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# QUEEN'S MEDICAL QUARTERLY.

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Old Series

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QUEEN'S MEDICAL QUARTERLY is presented to the Medical Profession with the compliments of Queen's Medical Faculty. Contributions will be gladly received from members of the Profession and willingly published.

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BUSINESS MANAGER: W. T. CONNELL, M.D.

This number is issued under the supervision of  
Dr. W. G. Anglin.

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**P**LANS for the new Medical Laboratories building are well under way. The grant of fifty thousand dollars from the Ontario Government is to be used for this purpose, and although it is impossible to get all the accommodation needed for this figure, it is expected that a very fine modern structure will be erected with everything in it up-to-date. At the request of the Faculty Dr. Ryan and Dr. W. T. Connell recently visited the new laboratories of the Harvard Medical School in Boston, and many details in furnishing and equipment will be introduced as a result. Mr. Joseph Power, the architect for the Faculty, is now preparing specifications and by the first of August it is likely work will be under way and that before winter the roof will be on. Then next spring will see it ready for furnishing and installation of equipment. The plans provide for a three story building, eighty-five feet frontage and about seventy feet deep. On the ground floor will be two lecture rooms and the museum. Each of the former will be twenty-five by fifty feet, to seat 120 students. The first and second floors are almost identical in arrangement. There will be four large laboratories in all, each of these being twenty-five by fifty feet. Then there are preparation and apparatus rooms, public health room, and some small rooms for carrying on research work. The animal room will be in the attic and will be

made sanitary in every respect. The preparation rooms, where incubators and ovens are necessary, will be fireproof, as recent experience shows the need for this. The building will be heated from the central plant. A very satisfactory site has been chosen close to the old medical building and with the front to the south. Excellent light will be available for all the rooms, and it will not be difficult to extend the building when another fifty thousand is given for the purpose. The building committee consists of Drs. Ryan, Garrett, Knight, W. T. Connell, Prof. A. K. Kirkpatrick, Mr. D. M. McIntyre, Rev. Dr. Macgillivray and Dean Connell as Chairman. Before the next issue of the QUARTERLY it is likely the corner stone will be laid and we may then be able to publish a cut of the building as designed. Next year it is proposed to remodel the interior of the old building so as to enlarge the dissecting and lecture rooms.

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#### THE FIRE IN QUEEN'S MEDICAL BUILDING.

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ON the morning of July 4th fire broke out in the incubator room of the Medical building, but, fortunately, had not made serious progress before being discovered by workmen on coming to work on the new gymnasium building on college grounds. The city fire brigade after a sharp fight quenched the flames, which were confined to the three rooms overlying one another in the south-west corner of the main building. The fire did not reach the roof, and apart from these three rooms the only damage done was by water and smoke. The contents of the rooms destroyed were unfortunately some of the most valuable in the building, including the library and the incubator and sterilizing apparatus of the bacteriological department, so that the loss on contents is considerably greater than on the building itself. The building was well covered by insurance, and an agreement has been reached with the insurance companies to assess the damage to building itself at \$1,500 (Fifteen hundred dollars). This shows how grossly exaggerated

were the reports contained in the local press and sent out by the associated press, e.g., one Toronto daily stated our loss as over seventy thousand dollars. These reports will no doubt do much injury in deterring students from entering the Medical department owing to supposed loss of building. Immediately after the insurance appraisal a staff of workmen were set to work, and already the work is so advanced that the entire building will be in first class shape by the 20th August.

Sufficient apparatus has already (July 20) been secured in the Bacteriological department to carry on the routine Public Health work now done in this department. Orders have already been placed for a complete outfit of incubators and sterilizers, and delivery is promised by the 1st of September.

The replacement of the Library will be a slower process, as unfortunately many bound copies of scientific journals were destroyed, many of which it will be difficult, if not impossible, to replace. It is expected, however, that the connection of the library with the Association of Medical Libraries will make this task easier, as duplicate copies can be secured in many instances.

Fire at any time is an undesirable visitor, but the Medical Faculty feel that they were at least fortunate in that the fire area was so limited, and that the fire occurred at a season of the year when repairs could be effected without interference with class work.

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### VASOMOTOR AMAUROSIS.

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THIS has reference to sudden blindness of brief duration, and, in the case related, limited to one eye. Very little literature is available on the subject, and most of what has been found is indefinite and unsatisfactory. Hughlings-Jackson speaks of "epileptic amaurosis" as a limited or substitutional attack in which the visual aura is the only symptom. Spratling describes a "retinal epilepsy" in which there is sudden blindness of both eyes of brief duration and not followed

by convulsions. Noyes, in his "Diseases of the Eye", gives a very interesting statement and history of a case.

My case is as follows :

The patient is a young business man, aet. 30, who first consulted me in August, 1905. His family and personal history were of the best. The single symptom of which he complained was periodic attacks of blindness in the right eye. For a year previous he had had these about once a month, and one had occurred a few moments before I saw him. Since that time they have become frequent, until lately only about ten days have separated the attacks. He describes an attack as a gradual closing in of the field of vision from the periphery till nothing can be seen and then a gradual clearing, in the reverse order, till vision is quite restored, the whole time involved being about three minutes. There is no warning of the onset, no headache before or after, and no association with any particular use of the eyes. An examination shortly after an attack does not show any variation from normal conditions. There is no narrowing of the field of vision, nor change in color sense. I have not been able to examine the eye during an attack.

Now in this case there is no suggestion of hysteria, migraine or epilepsy, so I have ventured to use the term "Vasomotor Amaurosis" as describing most accurately what likely takes place. In the case reported by Noyes an ophthalmoscopic examination was made during an attack and the arteries were found reduced in size, the veins being normal. The attack passing off in a few minutes the arteries grew larger and were then like those of the other eye. There were no signs of effusion.

The blindness is thus due to suspension of the retinal circulation in consequence of vasomotor irritation. Probably the origin of the irritation is in the superior cervical sympathetic ganglion.

The prognosis in such a case is of the utmost importance and interest. I can find no case recorded where the vision has been permanently affected. Dr. Noyes was of the opinion that the phenomenon should not be regarded seriously, and Dr. David Webster, who recently saw this case in consultation, writes that while he has seen similar cases at long intervals, he has never met one in which vision became permanently impaired.

J. C. CONNELL.

## EPIDEMIC CEREBRO-SPINAL MENINGITIS.

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**E**PIDEMIC cerebro-spinal meningitis is an acute, infectious disease, characterized by inflammation of the cerebral and spinal meninges, and runs a course of great irregularity.

The disease occurs in epidemics, one of which visited the Ottawa Valley in 1873; the second visitation was in the summer of 1905.

It is of the latter I wish to write. I have not been able to ascertain the exact number of cases that developed during this recent epidemic, but it was in the neighborhood of 125, of which I had an opportunity of studying 24.

