tie them before the constrictor is removed.

It is extremely important to remove at least an inch or two of the sciatic nerve in order to prevent the development of a painful neuroma, a frequent sequela of amputations unless neurectomy is practised. Such a complication seldom or never sets in if the nerve end does not remain in the scar of the amputation wound. We have ligated the large vessels, we have resected the nerve, and we will resort to surface compression to arrest unnecessary parenchymatous oozing.

Before we go any further, we will correct any possible mistake in the size of the flaps. You see, the anterior flap is about the right length, and falls down into its natural position without tension. I will compress the surface of the wound firmly with a gauze sponge for a number of minutes, after removal of Esmarch's constrictor, in order to prevent unnecessary loss of blood. In patients debilitated by such an extensive tubercular disease, as in this case, not a drop of blood should be wasted unnecessarily. The assistant should ligate any spurting points that may be seen when I remove the compress, after which compression is resumed if necessary.

I remember one case of amputation through the leg where I almost despaired of controlling the parenchymatous oozing; the more I ligated, the more it bled; surface pressure and douches of boiling water were of little avail. After a long siege by surface pressure, with irrigation of hot water, we resorted to permanent compression by compress bandage, and finally succeeded in controlling the hemorrhage. I found in the tissues subjected to microscopic examination numerous encapsulated trichina that had wrought serious changes in the structure of the vessels and other tissues, and I am firmly convinced that in many of these cases you will find some

tissue lesions that will account satisfactorily for the obstinancy of the parenchymatous oozing. Remember the important tissues concerned on the line of section made through the limb. I have attended to the nerve, I have ligated the arteries, I have ligated at the same time the large veins; the parenchymatous oozing has ceased; now I wish to protect as far as I can the most important anatomical constituents of the line of section, the vessels and the medullary tissue, against the deleterious effects of suppuration, should such a complication arise in this case. In debilitated patients, and where time permits, I bury the ligated vessels with the buried catgut suture, as an extra precaution against secondary hemorrhage should suppuration occur. I now wish to protect that most sensitive of all structures to infection with pus microbe, the medullary tissue, by closing the canal by the use of the periosteal flap. It is fortunate for pathologists and surgeons that we are now in possession, as a nation, of the rich pathological collection of the necrosed bone from amputated stumps harvested during the late war of the rebellion. Such specimens after amputation are now rarely obtained, owing to the effective wound treatment that is now almost universally adopted. It is this traumatic osteomyelitis, which so frequently resulted in pyæmia and death; it is this osteomyelitis that yielded the large collection of specimens of necrosed bone. Preservation of the periosteum, and securing and maintaining an aseptic condition of the wound, furnish the most reliable safeguards against osteomyelitis, necrosis, and pyæmia. After an amputation through the thigh, there is a tendency for the bone to project through the soft parts, giving a painful and often useless stump, and often making re-amputation necessary. This follows either in consequence of the flaps having been made short, or as the result of violent and prolonged course of contractions of muscles whose lower attachment has been sacrificed. Our flaps are of proper length, and we shall guard against the ill effects of muscular contractions by providing a temporary point of anchorage by means of a second row of buried sutures; this attachment will support the muscles below for three or four weeks, and be removed spontaneously by inactivity and pressure atrophy.

We are dealing with a very large wound; there will be considerable primary wound secretion, and as the hospital surroundings here are not the very best, and the patient is debilitated by disease, it is necessary to establish tubular drainage. Here I will drain by making a small buttonhole in the middle of the base of the posterior flap. I prefer to do this rather than drain from the angles of the wound, as I desire to obtain primary healing of the amputation wound throughout; at the same time the drainage will be at the most dependent point, where it will prove most effective. The flaps will be stitched in the usual manner, and the operation closed throughout. In the dressing it is important to guard still further against subsequent parenchymatous oozing during the period of reaction by making the antiseptic hygroscopic dressing copious, so that it will not only prove useful in absorbing and disinfecting the primary wound secretions, but will prove beneficial by exerting a continuous equable elastic compression, which not only guards against hemorrhage, but constitutes at the same time the best known means in securing accurate apposition between the wound surfaces. The stump will be supported by a hollow posterior splint, and will be kept in an elevated position for at least twelve hours.—*Chicago Clinical Review.*

### VARICOCELE.

CLINICAL LECTURE DELIVERED AT FREDMEN'S HOSPITAL

BY N. F. GRAHAM, M.D.,

Professor of Surgery in the Medical Department of Howard University, Washington, D.C.

GENTLEMEN,—We have here this evening two cases of well-marked varicocele, on which I propose to operate with the hope of securing a radical cure. Varicocele is simply a varicosity of the spermatic and pampiniform veins of the spermatic cord, which have become elongated, tortuous, dilated, and thickened. This condition, which I can hardly look on as a disease, is not commonly met with in the very young, or in persons advanced in years, but is not by any means rare during early manhood and the prime of life. The exciting causes of the development of this condition of the veins are chiefly due to gravity and mechanical obstruction to the return of the blood through the spermatic veins. This obstruction may be so persistent



as to cause very great enlargement and lengthening of the veins, so that they pass or drop below the testicle and reach down the thigh a number of inches. Such an exaggeration is not common. Ordinarily, the mass is of moderate size, not accompanied by pain, and having no effect on the virile powers of the individual. However, cases are met with in which the pain is quite severe, and in many instances the mental worry is considerable, and in some excessive. Varicocele of the left side is very much more commonly met with than that of the right, the proportion being about seven per cent. for the right and ninety-three for the left side, whilst about nine per cent. of all cases have varicocele of both sides. The reasons given for the greater frequency of the affection on the left side are, first, the greater length of the vein, and therefore a longer and heavier column of blood to support on that side; and, second, that the left spermatic vein opens into the left renal vein at right angles to that vessel and to its blood current. The veins on both sides are probably equally pressed upon at the inguinal canals by the abdominal muscles during exertion or in coughing. The left vein is also pressed upon by the loaded colon, which may act as an etiological factor. The right vein is shorter, and it opens into the inferior vena cava, not at right angles, as does the left, but more in the direction of the blood current. The length of the left vein and the manner of its connection with the renal vein are, I believe, the most active factors in causing the varicosity. The absence of valves in the left spermatic vein has not been so fully demonstrated as to warrant the opinion that that is an important cause.

Varicocele is most common during the period of the greatest activity of the sexual organs—from fifteen to thirty-five. At this period of life a freer supply of blood is necessary for the performance of the sexual functions. Constipation, much standing, and any violent exertion which calls into play the abdominal muscles predispose to the disease. Owing to the slowness of development and the absence of pain, the veins may become considerably enlarged before the change is noticed, but later on there is a sense of weight, dragging, and uneasiness in the testicle and cord. The drag-

ging pain extends up the loin, and this position is aggravated by long standing, or by very active muscular exertion. As you see in this case, there is a flaccid condition of the scrotum, and the testicle hangs lower than normal. In this first case you can see the veins, like whipcords, occupying the region of the spermatic cord, and in this other case the dilated and tortuous veins descend below the testicle. In the case before us the dilated veins can be easily seen and felt, are soft and elastic to the touch, and their feel is usually compared to a bag of earthworms. When the patient lies down the veins diminish in size, and fill up with great rapidity when the erect position is assumed. I ask this patient with the greatly enlarged veins to cough, and on placing my hand over the scrotum I can feel an impulse transmitted to my fingers, but not so marked as we get in hernia. The majority of the cases of varicocele met with in practice are not large or painful. Yet you will rarely meet a person suffering with this condition to whom it is not a source of great mental worry and anxiety, with the constant fear before him that he may become impotent at some time. Indeed, a large number who come under my observation fancy that the virile power is not as active as it should be, and for that reason alone (in the main, a fancy) they seek the advice of a physician. Many of them fall into the hands of charlatans, who seek to confirm their fears in order to extort money.

The diagnosis of varicocele ought to be made without difficulty, yet it has been mistaken for hernia. The reliable test in arriving at a diagnosis is to make the patient assume the recumbent position, when the veins will empty themselves, or the hernia, if reducible, will recede; then press the finger firmly over the inguinal canal while the erect position is assumed. If it is a varicocele, the veins will speedily fill; if a hernia, the tumor will be retained by the finger pressure. The history of a hydrocele is that the scrotum commences to fill from the bottom; is smooth and elastic; palpation develops fluctuation, and it is translucent, and does not diminish when the patient lies down.

The treatment of varicocele consists of the palliative measures and the operation for the radical cure. The former plan includes the constant wearing of a suspensory bandage.

The parts should not be kept too warm, for warmth and moisture relax and take away the support of the scrotum from the dilated veins. Cold in the form of a douche to the genitals night and morning, solutions of muriate of ammonia, hamamelis, etc., have been used with benefit. The bowels should be kept open in order to avoid loading of the colon, and, if the general health is defective, tonics should be administered.

When these measures are ineffectual it becomes necessary to operate, as in the cases before us. There are two methods generally adopted by surgeons—the subcutaneous ligature, a plan first suggested and put into practice by Ricord, but so improved on by Dr. Keyes that it is known as Keyes' method; also the incision and ligature by what is known as the open method. I rarely employ the latter, and only when I fail after repeated efforts by the concealed ligature. I do not confine myself to Keyes' plan, but very often adopt the plan so long successfully practised by the late Dr. Agnew, of Philadelphia.

We are now prepared to operate. The scrotum is shaved, and made aseptic by careful washing and a sublimate douche. I now throw fifteen minims of a four-per-cent. solution of cocaine into the upper part of the scrotum in the field of the operation. I have here, as you see, two of Keyes' varicocele needles; one threaded with strong twisted silk, which is not very thick, but has been tested, and is capable of bearing all the strain necessary to very firmly constrict the veins. I find the vas deferens located in the posterior part of the cord, near the base of the attachment of the scrotum to the perineum, which can be easily recognized by its hardness to the touch, and the manner in which it jumps from under the thumb and finger when squeezed. I separate the vas deferens from the mass of veins, carrying it backward. With it is carried the artery. They are now resting on the ball of the finger and thumb, whilst the terminal portion of the finger firmly compresses the walls of the scrotum. Anterior to and close to the nails, I now introduce the threaded needle, passing it completely through both walls of the scrotum from front to back, and then leave it in the hands of the assistant. I now take the unthreaded needle and intro-

duce it at the same point as the first, and now that its point is well within the dartos it is carefully worked between the dartos and veins, and so passed around the mass. I make its point emerge at opening of exit made by the threaded needle. Now the thread is taken out of the eye of the first needle, and the second is threaded with it and the needle withdrawn. It is clear that the mass of veins is now encircled with the thread loop, which I simply tie with a single instead of the friction knot, and cut off both ends short. By separating the integument of the scrotum the entire loop becomes subcutaneous, and, if no germs have been carried in, the thread will become encapsuled, and no harm will result. It is not an infrequent practice with me to cut only one thread, leaving the other hanging out, which enables the loop to be removed in from ten to fifteen days; a plan which is very satisfactory, indeed, and, as a rule, the patient is better satisfied if the entire thread is removed in the course of a few days. The scrotum will be now washed with a sublimate solution and wrapped in gauze—iodoform or bichloride gauze will answer equally well. The patient is to be placed in bed, where he will remain for a couple of days, after which he can move about, and can resume his work in ten or twelve days.

I will now operate on the next patient by the plan of Dr. Agnew, one which I like myself very much. The scrotum is prepared as for the other operation, and the field injected with cocaine. I now take this steel pin, two and a half inches in length, having a large head, and thrust it through both walls of the scrotum from behind forward, of course taking the same precaution as I did in the first operation to isolate the vas deferens and artery. Now, with the Keyes needle threaded with a strong silk thread, which is carried through the eye of the needle to its centre, I enter the scrotum at the point of exit of the pin, and, when within the dartos, carry the point round over the veins and bring it out at the same point entered by the pin. I now pull forward the loop over my finger, and withdraw the needle, unthreading it. The loop is slipped over the head of the pin, and the free ends of the thread tied over the point and drawn tightly enough to compress the veins. The point of the pin is now snipped off

with a pair of wire nippers, a small disinfected cork placed on the end, and the scrotum covered with gauze. The patient will now be placed in bed, where he will remain for a couple of days, after which he can get up and move about his room. At the end of eight days the pin will be pulled out, when the loop can be very easily withdrawn. This plan has advantages over any other in which the ligature is removed subsequent to the operation, for the moment the pin is taken out the knot is freed, and the thread is easily withdrawn. Considerable hardness remains for some time at the seat of the ligature, which is the cause of some solicitude to the patient, but it soon disappears completely in cases in which the thread has been removed; but often it is slow of disappearance when the thread is left in, as by the method first adopted by me to-night. In the case of nervous, anxious, inquiring subjects, I yet prefer the pin-and-thread method, for it saves explanations and increases the confidence of the patient.—*Internat. Med. Magazine.*

CARCINOMA OF THE SIGMOID FLEXURE, INTUSSUSCEPTION, AND INTESTINAL OBSTRUCTION: OPERATION, REDUCTION OF THE INTUSSUSCEPTION AND RESECTION OF INTESTINE: RECOVERY.\*

BY FRANK HARTLEY, M.D.

J.S., domestic, aged thirty-two years, Norway, single. Admitted to the New York Cancer Hospital, March 27, 1892.

*Condition:* Anæmic, emaciated. Her previous health has been good. Menstruation regular. Her family history is not known to her. Her present trouble began with diarrhoea on March 1, 1892, at which time and subsequently to it she lost a considerable quantity of blood. She has had severe attacks of pain in the abdomen up to the present time, with an absolute constipation during the past week.

*March 27th:* Examination without ether revealed a large tumor within the rectum, easily movable, and suggesting a carcinoma with intussusception.

*28th:* Under ether the diagnosis was con-

firmed by bringing the tumor through the anus. It was found to be a large sloughy mass, hard at its base, completely surrounding the intestine, and with a lumen in its centre admitting with difficulty the forefinger.

This was thoroughly disinfected with bichloride-of-mercury solution (1 to 1,000), and dusted with iodoform powder.

Iodoform gauze was then carefully packed around and into all crevices in the tumor. The mass was then reduced within the anus.

*30th—Operation:* Trendelenburg's posture. Median incision eight inches in length. Small intestine removed to the abdomen from the pelvis. The tumor was found to be within the rectum, and surrounded by a double invagination or intussusception. The outer or second intussusception was reduced with slight difficulty. This, however, did not allow the tumor to be brought into the abdomen proper. With a partial reduction of the first intussusception, however, it could be brought above the iliac fossa.

Considering the condition of affairs—a tumor within the gut with an intussusception—the natural method of operation seemed to be that recommended by Mounsell, of Melbourne, Australia, for in this way the sloughy mass could be reached, cut loose, and delivered without any possible contamination of the peritoneal cavity. Consequently, a long incision three inches in length was made over the lower segment entering the intestine; intussusciens, the tumor, and intussusceptum were delivered through this opening after protecting the mass with additional gauze.

The intussusceptum was then divided transversely a little below its neck. The divided ends were held in position until the arteries in the mesenteric border were securely ligated. Silk sutures were then passed through all coats of the intestine as they were held in position, according to Mounsell's recommendation, and tied.

One or two catgut ligatures were placed in the mucous membrane alone where it gaped. The fold was then reduced, and a Lembert suture was carried around the intestine above the larger and deeper sutures. After this the longitudinal incision in the lower segment was sutured by a few stitches of silk in the mucous

\*Read before the New York Surgical Society.

membrane, and a Lembert suture in the serosa and sub-mucosa. The cavity was wiped out with a sponge, The abdominal incision was closed with silkworm gut, rubber tissue applied over line of incision, and a bichloride dressing applied. After operation the course was uneventful, temperature having never arisen above 100°, or the pulse above 96.

*April 7th*: Primary union in the abdominal wound.

*8th*: Semi-fluid movement following an enema.

*11th*: Small movement.

*12th*: Large number of scybala removed.

Daily removal of these until the 14th of April.

*May 1st*: Has had daily voluntary movements. Sat up.

*7th*: Up and about the ward.

This case is of interest because of the happy recovery after enterectomy for carcinoma of the intestine combined with a double invagination, as well as being the first case of this kind performed here. To me it seems to be the method for enterectomy, especially in such cases as the above. The rapidity with which it can be done and the easy command one has over the hemorrhage seem to be the two great points in its favor.—*N. Y. Med. Jour.*

#### CROUPOUS PNEUMONIA CAN BE ABORTED.—

F. Gundrum, M.D., Escondido, Cal., writing to *The Medical News* of Oct. 22, says: SIR,—I read with considerable interest the article by Thomas J. Mays, M.D., in *The Medical News*, Sept 24, 1892, page 348, headed, "Can Croupous Pneumonia be Aborted?" My experience goes to show that this question can be answered most positively in the affirmative. I could give many more cases than the one here reported, but deem it unnecessary to occupy your valuable space with repetitions. About the middle of April, 1872, I was called to see Miss M. E., nineteen years old, a rather tall, slim blonde, one of a number of dining-room girls at the Revere House, in Iona, Mich. She was pretty sick for two weeks with a rather severe remittent fever, which left her much prostrated. On the sixteenth day I discharged her, leaving a prescription for a good stiff tonic, stock ale, and a generous diet. Two days later, at about 6 p.m., I was sent for in great haste to see my patient again. The evening before, while the

proprietor and his family were at supper, the girl got out of her bed, slipped on a light wrapper, and sat in a rocking chair, in order to agreeably surprise her friends when they returned. The evening was cold and blustery, and she became much chilled before she went back to bed. At 5 a.m. on the following morning she was seized with a severe chill. The proprietor of the hotel, having been an army nurse, set to work to get her out of this condition. She was quite ill all day, and in this condition I found her. She was pillowed up in bed, lying on her back, as she could breathe better in that position; her face, but more especially her cheeks, were livid; the finger-nails were inclined to look bluish. The respirations were 46, the pulse 130, and the temperature 106°. A short, hacking, "choky" cough was present. On physical examination, nearly the whole of the left lung was found to be involved in a process of acute inflammation. The crepitant r le could be heard over nearly the entire lung posteriorly. I knew well enough that the patient could not live in the debilitated condition in which she then was, if the disease followed its usual course; so the only chance was to abort the disease, if such a thing were possible. Fortunately, I had received, a few days previously, Niemeyer's "Practice" and, more fortunately, I had read the article on pneumonia, from which, for the first time, I had learned of the idea that pneumonia might be aborted by cold applications to the chest.