I shall not in this short paper attempt to give the history or geographical distribution of the many epidemics of this disease which have appeared at intervals for the last century or more, but will refer the reader to such writers as Netter, Boudin or Hirsch, who have given this subject much attention, and who have been foremost in placing this most fatal malady on a proper basis.

In the description of this disease which follows I will ask the reader not to compare the symptoms with those of a classical meningitis, for as the disease occurs in many forms, and as epidemics of this disease are usually a law unto themselves, it necessarily follows that my description will be at variance in many respects with those of other writers on this subject.

During the course of this epidemic, which lasted from June until October, I observed four well-marked varieties: (a) The foudroyant; (b) The mild or ordinary; (c) The intermittent or chronic; (d) The abortive.

I am aware that many writers have given many more varieties of this disease, but these four were all that came under my notice during this epidemic. I regret not having had an opportunity of performing a post-mortem on any of the victims of this disease, and must therefore leave the pathological changes completely out of this paper.

Of the 24 cases seen by me the following tabular summary will present the main features, while details of some of the cases follow:

Type.	Number of Cases.	Deaths.	Recovery	Sequelæ.
Foudroyant or Severe	6	5	1	The case which has recovered has complete paralysis of legs. Muscles are atrophied.
Ordinary	14	0	14	Four cases have more or less residual paralysis either of arms or legs; all are able to walk but one poorly.
Chronic	8	0	8	One case has paralysis of left upper arm with atrophy of Deltoid.
Abortive	1	0	1	

N.B.—No lesions of special senses were left as sequelæ in any of the cases which recovered. It will be noticed that in 32% of the cases which recovered there lingers some grade of paralysis, though in but two cases (10%) is the paralysis severe enough to interfere with locomotion.

It was July 1st, 1905, that I was called to see my first case. I found the patient, a boy of thirteen, in bed, to all appearances not very ill. His temperature was 103° F., pulse 120, respirations 26 to the minute. The history of the case was of little importance. The boy was at a pic-nic the previous day, and was taken very suddenly ill with vomiting and a most distressing headache, principally frontal. Upon examination I found total paralysis of the legs; the back muscles were not involved at this time, nor were the arms. A peculiar feature of this case was a well-marked dysphagia present. Respiration was uneven and at times of the sighing character. The pupils were dilated, even, and responded to light quickly. There was a total loss of appetite, and the vomiting, which was of the projectile character, gave the patient but little relief. There were no skin symptoms, save a small patch of herpes on the left cheek. The child suffered from pains in joints and back, and especially in the nucha. There was some rigidity of the neck muscles, but not at all marked. The mind was clear and remained so until death, which occurred the following day from paralysis of the breathing centre. This case was

ill just 48 hours. The paralysis was of the ascending spinal type, and prior to death the child had power to move only the head.

I had very little opportunity of studying this case in the early stages, for I think the boy must have been ill for a day or two and did not tell his parents. The vomiting ceased on the second day, as was the case in at least 95 % of the patients I saw with the disease.

My second case was more characteristic. The child was six years old, and had been complaining but a few hours when I was called. I found the temperature 102° F., pulse 140, rapid breathing and almost constant vomiting.

The face was peculiar in appearance and looked as though the child had been frightened. She complained of pains in the neck and legs, also in the arms, in fact the child presented many of the symptoms of a severe influenza (which, by the way, in its nervous form is not at all unlike meningitis). Photophobia was marked, so much so that the patient sought darkness as soon as the first ray of light appeared. The child was very restless, could not sleep, had muscular twitchings and a well marked retraction of the neck muscles. Upon closer examination I found Kernig's sign present, and upon the establishment of this important symptom I concluded it was meningitis of the cerebro-spinal type. In this case the skin presented a few small spots similar to those observed in typhoid. The urine was albuminous. Upon the second day the vomiting ceased, diarrhoea replaced the constipation of the first day, delirium became more muttering in character, headache more intense, paralysis of the legs, body and arms, in the order mentioned, developed, and on the third day the little one passed away, death having been caused as in the first case by failure of the breathing centre. The headache in this case was frontal, though at times it radiated to the base. The mind was never clear, nor did the face ever resume its normal expression. Opisthotonos was a marked symptom the first day and part of the second, but disappeared to a great extent before death. Rachialgia and cephalgia were marked symptoms. In this epidemic the latter symptom was much more constant than the former. In neither of the above cases were the organs of



special sense affected other than the photophobia already mentioned.

My next case was rather more fortunate. It belonged to the ordinary or mild type. I found the child with a temperature 102° F., pulse 120, respirations 26. The patient complained of pains in the neck and limbs; there was vomiting, headache and general restlessness. The mind was clear, the skin presented no spots, constipation was marked. I found Kernig's sign present, which was very easily obtained as soon as the child was asked to sit up in bed. Paraplegia developed on the second day, and extended as high as the lumbar muscles. In five or six days the temperature became normal, and in three weeks the patient was in excellent health, except that the paralysis persisted. This case has made a complete recovery, being now able to walk without the spastic gait.

I shall just mention one case more, illustrating the foudroyant type of this disease. A boy, aged sixteen years, previously in good health, drove ten miles to my office. Upon getting out of the buggy I noticed him fall suddenly to the ground. I assisted the lad into the office, and upon examination found he was suffering from meningitis. I immediately had his father drive him home, where he died some twelve hours later. This boy was ill about twenty hours.

I shall not take up space discussing the abortive type. I saw but one case, which to all appearances was typical meningitis, but the child was perfectly well within three days.

The symptoms I found most constant in this epidemic were :

(a) Vomiting. This was the earliest manifestation of the attack. It was present in every case, always of the same character, though not so severe in some cases. Projectile vomiting was characteristic.

(b) Pains in the legs, back and neck.

(c) Headache.

(d) Kernig's sign. I found this sign present in twenty-two of my cases. I consider it of all symptoms the most reliable.

(e) Constipation was common at the beginning, though diarrhoea often set in within a couple of days.

(f) Opisthotonos was noticed in many cases, the head in some cases was drawn completely back between the shoulders. In one case I noticed pleurosthotonos.

(g) Photophobia was observed in but three cases. I considered it rather rare in this disease.

(h) Paralysis was present in some form in every case. It sometimes appeared on the second day, but usually not until the third. It is worthy of note that while many observers have written on the absence of this symptom in meningitis of this origin, I have to record the very opposite. I did not see one well marked case that was not paralyzed. The character of the paralysis was not always the same. Usually the legs were paralyzed, occasionally the arms, and in one case I observed paralysis of the face. I would consider facial paralysis in cerebro-spinal meningitis the exception.

(i) Delirium. In nearly every case the mind was more or less disturbed; sometimes the delirium was of the wild, excitable character, but as a rule it was of the low, muttering variety.

(j) Albuminuria was present in about half the cases.

Epidemic cerebro-spinal meningitis is a microbic disease caused by the *Diplococcus intracellularis*. It is supposed that the pathogenic agents enter through the nose and throat. Other microbes have been found in the exudate, but it has been generally accepted that the one mentioned above is the real causal factor. The disease usually attacks un-hygienic houses, in which live as a rule delicate children, but in this epidemic the strongest children were the ones first attacked. During this epidemic moisture in the atmosphere seemed to favor a fresh outbreak; heat had but little influence.

*Contagion.* That epidemic cerebro-spinal meningitis is a contagious disease is now, I think, thoroughly established, though many physicians hold to the old belief that such is not the case. I am glad to say that the way is somewhat more easy for those who believe in isolation, since the Sanitary Journal of the Provincial Board of Health now classifies this disease among those that should be quarantined. The period of incubation has been stated to be from three to eleven days. I believe the contagion is carried in the clothing and bedding of the sick room.

The treatment of meningitis of this origin has been in many cases most futile. I believe nearly all the severe cases will die. A large percentage, say 75 % of the ordinary type can be cured, and all the mild cases will recover. Many drugs have been used in this disease, such as ergot, pot. iodi., pot. brom., sod. salicyl., salicylic acid, calomel, opium, &c. I do not think any of these drugs have much influence in modifying the course or termination of this disease. In three cases I used diphtheria antitoxin. They all recovered, but they did not belong to the severe type. The best results I obtained were from sod. salicylate and hot baths. I am of the opinion that hot baths, say water at a temperature of 106 to 108, is a measure worthy of much consideration. Of course, a dose of calomel and soda is good to start with, but I found nothing to replace the hot bath. In many cases not having the means of putting my patient into a bath-tub, I applied the heat by means of bricks. Take three or four brick and heat them in the oven, then soak them in boiling water for a few minutes, after which they are wrapped in dry flannel and placed under the sheets around the child, being careful not to come in contact with the flesh. The steam that arises from the brick acts well and to all appearances is quite equal to the bath. The effect is seen at once in quieting the child and relieving pains. The ice cap was used in every case. I am very doubtful if it has much influence. It is necessary to have the hair clipped to get the best results. Sod. salicyl, in fairly large doses, seems to have a favorable influence in lowering the temperature and relieving pain. 'Tis very important to keep the patient's strength up by nourishment easily digested. I have had no experience with lumbar puncture in the treatment of this disease, but from what I have read it would seem to have little influence. The patient should be in a very quiet part of the house, in a room free from bright light, but well ventilated. Permanganate of potash has given good results in the hands of many. I have found it a good drug in cases of auto-intoxication, and doubtless it would have a favorable influence in counteracting the poison of this disease.

This epidemic was much more severe at the beginning than towards the end. All my fatal cases occurred in the first

nonth. One peculiar feature of this epidemic was the absence of skin-complications. It would take a vivid imagination indeed to call it spotted fever. I saw some spots in one case only. Herpes was noticed in a few cases, it usually appearing on the cheeks or lips.

As a prophylactic treatment, I believe the mild anti-septic nasal spray is by far the best. Of course it is necessary to keep children away from the disease as much as possible. I employed the spray in a large number of cases living in the neighborhood of the disease, and not one of those children were attacked. I would strongly recommend it in every case should an epidemic appear.

The prognosis of this disease is unfavorable when ushered in with coma, convulsions intermittent respirations. As a rule the cases classified as the foudroyant will not recover; if they do, they usually leave behind them deformities that are worse than death. Many cases of the milder type will recover with proper treatment. It is well to be guarded in stating that any case will recover, for remissions often occur, and the patient often succumbs to the second attack.

Diagnosis of epidemic cerebro-spinal meningitis is sometimes very difficult. It is necessary to differentiate from typhoid, influenza, purpuric fever, typhus, rheumatism, myelitis, brain disease (as softening) tubercular meningitis, pneumonia, &c., &c. If one is careful to observe the suddenness of the attack, the character of the headache, the pains in the limbs and back, the retraction of the neck muscles, and, above all, these symptoms being associated with Kernig's sign, one is usually able to make a positive diagnosis. Kernig says that his sign is never found unless a meningitis exists. Other observers are alike positive. I found it in twenty-two of my cases. In order to properly demonstrate it, it is necessary to have the patient sit in bed.

J. E. MURPHY.

Pakenham, Ont.

## NOTES OF A EUROPEAN TRIP.

(Continued.)

OMITTING details of our travelling in Southern Italy, visiting Pompei, Naples, Rome and Florence, our next visit was at beautiful Venice, where we remained for three days. We arrived at 10 p.m., and while the rain poured down in torrents we were escorted to the waiting gondola and conveyed to our hotel facing on the Grand Canal. The next morning found us strolling through the streets, where never a horse is seen, till we reached the famous square of St. Mark's and the celebrated cathedral of the same name. What the hansom is to London streets, so the gondola is in this lovely city with its watery avenues, and we thoroughly enjoyed the luxury of seeing various points of interest as our craft was sent along by the sturdy gondolier. We admired the skill with which these graceful craft are propelled around corners and past other gondolas in the narrow canals with just an inch or two to spare but never colliding. We visited several of the glass factories for which Venice is noted, and watched the interesting process of manufacture.

Heretofore our time had been occupied in the manner of the average tourist, now we began the professional pursuit of our trip by going out on two successive days to the old University town of Padua to see the work of the surgeon whose fame has become universal through the operation for the radical cure of inguinal hernia which is associated with his name Bassini. Less than an hour's ride by train from Venice was occupied in the journey, and proceeding to the hospital we found the surgeon engaged in his clinic, with about fifty students in attendance. He received us courteously, our cards having been sent in to him, and enquired what language we wished to speak to him. Here we received our first impression of the linguistic ability of the continental surgeons we met from time to time who seemed to be able to converse in any number of languages, while two of our party at least were painfully conscious of the paucity of our own resources in that line.

The surroundings of Bassini's clinic were not luxurious, he worked with but one male attendant, and threaded his own

needles. The trained nurse was conspicuous by her absence : but we caught occasional glimpses of a couple of elderly women doing orderly work. On our way to the operating theatre we passed a patient being prepared for operation by a male attendant. The patient was lying stark naked on a zinc covered table and was receiving a vigorous bath in a manner which I am sure a patient in this country would have stoutly resented. This also we noted, especially in Vienna, that patients received but scant courtesy, and in many places were treated as if they were cattle.

The personal preparation of Bassini and his assistant was very thorough. They spent a long time in scrubbing up, and finally, clad in long rubber aprons and with arms bared to the shoulders they took handfuls of absorbent wool and dipping in a large basin of bichloride solution splashed the solution vigorously over arms and aprons, and were then ready to proceed with the operation.

We got the impression that it probably would be a good thing for Bassini to pay a visit to some of our hospitals on this continent, and this was confirmed when we saw the great contrast in the surroundings of Mickulicz's clinic at Breslau.

Leaving Venice in the early afternoon we were soon passing through the magnificent mountain scenery of the Austrian Alps, and arrived in Vienna the following morning in time for a late breakfast.