With the consent of the patient and her friends, I was allowed to try the "new treatment." A large tub was obtained, filled half full of "chunks" of ice, and then nearly filled with water. This was stirred rapidly until the temperature of the water came down to 50° F. A large double woollen blanket was wrung out of this water, and the patient was then wrapped in it from the chin to the toes. It was changed every thirty minutes until the temperature reached 104°, when the cold pack was not allowed to come below the middle of the thighs. At 1 a.m. the temperature fell to 102°, when only the chest and upper part of the abdomen were enveloped; by 6 a.m. the thermometer stood at 98°, the pulse at 60, and the respirations at 16, with the face pale. The patient was then thoroughly rubbed, put into warmed blankets, hot bottles applied to her feet, and a

half-ounce of brandy administered. She fell into a quiet sleep. At 10 a.m. I examined the chest again, and found no trace of the crepitant râle, and only a few moist râ at the base of the left lung. She received also four drops of the fluid extract of *viratrum viride*; then two drops every hour for four doses; then one drop until 4 a.m., when it was discontinued, it having lowered the pulse sufficiently. The patient made a rapid recovery. In regard to *veratrum viride*, I may say that I ceased using it many years ago, as it has no particular effect in controlling the temperature. In fact, the highest temperature I ever observed in acute lobar pneumonia was in the case of a young man, in which the temperature ranged between 104° and 106.5° for ten days, notwithstanding the fact that the pulse was never allowed to go over 70 or under 60 by the use of *veratrum viride*. I consider the application of cold to the chest a great, if not absolutely the greatest, therapeutic agent that we have in acute lobar pneumonia; but for various reasons—prejudice of patients or their friends, or the weak-kneedness of the doctor—few use it.

THE CÆSAREAN SECTION IN PLACENTA PRÆVIA.—Dr. W. H. Ford (*American Gynecological Journal*) says: The dangers of placenta prævia, as well to the mother as to the child, are due to the development of the placenta upon the lower segment, and to the canalization of this segment during labor. While the first of these conditions cannot be avoided, the second should not be permitted in placenta prævia totalis, or partialis. Delivery should be by Cæsarean section. In placenta prævia marginalis, if the circumstances were favorable, the os easily dilatable, the condition of the mother and child good, the head presenting or capable of being readily brought to engage, and the hemorrhage arrested or moderate, it would be well to follow the method of intra-uterine and vaginal tamponade, and deliver by forceps if the child should be in danger. But if the os were rigid, the hemorrhage profuse, the presentation lateral, the cord prolapse and not reducible, or the *fœtus evidently suffering*, I would have immediate recourse to the Cæsarean section. The Cæsarean should be performed as soon as the diagnosis is established and the condition of

the mother permits, to the exclusion of all other methods, as an elective and primary operation, and in all cases of *placenta prævia totalis* and *partialis*, and in placenta prævia *marginalis*, as soon as the conditions warranting it have been satisfactorily determined. In the two graver forms of placenta prævia, the Cæsarean section should be practised as a prophylactic measure, in place of any attempt to deliver by the natural passages, after the first hemorrhage. In cases where hemorrhage is late or sets in only as labor begins, and where, consequently, the placenta is most probably attached laterally, it is advisable, until this entire subject has been practically studied, to deliver per vaginam as a rule. If, therefore, the cervix be easily dilatable, and the hemorrhage moderate, we may proceed as suggested in the more hopeful cases of marginal implantation. But *even here* an undilated os associated with severe hemorrhage would constitute a very serious condition. If the rigidity were due to fibrosis, it should be abated by multiple incisions; if to carcinoma, the radial Cæsarean section would be indicated. If the cord were prolapsed, and after reposition still descended, the os being partly dilated and not dilatable, dangerous hemorrhage continuing meanwhile, the Cæsarean section would be unquestionably indicated for the safety of both mother and child.—*Med. and Surg. Reporter*.

A NEW TEXT-BOOK ON ANATOMY.—P. Blakiston, Son & Co. have the pleasure of announcing for early publication a new and systematic text-book on anatomy, prepared especially to meet the requirements of the students and surgeons of to-day, written by ten of the foremost anatomists and surgeons in the English-speaking world, and containing about 600 illustrations, nearly every one having been specially drawn and engraved, and many of which will be printed in colors. The retail prices will be from six to eight dollars in cloth and leather bindings.

At the meeting of the Toronto Medical Society held on Nov. 5, Dr. R. A. Reeve presented the society with a portrait of the late Dr. Beaumont. On motion of Drs. Graham and Macdonald, a vote of thanks was given him with hearty applause.

THE  
Canadian Practitioner

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

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TORONTO, NOVEMBER 16, 1892.

THE PAN-AMERICAN MEDICAL  
CONGRESS.

The preliminary announcement of the first Pan-American Medical Congress gives a vast amount of interesting information about the meeting which will be held in Washington on September 5th to 8th, 1893. As it is a goodly sized book of 64 pages, we are unable to do more than extract some items which will be of interest to our readers.

The regulation as to membership is that members of the congress shall consist of such members of the medical profession of the western hemisphere as shall comply with the special regulations regarding registration. The following are considered the constituent countries of the congress: Argentine Republic, Bolivia, Brazil, British North America, British West Indies, Chili, Dominican Republic, Honduras, Mexico, Nicaragua, Paraguay, Peru, Salvador, Republic of Columbia, Republic of Costa Rica, Ecuador, Guatemala, Hayti, Hawaii, Spanish West Indies, United States, Uruguay, Venezuela, Danish, Dutch, and French West Indies.

The sections of the congress will be: (1) General Medicine, (2) General Surgery, (3) Military Medicine and Surgery, (4) Obstetrics, (5) Gynecology and Abdominal Surgery, (6) Therapeutics, (7) Anatomy, (8) Physiology, (9) Diseases of Children, (10) Pathology, (11) Ophthalmology, (12) Laryngology and Rhinology, (13) Otology, (14) Dermatology and Syphilography, (15) General Hygiene and Demography, (16) Marine Hygiene and Quarantine, (17) Orthopædic Surgery, (18) Diseases of the Mind and Nervous System, (19) Oral and Dental Sur-

gery, (20) Medical Pedagogics, (21) Medical Jurisprudence, (22) Railway Surgery.

The general officers are: President, Dr. William Pepper, of Philadelphia; secretary-general, Dr. Charles A. L. Reed, of Cincinnati, and one vice-president for each constituent country of the congress. Dr. J. E. Graham, of Toronto, is the vice-president for Canada, or British North America. Dr. James F. W. Ross, of Toronto, is the representative of Canada on the Executive Committee. For each section there are a number of honorary presidents, one executive president, and several secretaries. Among such officers are the following from Canada: Section on General Medicine, secretary, Dr. Moorehouse, of London; section on General Surgery, secretary, Dr. F. G. Roddick, of Montreal; section on Military Medicine and Surgery, honorary presidents, Surgeon-General Bergin, of Cornwall, and Surgeon Strange, of Toronto; section on Obstetrics, honorary president, Dr. Adam H. Wright, of Toronto; secretary, Dr. J. C. Cameron, of Montreal; section on Gynecology and Abdominal Surgery, honorary president, Dr. James F. W. Ross, of Toronto; section on Therapeutics, honorary president, Dr. A. D. Blackader, of Montreal; secretary, Dr. J. L. Davison, of Toronto; section on Anatomy, Dr. F. L. Shepherd, of Montreal; section on Physiology, honorary president, Dr. Wesley Mills, of Montreal; secretary, Dr. A. B. Macallum, of Toronto; section on Diseases of Children, honorary president, Dr. A. D. Blackader, of Montreal; section on Pathology, honorary president, Dr. L. D. Mignault, of Montreal; secretary, Dr. John Caven, of Toronto; section on Ophthalmology, secretary, Dr. G. H. Burnham, of Toronto; section on Laryngology and Rhinology, honorary president, Dr. Stephen Dodge, of Halifax; secretary, Dr. G. W. Mayor, of Montreal; section on Otology, honorary presidents, Dr. Stephen Dodge, of Halifax, Dr. J. W. Good, of Winnipeg, and Dr. G. Sterling Ryerson, of Toronto; secretary, Dr. D. G. Wishart, of Toronto; section on Dermatology and Syphilography, secretary, Dr. J. E. Graham, of Toronto; section on Hygiene, Climatology, and Demography, honorary presidents, Dr. E. P. Lachapelle, of Montreal, and Dr. F. Montzambert, of Quebec; section on Marine Hygiene and Quarantine, secretary, Dr. J. J. Cassidy, of

Toronto; section on Orthopædic Surgery, secretary, Dr. B. E. McKenzie, of Toronto; section on Diseases of the Mind and Nervous System, honorary president, Dr. Joseph Workman, Toronto; secretary, Dr. Stephen Lett, of Guelph; section on Oral and Dental Surgery, honorary president, Dr. J. B. Willmott, of Toronto; secretary, Dr. Luke Teskey, of Toronto; section on Medical Pedagogics, honorary presidents, Dr. Fife Fowler, of Kingston, Drs. Walter B. Geikie and Adam H. Wright, of Toronto; section on Medical Jurisprudence, secretary, Dr. N. A. Powell, of Toronto; section on Railway Surgery, secretary, Dr. J. G. Roddick, of Montreal.

The following form the auxiliary committee for British North America: Ontario, Drs. J.F.W. Ross, John L. Bray, Jas. E. Graham, H. P. Wright, H. S. Griffin, V. H. Moore, Chas. E. Barnhart, W. H. Moorehouse, J. L. G. McCarthy, J. B. Lundy, H. Howitt, R. Henwood, A. Taylor, J. A. Eakins, D. S. Bowlby, R. A. Corbett, J. G. Scott, and A. B. Welford; Quebec, Drs. F. G. Shepherd, M. J. Ahren, R. A. D. King, J. A. Hamel, E. Gervais, F. J. Austin, E. N. Chevalier, and E. P. Lachapelle; Nova Scotia, Drs. W. S. Muir, A. D. MacGillivray, J. C. McDougall, W. H. McDonald, John Stewart, H. B. McPherson, W. B. Moore, C. J. Gossip, D. A. Campbell, A. Robinson, Miller, and Farrish; Manitoba, Drs. Chown, J. A. Macdonald, and R. Wilson; New Brunswick, Drs. J. Z. Currie, M. McLaren, Jno. B. Benson, H. B. Chandler, and F. L. Pedolin; Newfoundland, Dr. Alfred Hawey; Northwest Territories, Dr. J. H. C. Willoughby.