We went at once to the great general hospital. The numerous buildings cover a very large area, spacious courts, well supplied with shade trees and seats for the convalescent patients, separating the various clinics. While making enquiries as to the hours for the visiting surgeons, we were fortunate to meet an energetic American surgeon. He has a large private hospital in San Francisco and does a large amount of surgical work. He said, "Gentlemen, I come over here every three years to see what is doing. I am not here for fun. I have been here for three weeks and I will be glad to put you on to what I think is the best to be seen here." He spoke German fluently, and from this fact and the lavish use of tips he seemed to have the right to go where he pleased about the vast hospital, and we found his kindly proffered services invaluable. We

met him again in Paris, where he had preceded us, and found him as energetic as ever. One little incident will serve to illustrate the push of this surgeon. At one of the large clinics he handed his card to the chief surgeon in charge, and politely requested to see some of the work being done. He was treated discourteously, and there and then resolved to teach this particular surgeon a lesson. What could you do? we queried as he told us the story. "I'll tell you what I did do", he replied. "The surgeons here are appointed by the government and receive salaries. I went to our American consul and stated my grievance. He at once gave me a letter to the Minister of the Interior, who gave me a formidable looking document with a big seal attached ordering this surgeon to show me anything and everything he had in his clinic. When I presented this document to him you should have seen his jaw drop." "Why did you not tell me you were such an important personage", he said, "certainly I will show you everything".

The time spent in Vienna was entirely occupied in clinical work. After a hasty continental breakfast of coffee and rolls we reached Eiselbergh's Clinic at a quarter past seven in the morning, and for two hours observed the work of this famous surgeon. The rest of the day, often until 7 p.m., was spent in visiting clinics, such as skin, venereal, orthopædic and gynaecological. We saw some very fine plastic surgery and were especially pleased with Moorhoff's work in tubercular diseases of bone. After clearing away all diseased tissue he fills up the cavity, whether in shaft of bone or joint, with his iodoform "plombage", and applies an abundant dressing, which is not disturbed for ten days. One morning we were shown sixteen cases which had been operated on at different periods and all were doing well. The next morning he demonstrated his method to us by operating on a case of osteo-myelitis of the femur and excising a tuberculous ankle.

Of course we visited Lorenz's clinic.

Before leaving Canada an item had appeared in the Montreal press giving the names of the individual members of our party, and stating that we would visit Lorenz. You can imagine our surprise when we first visited his clinic to be greeted with a genial smile and outstretched hand, and the

words "Yes, gentlemen, I was expecting you. A gentleman from London, Ontario, who is here with his little daughter, handed me a newspaper clipping the other day, telling me that you were coming to see me". We saw a great variety of orthopedic work and his special operation for congenital dislocation of the hip.

From Vienna we went to Breslau and spent three days with that great surgeon, Mickulicz, who only a few months ago passed to his reward, a victim to inoperable cancer of the stomach. He seemed active and in good health when we were with him, but six months later Eiselberg performed a laparotomy, which was only exploratory. He was only 55 years of age and had gained a world-wide reputation. We saw him do the first two operations in the cabinet which he had invented, in which under lowered air pressure he operates on the thorax exposing the lungs the patient's head being outside the cabinet with rubber fitting closely about the neck. In his clinic we certainly saw the finest exhibition of aseptic scientific work which we saw on our tour, and he had the best assistance in the way of intelligent trained nurses. This was easily explained by the fact that he had travelled a great deal in England and America, and just a year previous to our visit to him he had spent three days with the Mayo brothers at Rochester, Minn.

Six hours' railroad ride brought us to Berlin. Here also we found ample opportunity for seeing good surgical work in such clinics as those of Bergmann, Israel and Landau. At the latter our party took a special course in cystoscopy, and received very valuable instruction in the use of the Nitzke instrument. From the large number of patients attending the clinic we had practice in catheterizing the ureter daily in at least four bladders, and so came to think that like in many other cases it was easy when you knew how.

We had the pleasure also of attending the elaborate functions at the opening of Koenig's new clinic -- a very costly and elaborate structure. Representatives of royalty and the government were present in all the glory of gorgeous uniforms.

From Berlin we journeyed by way of Cologne to Paris. Here we stayed a full week, and after devoting the morning



hours in Tuffier's clinic, we spent the rest of the day in sight-seeing.

Tuffier has been a prominent exponent of spinal anæsthesia, and we saw him perform several operations under this form of anæsthesia with perfect success as regards freedom from suffering and the absence of any untoward symptoms.

Crossing from Calais to Dover we were glad to see England's shores once more, and found ourselves in London on the evening of the last day in May, just in time to go out to Epsom Downs on the following day to see the Derby. It was twenty years since I had been in London before, and in visiting the various hospitals it was gratifying to note that the metropolis was keeping pace in the matter of lavish expenditure for equipment of surgical theatres and operating rooms.

Among other surgeons we saw Sir Victor Horsley, Pearce Gould, Hurry Fenwick, Morris and Barker. We spent two weeks in the metropolis, and were greatly pleased with the opportunities afforded for seeing surgical work. Of special interest were our visits to Freyer at St. Peter's hospital, and we were fortunate to see him demonstrate his operation of suprapubic prostatectomy. After the operation he provides very free drainage with absorbent dressings, which are frequently changed. Readers of the B. M. Journal are familiar with the great success which has attended his special work.

The impression was gained that if one had but a limited time at his disposal, it would be greatly to his advantage to spend it among the London hospitals. At Liverpool a visit was paid to the Royal Infirmary, and it was evident that much good work was being done there. A delightful trip across the Atlantic and up the noble St. Lawrence to Montreal brought our three months' trip to a close.

W. G. ANGLIN.

## CLINICAL CASES.

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### DEATH FROM CARBOLIC ACID BURN.

E. H., aet. 13, a convalescent in Strange Ward, General Hospital, on March 18th, 1905, while up and about the ward accidentally poured pure carbolic acid over her scalp and cheeks, none entering the nose or mouth.

I saw the patient in from five to ten minutes after the accident and found her in a state of collapse. The scalp and cheeks were coated with a white eschar, the respirations rapid, pulse weak and very rapid, and child murmuring incoherently and unable to stand, being supported by the nurse, who was applying alcohol.

The patient was immediately placed in bed, burned parts kept soaked with alcohol (methyl), a hypodermic of strychnine given, warm blankets and hot water bottles applied to the body, and the bed foot raised. She was given mag. sulph. one ounce in a pint of hot water by the rectum, and this was retained. This was given in view of the possibility of some of the carbolic acid being absorbed into the blood, though the alimentary canal was evidently not the channel of absorption, as the mouth and lips showed no sign whatever of carbolic acid cauterization. Half an hour after the administration of the mag. sulph. a pint of hot normal saline solution was given per rectum.