#### THE MEDICAL DEFENCE ASSOCIATION.

We had supposed that the conference between certain members of this association and the legislative committee of the Medical Council had been productive of a certain amount of good, and that, in consequence, the prospects of a fair and honorable compromise were all that could be desired. It was probably a matter of considerable surprise to the majority of Ontario practitioners when the letters of Dr. John H. Sangster, the secretary of the Defence Association, appeared recently in the *Toronto Mail*. From these it appears that the two bodies are not at all likely to come to anything

like an agreement before the next meeting of the Provincial Legislature.

It will be remembered that at the meeting held in the council chamber, September 29th, the Defence physicians modified their demands to some extent. They asked that the penal clause be repealed; that the matter of the annual fee be left in abeyance until after the next election; that only the four universities of Ontario with teaching bodies be represented; that the regular profession have seventeen representatives; that the homœopaths have five representatives; that protested elections be referred to county judges.

The committee of the council agreed to make the penal clause inoperative until after the next election; they refused to abolish the annual fee; they agreed to increased representation of the general profession; they did not object to institutions which neither teach nor grant degrees being deprived of representation; they agreed that protested elections should be referred to county judges.

It will thus be seen that the differences between the two parties were not great. The president of the council showed a conciliatory spirit, and acknowledged that much dissatisfaction existed throughout the province with reference to certain actions of the Medical Council. Dr. Armour, in discussing financial matters, scored heavily against the ex-president, Dr. Williams, in his exposure of the ignorance of the latter respecting the subject, and the incorrect statements which had been made on several occasions with regard to the subject. Dr. Williams, in a somewhat grandiloquent style, had shown conclusively that the net cost of carrying the building was only \$302. Dr. Armour showed from the official statement of the treasurer that the actual cost last year was \$5,232. He figures it out as follows:

The building had cost.....	\$96,390
After deducting the mortgage of..	60,000
The investment account is.....	36,300
The interest on investment and mortgage at 5 per cent. amounts to	4,891
In addition to the interest account, the cost of maintenance for the year was.....	4,510
Embracing caretaker, elevator-man, commission on rents, fuel, water, gas, insurance, repairs, taxes, and	

legal service, making the total yearly cost of carrying the building.....	9,329
Now deduct from this the income from rents.....	4,099

Making the net cost of carrying the building last year..... \$5,232

Dr. Williams showed more surprise than gratitude respecting the valuable lesson which he had thus received; in fact, we fear he let his "angry passions rise," and things became slightly *unpleasant*. The conciliatory and sensible remarks of Dr. Bergin and others mollified matters to a considerable extent, after which the formal demands of the Defence Association were made, and the answers given as above.

So far as we can learn, the general opinion is that the Defence members made the better showing at the conference; but they are quite likely to lose their advantage on account of the extreme stand, and the bitter tone, of him who is now writing for the association in his official capacity as secretary.

PRELIMINARY ADDRESS OF THE  
COMMITTEE OF THE WORLD'S  
CONGRESS AUXILIARY ON A  
MEDICO-CLIMATOLOGICAL  
CONGRESS.

A Local Committee of Arrangements has been appointed by the World's Congress Auxiliary, and an Advisory Council will be selected from those eminent in this department in different parts of the world to arrange a World's Congress of Medical Climatology, to be held at Chicago during the exposition season of 1893.

The design is to hold this congress at a time convenient to those who will attend the congresses of the other divisions of the Department of Medicine which are assigned to open May 29, 1893. This early date was chosen to accommodate those who will desire to attend the Medical Congress to be held in Rome in November of next year.

The following topics have been suggested, and others will doubtless be added before the final programme is announced:

The Leading Characteristics of the Climates of the various States, Countries, and Sections of the World.

Diseases Produced by the Climatic Peculiarities and Weather Changes in the various countries.

Relation of Climate to Consumption. Climates in which Consumptives Recover, or are Materially Benefited.

Health Resorts: Special Features.

Relation of Climatic Changes to Epidemics.

Changes of Climate due to Cultivation.

The effects of the Destruction of Forests, and other Changes incident to Civilized Life.

The relations of Diet and Climate.

What may be done to Improve or Modify Climates for the Promotion of Health and Comfort?

Geography of Carcinomatous and Sarcomatous Diseases.

Geography of Bright's Diseases.

Climatic Factors which Produce Epidemic Influenza.

Relation of Climate to Rheumatism.

Relation of Climate to Catarrhal Diseases.

Relation of Climate to Longevity.

Waters and Climate.

Climatic Effects upon the Eye.

Relations of Climate to Diseases of the Ear.

The Effects of Sun Spots upon Climatic Conditions.

What more can the Weather Bureaus do to aid Climatologists and disseminate Climatological Knowledge?

Comparison of Climate Differences as manifested by Similar Diseases in the North and South Temperate Zones.

Climatic relations to Remittent and Periodical Fevers, and to Continued Fevers.

Climatic relations to Malaria.

Acclimation. Disorders produced by Migration.

It is the purpose of the committee, with the advice of the council, to arrange for a report from each state and country of its climatic peculiarities. The health resorts of each state and section will also be properly represented.

The bearing of climate upon such diseases as Rheumatism, Catarrh, Cancer, Bright's Disease, and generally upon Health and Longevity, will form especially interesting questions for consideration in the congress.

The committee would be pleased to have



suggestions as to topics and modes of proceeding, as well as those who may take part in the discussions. Proposals for membership of the Advisory Council are also invited.

All communications should be addressed to T. C. Duncan, M.D., Chairman of the Committee, World's Congress Headquarters, Chicago.

### THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

The next meeting of this association will be held in Louisville, Ky., under the presidency of Dr. J. McFadden Gaston, of Atlanta, Ga. We learn from the preliminary programme, which has been forwarded to us by the secretary, Dr. W. E. B. Davis, of Birmingham, Ala., that over thirty papers had been promised some time ago. Among those who have promised to contribute are Dr. Gaston, Dr. Vander Veer, of Albany; Drs. Coe and Wylie, of New York; Dr. Joseph Price, of Philadelphia; Dr. Marcy, of Boston; Dr. Vance, of Louisville; Dr. Potter, of Buffalo; Dr. Kelly, of Baltimore; and Drs. W. E. B. Davis and J. D. S. Davis, of Birmingham. This vigorous young society has done admirable work, and we are glad to hear that the prospects for this meeting are very bright.

## Meeting of Medical Societies.

### CANADIAN MEDICAL ASSOCIATION.

*(Continued from page 502.)*

Dr. I. H. Cameron (Toronto): I have listened with great pleasure to the remarks of Dr. Bryce. I might say that quarantine of the old-fashioned kind is an exploded idea; the old-fashioned idea of putting people away for twenty or thirty days until the disease dies out will not meet the idea of life in the nineteenth century. The quarantine such as Dr. Bryce has outlined will be all-sufficient. Proof of that exists in the circumstance that, although the British ports had been exposed for some time to cholera, very few cases have occurred in the United Kingdom. By the prompt destruction of the germ in the way Dr. Bryce has suggested, the spread of cholera will be greatly prevented.

Dr. J. W. Milne (Vancouver): I am health officer of the city of Vancouver. You must discuss quarantine not only of the individual himself, but disinfection in every particular. To illustrate, although I do not wish to condemn any one at this time, either the Government or its officers, I will show how we were unprepared for smallpox in British Columbia. During the first week of June

the "Empress of India" arrived at Vancouver. She is one of the finest ships of the C.P.R. line. She brought over a large number of immigrants, chiefly Chinese, and some Japanese and other passengers. A Chinaman was found ill with the disease. He was quarantined at the station, eight or nine miles from Victoria, and the ship was disinfected. Only the Chinamen were detained. The Japanese and other passengers were allowed to go to Vancouver and everywhere. When that vessel left Japan, smallpox was epidemic there. Now the Japanese passengers should have been quarantined. The Japanese passengers went out through the country, and we have had smallpox there to a great degree; and to show you that our apparatus at that time was inoperative and not sufficient for the case, in the city of Victoria we had only one case for six weeks after the arrival of the ship, and within ten days afterwards we had forty cases in the city of Victoria. You can understand what a panic it caused. Although I have never made it known there, and though I have never asked for a commission to see how the disease came to spread so rapidly, I will show you one point that I believe was the cause of that disease spreading. Within three days there were, I think, six grocers all taken down with smallpox. Two or three of these grocers died, so you can understand the feelings of the people on that occasion. I believe the Japanese teas were one mode of infecting the people of the city of Victoria. If we had had the proper apparatus to disinfect the cargo at the time, I do not believe we would have had one-half the number of the cases that we had there. Forewarned is forearmed. The Government have since taken proper steps to have a proper disinfecting apparatus there, which should be, and I hope will be, sufficient.

Dr. Bergin (Cornwall): I think it is unfair to the Minister, and unfair to the country, that we should conceal anything that we think is absolutely necessary to be done to secure immunity in this country from cholera. Dr. Bryce has pointed out that he is merely outlining the general features of what he thinks necessary to be done at Grosse Isle, for all these things must be done. None of them can we afford to overlook if we would secure this country from cholera. Now, I would like to ask Dr. Bryce, who has lately visited Grosse Isle, what provision has been made for disinfecting the buildings there after the immigrants leave them, and before the passengers are introduced into the new buildings? I am asking this in the interest of the Government, and in the interest of the country. I am asking this more than all in the interest of the Minister, who, not being a specialist, has asked us to give him the fullest and freest information today. I am asking him whether we are provided with the best and most thorough material for disinfecting the ships—whether we have it for disinfecting the cargoes as well as for disinfecting the clothing? I ask what means we have—and Dr. Bryce has incidentally directed attention to it—what means we have of reaching the ship with the necessary material for disinfecting it? I would ask what means we have for removing the passengers safely and comfortably from the ships to the island? I would ask what means we have for thoroughly disinfecting the ships before the passengers are returned to them, or whether it would not be better

for the Government to provide such a vessel as Dr. Bryce has spoken of as being in use in Philadelphia, and whether it would not be, in the emergency, the better means to take for using the apparatus I have mentioned?

Hon. Mr. Carling : I can assure you it gives me very great pleasure, indeed, to meet the Canadian Medical Association. This discussion shows that you are fully alive to the interests of the country, and prepared to do everything you can to prevent anything like an epidemic of cholera in this great Dominion of ours. I can assure you that the Government are fully alive to the importance of having everything that can be done (as has been said by my friend, Dr. Bergin) by the Government of the Dominion to prevent cholera appearing in Canada attended to before next spring. (Applause.) We sent to Toronto, and the authorities there at the Isolated Hospital were good enough to let us have a disinfecting steam apparatus that they had constructed for use at Grosse Isle, at what they paid for it, and that they are now having a new one constructed. We are using that to the best advantage for this autumn, but for next spring we have plans and specifications, and are receiving offers for the construction of steam disinfectors to be made this autumn and to be placed in position this autumn, so that there will be appliances to disinfect any vessels that come up the St. Lawrence. I believe the largest vessel that comes up the St. Lawrence can be disinfected inside of 12 or 14 hours with these appliances. (Applause.) No stone will be left unturned to make every quarantine station in Canada as complete as it is in any other country in the world, not excepting the United States.

Dr. Bray : It has afforded me very great pleasure individually, and I am sure it has also every member of the association, to listen to your lucid explanation of what the Government is doing to prevent the introduction of cholera into this country. The object of inviting you here to-day, before this national association, composed of members from one end of the Dominion to the other, was to strengthen the hands of the Government, and of your department in particular, in the course that you are pursuing. When you have a body of scientific men who have made this subject a special study supporting the Government in the policy they are pursuing, I am sure it will not only strengthen your hands, but also tend to allay the fears of the public. I have very great pleasure in tendering you a vote of thanks from the association. (Applause.)

Hon. Mr. Carling : I am exceedingly obliged to the association for their kindness, and I hope this is not the last time that I shall have the pleasure of meeting you. I am sure it is the desire of the citizens of the capital to make your stay here as pleasant as possible. I concur in your opinion that the discussion to which we have listened to-day will be of advantage to the whole Dominion, and possibly beyond the limits of Canada.

Dr. Henderson (Ottawa) : In conversation with Prof. Webster, of Virginia, on the subject of cholera, he asked me to mention to the association that, during the late epidemic of cholera in the United States, he made inquiry as to the effect of occupation on the disease. He wanted a pointer as to prevention. He found that the mechanics

employed in workshops of copper almost entirely escaped the disease. He thought that this fact might be of value, and wished it brought before this association. His suggestion was that vaporized copper might be used as protection. If the vapor of copper in workshops prevented the comma bacillus from thriving, why should not the same vapor be used for the purpose of protection against cholera?

Dr. W. W. Dickson : I think the meeting should give an expression of opinion as to the disposal of the bodies and clothing of those that die of the disease. I think we should not go on burying the remains of those who die of such diseases as smallpox, cholera, and typhus. I think the bodies and the clothing should be destroyed by fire. It has been suggested that a committee should be appointed to prepare resolutions offering suggestions to the department as to the proper means of carrying out the idea which I have just been endeavoring to express.

Dr. J. A. Mullen : I think the committee should deal with the question as a whole.

Dr. Bray : I think this should be referred to a committee who will consider the matter thoroughly and report to the meeting, and the report will then be forwarded to the department.

Dr. J. E. White (Toronto) : I think the meeting should consider whether they are not reflecting on the officer of the department, who may be taking steps to do exactly what is now recommended to be done.

Dr. Bray : It would be indorsing his action.

Dr. Cameron moved that a committee be formed for the purpose of drawing up resolutions embodying the suggestions of this meeting on the subject.

The motion was agreed to, the committee appointed, and the meeting adjourned till to-morrow. The committee were : Dr. Bergin, chairman ; Dr. Bryce, secretary ; Drs. Dickson, Christie, Cameron, Playter, Milne, Lachapelle.

The committee brought in the following report, which was considered clause by clause, and adopted without amendment :

(1) That in the opinion of the association the time has come when public health interests demand the appointment of a permanent executive officer to supervise all matters relating to public health, such as quarantine and vital statistics, which are by law in charge of the Federal Government.

(2) That quarantine regulations should be made applicable to the protection of all the internal borders of the country, and that houses of observation and detention of suspects and hospitals for the treatment of the sick be supplied and equipped at Niagara and similar border points.

(3) That in view of the constant danger from clothing and baggage of immigrants, drying chambers should be constructed on every passenger ship, and their use enforced after the clothing and baggage are placed in the disinfecting solutions.

(4) That isolation rooms be supplied on the decks of all passenger ships for the treatment of those sick of suspected contagious diseases.

(5) That all passenger vessels be required to supply themselves with sterilizing apparatus for water for drinking purposes, such as that of West, used at the Philadelphia quarantine.

(6) That at quarantine stations all personal clothing, bedclothes, towels, etc., from the sick should be immediately placed in the disinfecting solutions, and that mattresses, pillows, etc., be burned immediately after use unless steam disinfecting appliances are at hand.

(7) That at whatever ports immigrants are to be permitted to land it is absolutely necessary (1) that facilities exist for housing and proper accommodation of suspects both from steerage and cabin, as well as for hospital accommodation, and extra tent accommodations should be always available; (2) that proper and sufficient bath-rooms be supplied at every station where suspects can safely and comfortably wash; (3) that a safe and adequate supply of wholesome water be always on hand; (4) that modern latrines, with proper conveniences for the observation of the defects of the subjects, be supplied, and that after disinfection the sewage from the latrines be disposed of in a manner that will insure perfect safety; (5) that furnaces and fans be fitted up either on the wharf or on the quarantine steamer, whereby holds and cargoes of ships can be rapidly and thoroughly disinfected; (6) that at every station where there is no deep-water wharf safe and commodious steamers be provided for landing passengers, and for patrol observation and other quarantine purposes; (7) that ample bedding and clothing be provided at every station to supply the necessities of persons landed from the ships; (8) that the means for the safe and speedy disposal of the dead at quarantine stations have been given careful consideration by your committee, and it is of opinion that the ordinary practice of burial employed in the past at such stations as Grosse Isle may, if continued, be attended with danger, and would hence tend to render these stations unfit for continued use as such, and under these circumstances it is believed that cremation of the dead is the best way of securing the safety of the living; (9) that, in view of the imminent danger of cholera reaching America in 1893, the association is of opinion that the Government may very properly consider the expediency of preventing immigration to Canada from infected countries; (10) that, in the opinion of the association, it is a matter for regret that, though it is twenty-five years since Confederation, no Government executive officer has yet been appointed to the charge of quarantine and other Federal health matters, and the association urgently presses the immediate appointment of such an officer, in order that the foregoing recommendations be carried out with the greatest possible rapidity, and that such officer should be a man of the highest scientific attainments, a well-known sanitarian, and one devoted to the work.

THURSDAY MORNING,  
September 22nd, 1892.

The president, Dr. Bray, in the chair.

Dr. J. E. Graham, of Toronto, opened the discussion in medicine by reading a paper on "Treatment of Pulmonary Tuberculosis." This paper was an exhaustive *résumé* of the treatment of phthisis as understood and taught to-day. Dr. Graham has fortunately spent the whole of last summer in Switzerland, and while there gave a great amount of attention to the prophylactic treatment of this disease, and he gave the association

the full benefit of his investigations. He concluded by saying that we ought to be encouraged by at least two circumstances: (1) The great number of cases of healed tuberculosis, as demonstrated by the *post-mortem* room. Osler found evidence of such present in 7.5 per cent. of those persons who died of diseases other than phthisis. Bouchard makes the statement that in 75 per cent. of the sections at the Paris morgue, some signs of previous disease had been found. In many cases, too, there had been a complete cure, as no cultivation nor successful inoculation could be made from the nodules. It is also a curious fact that in some instances where bacilli have been found, they will neither grow nor produce the disease in animals. (2) Many physicians of long experience can point to cases of complete cure. These facts ought to impress us with the importance of making an early diagnosis, so as to place the patient under the most favorable conditions possible, and at the same time ought to stimulate us in the discovery of new and better methods, so as to still further reduce the number of unsuccessful cases. "By intelligent and persistent efforts to destroy the bacilli, or to prevent their entrance into the body: by general sanitation; by the careful management of individuals who have a hereditary predisposition; and by the open-air treatment, if possible, in special hospitals, for incipient as well as advanced cases, the ravages of the disease would, in my opinion, be diminished by one-half, and perhaps to a much greater extent."

Dr. L. H. Bulkley, of New York, read a paper on "Lupus Erythematosus." The paper was discussed by Drs. J. E. Graham, F. Shepherd, and F. Strange, who all agreed that if the results claimed for the treatment should continue a troublesome complaint was about to be conquered, but that sufficient time had not elapsed to pass judgment.

Dr. T. Johnston Alloway, of Montreal, then read his paper on "The Dependence of Abnormal Eye Conditions upon Uterine Disease." The discussion was brief. Dr. Dupuis remarked that in almost every case reported the round ligament had been shortened, and asked Dr. Alloway to describe his operation, which was done.

The next paper on the programme was the discussion in surgery, which was opened by Dr. D. MacLean, of Detroit, in a very elaborate paper.

Dr. H. V. Moore continued the discussion, and referred kindly to the fact that he had been a pupil of Dr. MacLean's when he was professor in Queen's College, Kingston, that Ann Arbor had taken him away from us, and that which was our loss was their gain.