During this treatment we could note more carefully the condition of the patient. The pupils were somewhat contracted, and this was the only symptom which seemed to point to carbolic acid absorption. Towards the last I was informed the pupils were dilated (for before death I was called to another part of the building). The respirations were simply those of shock, rapid, shallow, sighing, with some frothy mucus at the angles of the mouth. A specimen of urine was drawn off about twenty minutes after the patient was placed in bed. It was of a pale yellow color, which was significant, though not conclusive, of the absence of carbolic acid in the urine, and hence in the blood; for if the patient's symptoms were par-

tially due to the action of carbolic acid on the blood, its action on the blood cells would have occurred and would have been manifested almost immediately in the urine by the dark color of hæmoglobin. No chemical examination was resorted to, for time would not permit. The child gradually sank and died within two hours.

The clinical picture presented was that of shock, excepting, perhaps, the contracted pupil, for which there is a possible explanation if we consider the region of the body burnt by the carbolic acid. The burnt region has for its cutaneous nerve supply the fifth nerve, through its supra-orbital branches. The fifth nerve also supplies the iris along with the third nerve, which supplies the circular fibres of the iris. The different impulses sent in from the burnt region were strongly stimulating and ultimately paralyzing to the medullary centres, and set up the condition of shock, but at the same time those impulses were stimulating to the 3rd nerve through the lenticular ganglion, and caused the contracted pupil. This is only a possible explanation, but considering how improbable is the absorption of carbolic acid from skin surfaces, owing to the coagulum it produces, and the fact that burns of the scalp are most productive of shock, and therefore most fatal, it seems only right that in this case we should attribute death to shock alone. However, in view of the discussion of, and differences of opinion on, the absorptive powers of skin surfaces, we cannot absolutely assert that some carbolic acid was not absorbed through the skin and so reached the blood.

#### RUPTURE OF KIDNEY.

WILLIE D., *æta.* 12, was run over by a hotel bus containing four passengers besides the driver, and, according to on-lookers, both wheels passed over the ventral surface of the body. After the injury, with the assistance of a companion, he walked home. Being near the scene of the accident I was called to see the boy.

I found him lying in bed, complaining of some pain, but presenting none of the appearances of 'shock'. Pulse was 80, regular and good tension. On examining the body found a bruise in the right hypochondriac region, about the lower border

der of the liver, with the skin somewhat abraded. This corroborated the story of the accident, which I was told during the examination. As the boy complained of pain and difficulty in taking a long breath, I gave a hypodermic of morphia, gr.  $\frac{1}{16}$ , and strapped the right side in the region of the bruise with adhesive, though the ribs were quite intact. On account of the boy's general condition I doubted the story somewhat of the accident. I left him resting quietly and went to my office. About an hour afterwards I received a message to go up at once to see the boy, and found that his mother was very much alarmed by the passage of urine intimately admixed with blood and containing several clots. This pointed to bruising at least of the right kidney, and the skin bruise over the lower border of the liver supported this view. On examining the boy I found now evidence of shock—pulse 120, weak and thready, anxious expression of the face, rapid and shallow respirations and cold, clammy skin; in fact the typical features of 'shock'. At the same time I revised my opinion as to the credibility of the story and thoughts of ruptured intestines as well as bruised kidneys came into my mind.

An ice bag was applied to the right lumbar region. Tincture nux vomica and whiskey were given by the mouth for a short time, and morphine (gr.  $\frac{1}{8}$ ) at four hour intervals was begun. Heat was applied to the feet. The boy's condition improved somewhat under this treatment until the evening of the second day, when the boy's temperature was  $102\frac{1}{2}^{\circ}$  F., pulse 140, and he became delirious, lying all night in a semi-conscious condition. The urine still continued to be bloody. The third day vomiting set in and became quite persistent, temperature and pulse remained the same, but the urine ceased to be bloody. Started using hot normal saline solution, one pint every six hours per rectum. Examination of the abdomen showed it tender and quite tympanitic and distended. Under the influence of the salines the bowels moved on the morning of the fourth day, and as no food could be retained by the mouth nutrient enemata (peptonized milk, three ounces) were started every four hours. The morphine was still given by the mouth, and part of it was retained. The evening of the fourth day showed the temperature  $102^{\circ}$  F.,

pulse 120, with better volume, abdomen much the same.

On the fifth day, the bruised kidney being still in mind, we started urotropin, gr. v., every four hours by the mouth, and bismuth subnit. gr. v. every six hours. The vomiting was less, but the nutrient enemata was still kept up with hot salines at intervals which served to encourage evacuation of the bowels and elimination by the kidneys, as well as keeping up the blood tension.

On the sixth day the temperature kept between 99 and 100, pulse 100 to 108, urine clear, abdominal distension less, tenderness less, the bowels evacuating themselves two or three times. Started milk by the mouth in small quantities, nutrient enemata at intervals of six, afterwards eight hours, as the amount of milk was increased.

Recovery was uninterrupted until the ninth day, when there was a return of the hæmaturia, quite as severe as the primary hemorrhage. The temperature went up to 100°, pulse 90 to 100. The hæmaturia persisted in spite of heroic doses of F. E. ergot (half drachm every four hours kept up for 36 hours). As we could get no effect from the ergot, we resorted to Basham's mixture, and he was kept on this until about three weeks after the accident, when he was able to walk about. In regard to the effect of Basham's mixture I found that the hæmaturia ceased gradually, and at the end of the week blood ceased to be apparent by inspection in the urine, though albumen was present for some time.

W. GIBSON.

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### STAB WOUND ALMOST SEVERING FEMORAL ARTERY AND VEIN.

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On the evening of May 1st, a boy aged sixteen years was admitted to the surgical ward of the Kingston General Hospital suffering from a stab wound in the inner part of the left thigh about the lower third.

The patient's condition, was one of nervous excitement and marked anaemia from repeated haemorrhages. The lips were bloodless and pulse ran about 120 and was of extremely low tension. A tight bandage had been applied over the wound the previous day to stop a haemorrhage, and in the meantime the limb below the point of injury had become very oedematous.

The following history was elicited from the patient : About one month previous to this date he was stabbed in the thigh by a schoolmate, the weapon used being a large pocket knife. An alarming haemorrhage resulted, but was fairly well checked by a handkerchief twisted tightly around the limb. A Doctor was sent for and the wound antiseptically treated, haemorrhage during this operation giving no trouble ; dressings and a bandage were then applied. It was not long however, before another severe haemorrhage occurred, and was with great difficulty brought under control. The patient gave a history of several such haemorrhages occurring within the past month ; the last severe one having taken place the night before entering the hospital.

The first step in the treatment was to elevate the limb on pillows and apply a tight bandage from the toes up to within a short distance of the wound. Fresh dressings were then put on, and the bandage continued over them, putting firm pressure on the dressing pads to prevent bleeding. Next morning the dressings were removed for the purpose of further investigating the extent of the injury. A most alarming haemorrhage of arterial blood followed and was controlled by an Esmarch's tourniquet bound tightly around the thigh. It was then decided that operative interference could no longer be delayed and the patient was prepared for the operating room. A nutrient enema was given about twenty minutes before the operation. On the operating table one Esmarch's tourniquet was applied high up on the thigh bearing strong pressure on the femoral artery, another was bound tightly around the leg, below the knee to prevent any venous flow. The wound was then carefully cleansed and the field of operation prepared in the usual way. An incision about two inches long was made along the length of the limb from the upper corner of the wound. On cutting through the deep fascia a large hematoma was en-

countered and the blood clots turned out. The femoral artery was found almost severed, a small strip of artery wall holding the two ends together. This was divided and the two ends tightly ligated with strong heavy cat gut. Oozing of blood still continued and on further investigation the femoral vein was found slit for one inch along its length. The question then arose whether the vein should be sutured with fine silk or firmly ligated with catgut as the artery. Objections to the former course were the danger of phlebitis and infected thrombi. Objection to the latter was gangrene of the leg from impaired circulation. The latter course however was followed and the long saphenous vein depended upon to return the blood. A few sutures of silk worm gut were then put in the flesh wound; the cavity of the hematoma thoroughly flushed out and gauze (iodoform) inserted. The necessary dressing pads and bandages were then put on. Rectal injections of salt solution were given every four hours and continued the next day, the patient's bowels having been thoroughly flushed out by an enema that morning. Sips of whiskey and mouthfuls of albumin water were given at intervals. That afternoon the patient's temperature was 100° pulse 125, and during the following few days the temperature ran between 99° and 100° and pulse 110 - 125 and often irregular. The condition was closely watched for any symptoms of deficient circulation through the limb and for phlebitis and thrombosis. The wound was dressed every second day.

The boys' condition improved till May 10th, when the temperature took on a septic character and continued so for a few days before the cause of trouble could be located. The leg was becoming more and more flexed on the thigh and any attempts to move it caused intense pain. A small tumor showed itself at the upper part of Hunter's canal; an opening was established between it and the wound, and a large quantity of pus evacuated. The temperature which had once reached 104° dropped that night to normal. The next day the patient was put under chloroform; a counter incision was made on the inner side of the thigh, over the site of the tumor, and the pus forming membrane thoroughly curetted away. Free communication was established between the two openings, large quan-

ities of peroxide were freely used to clean out the tract, and this was followed by a thorough flushing with sterile water. Iodoform gauze was inserted and the wounds dressed while under the anæsthetic.

The adhesions around the knee were slowly broken down by straightening the leg and the limb then kept in the extended position by firmly bandaging it to a well padded posterior splint.

That afternoon morphia had to be given for the pain, but the patient's condition otherwise was good. The wounds were dressed every second day and the limb gently flexed and extended.

In ten days the splint was removed and the patient allowed to walk about with a crutch and cane. Balsam of Peru was used with great advantage in healing the wounds.

By June 12th the patient was in good enough condition to leave the Hospital and go home. He was then able to walk without the aid of a cane, and very little lameness could be detected.

J. Y. HOGAN,  
Kingston General Hospital.

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### MOVABLE KIDNEY

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I have no wish to compile an elaborate statistical article on the above subject, but desire rather to offer a few remarks with the hope that they may be of some practical benefit to the general practitioner. Movable kidney is a very important exciting factor of a group of symptoms, which though quite common are often times obscure and perplexing, and I believe a displaced kidney is very frequently overlooked by a busy physician.

If we examine the extensive connection there exists between the nervous supply of the kidney and that of the other abdominal organs, we can readily understand why disturbance of the



renal nervous equilibrium may be accompanied by symptoms referable to these other organs and the importance of a clear understanding of this relationship will, I trust, excuse the following anatomical references.

The kidney is supplied by the renal plexus of the sympathetic system. This renal plexus is derived from the solar and from the aortic plexus while through them, it is connected with tracts in the spinal cord and with the pneumogastric nerve. Normally the kidney is held in its place partly by the peritoneum and the perirenal tissue, but chiefly by the apposition of the contiguous viscera. The support afforded by these viscera is dependant on the tension of the anterior abdominal parietes and should therefore the support afforded by these walls be withdrawn, as can occur, the result of repeated pregnancies, advancing age, obesity, &c., then the structures contained in the abdomen will "sag" or fall downwards, and since the kidney can rely very little on its own direct attachments to posterior wall, it naturally follows that displacement of this organ will be a prominent feature in visceral ptosis.

When the kidney is displaced its support is thrown chiefly on the renal vessels and in the renal plexus of nerves that surrounds these vessels with the result that there is manifested reflex disturbance of the organs and especially of the stomach. This is evident in the gastric derangements that almost invariably accompany movable kidney. Another affect are abdominal sensations which while obscure and ill defined are yet of such a nature as to render the patient's life miserable. These sensations are frequently of a dragging, "gone" character and begin after the patient has been on her feet for an hour or two, and thus almost prohibit the performance of ordinary household duties. This constant impression on the solar plexus wears her nervous system generally and neurasthenia results. This termination is assisted by the interference with the nervous control of the liver and intestines which tends to result in imperfect assimilation and consequent auto-intoxication. Appendicitis, too, is frequently an accompaniment of movable kidney and is caused by the pressure of the kidney on the return circulation from the appendix causing a chronic congestion. As stated above we believe that in many cases of movable kidney, the condition is

overlooked and feel justified in urging the importance of its recognition in view of the want of success attendant on treatment directed to the symptoms rather than to the cause thereof.

TREATMENT--Have the patient wear a binder, being a woman she will readily understand how the binder should be made, when you explain the object is that of supporting the abdominal contents from below upwards. To accommodate the width of the pelvis tell her to insert a "gore" over each hip. Let her use three or four straps and buckles, (vest buckles will serve the purpose satisfactorily) drawing the lower ones tightly enough to serve the purpose of support. Have her take the measurements while lying down, and if when applied, the binder tends to slip upwards let her use perineal tapes.

I have very rarely had to employ a pad in front of the kidney, any additional support thus gained is more than counterbalanced by the discomfort of the direct pressure. The binder if properly made and applied takes the place of the relaxed abdominal muscles, and thus relieves the strain in the solar plexus. In a comparatively small number of cases this mechanical support will not be sufficient--the symptoms still continue and the patient's life still miserable. You are then justified in proposing operation. There are a few points in connection with the operation of nephrorrhaphy I would draw attention to; one is the suturing of the organ in a position as closely approximately the normal direction as possible, another points to the method of applying the sutures.

In my earlier operations I sutured the capsule alone, but in these cases the sutures were not ultimately successful. I next introduced the sutures deeply in the renal structure and later on employed transverse sutures involving a considerable extent of the organ. The ultimate results in some of these cases were not very satisfactory, the history of these being that the patients returned after a few months stating that some sudden strain, as lifting &c., caused the kidney to become displaced.