Drs. R. A. Reeve, Dupuis, and Hon. M. Sullivan paid eulogies to Dr. MacLean and his work.

Dr. Hingston took exception to some of the remarks that Dr. MacLean had made about lithotomy and lithotripsy, also about the relative advantages of internal and external urethrotomy, which brought Dr. MacLean again to his feet to defend his position. A vote of thanks was tendered for the interesting and scientific paper.

Dr. J. G. Balfour, of London, read a paper on "Administration of Chloroform and the Dangers Incident Thereto." Dr. James Grant, the acting chairman, in opening the discussion, referred to the uses of chloroform in the final stage of labor,

and extolled it greatly. The discussion was continued by Drs. MacLean, of Detroit; Hill, MacLaren, and others.

Dr. F. Shepherd, of Montreal, presented a unique case of nerve suture, in which the brachial plexus had been severed, and the different branches united after some months having elapsed since the accident. The condition had very materially benefited by the operation. It elicited remarks from Drs. Dewart and Hill, of Ottawa, who had seen the case prior to the operation.

Dr. F. Shepherd also read a paper on "Intussusception, and its Treatment by Operation," in the discussion of which Drs. Hill, Bergin, Christie, and others took part.

Dr. Harrison, of Quebec, presented a report of a case of "Gunshot Wound of the Abdomen," which was discussed by Drs. Jas. Bell and I. H. Cameron.

Dr. Harrison, of Selkirk, opened the discussion in obstetrics, in the absence of Dr. J. Chalmers Cameron, of Montreal (who was to have opened the discussion), and apologized for the fact that as he was supposed to follow Dr. Cameron's lead, and that he had not known what line would be followed, he had not prepared his remarks; but even in the impromptu remarks that he made a wonderful amount of good, sound advice, plain statement of facts, as well as a review of obstetric operations since his early professional life, were embodied, and it was one of the most enjoyable half hours of the meeting.

Dr. Machell, of Toronto, presented a specimen of bowel from a case that he had invaginated some days previously in Toronto.

The meeting was then adjourned—the next meeting to be held at London in September, 1893.

## Correspondence.

### UNIVERSITY SENATE ELECTIONS.

Editor of THE CANADIAN PRACTITIONER :

SIR,—In your editorial on the University Senate elections you say:

"Those who organized the opposition worked with tremendous determination, and left no stone unturned to attain their ends. The friends of those whom they wished to defeat took up the gauntlet with unbounded enthusiasm when they obtained some knowledge of the true inwardness of the attack. . . . What dreadful thing happened in the Medical Faculty of the University of Toronto to divide its members into two factions engaged in an unholy war? I know not."

Now I submit that these two extracts convey two scarcely consistent impressions. If the friends of yourself and Drs. McFarlane and Aikins knew something of "the true inwardness of the attack" on you, how is it that you did

not, or do not, know why the members of the faculty were divided into two "factions"?

I have hitherto thought that you knew, but that the enthusiasm of your friends did not permit them, when in the thick of the fight, to recognize the true character of the situation, and I am aware that they fought for you and Drs. McFarlane and Aikins with the notion that the opposition to you was based on personal grounds. Now you say you do not know. Evidently you do not feel quite certain that your friends had, after all, some knowledge of the "true inwardness" of the affair.

If my interpretation of your language is correct, then it is possible, I believe, to convince you that the opposition to yourself and Dr. McFarlane was, and is, based on other than personal grounds. For that purpose I am ready to discuss, temperately and fairly, in the columns of THE PRACTITIONER, in the University Council, or in the Medical Faculty, all the causes of that opposition. That you do not know why myself and others have opposed you is not my fault; since I endeavored, over two months ago, to make my attitude toward you and Dr. McFarlane, and the reasons for it, perfectly clear to you.

You say also: "I regret exceedingly that Dr. John A. Mullin, of Hamilton, should have been dragged into the fight, and subjected to the humiliation of a defeat through no fault of his own." The word "dragged" and the expression "true inwardness" smack somewhat of an imitation of the ruling habit of *The Ontario Medical Journal*. Wherein consisted the humiliation? Dr. Mullin was defeated, it is true; but he stood up and fought fairly, and neither he nor any one of his colleagues of the ticket solicited votes for himself or collected ballot papers, to say nothing of plumpers. Had he or his colleagues done these things, defeat to them would have been a humiliation. These are stones which they left unturned. On the other hand, how can a success, in which these methods were important factors, be reconciled with the dignity of the university?

You cannot wish more heartily than I do for accord and union in the Medical Faculty. That may be attained, in my humble opinion, by the members of the faculty dealing with the "true inwardness" of questions of policy in a large-

hearted way, and not by referring to the motives of those on the one side or on the other. I find in the policy for which you are to a certain extent responsible, and which is, I think, a bad one for the university in the long run, quite enough to keep me from troubling myself about the motives of yourself and your friends; and against that policy, whether it has the support of friends or foes, I propose to fight, in season and out of season, with a determination, I trust, undamped by any failure which the hour may bring. Yours, etc.,

Toronto, Nov. 7.

A. B. MACALLUM.

[I presume that Dr. Macallum, in the above letter, refers to his circular of August 25, when he says I ought to know why he is opposed to me. I may briefly say, with reference to that circular, that the statement that I have done any thing directly or indirectly to lower any standard in the University of Toronto is absolutely untrue. Personally, in a certain sense I cared nothing about the contents of the circular; but, I must confess, its issue caused me no little surprise. Dr. Macallum showed a great amount of magnanimity in accepting a professorship in the university, not because he wanted it, but because he desired to improve matters in the Medical Faculty. His charming method of giving expression to this aspect of his position was really quite touching in its modesty and simplicity. Perhaps the utterances of one so disinterested were worthy of more consideration than they received.

He told us in his circular that he had been for seven years a university examiner in the Medical Faculty. He had, during that time, seen many iniquitous things in the way of standard lowering. It seems to me an extraordinary thing that this great and high-minded man allowed the Senate to remain in ignorance of such facts for many years, and chose the middle of a bitter election campaign to give his information to the public, evidently for the purpose of making capital for himself and his colleagues.

But he didn't solicit votes for himself; therefore, it seems to be all right. Personal canvassing is very undignified. The "come tickle me, Tommy, and I'll tickle you" plan of conducting an election contest is better form. Each candidate in the combination can look holy and virtuous, as he works only for his colleagues, and

relies on a generous reciprocity and the work of a thoroughly organized committee to bring in the votes. I have no desire to quarrel with the method; I rather like it, especially as I find it is such a source of comfort to a man like Dr. Mullin, who, as I thought, had been rather badly treated. I may say in this connection that I hope my allusion to Dr. Mullin was not considered unkind. What I said with reference to him was founded on information derived from one of his warmest friends. I certainly thought that he had gone into the contest with great reluctance.

It is somewhat unfortunate, in connection with Dr. Macallum's non-solicitation of votes, that so many strange rumors have reached us from western towns, where he made friendly calls on the resident physicians. It is well to know, however, that he was probably doing good missionary work, and nothing so wicked as soliciting votes. Will our friends in the west who have wrong ideas on the subject kindly make a note of this fact?

Dr. Macallum intimates that he will continue (as he expresses it) "to fight in season and out of season." I quite believe him; and if he can sacrifice or injure an occasional friend while on the warpath, it will probably give him immense satisfaction, because it furnishes such tangible evidence of his earnestness in his cause. In another portion of his letter he speaks of his readiness "to discuss temperately and fairly," etc.

"Now I submit that these two extracts convey two scarcely consistent impressions" (Macallum.) It may be, however, that the doctor, in talking about discussing anything "temperately and fairly," was simply becoming facetious.—A.H.W.]

## Book Reviews.

*The Diseases of the Stomach.* By Dr. C. A. Ewald, Extraordinary Professor of Medicine at the University of Berlin, etc. Authorized translation from the second German edition by Morris Manges, A.M., M.D., attending physician to outdoor department, Mt Sinai Hospital, New York city, etc. Pp. 495, 30 illustrations. New York: D. Appleton & Co., 1892; Toronto: J. A. Carveth & Co.

A review of an important new work like this should contain at least an allusion to the work.

of both publishers, translator, and author. The printer's errors are very few, the letter-press clear and distinct, the paper and binding of the best. For the translator too much cannot be said in praise of the way in which he has done his part. No Teutonisms appear on careful reading, and every one knows how hard it is to make the English of a translation sound like English at first hand, and avoid the idioms and idiosyncrasies of the original. The style and literary merits of this translation are superior, one may safely say, to the majority of treatises originally composed in English upon medical subjects.