In a review of the progress of surgery during 1902 by Watson & Cattell in *International Clinics* vol. 1, I noticed reference to a new suture for friable organs employed by Max Brodel, and being discouraged with the results of the other

methods as described for anchoring the kidney I tried Brodel's suture.

This method, which is simple and easily followed, I have employed five times during the last three years, and with excellent results in four of them. One of the patients was confined about a year after the operation without any material displacing effect on the kidneys, so her physician states. Three I have since examined, and found the kidney apparently in its normal position, while the last one is still in hospital, having been operated on about two weeks ago. The method referred to is as follows: Introduce the suture (I use kangaroo tendon) through the quadratus lumborum and its fascia, seize one end of the suture with artery forceps, then pick up the renal tissue for about half an inch in length and depth, then re-introduce the needle at the distance of about half an inch from exit of first loop and so on, making three loops or bridges, and then carrying the needle through the quadratus and fascia tie it to the end held in the artery forceps. These bridges of renal tissue prevent the suture from tearing out and, according to Brodel, will support three times as much weight as the straight suture. The lower end of the kidney is sutured in a similar manner.

D. E. MUNDELL.

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## SURGICAL NOTES.

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### COMPOUND FRACTURES.

CASE I.—Miss L., aet. 23, in a runaway accident was thrown from the wagon and sustained besides minor injuries a compound fracture of the right humerus. The fracture was cleanly transverse of the shaft, about one and a half inches below the head, and the upper end of the lower fragment punctured the flesh and protuded against the right breast, more than an inch of bare bone being exposed.

The accident occurred about 4 a.m., and the patient reached the hospital after a long drive and a railway journey some twelve hours later with a temporary dressing applied to the arm. Chloroform was given, and assisted by the house staff I proceeded to reduce the fracture. The exposed bone was cleansed with pure carbolic acid, followed by alcohol, and then covered with a sterile compress, while the surrounding skin was rendered aseptic in the usual manner with ethereal soap, bi-chloride solution, alcohol and sterile water. Then with a glass syringe hydrogen peroxide was injected forcibly into the wound, followed by sterile water, no stronger antiseptic solution being brought in contact with the lacerated tissues.

Reduction was now made by traction and manipulation, the index finger of the gloved right hand satisfying the surgeon that the ends of the bone were in accurate apposition, with no intervening muscular fibres. Retentive apparatus, consisting of coaptation splints and an external angular splint of poroplastic, was applied. The angular splint extended from above the shoulder to the wrist, and served to keep the arm at rest while the dressing of the wound was done. The patient's temperature remained normal throughout the treatment, and the result was all that could be desired. Six weeks after admission the patient left for home with good union of the fracture and without any retentive apparatus.

CASE II.—V. S., farmer, aet. 55, while inspecting a blast which had failed to explode, used a tamping iron in the hole. The sorrowing relatives did not attend the funeral, but the man was brought to the hospital with a series of compound fractures, viz., nasal bones, upper maxilla and right humerus. The tamping iron had evidently gone clean through the arm from within outwards and upwards, producing a compound comminuted fracture of the middle of the shaft of the humerus.

Dr. Freeman, of Inverary, had given the patient skilful attention, suturing the facial wounds and applying retentive splints to the arm. Twelve hours after admission to hospital under an anæsthetic the arm was cleansed in a similar manner to that of the preceding case and several pieces of bone removed from the arm, as they were almost completely detached from the surrounding tissues. Coaptation splints and an exter-

nal angular splint were applied, and the wounds dressed at intervals of two or three days. Here also there was no rise of temperature. At the end of four weeks' treatment the wounds had healed, and the ends of the bones being brought in apposition a plaster of paris bandage was applied to the arm from the hand upwards to a spica of the shoulder and the patient allowed to go home.

In 2<sup>d</sup> week the plaster bandage was removed and it was found that an excellent result had been obtained, with firm union of the fractured humerus.

The point to emphasize in these two cases is that no stronger antiseptic than hydrogen peroxide was used in contact with the injured soft tissues, and the sterile gloved finger used in exploring the wounds.

#### ACUTE INTESTINAL OBSTRUCTION.

CASE I.—A. B., aet. 17, a slightly built lad, was brought to hospital with a history of obstinate constipation resisting all efforts at treatment by cathartics and enemata extending over a period of five days. On admission the patient was found in a collapsed condition, temperature subnormal, pulse 120 and feeble at that, stercoraceous vomiting profuse. Instead of the usual distended condition of the abdomen it was found on palpation to be uniformly flat and resisting. Previous to operation the stomach was washed out with a 5 per cent. solution of salicylate of soda and a nutrient enema given. Laparotomy was performed by a median incision and the intestine and peritoneum found to be covered with small tubercular nodules. Numerous bands of adhesions united the intestines and a specially thick band passed over the ileum at its junction with the caecum. These bands were all broken down and the thickened and adherent appendix removed. At one time in the course of the operation the major portion of the small intestines were brought outside the abdomen protected by warm sterile towels. The abdominal wound was closed, and the bowels moved by enemata the following day. Recovery was uneventful. The patient came into hospital on May 9th, and left for home on the 1st June.

CASE II. —W., aet. 49, was brought to hospital for treat-

ment for intestinal obstruction. Efforts to relieve him had also extended over five days. His abdomen was very much distended and he complained of intense pain.

Owing to his age and the prominent symptoms, pain, collapse, tympanites and a sense of resistance in the left iliac region, volvulus was diagnosed. He received the same preparatory treatment as the previous case and a median incision was made below the umbilicus. The small intestine was enormously distended—a thick band was found running up from the left iliac region and crossing the ileum about three feet from the cæcum. This was divided and the portion of ileum beneath found to be gangrenous.

Traced downwards this band led to a mass in the pelvis the size of a child's head. This mass was enucleated and proved to be a lipoma. The abdominal wound was closed without resection of the gangrenous bowel, as the patient was rapidly sinking, and he died shortly afterwards.

The proper procedure in these cases of acute intestinal obstruction is undoubtedly to operate early, i.e., after twenty-four hours of medicinal treatment has failed to overcome the constipation.

The cases are analogous to strangulated hernia, and only harm can come from delay. Where stercoraceous vomiting has set in, washing out the stomach with salicylate of soda solution is desirable and leaves the patient in an improved condition for operation.

An early resort to operation in these cases should give as good results as those which are obtained after herniotomy for strangulated hernia performed as soon as the diagnosis is made. The mortality of cases treated without operation is fully 95 per cent., if not more.

#### A CASE OF GASTROSTOMY.

Mrs. L., aet. 63, was referred to me by Dr. J. C. Connell on January 19th last. She had been under his care at intervals for some months previously for stenosis of the œsophagus due to carcinoma. When I saw her it was impossible for liquid food to reach the stomach, and life was being sustained by nutrient enemata.

She was a farmer's wife, and her general health had been excellent up to this time. In consultation it was decided to suggest a gastrostomy with the view of prolonging her life and rendering it as pleasant as possible. The patient and her husband cheerfully consented to the operation, as we assured her that an ample supply of nourishment could be introduced directly into the stomach through the abdominal opening and all source of irritation removed from the diseased œsophagus. The patient was prepared in the usual manner and Kader's method of opening the stomach followed. A vertical incision was made from the costal margin over the left rectus muscle, splitting the fibres and entering the abdominal cavity. The stomach was gently drawn out of the opening with the fingers and the site for the incision chosen on the anterior wall remote from the pylorus and as high as possible. This site was seized with a pair of forceps and gentle traction maintained, while with a continuous suture of fine silk a sufficient area of the stomach wall was sutured to the peritoneum and fascia. A purse string suture of chromic catgut (fine) was then inserted close to the apex of the cone, and a second one about a quarter of an inch lower down around the stomach wall. These stitches passed through all the layers of stomach except the mucous membrane. With a tenotomy knife a small incision was made in the centre of the inner circle and a pure rubber tube with a lumen one fourth of an inch in diameter pushed through for a couple of inches and the first purse string suture tied tightly about it. Pushing on the tube invaginated the stomach wall and then the second suture was tied. Then three Lembert sutures on each side assisted in approximating the serous surface of the stomach wall to the tube and effectually guarded against any leakage. The stomach wall was then sutured to the adjacent skin, and superficial drainage provided both above and below the opening. The usual dressings were applied and some salt solution at once introduced through the tube into the stomach, and the outer end of tube was closed by compression forceps. This was followed a few hours later, when the patient had recovered from the anæsthetic by some six ounces of warm milk, and thereafter food was regularly introduced at intervals of two or three hours—milk, malted milk

and eggnog forming the dietary, while plenty of water was also given.

The wound healed nicely and the patient was very comfortable, but smilingly complained that the food did not *taste* very good. The patient left for home on Feby. 16th, taking with her a No. 12 catheter and funnel for introducing into the stomach at feeding time. The original tube was removed in two weeks from time of operation. It was confidently expected that life would be prolonged in this case from six months to a year or more, but about two months after going home the patient succumbed to an attack of apoplexy.

#### VAGINAL HYSTERECTOMY.

Mrs. F., aet. 50, was referred to me by her physician for curettage of the uterus, as from the clinical history he suspected cancer of the endometrium. The patient had but one child thirty years ago and no miscarriages. She had passed the menopause five years ago, but of late had occasional hemorrhages and profuse offensive discharges from the vagina. She was a spare, active woman, of neurotic type, and was not suspicious of the serious condition present.

Some years previously she had been informed that she had cancer of the left upper maxilla, and its removal by surgical means was advised. This was objected to, and after several months treatment by a specialist the tumor disappeared, but a large scar of the cheek remained due to the continued application of X rays.

The husband was therefore anxious that a positive diagnosis of cancer should be made before he would allow of such a formidable operation as complete hysterectomy. Accordingly the patient was anæsthetized, and the diagnosis made by dilating the cervical canal—the cervix was apparently normal—and curetting away fragments of tissue, which were readily obtained. The uterus was but slightly enlarged and was freely movable.

On examination Dr. W. T. Connell pronounced the disease to be columnar celled carcinoma of the body of the uterus.

After a few days the patient returned to her home and there was informed of the serious nature of the disease, and that her only hope for prolongation of life was the complete removal



of the uterus and ovaries. She decided to return to the hospital and submit to operation. The vaginal route was selected as being safer, although the vaginal outlet was so narrow as to require an incision into the perineum on either side to give the necessary room.

The patient was carefully prepared in the usual manner, and as a first step in the operation the cervical os was tightly closed by four heavy silk sutures. These were left long and facilitated the manipulation of the uterus. The mucous membrane, being divided transversely on the anterior lip of the cervix, was pushed up by the finger and handle of the scalpel and the bladder cautiously separated from the cervix—a sound in the bladder serving as a useful guide. The incision was now carried round each side and posterior aspect of the cervix and the recto-vaginal pouch opened with scissors. With an Olshausen's needle silk ligatures were placed successively on the uterine and ovarian vessels on the left side until the fundus was reached, the tissues between the uterus and the ligatures being divided with scissors. The uterine vessels on the right side were then similarly secured and the fundus delivered on the left side, when the operation was completed by removing the right ovary and tube from above. A few catgut sutures were applied to the vaginal vault, leaving only a sufficient opening for the silk ligatures and a strip of iodoform gauze for drainage. The vagina was then tightly packed with gauze, after the lateral incisions extending into the perineum had been sutured with silkworm gut.

The urine was now drawn off by catheter and was clear, proving that the bladder had not been injured. The patient suffered very little pain after the operation, but one hypodermic of morphia being required. The urine was drawn off three or four times each twenty-four hours for several days. The bowels were moved on the third day and the packing changed on the fourth day, and after that every second day, with careful cleansing of the vaginal vault with pledgets of cotton. The ligatures came away at the end of the fourth week, and a week later the patient returned to her home. The cancer involved the whole body of the uterus, but did not extend beyond, and the prospect for non-recurrence is very favorable.

W. G. ANGLIN.

## MEDICAL NOTES.

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AT the annual session of the Medical Council of the College of Physicians and Surgeons of Ontario, held in Toronto July 3-6, Dr. W. H. Moorehouse, of London, was elected President, and Dr. Wm. Spankie, of Wolfe Island, Vice-President, the other officials remaining as before. Considerable business was transacted, the work of the Discipline Committee being particularly interesting. The question of erection of a new building to house the administrative staff, &c., was also considered, and it was decided to keep the cost of such building within \$75,000, and to the Property Committee were left details of site, size and plans of new building. The Council decided to hold its next annual session in Kingston in July, 1907.

The seventy-fourth annual meeting of the British Medical Association, to be held in Toronto Aug. 21-25, promises to be markedly successful. Nearly 500 British members have signified their intention to be present. Among these may be mentioned such noted men as Sir Victor Horsley, Sir James Barr, Profs. Wm. Osler, Clifford Allbrett, Halliburton, Sims Woodhead, C. S. Sherrington, John Glaister, R. T. Hewlett, A. S. Grunbaum, Drs. W. S. A. Griffith, G. A. Gibson, H. Ashby, Gustav Mann, R. Muir, Armand Ruffer and F. W. Mott. As the Ontario Medical Association and the Canadian Medical Association meetings are to be merged in this meeting a large turn-out of Canadian medical men is assured. A large number of prominent American medical men are expected to be present and take part in the proceedings; in fact the programme of some of the sections is decidedly 'American'. This will give Canadians the opportunity of judging between the English and American leaders in the various departments and ought to prove not the least interesting part of the proceedings. An excellent social programme has also been provided by the Toronto people, so that business and pleasure will be well combined.