But for the more important part played by the author we may say, first, that the series of lectures of which this is the second part in the trilogy was Ewald's *Feriencourse für praktische Aertze*. The first volume "discussed the physiology of digestion in its practical relations," and the third, not yet published, is to take up intestinal diseases. The lectures are clinics, stenographically reported, with cases presented and detailed. The subjects upon which most stress is laid are gastric dilatation, gastric ulcer, gastric cancer, and gastric catarrh. A chapter of peculiar excellence upon the "Innervation of the Stomach," written by the author's brother, Dr. R. Ewald, Professor of Physiology at Strasbourg, must also be mentioned, as well as those upon methods of examination, especially the use of the stomach tube, and the chemical examination of stomach contents. One of the author's peculiar merits is his freedom from every rule of thumb, from enslavement to anything absolute or mechanical in determining his diagnosis. The exception is always as clearly stated as the rule, and yet the vagueness to which this might be expected to lead is neutralized by his large clinical experience. His views are advanced, not to say peculiar in certain cases, but well tempered by sound conservatism. The obscure question of the causation of gastric ulcer is well discussed, and decided opinions given on such points as the connection between floating kidney and gastrectasia, and the value of peptonized rectal injections. He claims that it is useless to peptonize them. The pathology of each disease is taken up at great length, and is of the most modern kind. For instance, he does not believe in melanotic car-

cinoma, and has the very latest views on "gastric anadenia." The national pride of the author is so evident as to be almost amusing. English writers (the bibliography of the work is very extensive) are treated with more consideration than French, though he fairly tries to give honor where honor is due, and in no case treats an opponent discourteously. "The failure to recognize a cancer probably occurs less frequently with us in Germany than elsewhere." "The Germans were the first to destroy this conception of dyspepsia as a disease"—such sentences as these occur, but are perhaps fairly counterbalanced by others of the opposite strain. The author's remarks on the use of *condurango* in gastric cancer cannot be omitted from a critique already too long: "Like so many of our new remedies, it owes its reputation as a specific to the implicit faith of some half-civilized or wild Indians, and to the speculation of enterprising exporters. At first it was received by acclamation by the medical world, which is pervaded by a surprising *naïveté* and an ineradicable optimism whenever new specifics for incurable diseases are introduced." Thus much of a concession to conservatism, sound and worthy, while the text-book is fully abreast of the times, and most valuable to the general practitioner who reads it.

*The Essentials of Histology, descriptive and practical, for the use of students.* By E. A. Schaper, F.R.S., Jordell Professor of Physiology in University College, London; Editor of the Histological Portion of Quain's "Anatomy." New (third) edition, revised and enlarged, illustrated by more than 300 figures, many of which are new. Philadelphia: Lea Brothers & Co., 1892; Toronto: J. A. Carveth & Co.

This really excellent little work on histology will be welcomed in its third edition by both students and teachers. A better work on the subject in the English language can hardly be found. None contains in so small a space the valuable information this one does. It has rightly deserved the popularity it has already gained. It will not lose by this new appearance. Some valuable additions and changes have been made, particularly on the subjects of muscle and of the central nervous system and nerve-endings. The chapters on muscle have been changed to

correspond with the latest work on the subject, and to make the subdivision of the work that holds throughout the book into lessons more effectual. The additions to the chapters on the central nervous system and nerve-endings illustrates well the value of Golgi's, Marchi's, and the author's modifications of the Weigert-Pal methods of preparation. These methods have been added to the already valuable section of this book devoted to "General Methods of Preserving and Hardening Tissues and Organs." The illustrations are good; the text is clear, concise, and readable. It is an excellent work for the student.

*Pye's Surgical Handicraft.* A manual of surgical manipulations, minor surgery, and other matters connected with the work of house surgeons and surgical dressers. First American, from the third London edition. Revised and edited by T. H. R. Crowle, F.R.C.S., Surgical Registrar to St. Mary's Hospital, etc. New York: E. B. Treat, 5 Cooper Union, 1892. Toronto: J. A. Carveth & Co.

This work has been before the profession since 1884, and it has now reached its third English edition. We think that the publishers have done wisely in arranging an American edition of this useful manual. It is stated that the work is mainly intended for house surgeons and surgical dressers; to such we heartily recommend it as a useful guide in the wards and in the operating room. It is essential that a house surgeon should provide himself with a reliable text-book, in which he will be able to find all necessary information with regard to the uses of the various forms of surgical apparatus, and in which he may learn of the principles involved in their application. We can confidently affirm that the work at present under review will be found thoroughly reliable and admirably suited for the purpose indicated. The work forms an excellent treatise on minor surgical operations. The chapter on fractures is carefully written, and is most comprehensive; the uses and abuses of splints being fully and clearly set forth. The general practitioner will find this book of value, in that it presents a large amount of information concerning surgical appliances which it is difficult to obtain from the larger works on surgery, such as the method of applying plaster-jackets,

the methods of using different forms of apparatus for club foot, etc.

The publishers have presented us a very neat volume, printed in clear type, on good paper. The illustrations are excellent.

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## Personal.

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THE Hon. Edward Blake sailed for England, Nov. 2.

DR. WM. B. THISTLE was elected President of the University of Toronto Medical Society at the first meeting of this session.

DR. LAPHORN SMITH, of Montreal, was elected a Fellow of the American Gynecological Society at its recent Brooklyn meeting.

DR. EDGAR M. HEWISH (Vict. '83), of Philadelphia, paid a short visit to Toronto on the first week of this month.

AT a meeting of the corporation of the Toronto School of Medicine, held November 10, Dr. J. E. Graham was elected the representative of that body in the Senate of the University of Toronto.

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## Obituary.

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GEORGE ROSS, M.D.—McGill Medical College has sustained a great loss in the death, Nov. 9, of Dr. Ross, Associate-Dean of the Faculty. He had succeeded Dr. Howard as Professor of the Practice of Medicine, and was one of McGill's most gifted men. He was only 47 years of age at the time of his death, but he had lived long enough to become recognized as one of Canada's greatest physicians. His confrères in Montreal had given him the highest honors at their disposal. He was President of the Canadian Medical Association in 1890. His health had been failing for some years, and his last illness was somewhat extended. His friends, and they were many, in all parts of our Dominion, have our heartfelt sympathies in their sad bereavement.

## Therapeutic Notes.

THE USE OF COD LIVER OIL IN RHEUMATISM.—Cod liver oil has obtained such a definite reputation against tuberculous and scrofulous affections that we are apt to forget its virtues in other maladies. In the first instance, it was employed against chronic rheumatism, and gained enthusiastic opinions. I have before me the original report in reference to this latter use by Dr. Bardsley, of Manchester, who in April, 1807, wrote that it had then for thirty years enjoyed a very high local reputation. It had been much used in the Manchester Infirmary by Dr. Percival and by Dr. Bardsley himself. The latter reports that it is variable in its efficacy, often in the mild and more common forms not doing any appreciable good. He thought it most useful in chronic cases in elderly persons and in women debilitated by parturition. He thought that it seldom did good unless it fattened. His dose was half an ounce to an ounce and a half twice a day, and he found warm beer to be, with the laboring classes, the favorite vehicle. If benefit was obtained, it ought to be continued for six or eight months. He asserts: "I have seen a few patients recover entirely by the exhibition of the oil who on their admission into the house were unable either to preserve the body in an erect position, or support its weight on the lower extremities." The consumption of cod liver oil in the Manchester Infirmary from 1776 to 1807 had averaged fifty or sixty gallons annually. It now amounts to four hundred gallons. The profusion with which new chemical remedies have been supplied to us of late years may, it is very possible, have led to the comparative neglect of old ones, and that, perhaps, not always to the advantage of our patients.—*Archives of Surgery*.

THE TREATMENT OF HEPATIC COLIC.—Coladon (*Wiener. medicin. Presse*, No. 33, p. 1330) describes among the prodromes of an attack of hepatic colic a peculiar drowsiness; general lassitude, notwithstanding sound sleep; irregularity of pulse, especially at the temples; a false sense of hunger; a sense of emptiness in the epigastrium, or distinct nausea; a sense

of contraction of the œsophagus; eructations and polyuria. Then follow a sense of pressure in the hypochondrium, abdominal distension, and tenderness in the region of the gall-bladder. During this stage treatment should be expectant; purgatives and emetics do harm. Absolute mental and physical rest are to be recommended, together with a restricted diet. When the attack has set in, subcutaneous injections of morphine, particularly at first, are to be avoided, on account of the danger of causing impaction of the calculus. Inhalation of chloroform, short of complete anæsthesia, will serve to mitigate the intensity of the pain without diminishing the contractility of the biliary passages. The application of a hot-water bag to the epigastrium and another to the back is also a useful measure. As the attack is coming to an end, purgatives are to be given for the purpose of carrying the calculi out of the intestinal canal. Cholagogues find an indication here, of which ox-gall and podophyllin are to be preferred. Podophyllin is to be given in small doses for several days. To prevent the recurrence of an attack, the best measure is a careful regulation of the diet. Cold douches upon the right hypochondrium are useful. Massage of the hypochondrium is an important mechanical prophylactic measure, and may be practised by the patient daily, morning and evening, for fifteen minutes.—*Medical News*.

FILTERED OR BOILED WATER?—M. A. J. Martin, under this title, presents a very carefully studied paper. Recognizing the fact that many filters, so far from separating the bacteria, may even make the water richer in these organisms, this method cannot be recommended. Boiled water has lost its carbonic acid gas, and the salts of lime and magnesia are precipitated; the taste is flat, although on standing in a cool place it reabsorbs the greater portion of the lost gas. Even boiled water ought not to be long preserved. The problem apparently was solved in heating the water without loss of air, cooling it mechanically, and adding oxygen by means of an air-pump, or it can be boiled in closed bottles. Various ingenious apparatus have been devised for boiling water in closed vessels under pressure, and cooling it in the same apparatus. Investigations



have shown that the slight differences observed in the chemical composition of the water before and after sterilization have not altered its potability. With a filter, one can drink only the water of which he knows the source; with boiling, one can use any water. Boiling, then, should be the procedure of choice as soon as any suspicion arises; it should be the rule, especially in large cities, during the progress of any epidemic.—*Gazette hebdomadaire de Médecine et de Chirurgie—American Journal of Medical Science.*

**THE ACTION OF CHLOROFORM ON THE HEART.**  
—According to a telegram received from Surgeon-Major Lawrie on Monday last, he has by means of a series of ingenious experiments at last succeeded in obtaining irrefutable proof of the Hyderabad Commission that chloroform does not act directly on the heart. By a modification of the experiment of cross-circulation, he was enabled to investigate the action of chloroform vapor on the nervous system apart from the rest of the organism, and *vice versa*. Briefly stated, he found that if the blood containing the chloroform vapor were prevented having access to the brain no effect is produced on the respiration function, the blood pressure does not fall, and anæsthesia is not brought about. By reversing the experiment, the chloroform-laden blood circulating in the brain only, the characteristic fall of blood pressure occurs and anæsthesia follows. It is of course impossible to criticize results until we have been made acquainted with the details of the experiments; but unless some flaw in the *modus operandi* vitiates the findings, the results of Mr. Lawrie's investigation would appear to furnish the actual proof of the much-contested conclusion formulated by the Hyderabad Commission.—*Medical Press and Circular.*

**BENZOATE OF SODA IN THERAPEUTICS.**—Dr. Liégeois has written an exhaustive paper on the value of benzoate of soda in therapeutics. He considers this agent as of the greatest importance in the affections below named, provided it is given in large doses. The pain, dysphagia, and inflammation of the pharynx in the common sore throat are favorably modified and cured in two or three days by the admin-

istration of 1 drachm in children, and 3 drachms in adults, of benzoate of soda daily. In diphtheria it is certainly of service either internally or in insufflation, but is not equal to applications of salicylic acid. In laryngitis and the ordinary acute bronchitis, M. Liégeois considers it as a good expectorant when given at the onset. He prescribes it as follows:

R.—Benzoate of soda ʒj.  
Tinct. aconite, *m xx*.  
Cherry laurel water, ʒj.  
Syrup of tolu, } *aa* ʒ ij.  
Syrup of codeine, }  
Water, ʒij.

To be taken in the twenty-four hours.

Associated with tannin, benzoate of soda gives good results in Bright's disease if persevered in:

R.—Benzoate of soda, } *aa* ʒ jss.  
Tannin, }  
Ext. of gentian, q. s.

Divide into 100 pills. Take 6 daily.

Given in small doses in uric acid gravel, it transforms the insoluble urates into soluble hippurates, and thus eliminates it from the urine. As a cholagogue, benzoate of soda occupies the first rank; he associated it with salicylic of soda and rhubarb:

R.—Benzoate of soda, } *aa* ʒ j.  
Salicylate of soda, }  
Rhubarb (powdered), }  
Nux vomica (powdered), grs. x.

Divide into 20 powders. Take 2 daily.

—*Medical Press.*

**RHEUMATIC BRONCHITIS.**—

R. Sodii salicylatis . . . . . ʒvi  
Glycerine . . . . . ʒiv  
Vini colch, rad . . . . . ʒvi  
Syr. scillæ comp . . . . . ʒiiss  
Tr. opii camph . . . . . ʒij—M.

Sig.—A teaspoonful every three or four hours in a little water.—*Dr. N. S. Davis, in Med. and Surg. Reporter.*

**MIXTURE AGAINST VOMITING.**—

Menthol, . . . . . ʒss  
Alcohol, . . . . . ʒss  
Syrup, . . . . . ʒiiiss

A teaspoonful every hour.

—*Med. Press and Circular.*

THE DIETETIC TREATMENT OF ULCER OF THE STOMACH.—Dr. F. Roux states that the treatment of this disease must not be based upon the principle of reducing the work done by the stomach to a minimum. The diet must consist of substances which are digested in the intestines, such as milk, eggs, farinaceous food, fruit, and green vegetables. Farinaceous foods play an important part in the treatment of gastric disease; together with eggs they should constitute the chief diet; but, in order that they might not irritate the gastric mucous membrane, they should be administered in a soluble form. Of potatoes, beans, and lentils, the meal of the latter is probably the best, as it contains a large amount of nitrogen and a quantity of iron equal to that contained in meat. Light puddings are nutritious, especially when made with eggs; green vegetables are useful; carrots and turnips should be mashed; green peas and salads may be eaten; cabbage should be prohibited; fruits should be cooked, as they are not readily digested in the raw state. The single exception to this are grapes, which can be given at any time and in any quantity, especially if constipation is present. They are best taken in the morning and middle of the day.—*Journal d'Hygiène*.

FOR INTESTINAL ANTISEPSIS, Dujardin-Beaumont suggests the following:

Rx. Salol,  
Salicylate of bismuth,  
Bicarbonate of sodium, aa 150 grains. M.

Sig.—To be divided into 30 powders in capsules. One capsule to be taken before breakfast and before dinner.—*Coll. and Clin. Record*.

ANTIPYRIN IN EPISTAXIS.—Dr. E. G. West, of Boston, says he has yet to find an agent so reliable in epistaxis as antipyrin. It is his custom, when a case of unusual violence occurs, to saturate a pledget of cotton with a solution of antipyrin or with the dry powder, and introduce it into the nostril. It has stopped the bleeding in every instance that he has applied it. The patient, by this method, is spared the disagreeable tarry clots formed by the solutions of iron so commonly used for this purpose.—*N. Y. Med. Jour.*

WHEN it is desirable to prescribe podophyllin it is well to remember its solubility in tincture of ginger, in which it may be administered as follows:

Rx. Resinæ podophylli, - gr. ij  
Tinct. zingiberis, - . f̄j. M.

Sig.—Dose, a teaspoonful in a glass of sweetened water on retiring.—*Med. and Surg. Reporter*.

FOR OFFENSIVE PERSPIRATION.—Filter paper impregnated with a solution of salicylic acid, laid between the toes and around the foot prior to drawing on the stocking, will, it is said, entirely prevent any foetid odor from the perspiration of the feet.—*American Druggist*.

## Miscellaneous.

CANADIAN DOCTORS AND THE ANNUAL TAX.—The medical men of Ontario view with extreme disfavor the proceeding of the Medical Council in obtaining legislative authority to impose an annual fee of two dollars and a certificate of registration from every medical practitioner, and a conference recently took place between the Legislative Committee of the Ontario Medical Council and representatives of the Medical Defence Association. In addition to the objections taken to the annual fee, the Defence Association demand that the territorial representation on the council be increased from twelve to seventeen, and that the number of representatives from the universities be cut down. After a long discussion, the Legislative Committee agreed to an increase in the territorial, *alias* provincial, representation on the council, and to the suspension of the amendments to the defeated 1890 Act, which provide for the annual tax, but they declined to advise that the number of university representatives be curtailed. The Defence Association is not satisfied with these apparent concessions, on the ground that the penalty for non-payment of the tax, viz., erasure from the register, was never enforced, and was therefore *de facto* suspended. The association is an influential body, and we trust they may effect in Ontario what the profession over here is beginning to clamor for; that is to say, a reduction in the number of

council members representing petty corporate interests, and an increase in the proportion of elected members. Such a reform would be worth paying two dollars a year for.—*Med. Press and Circular*.

**CYCLING FOR CHILDREN.**—Something like a newspaper controversy is going on as to the question whether cycling is injurious to health. The matter was very well put by Dr. Luff in his address to the students at St. Mary's Hospital, and extensively quoted from our pages in the public press. Cycling is no exception to the golden rule of moderation in all things. It is the pace that kills, and unfortunately most cycling clubs appear to be disposed to encouraging racing unduly. This is a great mistake; it makes the mere traversing of the ground an end, whereas it ought only to be a means to an end. The safety bicycles, which are now the favorite pattern, encourage, if they do not compel, a style of riding which tends to bow the back and contract the chest. The effect on boys and youths who are not naturally well developed is undoubtedly injurious, and we should regard with some suspicion the advice given by a medical writer in the *Bicycling News*, which would encourage parents to let their children bicycle. The tricycle is much better adapted for them, and, if of proper size and properly adjusted, its use may be of benefit if the amount of exercise is carefully regulated. Probably the best companion for a child is a middle-aged rider who traverses a moderate distance, at a moderate pace, who will not indulge in trials of speed against time, and is not ashamed to dismount at a hill too steep to be ridden with comfort. The strain upon the heart on a steep incline, especially if the surface is bad, may be seriously injurious.—*Brit. Med. Jour.*

**THE VICE-CHANCELLORSHIP OF THE UNIVERSITY.**—At the meeting of the Senate, Nov. 11, Mr. W. Mulock was re-elected vice-chancellor, practically without opposition. It was conceded by all that he would be elected as a matter of course, but certain parties wished to place themselves on record as voting against him, and Dr. I. H. Cameron good-naturedly allowed himself to be the medium for their purposes. The vote stood: Mulock, 31; Cameron, 15. Dr. Cameron

explained that he did not wish the position, and could not take it if he were elected. Notwithstanding his explanation, his action in allowing his name to stand caused considerable surprise, and, in some quarters at least, regret.

**THE WINYAH SANITARIUM** for diseases of the lungs and throat, in Ashville, N. C., was destroyed by fire, August 24; but the occupants (175 in number) were removed without any accident. We understand the sanitarium is being rapidly rebuilt, and it is expected that the new structure will be ready for the reception of patients, on Nov. 20, and will still be under the direction of Dr. Karl Von Ruck, who is very well known in the United States, and to a certain extent in Canada, through his contributions to medical literature.

**MESSRS. LEA BROTHERS & Co.** will shortly issue a text-book on Nervous and Mental Diseases, by Dr. Landon Carter Gray, Professor of Diseases of the Mind and Nervous System in the New York Polyclinic.

**ALARMED.**—Physician (after examination)—Well, colonel, you have water on the brain. Kentuckian—Great heavens, doctor! Is there any danger of it reaching my stomach?—*Life*.

**THE** books and surgical instruments of the late Dr. John Fulton will be sold by auction at The Mart, 57 King street east, Toronto, on Friday, Nov. 18.

It is said that the numbers of medical students in Edinburgh are much less this session than they have been for several years.

**THE** second International Dermatological Congress was held in Vienna from September 5th to 10th, 1892.

**ANTIPYRINE** is reputed to possess hæmostatic properties when applied to the bleeding part in the form of a saturated aqueous solution.

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